BODY-DISSATISFACTION IN WOMEN:

THEORY, GROUP COUNSELLING INTERVENTION, AND MEASUREMENT

by

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Abstract

While research indicates that women's body-dissatisfaction is an important and widespread issue in counselling, few attempts have been made to deal with this problem directly or systematically in a therapeutic setting. This author created a counselling intervention for women to increase their acceptance of and satisfaction with their bodies without changing the bodies themselves (through weight loss, exercise, etc.).

One of the major assumptions underlying the creation of the intervention was that, in order for a woman to begin to change her negative body image, she must first understand how her attitudes towards her body were developed and are maintained through socio-cultural influences. Self-acceptance was the key, and it was believed that the combination of an understanding of the origins of women's body-hatred, coupled with group support over a period of time sufficient to absorb new ideas and attitudes, was needed to bring about positive change.

A group counselling intervention of seven two-hour sessions, held over a period of seven weeks, was created. Each session focussed on a theme: (1) the Media and its influence; (2) historical perspective on body-dissatisfaction among women; (3) power (physical strength, control over the body, pregnancy); (4) menstruation; (5) fear of fat; (6)

sexuality; (7) aging and menopause. Sessions were a combination of information from the leader, group discussion, physical awareness exercise, readings, and homework assignments.

A new measure of women's body satisfaction was created in the form of a questionnaire. The author was not satisfied that existing scales measuring body-satisfaction were sufficiently comprehensive to give a true picture of a woman's feelings about her body. This new Questionnaire assesses a women's attitudes about her body and women's bodies in general in a much more broadly-based way. Preliminary tests of the Questionnaire suggest that it is both reliable and valid. The Questionnaire was administered both before and after the Workshop to an experimental group (12 women) who attended the Workshop, and a wait-list control group (16 women).

A t-test on the change scores from pretest to posttest revealed that the experimental group had improved significantly more than the control group, $t(24) = 2.65$, $p = <.01$ for a one-tailed test. In addition, the change from pretest to posttest was significant for the experimentals ($p < .005$ for a one-tailed test) but was not significant for the controls. Other analyses consistent with the conclusion that the Workshop was effective in increasing the experimental's body-satisfaction included: (1) the women's own subjective evaluation of their progress; (2) a significant correlation between leader ranking of participant progress with change scores; (3) anecdotal evidence from subjects' reports.

The thesis includes an extensive review of the literature of women and body satisfaction with a large list of references. In addition, a theory on the origins of women's body-hatred has been presented.

The Appendices offer a detailed description of Workshop sessions (including ideas presented, activities, homework assignments, resources, etc.) which should prove useful for the counselling practitioner. A copy of the questionnaire can also be found in the Appendix.

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Dedication

To Bram

With limitless gratitude

and

To every woman who has hated her body,

With compassion and understanding

Background Information

Statement of the Problem

While the overwhelming majority of women is deeply concerned with their bodies, there have been few instances where these psychological concerns have been taken seriously and explored either practically or philosophically (Harmon, 1973). Examination of the psychological literature for the last 10 years indicates that almost no one has attempted to address this situation directly or systematically with a therapeutic intervention.

One explanation for this is that women's body-dissatisfaction is taken for granted, ridiculed, or trivialized by the public in general (Berscheid, Walster, & Bohrnstedt, 1973; Chernin, 1981). Indeed, it is expected that even counsellors in the therapeutic setting may be unaware of the importance of this problem to their client's well-being.

Therefore, it was the intention of this thesis to review the theory and research associated with body-dissatisfaction, and create and assess the outcomes of a group intervention.

Research indicates that body disliking among North American women is a widespread phenomenon (Chernin, 1981; Douty, Moore, & Hartford, 1974; Friar Williams, 1976; Folb, 1979; Friedman, 1979; Garner, Garfinkel, Schwartz & Thompson, 1980; Kullman, 1978; Lasky, 1974; Leiblum, 1980; Pendergast, 1976; Sturdivant, 1980). In one study, as

many as 70% of high school girls were unhappy with their bodies and wanted to lose weight (Garner et al., 1980). Thompson (1978) reports satisfaction for only 2% of a sample of women examined. The highest estimate for satisfaction that had been reported in the psychological literature for the last decade was found by Berscheid et al. (1972). They conducted a study through Psychology Today magazine, and of their sample, 77% of women were pleased with their bodies. This figure is surprisingly high in light of prevailing opinion. Nevertheless, even relying on this statistic, there remains almost one-quarter of the female population dissatisfied.

Body-dissatisfaction among women is reflected in the epidemic number of anorexics and bulimics (Armillay, Arnold, Ashton, Grogan, & Weida, 1980) almost all of whom are female (Chernin, 1981). In addition, it is mostly women who enroll in diet organizations and who undergo surgery to lose weight or to change their physical appearance (Chernin, 1981). Even the most beautiful women hate their own bodies (Friar Williams, 1976).

Women's dissatisfaction with their bodies is an important therapeutic issue (Chernin, 1981; Friedman, 1979; Harmon, 1973; Pendergast, 1975; Sturdivant, 1980). Whether or not a women likes her body is an important and influential factor in how she views herself in the world (Douty et al., 1974; Kullman, 1978; Thompson, 1978).

Research has indicated that physical attractiveness is indeed an important factor in social interaction (Berscheid et al., 1973).

Harmon (1973), in her article on the subject of women and their bodies, proposes that women in North American society are striving to achieve an impossible ideal of female physical perfection. This impossible ideal, coupled with the importance society places on a woman's attractiveness, creates a situation which is likely to cause women psychological distress. "It is as though a school created a complete curriculum in only one subject and then programmed the majority of students into repeated failure experiences" (Harmon, 1973, p. 87).

The suggested consequences of women's body-hatred are many and profound, including: (1) the loss of self-esteem (Berscheid et al., 1973; Clifford, 1971; Douty et al., 1974; Garner et al., 1980; Haft, 1975; Harmon, 1973; Hendry & Gillies, 1978; Hogan & McWilliams, 1978; Kessler, 1979; Rabkin, 1982; Secord & Jourard, 1953); (2) anger both at society for its pressures and at themselves for being complicit (Harmon, 1973); (3) certain psychological disorders such as schizophrenia, neurosis, or depression (Marsella, Shizuru, Brennan & Kameoka, 1981); (4) addiction to alcohol or opiates (Weathers & Billingsley, 1982); (5) alienation from their bodies (Chernin, 1981; Friedman, 1979; Kullman, 1978; Slatkoff, 1983); (6) menopausal depression (which may have more to do with body image than with hormone changes) (Kullman, 1978); (7) anorexia nervosa and bulimina, which are appearing at an alarming frequency (Armillay et al. 1980; Ben-Tovim, Witehead & Crisp, 1973; Chernin, 1981; Slade, 1977; Taylor and others [sic], 1978; Wingate & Christie, 1978); (8) the physical and emotional consequences

of chronic dieting such as irritability, poor concentration, anxiety, depression, apathy, lability of mood, fatigue, social isolation, and, if body weight falls below a specific level, the cessation of normal menstrual functioning (Chernin, 1981; Garner et al., 1980); (9) negative menstrual symptoms (Cassidy & Ritenbaugh, 1982; Di Nardo, 1975); (10) competition among women which alienates women from each other (Friedman, 1979; Kilbourne, Vitagliano & Stallone, no date); (11) the postponement of the pleasures of life, in some obese women, until they become thin (Flack & Grayer, 1975; Rabkin, 1982; (12) poor sexual satisfaction (Berscheid et al., 1973; Friedman, 1979, Young, 1980).

Definitions

For the purposes of this study, the following definitions are given.

Body image. The perceptions, attitudes, emotions, and personality reactions of the individual in relation to her body: a plastic, dynamic entity which is continually being modified by new precepts and new experiences. This definition is a combination of Kolb's as reported in Marsella et al. (1981, p. 361) and Gorman's, described in Thompson (1978, p. 19). These were chosen because they defined body image as a subjective, changing, psychological experience.

Body-satisfaction. Expressed thoughts or feelings of satisfaction for one's own body.

Body-dissatisfaction. Expressed thoughts or feelings of dissatisfaction for one's own body.

Sources of the Body Image Literature Reviewed in the Thesis

The examination of the literature on body image included only literature dealing with women. Also, the population with which this thesis deals includes only "normal" women, so information concerning body image and physical (e.g., amputation) or psychological (e.g., schizophrenia) abnormalities received little or no attention.

Many of the ideas relevant to this thesis are presented in Appendix I of the thesis, which includes background information for each Workshop session. In this manner, the author hoped firstly to avoid repetition, and secondly to develop a more useful tool for the counsellor who may be interested in portions of this topic rather than the topic as a whole. For example, should a counsellor have a client who is experiencing body-hatred around the issue of aging, it would be easier for the therapist to gather relevant information if she were able to look in the part of the Appendix dealing with the women and aging session of the Workshop.

The above notwithstanding, a brief overview of the kinds of literature in the field of body image will be provided here. In her analysis of the literature, the author referred to three basic sources: scientific literature, feminist literature, and popular literature.

Scientific literature. The examination of the scientific literature covered material since 1973. It was decided that it would not be profitable to research this area over a longer period for several

reasons. First, the women's movement, which has changed the way women are seen in our society to a significant extent, began in the early 1960s and only gained momentum by the late 1960s. It wasn't until the early 1970s that attitudes and ideas generated by this movement began to filter into the scientific literature on counselling. For example, Harmon's article . . . And soma (1973) (which was philosophical in nature) seems to be the first evidence that people were beginning to think that women's feelings about their bodies might be an important variable in successful counselling. Therefore, it would have appeared anachronistic to review the scientific literature before the 1970s. Second, in moving from the the present backwards, in the psychological work of the last decade, the number of articles on body image decreases with each year, and the relevance to this thesis topic decreases dramatically. Psychological Abstracts 49 (1972) listed only 4 articles dealing with body image, while in 1983, 69 (covering only January to October) there were 21 articles. In addition, writers in the last decade refer back to few articles relevant to the topic of women and body-dissatisfaction. Those earlier references which seemed to have interesting and useful information were examined. Even within the last decade, however, there has not been a great deal of literature dealing specifically with the question of women's acceptance of their bodies from a philosophical perspective. For example, Harmon's article (1973), which was published in an issue of the Counselling Psychologist dealing solely with the issues surrounding the counselling of women, has not been cited once in the 10 years following its publication.

Most of the discussions of this topic have taken place in the feminist literature.

There are certain topics concerning body image which are explored in the scientific psychological literature, but which do not have direct relevance to the focus of this thesis. It might be interesting to the reader to have some idea of what concepts, not covered in this paper, are being researched in the area of body image. To that end, a list of brief examples of what can be found in the scientific psychological literature can be found in Appendix II.

Feminist literature. Feminist literature includes magazines, periodicals, and books written from a feminist perspective, which provide a feminist analysis and philosophical, sociological, and psychological explorations of women and body-hatred. This category includes both works which are dealing directly with body-dissatisfaction, and those concerned with the status of women in general. The majority of the analysis for the Workshop sessions came from such sources and will be reported in depth in the Background Information section as well as in Appendix I. In this category, although there has been much written on women and obesity, there is less available on "normal" women in regard to body-satisfaction.

Popular literature. Popular literature includes magazine articles, newspaper articles, and books. Most articles from sources in this category exhort women to change their bodies in order to be acceptable. There is little writing which advocates self-acceptance. The nature of these writings will be discussed in greater detail in

Appendix I, Workshop Session I, dealing with the Media Session of the Workshop.

Origins of Negative Body Image in Women

One of the major assumptions underlying the creation of this intervention was that in order for a woman to begin to change her negative body image, she must first understand how her body image was developed and is maintained. The main thrust of the Workshop created was to explore this issue in depth. The author's analysis of the cultural origins of negative body image in women was the material which formed the basis for this intervention. Therefore, so that the reader may have a complete picture of the thinking behind the creation of this Workshop, an analysis of the origins of negative body image in women will be presented here.

Cultural Attitudes About Women's Bodies Which Create Disliking

Unattainable ideal of female beauty. When searching for influences which are likely to create body-dissatisfaction among women, the first issue which comes to mind is the unattainable ideal of female beauty which is presented to women in North American culture. In speaking of any ideal, one must be cautious because what might be considered the current ideal is assuredly not a universally held taste in female beauty, and there may be many who would not find this ideal particularly appealing. Nevertheless, this author, along with others (Douty et al., 1974; Harmon, 1973; Kilbourne et al., no date; Pendergast, 1975), believes that there are current standards and ideals

(put forward by the media) which are extremely narrow and, in most cases, unattainable.

It is in the economic interest of the producers of fashion, cosmetics, and diet-related products (to name only a few) to encourage North American women to strive to achieve what is, in truth, an unachievable ideal. It is estimated that $16,000 per minute is spent in the U.S.A. on diet-related products (Ritenbaugh, 1982) (diet here refers to items intended to produce weight loss). Fashion and beauty are $40,000,000,000 a year industries (Kilbourne et al., no date) in the U.S.A. It is likely that money spent in Canada is proportionally large. Advertizing campaigns aim to engender dissatisfaction among women in order to encourage them to buy products (Kilbourne et al., no date). One American study showed that there was an increase of 350% in the purchase of beauty and personal care items in a 9-year period (Fisher, 1983). Fisher suggests that this indicates that these campaigns have been very effective.

Some might argue that there are two ideals today--the ultra-slim fashion ideal, and the buxom, rounded ideal of men's magazines. What these ideals have in common is that for the overwhelming majority of women, they are impossible to achieve.

The unachievable standard of female beauty which is held up to women is one major cause of women's not liking their bodies (Douty et al., 1974; Pendergast, 1975). What all women have in common is that each one of them, during her youth, was given some standard of ideal

physical beauty which was unattainable (Harmon, 1973; Kilbourne et al., no date).

It is interesting to note that today's ideals were not necessarily the ideals of past centuries. A major source of information on this subject is the works of artists (Bennett & Gurin, 1982) which indicate that standards of beauty are constantly changing. Information about past ideals, taken from art, is of necessity inferential. Indeed, it is difficult to determine whether or not the ideals represented by the artists were widely accepted, or whether or not they affected the majority of women. There are, however, some fairly clear trends which imply that there were different ideals at different times. The point here is that, while standards of beauty have been constantly changing, the major proponents of today's ideal, or ideals (mainly the advertizing media), tend to imply that their standards of beauty are fixed and unchangeable. An examination of art through the centuries, with the above mentioned cautions, indicates that this is simply not the case.

For instance, examples of art from over 20,000 years ago, emphasized fat females, and a positive attitude toward plumpness was demonstrated in ancient Greek art (Ritenbaugh, 1982). Compare this to the thin ideal exemplified by Twiggy two decades ago. These variations in the ideal point to the changeability of standards of female beauty. Even within the last 72 years there have been many shifts--from the fashionably obese woman of 1911 with her impressive decollete (Chernin, 1981) followed by the flat and boyish flapper, through the voluptuous plumpness of a Marilyn Monroe, then to thinner and thinner Miss America

pageant winners and Playboy centrefolds (Bennett & Gurin, 1982; Garner et al., 1980). Thus, for a 72-year-old women, even if she were fortunate enough to possess the prevailing style of beauty in her youth, the rapid change in styles would render her type unattractive in later decades. In the author's opinion, it is difficult to like your body when the prevailing ideal does not fit your figure type.

We live in a youth-oriented society in which the stigma of aging is well documented (Kullman, 1978; Posner, 1977). Youth and beauty are synonymous in our culture; conversely, to be old is to be ugly, especially for women. The ideal presented in current fashion magazines is that of an adolescent. In more extreme cases, 10-year-old models have been made to appear adult and sophisticatedly sensuous, dressed in adult clothing, and used to sell adult products (Kilbourne et al., no date). It is unlikely that a fat women of over 40 years of age will be satisfied with herself when she makes a comparison to such an ideal (Chernin, 1981).

Thinness is related to youth (Donahue Transcript, 1982; Ritenbaugh, 1982). While the ideal has gotten thinner and thinner, most women in North America have gotten heavier (Garner et al., 1980). Currently 30% of the female population of the United States wears a size 16 dress or larger (Chernin, 1982); a typical model would wear a size 7 or 9. It is reasonable to conclude that this situation is the same for Canada. Weight is an area for dissatisfaction for all ethnocultural groups in our society (Berscheid et al., 1973; Marsella et al., 1981). However, the move to thinness as the ideal in North

America does not necessarily extend to other parts of the world. Many societies consider plumpness both sexy and beautiful (Garner et al., 1980; Ritenbaugh, 1982).

What is beautiful is good. Research suggests that a stereotype of physical attractiveness exists (Dion, Berscheid & Walster, 1972). Physically attractive people are generally believed to have more favourable personal qualities, such as intelligence or greater social power. Generally, physically attractive individuals are liked better than unattractive individuals (Hendry & Gillies, 1978). Thus, physical appearance is related to self-esteem to the extent that it influences feedback from others, either positive or negative (Dion, 1972; Berscheid & Walster, 1972). Beautiful women are treated differently in our society. Conversely, a woman who is perceived as unattractive will not be treated as well. It will be difficult for her to like her body when its perceived lack of attractiveness may mean that she will receive less of life's rewards.

Dion (1972) indicates that this stereotyping of people through appearance begins early, with adults reacting differently to attractive and unattractive children. Thus, a woman who has been considered unattractive all her life, in order to like her body, will probably have to expend a great deal of energy to overcome internalized negativity which is the result of a lifetime of unfavourable feedback.

Being fat is bad. Thinness and beauty are linked in North American culture. Therefore, if to be thin is to be beautiful is to be good, then it follows that to be fat is to be ugly is to be bad

(Staffieri, 1967; Staffieri, 1972). Although the average woman under 30 has gotten heavier in the last 20 years (Garner et al., 1980), the fat woman is considered a social deviant because she doesn't conform to the norms of slimness (Flack & Grayer, 1975). Fat women experience ". . . job discrimination, social exclusion, personal shame and low self-esteem, exploitation by commercial interests, inability to buy most health and life insurance, unsympathetic treatment by doctors, and public ridicule" (Chernin, 1981, p. 123).

Furthermore, there is a saying that you can never be too rich or too thin. This is consistent with a documented relationship between thinness and wealth in our society (Garner et al., 1980; Ritenbaugh, 1982). Wealthy women tend to be thinner than middle- or low-income women for several reasons. First, rich women tend to be thin through selection. Most women obtain their wealth through their husbands, and wealthy men are more likely to choose women who they think are beautiful. Since beautiful equals thin, it is more likely that rich men will marry thin women.

Second, middle- and low-income women are more concerned with food costs and choose foods that are the least expensive but still filling (such as bread, potatoes, rice, noodles and other high calorie foods). In contrast, rich women are able to eat the "best" foods (i.e., those that are highest in density of nutrition but lowest in calories) (Ritenbaugh, 1982). As well, the rich woman is often in a position to have her meals prepared for her, saving her both from the effort of creating interesting but low calorie meals and from the temptation

which comes with food preparation. Thus, rich women tend to be thin (or remain thin) through circumstance.

Third, rich women have the time and resources to take care of their bodies, and they are able to afford such things as fat farms, spas, diet foods, weight-loss therapy, and exercise programs (Ritenbaugh, 1982). It is reasonable, therefore, to conclude that thin women are more likely to be rich, and rich women are more likely to remain thin.

The above analysis illustrates how the fat woman is doubly deprived. First, she is deprived socially (lack of social approval), and second she is deprived economically (she is less likely to marry wealth or to obtain a high-paying job). It is small wonder then that fat women despise their bodies.

There is something unacceptable about being female. Women's preoccupation with dieting may come from a desire not to be female in a sexist society (Berscheid et al., 1973; Chernin, 1981; Haft, 1975). For most women, the focus for weight reduction is the mid-torso which includes those aspects of the body which are considered most female (breasts, hips, thighs, belly, and buttocks). It appears that women who are pleased with their roles as female in our society are more likely to like their bodies. Haft (1975) found that those women scoring high on the Femininity Index (a measure of "traditional female roles") rated higher on self-acceptance of their bodies.

Large and fleshy women are unacceptable. There seems to be an abhorrence of large fleshy women in North America, and to some degree, this abhorrence appears to have some relation to power.

First, the fleshy woman is rejected by women. As a woman gets fatter and fatter, she looks more and more female (i.e., the most female aspects of her body are accentuated--breasts, buttocks, and thighs). In the last section we saw that there is something unacceptable about being female. Perhaps one reason women do not want to be female is that the vast majority of women have less power (both power over and personal power) than men. As women have striven to attain power in the twentieth century, there has been a parallel striving to look less female (with large, rounded, obviously female bodies) and more male (Bennett & Gurin, 1982; Chernin, 1981). Among the first women to break with traditional female roles were the flappers of the 1920s who had boyish appearances with their bound breasts and bobbed hair. It is not mere coincidence that since the second wave of feminism began in the 1960s, the female silhouette most sought after by women has gone from the voluptuousness of a Marilyn Monroe to the angularity, more androgynous (looking both male and female at the same time) appearance of today. At the same time, there has been a dramatic increase in anorexia nervosa, bulimina, and weight-loss groups (all of which are closely associated with thinness). As well, the business or professional women today is often seen in clothes such as three-piece suits, which seem to emulate those worn by men. In women's magazines,

the advice offered to women who want to get ahead is to emulate men in speech, manner, and dress (Rockett, 1985).

To summarize, women have associated being powerful with being male, and they have attempted to look more male and less female (i.e., large, fleshy, and obviously female) in the hopes of attaining some of the privilege accorded to men. Thus, women reject the fleshy and obviously female silhouette because it is seen as synonymous with less personal power. Additionally, this attitude is reinforced by the evidence that thinness is associated with wealth (and wealth with power) which was discussed above.

Second, large fleshy women are rejected by men. In the classic male-female hierarchy, the female is subservient to the male, the female is physically weaker than the male, and the female is supposed to be smaller than the male. Berscheid and Walster (1972) imply this with their statement that ". . . the cardinal rule of dating [is] that the man be taller than the woman" (p. 46). Thus small and weak is "feminine," large and strong is masculine. A large and/or fleshy woman breaks the traditional sex-role stereotype of size. Her size is seen as a challenge to the power and dominance of men. She is, therefore, more likely to threaten men, and she is more likely, ultimately, to be rejected by them because of her size.

In conclusion, we have seen that the large and/or fleshy woman is rejected by both men and women, and in both instances that rejection is related to power. For the above reasons, the large, fleshy woman is not likely to be satisfied with her body.

Attitudes of the medical profession. Negative attitudes toward obesity (especially in women) are common in the medical profession. ". . . Doctor Albert Stunkard writes 'As early as medical school I had been aware of the condescending and punitive attitude of some doctors towards their obese patients . . . .'" (Rabkin, 1981, p. 12, 18). The measure of obesity has been based on actuarial tables (ideal height/weight charts) generally prepared by insurance companies. At the present time in history, according to these charts, the average woman is obese (Ritenbaugh, 1982). The basic notion underlying the chart is that fat isn't healthy (Bennet & Gurin, 1982). However, there is an enormous amount of biomedical evidence that contradicts and challenges this notion (Chernin, 1981; Graves, 1982; Ritenbaugh, 1982). The actuarial tables themselves have been severely criticized as they are based, for the most part, on extremely biased samples of young people from the upper socio-economic classes (Chernin, 1981; Graves, 1982; Ritenbaugh, 1982). Ritenbaugh (1982) in her article Obesity as a culture-bound syndrome claims that obesity is not associated with an increased mortality rate. Indeed, only 9% of the population is at risk due to obesity. Rather, heavier is seen as healthier, or at least as no less healthy (Chernin, 1981; Graves, 1982; Ritenbaugh, 1982). Graves (1982) points out several benefits of fat: (1) that extra fat can help a person survive a bout of cancer or a heart attack; (2) that for women fat is necessary for the normal sexual and reproductive functions; (3) that peripheral fat increases the level of estrogen in

older women; and (4) that estrogen has been found to reduce the risk of osteoporosis (a weakening of the bones) found especially in old women.

Both Ritenbaugh (1982) and Chernin (1981) believe that the medical profession has itself been influenced by cultural norms of thinness for women, rather than by hard biomedical evidence. When such a powerful group of individuals as doctors hold negative attitudes toward "overweight" women, it becomes almost impossibly difficult for the fat woman to like and accept her body. The idea that obesity might not be a health risk is a highly controversial one, and will be examined in somewhat more detail in the description of the Fear of Fat Workshop session, in Appendix I of this paper.

The body is to be controlled or reviled. Both Christian and Buddhist (as well as other religious) teachings revile the body and exhort us to control it (Chernin, 1981; Ritenbaugh, 1982). The anorexic is an extreme example of the subjugation of the body, and many anorexics are admired and respected for their willpower and control of their unruly flesh (Chernin, 1981). Obesity is seen as a result of the moral failings of gluttony and sloth. Therefore, as long as a part of our culture actively teaches revulsion of the body, women are less likely to accept their bodies, let alone actively enjoy them.

Women's bodies are dirty. Little girls are taught to be modest, and, yet, an implicit message in this modesty is that there is something dirty about our genitals and sexual parts (Kullman, 1978). Little girls are sometimes taught to use a separate washcloth for their genitals (Leiblum, 1980). As a child, I was confused by the double

standard in the small French Canadian village where we spent our summers. Women were not allowed into the village wearing shorts, while men were. This was a rule created by the local Catholic Church, and this attitude was not unique to our village. Indeed, even today, women are not allowed into the Vatican with bare arms. Somehow, the implication of all of this is that women's bodies are not clean.

Most women have had to contend with the Whore/Madonna contradiction in our society where a woman's body is described simultaneously as a temple and/or as dirty or hateful (e.g., the vagina is sometimes referred to as "the gates of hell"). Women are called nymphomaniacs, yet there is no commonly used term to describe such behaviour in men. If woman's sexual desire can be seen as extreme and pathological, then her body becomes her betrayer (Chernin, 1981; Kullman, 1978). What must a woman feel about her body if she is pregnant and unwed?

Negative attitudes about menstruation, pregnancy, and menopause. Life processes peculiar to women--menstruation, pregnancy, menopause--are often depicted as bizarre, threatening, awesome, mysterious, and even contaminating (Pendergast, 1975; Posner, 1977). Freud believed that the Medusa head (which turns anyone who looks at it into stone) is a symbol of female genitals (Friedman, 1979). The message here is that female bodies are not acceptable.

The menstruating woman has been called filthy, sick, unbalanced, and ritually impure (Daly, 1978). In all cultures, negative feelings toward menstruation and the menstruating women are expressed (Kullman, 1978; Shuttle & Redgrove, 1978). It is, therefore, not in the least

surprising that many women have negative feelings about menstruation, which is, nonetheless, a normal, healthy female function which happens to most women once a month (Kullman, 1978).

It is not acceptable for women to be strong. In order to be feminine a woman is expected to be weak. This attitude often becomes a self-fulfilling prophecy (Harmon, 1973). Women exercise to be pretty, not strong, and they are generally unable to handle external threat or heavy work. Thus, in perpetuating their weakness, women's bodies become inadequate for their needs, and they must look to men to have them met (Harmon, 1973). This being the case, a woman is not likely to find her body satisfying.

To be an athlete and to be feminine have often been mutually exclusive (Snyder & Kivlin, 1975). Only certain sports are acceptable for women, generally those stressing aesthetics rather than power or hard physical contact (Snyder & Kivlin, 1975). Yet female athletes have a better body image than nonathletic women (Snyder & Kivlin, 1975; Snyder & Spreitzer, 1976). Thus, many women find themselves in a "Catch-22" situation; if they participate strenuously in athletics, they might develop a greater liking for their body, yet to do so is to challenge female sex-role stereotypes. Again, forces conspire to keep a woman from liking her body.

Women judge their bodies through the eyes of others. Women will often mistrust their own perceptions about their bodies and allow themselves to be described from without, generally through the eyes of men (Friedman, 1979). An example of this is the characterization and

definition of female sexuality. In the nineteenth century, medical experts believed and taught that it was not normal for a woman to have sexual feelings (Friedman, 1979).

In the twentieth century another damaging attitude is the medical notion of female frigidity, which often creates feelings of guilt or inadequacy in women and has been destructive to self-esteem. In many sex manuals, the body of a woman has been described through its use to men and the male sexual experience has been the model (Friedman, 1979). For example, although Masters and Johnson found no difference between the clitoral versus the vaginal orgasm, Lowen, in his work Love and Orgasm, has this to say about clitoral stimulation: "I advise my patients against this practice since it focuses feelings on the clitoris and prevents vaginal response. It is not a fully satisfactory experience and cannot be considered the equivalent of a vaginal orgasm" (In Friedman, 1979, p. 215-217). Vaginal penetration is important for male satisfaction and not necessarily for female satisfaction. In allowing delineation from without, women become alienated from their bodies and are less likely to value them.

By not trusting their own perceptions about their bodies, women estrange themselves from their own bodies and leave themselves vulnerable to the judgements of others. For many women, their major goal in life is to look good for other's approval (Pendergast, 1975). Parents want pretty daughters, and husbands want pretty wives. Lasky (1974) found that, when a group of overweight college women were divided according to their parents' attitude toward their childhood weight,

there were differences in body-liking (although in what way the parental attitudes were different was not clarified in the article).

If, as we have seen above, this culture has many negative attitudes toward women's bodies, a woman looking to that society for approval is likely to experience dissatisfaction. Many women feel disgust at their natural smells and female bodily functions (Friar Williams, 1976; Friedman, 1979). Why else would they consider purchasing vaginal deodorant sprays and douches?

Kessler (1979) reports that "the obese tend to externalize the source of evaluation about their body size, shape and attractiveness . . . ." (p. 5073). Flack and Grayer (1975) discovered the same thing about overweight women and, in addition, report that, "Social support is offered only when there are promises to change, resolutions to go on a diet, and expressions of guilt" (p. 484). Thus many women who might be willing to find their bodies attractive and satisfactory (even though the bodies do not reflect the present standard of beauty), find that social acceptance is conditional upon changing that body. Liking one's body under such pressure is very difficult.

How is Body Image Developed?

Among researchers in the area of body image, the most commonly held theory of the development of acceptance or rejection of the body is social learning theory (Fisher & Cleveland, 1965 in Thomson, 1978; Staffieri, 1967; and Thompson, 1978). A person's self-image evolves

slowly, based on inferences from her perception of how others evaluate her body (Douty et al., 1974). For example, from their mothers, many women develop negative body images as mothers are themselves conditioned not to like the female body. They may be jealous of their daughter's youth and make negative comments about her body (Kullman, 1978). It is mothers who encourage their daughters to conform in order to survive. It was Chinese mothers who bound the feet of their daughters, and mothers perform clitoridectomies and infibulation in African countries (Daly, 1978). In this way, body image, both positive and negative, comes about through social interaction and learning.

In addition to negative judgements about certain body types per se (for example, fat women), these types are often stereotypically linked to negative personality traits. In the sections on "What is beautiful is good" and "Being fat is bad," we were introduced to the notion of stereotypes relating body types to personalities. Within the psychological literature there have been discussions concerning the belief that certain body types predispose people to certain character traits (e.g., the jolly fat women, or the nervous thin person). "An overview of a variety of studies, using a number of different techniques, leads to the conclusion that there is little support for a constitutional basis and a growing body of literature for social mediation as the explanatory process . . . ." (Staffieri, 1972, p. 125). Lerner and Gellert (1969) explain it this way: (1) The stereotypes exist in people's minds; their reactions to children are based on stereotype; (2) The child begins to believe in the stereotype, which in turn leads

to a self-fulfilling prophecy; (3) The child then begins to behave in the expected manner; (4) Thus the stereotype is confirmed and a vicious cycle sets in. Authors such as Brenner and Hinsdale (1978), Hendry and Gillies (1978), and Berscheid and Walster (1972) agree with this analysis. Berscheid and Walster (1972) have shown that this stereotyping begins at a very early age. Staffieri (in Lerner & Gellert, 1969) reported that by age five stereotypes were minimal, but, at age six, they were full blown. Lerner (in Brenner & Hinsdale, 1978) found the same thing.

Thus, for example, a chubby girl is told that her body is not acceptable, and at the same time she is informed that chubby children are lazy and lack energy and have no impulse control over food. These attitudes carry over into adolescence, when it appears that social learning in relation to body image plays an important role (Brenner & Hinsdale, 1978; Clifford, 1971; Koff, Rierdan & Silverstone, 1978; McLean, 1976; Minahan, 1971). Those who consider themselves ugly in adolescence continue to have lower self-esteem as adults (Berscheid et al., 1973).

Economic factors contribute to women's body-dissatisfaction. Advertizers consciously design unattainable standards of female perfection in order to sell cosmetics, fashions, and diet products (Friedman, 1979; Kilbourne et al., no date; Pendergast, 1975). They deliberately create insecurity so women will be more likely to buy their goods. The market place is the major promoter of the ideal of perfection. Thin

and average persons predominate on television. In one study of commercials the only overweight people who appeared were members of minority groups and in most cases they were men (Kurman, 1978). A multi-billion dollar industry in fashion and beauty thrives on and promotes women's weak self-concept (Kullman, 1978). One half of a million dollars is spent every minute on cosmetics in the United States (Kilbourne et al., no date).

Another reason the media encourage women not to like their bodies is the lucrative diet industry (Garner et al., 1980; Ritenbaugh, 1982). There is a great economic gain to be had from women's discomfort with their bodies. Ritenbaugh (182) reports an estimate by Calloway that the money spent on diet-related items in the U.S.A. is $16,000 per minute! In order for merchandizers to sell products, women must be convinced that they are not adequate in their natural state (Friedman, 1979; Kullman, 1978; Posner, 1977). To be acceptable, a women must: shave her armpits and legs; tweeze her eyebrows; bleach or use electrolysis for facial hair; wear make-up; wear contact lenses; restructure her body with brassieres or girdles, or even have plastic surgery; constantly worry about her weight; have her hair coiffed; straighten, darken, lighten, curl her hair, or cover up gray hair with dyes; shape and polish her fingernails and her toenails; remove rough patches from her feet, elbows, knees; use colognes and powders to smell better; deodorize her underarms and genitals; use oils to soften her skin; clean her facial pores with masks; etc. (Kullman, 1978). Above all she must obliterate all signs that she is aging (Posner, 1977).

Such attempts to transform a women's body are not likely to engender body-liking for the natural state.

Is There Social Utility in Women's Dissatisfaction With Their Bodies?

We have seen that there are many reasons why women dislike their bodies, and many forces conspiring to keep women dissatisfied. There are, of course, the economic reasons mentioned above, but it may be that there is an underlying motive which has yet to be explored, in any depth, in the literature. Is there social utility in women's body-hatred? One of the ways women in our society are controlled and made tractable is through their insecurities about their bodies. At this point it might be useful to explore the relation between women's physical attractiveness and power. In the nineteenth and twentieth centuries, unless she was independently wealthy, a woman's only source of power was from men, through her beauty. This can be illustrated by the following poem by Richard Brautigan (1970):

15%

She tries to get things from men
That she can't get because she's not
15% prettier.

(p. 6)

Thus, in her almost adolescent preoccupation with her body, a woman continues the pattern of seeking power, from men, only through her attractiveness. By not taking power directly, women remain in the weaker position.

While it is obvious what women have to lose by hating their bodies, it may be useful to ask, at this point, whether there is anything that they gain. Chernin (Donahue Transcript, 1981) believes that the implications of women's body-hatred are profound. She says, "I put it as a series of riddles. If I am not disliking myself because of my body, why else might I be disliking myself? If I am not trying to control my appetite, what might I be trying to control" (p. 15, 16). Perhaps women are trying to control their outrage at their oppression in this culture. In turning their anger and rage inward in the form of body-hatred, they avoid the larger, and much more threatening issue of whom they really hate and are angry with, and why.

Research

Changing Negative Body Image

Before giving the specific details of the Workshop created for this thesis, the author will: (1) report on other interventions in the field; (2) discuss how the research differed from what had been done before, and what contributions to the field this work will make; and (3) present the counselling theory behind this study.

Interventions in the Area of Body-Dissatisfaction

There are few scientific reports of attempts to intervene therapeutically in the area of body-dissatisfaction. In 1978, Loftis, Clance and Joesting declared, "There is no known research which directly relates to changes in body-cathexis as a result of psychotherapeutic intervention" (p. 1273). There are, however, a few studies before that statement was published, and several afterwards, which will be discussed here.

Most interventions aimed at increasing women's liking of their bodies, whether scientific or "popular," aim at changing the body itself, or at least hiding its faults. Women's magazines are filled with advice and attempts to make women over into more acceptable shapes and appearances. Even in the psychological literature, an example of this attitude can be found in the study done by Zamarin (1976) which

evaluated a commercial "charm" course in terms of how effective it was in improving the women's appearance as rated by outside judges. There was no attempt to increase the women's acceptance and liking of their bodies as they were. Such organizations as Weight Watchers or the Diet Centers follow the same philosophy.

It has been claimed that body image can change positively as a result of psychotherapy in general (i.e., therapy which does not take body-dissatisfaction as its focus) (Cleveland in Thompson, 1978). However, McCuistion (1974) compared 20 experimental subjects to 20 controls in an attempt to see whether or not sessions at a self-help clinic had any effect on body-satisfaction, and no statistically significant difference between groups was found. "Nonsignificance was attributed to lack of sufficient time between pretest and posttest for changes in body image to occur" (p. 5226). It was not clear, however, whether or not this study had any body image focus during therapy. The issue of how long it takes to change such a long-standing emotional, cognitive, and behavioural pattern as body-hatred may be important here. It is for this reason that change only on the cognitive level was expected in the study this author ran. The lack of focus on body issues might also explain the nonsignificant findings.

Loftis et al. (1978) wanted to see if individual psychotherapy itself would have any effect on body-satisfaction. They compared two groups. The experimental group was women seeking therapy, while those in the control group were not. Differences between groups were not statistically significant. Their nonsignificant results might be

explained by the following factors: (1) The intervention had an individual rather than a group format, and a group style of therapy may be needed for such psycho-social change as body-liking; (2) The control and experimental groups were not comparable (controls may already have had high body image); (3) The intervention was brief (the range of sessions being between 12 and 20); (4) There was no direct focus on physical activity or body issues.

The work of researchers Harris, Nolte and Nolte (1980) and Rankin (1975), both using group formats, did place a slightly greater emphasis on body as a focus of therapeutic work, and they found significant results in both cases. Harris et al. compared two groups of teenagers (mean age 15 years). The experimental group was given therapeutic intervention using body experience and imagery, while the control group went on a field trip. This intervention lasted only one month, but those in the experimental group were more satisfied with their bodies, rated on a Body-Cathexis Scale, after the group intervention. Thus, it appears that the time limit itself, as in the McCuistion study above, may not be sufficient to explain nonsignificance. Rankin's work appears to bear this out. Rankin also worked with adolescents (females only) and included nonverbal communication as part of the groups (e.g., emphasis on body language, movement exercises, awareness techniques). The results indicate that although body-liking was not the focus, some emphasis on the body would improve body-cathexis scores. The group format also seemed to be beneficial to the main issue of body-liking. It would be hasty, however, at this point, to conclude that the body

focus was the main difference between these two studies and that of McCuistion. Neither the setting nor the populations are comparable.

Thompson (1978) included even more emphasis on the body, but again did not deal directly with the issue of body-satisfaction in a cognitive way. Basically, he offered a Gestalt therapy group, but he included a focus on muscular tensions as a part of the therapy. The subjects were older than those of Harris et al. (1980) and Rankin (1980) (experimentals mean age 22; controls mean age 26). The study was somewhat better designed with controls being matched to experimentals based on pretest scores on the Secord-Jourard Body-Cathexis and Self-Cathexis Scales. The results indicated a significant change in body cathexis using Gestalt body awareness techniques. The positive results can be explained either by the fact that there was more emphasis on the body or by the fact that Gestalt therapy, in general, is useful for affecting body-liking, or both.

With the next study to be examined, by Clance, Matthews and Joesting (1979), the emphasis on the body increases again. In this study as well, there was significant gain in body self-acceptance of the experimental group. Especially interesting here is that the gain was greatest for the females in the group. Clance et al. (1979) compared a psychology of adjustment class to a control group of an introductory psychology class. Sessions in the experimental group included such structured activities as guided fantasies, self-expression, and, most important to this discussion, physical communication and awareness exercises from a book by Gunther (1968), Sense Relaxation: Below your

mind. It would appear that some sort of physical activity might have an effect on body-satisfaction, and, for this reason, some sort of physical activity was included in each session of the proposed Workshop.

In an interactional training class, coupled with Bando Karate training, "T.V. Matthews' unpublished work showed body-acceptance and self-acceptance were higher for females following their participation in a course in psychological adjustment as compared to their precourse scores" (Loftis et al., 1978, p. 1273). This study did achieve significance and perhaps the important factors were the fact that the intervention had a group format and, especially the fact that there was emphasis on the body through karate training. It might be that, in beginning to see the body as a strong tool for defense purposes rather than merely an attractive vessel, body-liking changes. It was for this reason that a self-defense (strength training) component was included in this author's Workshop.

As there is greater focus on the body and more emphasis on body-self-acceptance, positive results seem to become more frequent and predictable in the studies found. Flack and Grayer (1975) found that "A group for obese women in which consciousness-raising is a goal, the social consequences of obesity are dealt with, and the women are given unconditional support can result in self-acceptance and a less conflict-laden choice about weight" (p. 487). However, while the authors of this article tell us that positive change was made, there

was no attempt at quantitative measurement of their subjective findings. The format, though, did seem to include the variables which appear to be important for the success of an intervention aimed at self-acceptance: First, there was a group format ("Each group became more strongly and more quickly cohesive than other groups the therapists had experienced" [p. 485]). Second, the focus was on understanding body-hatred. Third, the thrust of the groups was body-self-acceptance. Fourth, the women were not asked to change their bodies but were given unconditional support (". . . they soon became aware of buried anger and repressed defiance at not being accepted unconditionally" [p. 485]).

The study which most closely parallels the research of this thesis is that of Kullman (1978). Her course description was as follows: "This group is designed for women who want to experience their bodies in more positive ways. The course combines body awareness exercises with intense discussions. Emphasis is on listening and understanding the body, finding alternatives to physical complaints and illnesses, and accepting and liking the body the way it is . . . ." (p. 32). Altogether, she ran her study eight times, with eight separate groups. The groups themselves met weekly, for two-hour sessions, and they met eight times. Each week they were given homework to be done between sessions. Each session had a theme, and some of the themes discussed were: (1) the relationship to their mothers and what their mothers had told them about their bodies and being a women; (2) the same as #1 but for fathers; (3) itemizing of their body parts and of how they felt

about each one; (4) in one optional class, an examination of their genitals with a speculum (aided by a nurse). Other sessions had optional themes based on the needs of each group. Unfortunately, Kullman did not measure body-liking directly. She was more interested in self-concepts and relationships between women. She found statistically significant differences (in a positive direction) between her groups, as measured on the Tennessee Self-Concept Scale and the Lennard Relationship Inventory ($p < .05$) compared to controls.

From the above discussion, it appears that the crucial elements for success of an intervention seeking to improve body-satisfaction might be: (1) a group interaction; (2) focus on body-acceptance; (3) social analysis of body-dissatisfaction; (4) enough time for change to take place; (5) homework to be done between sessions; (6) unconditional acceptance on the part of the leader; (7) intense emotional sharing on the part of the participants; (8) physical activity and awareness exercises.

Contributions of the Thesis Research to the Field of Counselling

At this point it will be useful to examine how this research contributes to the field of counselling in general. We shall also look at how this design adds to and hopefully improves upon those studies mentioned earlier.

The vast majority of the literature in the field of women and body-satisfaction tells us just what relationship women have to their

bodies, but it seldom attempts to explain why women dislike their bodies from either a cultural or a philosophical perspective (Chernin, 1981). In addition, almost all interventions in and out of the scientific community have attempted to increase body-satisfaction through changing the bodies themselves, rather than by advocating self-acceptance. Also, with the exception of the work by Kullman (1978) and Flack and Grayer (1975), interventions have not challenged cultural ideas about women and their bodies in a therapeutic setting. The content of the present study was designed to fill these gaps.

Although Harmon, in her theoretical article in 1973, brought this issue to the attention of counsellors, there has been very little tangible response to it. Indeed, Harmon's article has not been cited even once in the following ten years.

While acceptance of the body appears to be important in the maintenance of a woman's positive self-concept (Harmon, 1973; Kullman, 1978; Sturdivant, 1980), there has been little attempt to create and execute interventions which focus specifically upon increasing women's body satisfaction.

The present study differed from what has already been done in many ways. First, a measure other than the Secord-Jourard Body-Cathexis Scale was created and utilized. This measure moved away from rating body parts and concentrated on measurement of changes of attitude as well as body self-acceptance. Second, the presenting issue was body-dissatisfaction. Third, there is a great deal of information concerning dissatisfaction among obese women, but little on women who

are not obese. This study also considered non-obese women with body-dissatisfaction. Fourth, while much feminist literature explores the origins of body-dissatisfaction among women, almost none offer an intervention. Fifth, while Kullman (1978) created a somewhat similar course, she did not measure body-liking per se, and she did not gather any feedback on what the participants found useful. The present research made these additions.

One of the major contributions of this work will be to bring this issue to the attention of counsellors. Therapists need to be aware of how their own values about women and their bodies might affect their female clients. It is reasonable to believe that counsellors respond according to how they are socialized (Flack & Grayer, 1975; Friedman, 1979). As cultural attitudes toward women and their bodies are often oppressive, it may be that the stance of the therapist herself is counterproductive in some instances. Most counselling theories do not focus much attention on the body at all, and the present study has made it clearer that body issues are important variables for counselling success. In addition, the Appendix section of the thesis can be used by counsellors as a guide and aid to understanding the body-satisfaction issues of their female clients. As well, the Appendix may be used as a self-help guide for women who don't like their bodies, as it will offer new ideas and insights, as well as resources for each session topic.

While much of the feminist literature advocates that small women's growth groups bring about positive changes in self-concept, there has

been little attempt to test this theory experimentally (Kullman, 1973). The present study attempted to do just that. Also, feminist theory contends that information sharing can bring about personal growth and positive change. The research offered an opportunity to evaluate the usefulness of an information-sharing/emotional-sharing format.

Theory Behind the Study

Self-acceptance is the key. One of the assumptions behind the research was that body-hatred has a profound effect on a woman's life. As seen above, body-dissatisfaction severely damages a woman's self-esteem. Therefore, in order for a woman to feel good about herself, one place to begin the resocialization process is with her relationship to her body (Kullman, 1978). In order to achieve increased self-esteem, self-acceptance is the key and central issue. There is a great deal of experimental evidence showing that people do rate themselves and that their emotions and behaviours are greatly affected by the kinds of self-ratings they choose (Ellis & Grieger, 1977).

Body-satisfaction must be placed in the cultural context. Generally, women's dislike of their bodies is culturally derived. There is no intrinsic problem with the bodies per se, but, rather, dissatisfaction reflects how much the body deviates from the currently accepted ideal. For a woman to accept her body, she must begin by understanding the origins of her dissatisfaction. She needs to become

aware of all the forces which conspire to keep her unhappy with her body. In order to accomplish this, she must understand her own body-dissatisfaction, and that of other women, within the larger social context. Feminist therapy insists that all therapy be placed within the cultural context; it is not enough to be a non-sexist counsellor (Griffith, 1975; Friedman, 1975; Kullman, 1978).

The theory behind this attitude is that it is the environment in which we live, rather than intrapsychic dynamics, which plays the major part in women's individual problems (Kullman, 1978). The woman is not sick; rather it is the society which is ailing (Folb, 1979; Whiteley, 1973). Thus a woman's body-dissatisfaction is not her issue alone, but part of a much larger social/cultural/political problem. Understanding how body-dissatisfaction among women fits into the larger social picture will help a woman come to terms with and accept her body.

Counselling theory in general. Most psychological problems stem from a lack of awareness. Increased awareness can lead to change in a positive direction. "Kleck (2)--believes that a stigmatized characteristic such as obesity elicits from society responses which interfere with one's optimum social-emotional development. Self-awareness instruction may be one means to help such a stigmatized person overcome low self-esteem which often results from an undesired physique . . . ." (in Brenner & Hinsdale, 1978, p. 56). The belief is that this will be true for all women who dislike their bodies whether or not they are obese.

Another assumption was that through the combination of social analysis, coupled with group support and sharing, there will be a change in self-concept in a positive direction. Work by Loftis et al. (1978) indicates that psychotherapy, which is general and does not have women's body-hatred as its focus, is not enough. "Body-Cathexis and Self-Cathexis Scales were administered to 24 people who received individual psychotherapy and a control group of 25 students. Body-Cathexis and Self-Cathexis tests were given before and after the therapeutic sessions. No significant differences were obtained" (p. 1273).

The connection between counselling and education is a strong one, and in fact sometimes it is difficult to tell where counselling leaves off and teaching begins. Before a woman suffering from body-dissatisfaction can begin to like her body, she needs a great deal of information about how she came to dislike her body, and what societal pressures there are upon her to maintain that body-hatred. Thus, this author believes that there must be a strong educational component in any intervention in this area.

If the major thrust of this intervention was the educational component coupled with the group sharing, then why was it necessary to have a counsellor rather than a teacher as a leader? The pilot work for this study indicated that women's body-dissatisfaction affects them at a very deep emotional level. Exploration of such emotionally-charged material might have had wide-ranging psychological repercussions. Counselling abilities such as good listening skills and group

management capabilities, among others, were needed to ensure that each woman's emotional and psychological needs were considered and that psychological safety was maximized.

A research review (Ellis & Grieger, 1977) suggests that cognition, emotion, and behaviour are interrelated. A change in one part of the system will change the system as a whole. Thus if a woman's thinking about her body can be changed, her feelings and behaviour will also change. This author thinks that attitudes (cognitions) can be changed. Body image develops through a combination of cognitions, emotions, and behaviours. However, because in this author's opinion societal attitudes play such a large part in that development, cognition should be the main focus of an intervention in this area. Nonetheless, for the most positive results, work on all three levels was planned.

It was thought that a group format would lead to cohesiveness and would be likely to create an atmosphere which would encourage openness both intrapsychically and interpersonally. A woman must identify and examine her attitudes about her body before she can change them, and group support makes this more likely. Once her attitudes begin to change, her body image will begin to alter. It was also intended that the group would also support her new, positive attitudes about her body. As well, the researcher believes that support without pressure actually to change her body would lead to self-acceptance.

Some theorists say that the actions and attitudes of others about our bodies are more important for our body image than our own

attitudes. In contrast, this author believes that we are able to affect other's perception about our bodies if we project a belief in our own attractiveness.

Prediction regarding outcome. Positive outcome in most therapy is a matter of degrees, not absolutes. The author predicted, therefore, that if this Workshop were successful, it would produce women who were more accepting of their bodies rather than totally accepting.

Method

Goals of the Study

The purpose of this intervention was, by imparting information, to create a situation in which women could uncover and challenge their life-long patterns of body-hatred. Through an examination of the socio-cultural pressures on women which increase body-dissatisfaction, it was hoped that damaging myths about women and their bodies would be dispelled.

The aim was for the participant to move from definition and analysis to an understanding of the consequences of body-dissatisfaction as it applies to her own life (Rea, 1981; Whiteley, 1973). It was anticipated that there would be change, in a positive direction, in the women's attitudes about women and their bodies in general. It was hoped that this would, in turn, lead to greater self-acceptance and liking of their own bodies, and any decision to change their bodies would be made from that position of acceptance. It was hoped that the women would begin to see themselves in a more broadly-based way, and not as "just another pretty face or body."

Research Question

The research question was: Would a group intervention in the form of a short course focussing on women and body-dissatisfaction be

effective in improving women's satisfaction and acceptance of their bodies? More specifically, would a format which included both didactic information of the cultural, psychological, sociological, and political issues around body-dissatisfaction, coupled with shared experiences and support from other women in a group therapeutic setting, result in changed attitudes in the participants? Would these changed attitudes reflect themselves in increased body-acceptance measured on the Questionnaire developed for this study? Would a treated experimental group have a greater average change score than an untreated wait-list control group?

Pilot Study

In order to see whether or not this was a viable project, a pilot session was run. Fourteen women were gathered, representing a wide cross-section of life-styles, similar to the target population for the Workshop. The purpose in drawing these women together was two-fold: (1) to see how a group of women would react to the opportunity to discuss this topic; and (2) to generate information for the intervention and the Questionnaire. The women were asked to think about the issue of how they felt about their bodies before they arrived.

After some time was spent getting acquainted, the women were gathered together in a group and for two hours they discussed their relation to their bodies.

What was learned from this experience was the following:

1. Almost all women present didn't like their bodies. This confirms the notion that many women are dissatisfied with their bodies.
2. Women such as those who attended would be willing to talk and share this dislike.
3. This area is stimulating for many women.
4. Body-dissatisfaction interferes with a woman's well-being.
5. Group cohesion can be obtained quickly with this format and topic.
6. A group intervention such as that which had been proposed would be welcomed and useful.
7. Confirmation of information and theory upon which this intervention has been based.
8. The depth of feeling in this area is profound.

Subjects

A group/workshop for women only, focussed on women and body-satisfaction, of seven two-hour sessions was advertized in newspapers, on radio and television, with posters, and through word of mouth. It was advertised as a workshop aimed at increasing body-acceptance and satisfaction without any change in the body itself.

While this Workshop was being prepared, the researcher had gathered names of 21 women who were interested in participating in such

a workshop, and who had asked to be notified when the Workshop was to be given. The leader telephoned these women, in order, and those who committed themselves to attend the Workshop were placed on the experimental group list in a first-to-commit, first-served basis. Those who were unable to attend the seven-week Workshop (because of other commitments) were asked to be a member of the wait-list control group. Of the original 21 women on the list, 8 were members of the experimental group and 8 were members of the control group (a total of 16 subjects from the list).

There was a total of 29 subjects (12 Es, 17 Cs). The final 13 subjects were chosen on a first-come, first-served basis (with one exception). Those who contacted the leader first were assigned to the experimental group, and once that was filled, the remainder were placed in the control group.

Before the Workshop began, two women dropped out of the experimental group. The first one left because of family problems (she was replaced by reassigning the first woman on the control group waiting-list to the experimental group). This woman was unable to be in the control group. The second woman dropped out on the morning of the day that the Workshop began. The researcher attempted to contact women on the waiting-list, but was unable to find someone who would attend with such short notice. The final participant was chosen at the last minute because: (1) she happened to telephone minutes after the researcher stopped trying to find a replacement from the control group; and (2)

she lived close enough to obtain the Questionnaire and finish it in time to begin the first session.

Procedure

The Workshop was advertized in the media. For each women expressing interest there was a written statement of goals and an explanation of the responsibilities and expectations both of the leader and the participants. The leader asked for commitment concerning attendance and sharing. Anonymity was promised in all articles written concerning the group. A research release form explaining the nature of the research was signed by participants.

Seven two-hour sessions were held following a pattern similar to that created at Christopher Street (no date) for work with incest survivors. A portion (or portions) of each meeting had a lecture format where information on the following topics was presented by the leader: (1) a) Introduction and b) the Media and its influence; (2) Historical perspective on body-dissatisfaction among women; (3) Power (physical strength, control of the body, pregnancy, health)--Whose body is it?; (4) Menstruation; (5) Fear of fat; (6) Sexuality; (7) Aging and menopause--Group farewells and ending ritual. Although didactic in nature, this portion of the session was informal in tone.

Following the lecture, there was personal group sharing of reactions to the material presented and a discussion of the results of

homework assignments. During the discussion, the group leader continued to share ideas and information as the need arose.

Homework assignments were given each week, such as: journal writing; monitoring the effects of the media and personal history of body-dissatisfaction (see Appendix I for more detail).

Each week, a short period of time was spent on some physical activity.

All the women took the Questionnaire twice; once before the Workshop was given, and once after.

Feedback forms were distributed and collected (see Appendix IV).

The researcher also noted her own perceptions of the progress of each participant after every session. This information was compared with the Questionnaire change scores.

A fee of $15 was charged for two reasons: first, to defray the costs of xeroxing handouts and serving coffee; and second, as a token of commitment to attend the group. All monies not used were returned to the participants who chose to use it for the group party.

Measurement

A Questionnaire was developed which measured changes in body-satisfaction (see Appendix II).

Rationale

The author chose to cover such a wide variety of topics because the issue of women's body-dissatisfaction is such a highly complex and multi-faceted one. The social and cultural context of body-hatred was broadly analyzed and challenged. Social analysis was needed if the participant was to believe that hating her body was not her individual problem alone, but a part of a troubled society. In this way she could begin to stop blaming herself and could start on the road to self-acceptance.

A group format was used for many reasons. Some of the thinking which led to this decision is presented here.

A major innovation of twentieth century feminists is the small group experience (Whiteley, 1973). The Consciousness-Raising Group (CR) operates from the premise that it is not the woman who is sick but the society which is ailing, (Folb, 1979). The format of the study did not follow the CR plan exactly, as the intervention had a leader. It was believed that a leader was needed for the reasons mentioned above in the Theory section. In addition, the participant/leader was able to model behaviour and show that although the struggle to come to terms with one's imperfect body is not an easy one, it is possible.

The group format has been demonstrated to be a particularly strong format in dealing with issues which affect women (Berscheid et al., 1973; Flack & Grayer, 1975; Folb, 1979; Kullman, 1978; Whiteley, 1973). Kullman (1978) reports many research instances where women in

support groups were able to grow and make positive change. In such groups, women are made aware of their condition as women in our society (Whiteley, 1973). Barriers between women can be broken down, and the competition between women reduced. If a woman in the group could come to accept another woman's imperfect body, then she would be more likely to begin to accept her own. In addition, sharing with other women exposed her to more ideas than she or one therapist alone could think of. The self-revelation of others provided a positive example which increased the individual woman's openness with herself and others. In beginning to see her issues she could more effectively deal with them.

Groups end a woman's sense of isolation in her dilemma with her body. The participant was able to realize that though her body is unique, her feelings about it have been acquired through social interaction, as have other women's (Kullman, 1978). Women discovered that they were not alone in their pain, but that their experience is common to many (Folb, 1979).

The support from other women for their changing actions and ideas gave the participant strength to continue growing and changing in a positive direction. In addition, the all-female group broke the male-approval model and led to women defining themselves in female terms which, in turn, gave them the pattern to be self-approving.

For most women, body-dissatisfaction is a long-standing problem. The author believed that to counter these negative feelings in only seven weeks, hard intense work was needed. It was for this reason that homework suggestions were made.

The homework gave the women the opportunity to continue thinking and working on the issues between sessions. In addition, it facilitated the in-depth exploration of their own personal concerns in a way which would have been impossible in the group due to lack of time and the need for every woman to participate.

Physical activities were included in the Workshop because they permitted the women to experience themselves as subject rather than object. Some activities (such as those focussing on strength) allowed the women to experience their bodies in ways in which they might never have experienced them before. Also, physical activity increased body awareness and reduced the mind/body division.

It was necessary to create a new tool of measurement because there appeared to be none available which measure social attitudes toward the body. The tests available in the area of body image were reviewed by McCrea et al. (1982) and variables measured included: body anxiety; body-satisfaction; concept of body size; plasticity of the body scheme; position of the body image in space; and preferred body proportions. The only test which was of relevance here was that one dealing with body-satisfaction. All the work uncovered by the author in this area of body-satisfaction uses the Secord-Jourard Body-Cathexis Scale to measure body liking. The scale was not chosen for this study for several reasons. First, its emphasis is only on measuring liking of body parts and one question asking for a measure of liking of the body as a whole. It does not deal with cultural attitudes. Second, the major reason not to use this test was that the scale implies that there

is an ideal and that satisfaction depends on variation from that ideal (McCrea et al., 1982). Although this may not have been the intention of the authors of this scale, the Questionnaire asks the subject to take a body part and rate it. One of the female subjects in Thompson's study (1978) declared that the scale items suggested ". . . 'women-as-object' (i.e., as an ornament or a stereotypic ideal) rather than a more internally validated attitude" (p. 78). In asking herself, how she would answer this Questionnaire, this author felt that there were two ways to respond: (1) how she really feels about her particular body part; or (2) how she is supposed to feel according to the present ideal. This can produce unclear results for the researcher. The test also puts the respondent into a critical rather than an accepting frame of mind. Also, it tends to view the body in a fragmented way rather than holistically. Because the Workshop aimed toward internal validation, eschewing self-rating, and acceptance of the body in a holistic way, to begin the experiment with the Body-Cathexis Scale would have set a tone in direct opposition to that which was desired and would have become counter-productive. Two open-ended questions were added to the Questionnaire created. They were: (1) What I like about my body is . . .; and (2) What I dislike about my body is . . . . These questions were included to see if issues not appearing on the Secord-Jourard Body-Cathexis Scale would be included.

The Questionnaire measured the woman's subjective satisfaction with her body, based mainly on the definition of body image used in this study. Because body image is a subjective reality, it appeared

that the only reasonable way to test it was with this kind of an instrument. There is support in the literature (Lerner, Karabenick, Stuart & Stuart, 1973) for the belief that subjective measures in this area can be more useful than objective measures. In addition, as there was no follow-up data obtained, the only way to find out about possible future behaviours was through self-report.

There were potential problems of reliability and validity with self-report. There was no way to tell if a respondent was being honest either with herself or with the interviewer. Nonetheless, Kullman (1978) points out that subjective report itself is valuable as it is a behaviour and an observable one.

Another problem with the kind of questionnaire used (Likert type of scale) was the assumption that all items were weighted the same (Kullman, 1978). There was no way to tell which items were important to which women. The assumption was that different items would be important for different women. Indeed, the researcher could not be certain that the relative importance of each item would not change for the same woman each time she took the Questionnaire. There was also the problem of possible response set, where the respondent checks off the same letter for every question.

Questionnaire Validity and Reliability

The Questionnaire was tested for face validity by the use of four expert judges. There were: (1) a male experimental psychologist

familiar with testing issues; (2) a female counsellor, with seven years of counselling experience, who was employed for six years in the field of Questionnaire construction; (3) another female counsellor who works in the field of bioenergetics and who is presently doing research on eating disorders, an area which covers much of the same material found in the proposed study; (4) the original outside member of the author's committee who teaches both Women's Studies and English, is knowledgeable in the area of women's issues, and who aided in Questionnaire clarity.

The Questionnaire was refined through administration to the expert judges, with feedback from them on clarity and meaning of questions. The Questionnaire was then changed in response to suggestions. In this manner, it was refined until all identified problems were eliminated.

Reliability was tested by administering the Questionnaire to a group of women who were similar to the target population, but who were not necessarily dissatisfied with their bodies. In fact, more women who said they liked their bodies were asked to participate, as the experimenter was reluctant to lose any potential subjects for the research. The women took the Questionnaire twice, two days apart. One subject was lost through administration error, leaving an N of 8.

Statistical correlation for stability was run. Scores on the Questionnaire could range from a minimum of 49 to a maximum of 245. Scores for this sample ranged from 126 to 231. The test-retest reliability coefficient was 0.99, indicating that the measurement instrument is very stable.

In addition, reports from these eight women indicated that it can be very helpful in assessing body-satisfaction, providing evidence for the validity of the Questionnaire: "Made me aware that I actually am quite fond of my body . . . . The questions focussed my awareness." ". . . a clearer thinking than usual about my body has emerged." "Did some deeper thinking than usual about my body and discovered I liked it more than I thought I did." "Generally, though, thought the questions were good for your purpose." "Allowed me to see how far I had come from not liking my body to liking it."

As well, the researcher's predictions, based on her personal familiarity with these women, as to their relative scores on this pilot test were very accurate, further attesting to the Questionnaire's validity.

Results

There were 12 experimental subjects and 16 control subjects in the study. However, data were not complete for all subjects on every occasion. Therefore, each time results are given, a statement will be made detailing from how many women data were received. The level of significance was set at .05.

Demographic Data

The experimental group (12 women reporting) consisted of women aged 25-54 with a mean age of 35.50 years. There were three students, two counsellors, three clerical workers, one teacher, one nurse, one park worker, and one unemployed woman. The group included three married, six divorced, one separated, and two single. Three women identified themselves as lesbians. Six women were living with partners, and they had been living with them from 1 to 11 years. In regard to education, two women had completed grade 12, five had some university education, one had completed nursing training, three had bachelor's degrees (two with some postgraduate education) and one had a master's degree.

The control group (15 women reporting) was made up of women between the ages of 21 and 56, with a mean age of 35.80. There were two homemakers, two teachers, three counsellors, one university professor, one volunteer, three students (one of whom was also a saleswoman,

another also a homemaker), one nurse, one fitness instructor, and one unemployed woman. The marital status of the women included: seven married, one separated, four single, one divorced, one widowed, and one who described her marriage as on and off. Seven women were living with partners, and they had been living with them for 4 to 20 years. In regard to education, one had completed grade 8, one had completed grade 10, one had completed grade 12, three had some university education, four had bachelor's degrees, one was an RN, one had a teacher's certificate, one was a master's candidate, one had a master's degree, and one had a Ph.D.

The proportion of the experimentals that was from the original list was not significantly different from the proportion of the controls that was from the original list, X^2 (1,$\underline{N}$=28).

Questionnaire Data

Each item on the Questionnaire developed for this study was given a value from 1 to 5, with 5 being the most desirable. The scores were then added up, and a higher score was interpreted as indicating greater body-satisfaction on the part of the subject.

The experimental subjects (eight reporting) took the pretest Questionnaire between June 24th and July 17th, and the posttest Questionnaire between August 29th and September 10th. The length of time intervening between the two testings ranged from 45 to 71 days with a mean of 61.75 days. The control subjects (11 reporting) took

the pretest Questionnaire between June 26th and July 5th, and the posttest between August 15th and September 6th. The interval ranged from 46 to 65 days, with a mean of 57.18 days. The difference between the means was not significant, $t(17) = 1.47$.

The experimental group (12 reporting) and the control group (16 reporting) were not found to be significantly different in a comparison of the E pretest mean (165.40 with SD 26.30) with the C pretest mean (165.30 with SD 29.30), $t(24) = .0009$. A t test between the change score mean of the experimental group (12 reporting; EX = 26.27; SD = 19.82) and the change score mean of the control group (16 reporting; CX = 6.94; SD = 18.44) yielded a significant difference, $t(24) = 2.65$, $p = <.01$ for a one-tailed test.

The change from pretest to posttest was significant for the experimentals, $t(10) = 4.59$, $p < .005$ for a one-tailed test. The controls did not improve significantly, $t(14) = 1.50$.

Question 56 of the second Questionnaire asked the subjects to evaluate (on a 5-point scale) whether or not their acceptance of their body had increased, decreased, or remained the same since taking the Questionnaire the first time. A t-test was run between the two groups (EX = 4.25, ESD = .87; CX = 3.25, CSD = .93) yielding a significant $t(24)$ of 2.90, $p < .005$, with a one-tailed test.

In order to see whether the women's judgement of their overall degree of change was reflected in their actual change score, a correlation was run between scores on Question 56 and the Questionnaire change

scores (all women reporting). The correlation (df = 10) for the experimental group was .72, which was significant at the .01 level for a two-tailed test. The correlation (df = 14) for the controls was .28, which was not significant.

After each session, the leader/researcher made notes concerning her perception of the progress of each participant in the Workshop. Prior to examining the final data from the Questionnaires, she ranked the participants in terms of how much progress in accepting their bodies she assessed them to have made throughout the seven weeks of the Workshop. A Spearman rho correlation was run using E change scores on the Questionnaire and comparing them with the leader's ranking. The correlation yielded an r of .66, which was significant at the .02 level with a two-tailed test.

The open Questions 51 and 52 (all women reporting) dealt with the participants' likes and dislikes about their bodies. The manner in which the questions were answered was so diverse from subject to subject that it was inappropriate to attempt to analyze these questions statistically. Nevertheless, the responses did permit the researcher to organize the material into a descriptive table of responses which will be included here. These results will be discussed fully in the Discussion section of the thesis.

The table will be presented in the following manner: each category of responses will be named; when necessary, an example (or examples) will be given in order that the reader may understand the category more easily; data indicating how many women responded in this

manner will be given for both experimental and control groups, both pretest and posttest.

Question 51 Data Summary

All women reporting

Category	E1	E2	C1	C2
List of body parts	7	4	9	7
Refers to the body as a whole	0	3	0	0
General positive statements (e.g., "There is nothing I would change about my body")	0	6	5	4
General negative statements (e.g., "Not much")	0	0	1	1
Qualified statements; condition liking (e.g., "calves when toned," "sometimes my face")	2	1	3	0
Face or head only	1	0	2	2
Statements of acceptance (e.g., "I can change it if I wish to, but I am beginning to like and enjoy the way it is now." "I am getting to know my stomach and starting to like it.")	1	2	1	1
Health	1	4	6	4
Body as a tool; as it functions (e.g., "able to do the various physical activities I am involved in")	1	3	2	2
Strength, power	4	5	6	5
Energy, endurance	2	0	2	1
Grace, co-ordination, flexibility, athletic ability	2	0	7	6
Sexuality (e.g., "responsivity in sexual encounter")	2	0	4	4
Genitals	1	2	2	1
Sensuality; responsiveness; senses; source of pleasure (e.g., "responsiveness to touch"; "my body can provide me a means of enjoying life.")	3	3	3	3

Category	E1	E2	C1	C2
Weight	2	2	5	4
Presence, overall femininity (e.g., "My inner sense of my presence," "I carry myself quite well . . . I have a presence."	1	1	1	1

Question 52 Data Summary

All women reporting

Category	E1	E2	C1	C2
Statements of acceptance (e.g., "I now realize that there is nothing about my body that I dislike"; "I am naturally concerned with aging. But that is part of life so I waste little time dwelling on it."	0	4	1	1
Health	0	5	3	2
Flexibility	2	0	2	1
Strength	0	2	0	0
Body as a tool	0	1	1	1
Weight	6	4	10	7
Age	1	0	3	3
Breasts	4	3	8	4

Question 53 (which asked for percentages of time spent on different activities) was also not analyzed statistically because many respondents reported (both when answering this question as well as in Question 55, which asked for comments on the Questionnaire itself) that they had been very confused by this question. A fuller description of the difficulties with this question will be found in the Discussion section.

Question 57 appeared only on the second Questionnaire and asked whether or not the Questionnaire itself addressed the respondent's concerns about her relationship with her body. The scale for this question went from "All of them" to "None of them." In the experimental group (all women reporting), nine indicated that all of the issues were addressed, and three indicated that most of their issues were addressed. In the control group (thirteen women reporting), five indicated that all of their issues were addressed, five indicated that most of their issues were addressed, two indicated that some of their issues were addressed, and one indicated that none of her issues were addressed. The proportion of experimental subjects who reported that all their issues were addressed was not significantly greater than the proportion of the controls, who indicated that all of their issues were addressed, $\underline{X}^2(1, n=25) = 3.38$.

Question 54 (appearing on the second Questionnaire only) asked the respondent how much (if at all) taking the first Questionnaire had caused her to change her thoughts or feelings about her body. This question was included in order to evaluate whether or not there was a

test-retest effect with the Questionnaire. All 28 subjects answered this question. The answers fell into five categories (1) women who said that the Questionnaire had had no effect (3 Es, 9 Cs); (2) women who said it had had some effect (2 Es, 2 Cs); (3) women who didn't know (1 E, 1 C); (4) women who believed that taking the first Questionnaire had led to changes in their attitudes about their bodies (1 E); (5) women who said that the Questionnaire had helped them understand exactly how they felt about their bodies (5 Es, 4 Cs).

A workshop feedback form (see Appendix IV) was issued along with the final Questionnaire to those in the experimental group. The feedback form listed the five elements of each workshop session. The participant was asked to indicate which element or elements of each session she found useful or valuable. Each element had a maximum possible total of 56 (eight women reporting x seven sessions). The results are reported here: (1) Information from the leader - 33; (2) Group discussion - 35; (3) Xeroxed readings - 38; (4) Homework suggestions - 17; (5) Body awareness activity - 21.

Discussion

The speculation that body-dissatisfaction among women is a widespread phenomenon was borne out by the very large response to the advertizing for the Workshop. At a time when many counsellors were having difficulty filling workshop groups and in the summer when many people are reluctant to make a seven-week commitment which might interfere with vacation plans, this author received calls from over 100 women. While the small fee ($15) was most certainly a factor, 65 women (not including the experimentals) agreed to pay the full fee of $65 and asked to be placed on a waiting list for future groups.

This section is a discussion of the results of the research carried out for this thesis. The discussion will follow this outline: Evidence that the experimental and control groups came from the same population; Evidence that the Workshop was effective, with mention of limitations and qualifications to this belief; Consideration of the reasons why the Workshop was effective; Examination of the Questionnaire as a tool or measurement.

Evidence that the Experimental and Control Groups Came From the Same Population

The assumption is made that the experimental and control groups came from the same population. In this respect, the most important evidence is that of the t-test comparison of the pretest scores, which

yielded a non-significant *t*, indicating that the two groups did not differ in regard to the Questionnaire before the Workshop.

Demographically, the experimental and the control groups did not seem to differ in any significant way. The mean age of each group was almost identical, and the age ranges of the two groups were very similar. Both groups were comprised of women in a variety of marital and living situations. In addition, there was a large range of education in each group. Occupations in both groups were quite diverse, with similar occupations in both groups. Questionnaires appear to have been taken at the same time by both groups and a *t*-test comparison of the time elapsed between pretest and posttest did not yield statistically significant results. In addition, assignment to each group was random, placement being made on a first-come, first-served basis. Finally, some might argue that the women whose names the researcher had on a list prior to advertizing the Workshop might represent a particular portion of the population with whom the author came into contact and would differ in this respect from the control group. However, the proportions involved were not significantly different between the two groups.

There is one respect in which the groups may have differed. Three women in the experimental group identified themselves as lesbians. It is not known if there were any lesbians in the control group, as none of the controls were stated lesbians. On the other hand, it is not known whether or not lesbians would differ significantly in respect to body-satisfaction, and the concerns expressed by those lesbians in the

Workshop did not appear to be different in any way from those of the heterosexual women. Therefore, after consideration of all the evidence, we may conclude that the experimental and control groups represent the same population.

Evidence that the Workshop Was Effective, With Mention of Limitations and Qualifications to This Belief

There is strong evidence that the Workshop was effective in increasing the body-satisfaction of the participants. The major evidence for this belief is the statistically significant difference between the change scores of the experimental group compared to the untreated control group which indicates that participants in the experimental group improved more than the control group. Additionally, the t-test comparison between pretest scores and posttest scores within groups indicated that the experimental group had made significant improvement, while the control group did not, suggesting that without the intervention of the Workshop, the women's body-satisfaction would not have improved. As well, Question 56 asked the women to assess their own progress on a five-point scale, and here again there was a significant difference between experiment and control groups in favour of the experimental group (supporting the belief that the intervention was successful). Thus, in terms both of the Questionnaire scores and the women's direct estimation of their degree of improvement, the Workshop appears to have been effective.

There was also strong anecdotal evidence of the success of the Workshop in the form of statements from the participants themselves. These statements come from two sources: (1) statements recorded by the leader during the Workshop sessions; and (2) written comments made on the Questionnaires. Where exact wording is available, quotations will be used. All the rest of the statements are approximate, with every attempt made to record accurately. The recurring theme in the anecdotal statements was one of change. The statements and observations refer to positive movement of the Workshop participants' feelings, attitudes, and behaviours with regard to their bodies.

There is evidence that changes on all three levels did occur, although it is possible that not all women improved in all three respects. As one woman expressed it, "It is difficult to be specific as I now feel good about my body as a whole, physically, mentally and spiritually. I am excited about this process of getting to know me."

Many women made general statements about emotional changes which indicated that the Workshop achieved its goal of increasing body-satisfaction. "I now realize that there is nothing about my body that I dislike." One woman said that she made changes every week, and by the next session they were a part of her. One woman's statement about her body on the first Questionnaire was, "I just plain don't like my body." This same woman reported on the second Questionnaire, "I have decided I am quite satisfied with my body, it is my best friend." It was reported that two husbands had noticed the increases in their wives' acceptance of their bodies. One husband was pleased that now

his wife liked her body as much as he did. The other wife began believing her husband's compliments about her body. Another woman had noticed that formerly her journal had been filled with self-hatred about her body, and she reported after several weeks in the Workshop that she now felt confident and good in her body. This woman said that the Workshop was the most important thing she had done for herself in her life. Other women made these comments: "Generally, I like my body most of the time."; "Generally, I seem more content and pleased with my body than previously."

Cognitively, the women appeared to understand the causes of women's body-dissatisfaction, as presented by the leader, and were able to incorporate new ideas. They began to see how their attitudes about women's bodies in general influenced their feelings about their own bodies. "The Workshop greatly affected my attitudes about my body." "So it's my mind that I dislike--but even this I like due to realizing changes in attitude are very available to me." One women, before the Workshop, had believed that menstruation was a taboo topic of conversation. During the Workshop, she reported that she no longer thought of female functions such as menstruation as illness, and she was willing to talk about her menstrual cramps at work.

It was one of the goals of the Workshop that women would move from an analysis of women's body-hatred in general towards a greater understanding of how these attitudes affect her life, leading finally to greater self-acceptance. It was also an objective of the Workshop that once the women came to accept their bodies, decisions about changing

those bodies (diet and make-up) would be made from that stance of self-acceptance. For example, one woman gave up dieting after receiving information about the success rate for dieters. She realized why it was so difficult for her to stay on a diet and lose weight (not merely lack of willpower) and decided that she was better able to come to terms with her weight: "I am much more comfortable with my fat. I can now acknowledge it, touch it, relate to it as it is, a part of the whole of me." Another woman resented the time spent every morning putting on make-up, which she felt impelled to do because of family pressures. She stopped wearing make-up, even in the face of her sister-in-law's disapproval and criticism.

During the course of the Workshop, many women reported behavioural changes. One woman was very sensitive about her unusually hairy legs and almost never appeared in public in shorts. She came to several meetings wearing shorts and no socks. Many women reported learning how to derive pleasure from their bodies. One woman said she finally felt safe enough about her body to go for a massage. Another participant reported that she wore her red jogging suit out of the house for the first time, while another felt bolder wearing tights and exercise leotard. A woman with varicose veins had not gone out of the house without stockings for 14 years, and she came to the third session with bare legs.

A goal of this study was that ". . . the women would begin to see themselves in a more broadly-based way, and not as just another pretty face or body." It appears that this goal was realized for some women.

"What I like about my body now is that my pleasure of it is not specifically related to its outward appearance."

Originally, this researcher did not anticipate that there would be any measurable change in the women's body-satisfaction in just seven weeks. She assumed that body-dissatisfaction which had been developed over so many years (40 years in some cases) would not change dramatically in only seven weeks. Surprisingly, however, the evidence indicates that the intervention was able to make measureable changes. The anecdotal reports suggest dramatic changes. It is more difficult to determine whether or not the changes in the forced-choice Questionnaire scores, although statistically significant, were dramatic. The Questionnaire is a new tool, being used for the first time, and more information about the sensitivity of this instrument needs to be gathered before any claims to dramatic change can be made. It is, nevertheless, interesting to note that two experimental subjects increased their scores by over 50 points (change scores of +57 and +63). A total of four experimental subjects increased their scores by 30 points or more. In the control group, no one improved by more than 29 points; there was one negative change of -40 points. Thus, it is possible to conclude that (in terms of statistics) the Workshop was successful in bringing about change, but not possible to claim (with no reservations) that the changes were dramatic. For all that, it was predicted that positive outcome in therapy being a matter of degree, if the Workshop was successful, it would produce women who were more accepting of their bodies than totally accepting. It appears that this

prediction was accurate. Therefore, from the anecdotal and statistical evidence this author feels secure in concluding that this specific Workshop achieved its stated goals. Also, because of the random selection of participants, it is also safe to conclude that a workshop following the same outline as this one would also be successful in increasing woman's body-satisfaction.

Nevertheless, there are some reservations which need to be addressed. While there were many statements from Workshop participants concerning positive changes in their satisfaction with their bodies (those reported above being only some and not all of the statements available), it was noted that some members of the control group also made positive statements about their bodies. For example, "I am naturally concerned with aging. But that is part of life so I waste little time dwelling on it," or "Basically, I am happy with my body . . . ." or "I like my body in general." There were, in total, only four such statements found in the Questionnaires of the control group, compared to many more from the experimental group. Naturally, there was a greater opportunity to gather such positive statements from those in the Workshop, because much more time was spent with the experimental subjects than with the controls. However, while there are general statements of acceptance among the control group, what distinguished the statements of the experimental group from those of the control group was the mention of change. None of the statements from the control group include the element of change, indicating that the women were content with their bodies before participating in the study. It

is reasonable, therefore, to conclude that changes in the experimental subjects were due to the intervention of the Workshop.

However, an examination of the change scores for the control group indicates that, at least numerically, some women from this group appeared to improve without aid of the Workshop. Although not statistically significant for the group as a whole, there were increases in some women's scores, although no-one improved more than 29 points. This may be explained in several ways. First, some women may actually have increased their body-satisfaction on their own. Second, it is both the nature of Questionnaire data and a fact of life that people's attitudes about themselves will vary form day to day. Third, this may reflect practice or a desire on the part of the subjects to improve.

Another reservation which needs discussion is the fact that, in terms of change scores, some women from the experimental group did not improve. One woman had a negative change score, another only improved 1 point (hardly enough to claim improvement). Some of the arguments in the preceding paragraph apply here, and need not be repeated. One additional explanation might be that these women had high scores to begin with. Both the woman with the negative score and the woman with the change score of 1 had a score of 200 and 199 respectively on the pretest. However, other women with similarly high scores on the pretest (if we are to consider a score near 200 to be a high score) <u>did</u> improve (in the experimental group; a woman with a pretest score of 202 had a change score of 27, another with 193 had 20). So the idea that

the lack of improvement can be explained by a high initial score on the pretest does not stand up, and we must look elsewhere.

In the opinion of the leader, the major explanation for these two cases on nonimprovement is the fact that these women differed from the rest of the group in that they were self-identified as feminists and came into the group with a very sophisticated and subtle analysis of women's body-dissatisfaction from a socio-cultural perspective. Thus, for these women, the Workshop had much less to offer (as the bulk of the leader's input was that very socio-cultural analysis). It is this author's opinion that this awareness and analysis prior to the group may have contributed to the lack of improvement of these two women on the Questionnaire as a whole. Consistent with this assumption is the fact that the only other self-identified feminist in the experimental group had the lowest change score (+14) of all the remaining experimentals.

Although these three feminists showed least improvement on their overall Questionnaire scores, it should be noted that two of them, nonetheless, rated themselves (Question 56) as having "somewhat increased" in acceptance of their bodies; the third with the Questionnaire change score of -7 did rate her self-acceptance as having "decreased somewhat," she attributed this to ". . . what is happening in my life," rather than to the Workshop itself.

Notwithstanding the positive evidence as to the success of the Workshop, some cautions and reservations should be identified. Some of the improvements seen in the experimentals may have been the result of

a desire on the part of the participants to improve (either for their own satisfaction, or to please the leader), rather than a reflection of a genuine change in attitude. Blind administration and scoring of the Questionnaire by an independent researcher might have helped to guard against the potential source of participant (as well as experimenter) bias--although it might not have eliminated it entirely.

One result of the Workshop which surprised the researcher was that the women did not become intensely emotional in discussions as had been predicted. This may have been due to several factors. Perhaps the researcher was incorrect in making this prediction based on the pilot study; the women in the pilot experiment might not have been representative of the population as a whole. However, this author believes that the lack of emotional depth in discussions was due to other factors. It is the opinion of this researcher that the group was too large. Twelve subjects were used for two reasons. First, in order to increase the power of statistical comparison; second, to insure that there would be a large enough N should some women drop out of the group (only 1 of the 12 women left early, because of prearranged vacation plans and she asked for the readings and read them before taking the posttest Questionnaire). The large group did not allow for deep explorations of each individual's feelings as discussion time was at a premium. Without the time to reach closure in emotional explorations, the women appeared reluctant to delve past a certain point, and the leader felt that such reserve was appropriate and did not encourage deeper exploration. Future groups such as this would be better suited

to only eight women. It is not the intention here to imply that the group did not have a great deal of intimacy, for the opposite was the case. The subject is raised merely to indicate that a smaller group might have been more intimate, emotional, and ultimately beneficial to the participants.

Another reservation which should be addressed is the fact that statistical conclusions are based upon measurements taken on a new Questionnaire. As results are only as good as the measures used to evaluate them, before any sweeping statements about the ultimate effectiveness of the Workshop can be made, more research into this Questionnaire is needed. This issue will be explored more fully below.

A limitation of the research is that no follow-up data were obtained. Thus, while we may conclude that the Workshop was successful at the time of the second Questionnaire, it is not known whether or not these changes lasted. Future research might include a third Questionnaire six months after the group ended.

It should be mentioned here that there is the possibility of bias in the findings of this study as the group leader and the researcher are one and the same person. Question 54 was included in the Questionnaire in an attempt to evaluate test-retest effects. Unfortunately, from some of the responses of the subjects, it appears that many women did not understand the purpose of the question; in future this should be explained more clearly. From the self-report of the subjects, the test effect seems to have been minimal, and the statistically significant differences between groups tends to support this belief.

However, some women indicated that taking the first Questionnaire may have been a part of the process which led to change. For example, "It had some effect as a further step in a continuing process of self-acceptance," or "It has directed my thoughts to thinking more positively about my body." Others indicated that the test alone, without the Workshop, would not have made much change: ". . . without the Workshop it wouldn't have made a great deal of difference." As well, because of the confusion evident in some comments, some respondents may have mistakenly thought that the researcher wanted the first Questionnaire to have changed the way they thought about their bodies, and in a misguided attempt to aid the experimenter they reported that it had. This, coupled with all the evidence above, indicates that a retest effect alone is not a sufficient explanation of the effectiveness of the Workshop.

Reasons Why the Workshop Was Effective

Assuming, as seems well justified, that the Workshop was indeed effective, the next logical area of attention should be an examination of why this was so. Earlier in the thesis, this author presented her analysis of why interventions of other researchers in this area were, or were not, successful. Keeping that analysis in mind, the following elements were seen to have contributed to the effectiveness of the Workshop.

First, the focus of the Workshop was body-liking and self-acceptance of the body.

Second, the educational component seems to have been very important (readings were mentioned 38 times in the feedback forms, information from the leader 33 times). The major thrust of the intervention was to help women place their body-hatred within the cultural context, and this information, which the leader supplied, was deemed very helpful. In addition, it was noted earlier that the Workshop was most successful for those who found the analysis to be new.

Third, information sharing played an important part in the success of the group. Discussion was given high points on the feedback form (35 references). The homework assignments were not mentioned as often, and one explanation for this is that some women when answering the feedback form may have confused the homework assignments with the readings, as both were distributed together at the close of each session. Nevertheless, this author thinks that the ideas and suggestions on the homework sheets were useful, and would be particularly so if a participant wished to continue her progress toward greater self-acceptance.

Fourth, the group format seemed to facilitate changes. The women's movement has used the small growth group for many years, and it has proved to be a useful tool for positive change. This group became cohesive quite quickly, despite its size. The leader noted cohesion at the third session. The group was quick-paced with a high energy level despite hot weather and an overly warm room. Women were reluctant to

stop when time was up, and many were surprised that the two hours had passed so quickly. The group format was necessary for support, and several times women reported how work in the group had helped them make changes and stand fast in those changes in the face of opposition. One woman was encouraged to claim her body in the session on power and control, and as a result of group support she was able to return to her doctor and demand that he take her seriously. Two women discovered that they both had "strange" eating habits, and this discovery helped them accept and be comfortable with their eating patterns. All the women in the group wanted to continue meeting after the Workshop ended, and many carried on for a time. Whether or not those sessions continued for a long time is not known.

Fifth, Clance et al. (1979) speculated that they were able to achieve statistically significant differences on the Body-Cathexis Scale because their intervention included a physical activity. This researcher did not find this to be the case, even though most of the exercises in the Workshop were taken from the same sources as Clance et al. Compared to the other elements, the physical activity was not thought to have been particularly useful by the participants. However, they did indicate that the self-defense exercises were beneficial (these exercises were not from the same source as Clance's). The leader also noted that the self-defense activity created high energy and excitement in the women, and they found it very stimulating to feel the strength in their bodies. There are several possible explanations for why the participants did not find the physical activities useful.

First, perhaps the particular activities were not well chosen. Second, it is possible that not enough time was set aside to experience these activities deeply, and there was little time for de-briefing. The one exception to this was the self-defense activity, which was given much more time, and which was de-briefed in more detail. This fact supports both the first and second explanations. Third, maybe the activities were not explained fully enough, nor integrated well enough into the rest of the session. Fourth, perhaps the activities were not given sufficient focus to be remembered at the end of the seven weeks when the feedback forms were filled out.

Sixth, the Workshop took place over a seven-week period, and it was this author's contention that adequate time was an important factor in the success of the research.

Seventh, the modelling of the leader seemed to have an effect. Her comfort with her less-than-perfect body (according to the current ideal) inspired other women in the group. One woman commented that the leader's enjoyment of her round belly had led to an acceptance and enjoyment of her own.

The feedback forms indicated that it was the <u>combination</u> of all the above elements, rather than any one alone, which led to the Workshop's effectiveness. One participant wrote, "The changes came with the interactions within the group, the readings, etc."

It is possible that the personality, training and experience of the leader played a part in the success of the intervention. It would be interesting to see if the same Workshop, with the same format and

content, would be successful with another leader who shared the information, ideas, and analysis of this leader. Also, it should be noted that the subjects in this study were physically and psychologically "normal" (e.g., no amputees or women suffering from anorexia nervosa). As well, the Workshop was for women only. Any generalizations from this Workshop to the possible success of other Workshops must take these points into account.

Examination of the Questionnaire as a Tool of Measurement

As this was the first time this particular scale of women's body-satisfaction was used, it seems appropriate to discuss the effectiveness of the Questionnaire as a tool of measurement. Preliminary work, discussed above in the Method section under "Questionnaire Validity and Reliability,' indicated that the Questionnaire had both face validity and high stability. There is further evidence for the validity of the Questionnaire. First, the fact that Question 56 (where the women indicated their own evaluation of their progress) correlated with the change scores of the experimental group is consistent with the belief that the Questionnaire is a sensitive measure of women's body-satisfaction. It seems likely that women in the Workshop would have been able to estimate fairly accurately their progress toward body-satisfaction, as they were engaged in a close scrutiny of their feelings and attitudes about their bodies, and would have been sensitive to change. The fact that women in the control group were <u>not</u> able to

assess their progress, as suggested by the lack of a correlation between overall change scores and Item 56 in this group, does not contradict the assumption of validity here. A woman who had not been engaged in a structured examination of her feelings about her body (such as the Workshop provided) would not have been likely to know whether or not her feelings about her body were different from those she had seven weeks earlier.

Second, the correlation between the leader's rankings of the progress of each participant and the subject's change score on the Questionnaire also lends support to the belief that the Questionnaire was indeed measuring what it was meant to measure. Still, this support must be qualified by the fact that both the Questionnaire and the leader's ranking were based on the same criteria for improvement. Another leader might have rated the participants differently.

Third, the results of Question 57 (which asked the women whether or not their issues were addressed in the Questionnaire) indicate that the overwhelming majority of the women's issues were addressed in the Questionnaire. This suggests that the Questionnaire was broadly based and cannot be criticized for being esoteric. This, in turn, lends support to the belief that the Questionnaire is indeed measuring body-satisfaction. There is, however, one reservation here. Unfortunately, it did not occur to the researcher to ask this question (57) on the first Questionnaire, before the women taking the Workshop could have become sensitized to those issues which the researcher deemed important enough to include in the Questionnaire. This might

explain the fact that, while not statistically significant, more women in the experimental group indicated that all their issues had been addressed by the Questionnaire than did the controls. Also, the experimental subjects might have been trying to please the researcher/leader. Future replications of this study would improve the methodology if Question 57 were asked on the first Questionnaire. There was one woman from the controls who indicated in Question 57 that none of her issues had been addressed by the Questionnaire. This woman wrote, "My thinking has changed tremendously . . . I no longer feel a need for the Workshop." It seems likely that she was no longer a member of the population at which this intervention was aimed.

Fourth, support for the idea that the Questionnaire is a comprehensive instrument measuring body-satisfaction can be found in the fact that, on Question 57, the women who thought that not all their issues had been addressed made few suggestions.

Although sparse in number, the suggestions were of interest to the researcher for possible revisions of the Questionnaire. One woman wanted a question about medical issues of power and control over her body. This was not included in the Questionnaire (although it was the topic of a Workshop session) because it was an element over which the women had little or no control, and the Questionnaire aimed to measure only those areas over which the woman might be able to effect change. Another woman suggested a question about scars, but it was the stated purpose of this Workshop to deal only with normal healthy women, and while scars might form an important part of the focus of feelings about

her body, it was not part of the focus of the Workshop. Another woman would have liked a question about breast concerns, and a future Questionnaire would contain some. Other suggestions included diet, exercise, fitness, and health. These areas were not covered in the Questionnaire because it was thought they did not reflect body-liking directly. Revisions of the Questionnaire will take these suggestions into consideration.

The fifth reason for thinking the Questionnaire was effective is the anecdotal information in the form of statements on the Questionnaire supporting the idea that it is a sensitive tool for assessing body-satisfaction. For example, ". . . it made me aware of my thoughts and feelings concerning my body"; ". . . it made me realize I was mostly positive about my body."; "The Questionnaire has helped me think about my body in a clearer light . . . ."; ". . . the Questionnaire is great, very specific."; "The Questionnaire, overall, is very thought provoking."; ". . . a comprehensive Questionnaire, I thought."

There are some reservations about the Questionnaire which will be addressed here. The Workshop and the Questionnaire were created by the same person and would undoubtedly reflect the same areas of concern. In addition, questions were drawn from the material prepared for the Workshop itself. The researcher intended that the Workshop be broadly based, and it was assumed that a Questionnaire based on the Workshop material should be similarly broadly based. The concern here is that the Questionnaire might have omitted areas which need to be included if one is to have a truly comprehensive instrument with which to measure a

woman's body-satisfaction. The evidence outlined earlier above, however, does not lead one to believe that items of importance were ommitted. Rather, it confirms the breadth of the Questionnaire.

There were some specific criticisms of the Questionnaire which subjects noted. The most glaring problem with the Questionnaire was with Question 53 (which asked for percentage of time spent on various activities). Difficulties with this question were enormous. Subjects criticized the question as being awkward, unclear, and hard to answer. Some women responded in minutes, some in percentages, and some in both. Therefore, there was no way to make any comparison, and any analysis would have been very misleading.

One woman felt that the Questionnaire was designed for younger women, and it would be useful to test the Questionnaire with more women over 50 to see if this is true. Several women reported that Question 9 (which asked if pregnant women should wear clothing which accentuated their stomachs) was unclear, and refinements need to be made. Question 29, which explored subject's comfort about appearing in a bathing suit around women needs to be clarified; it was the author's assumption that women would be more comfortable at a swimming pool with women only than with men around. The comment of one respondent questions this assumption.

From the above discussion it may be concluded that the Questionnaire appears to be measuring what it was intended to measure (women's body-satisfaction) and that it is quite sensitive. With a few minor revisions, this Questionnaire could be used as a diagnostic tool for

counsellors wanting to assess the degree of body-satisfaction of their female clients.

The open questions (51 and 52) were included in the Questionnaire for two reasons. First, the researcher wished to make a comparison with the Secord-Jourard Body-Cathexis Scale. Almost everyone who has researched body-satisfaction has used the Body-Cathexis Scale, yet this author chose not to (for the reasons stated above in the Measurement section). The researcher wanted to see if the Body-Cathexis Scale was a comprehensive measure of women's body-satisfaction. Results indicate that the women's concerns went far beyond those items in the Body-Cathexis Scale, as can be seen in the following items taken from both groups (the first Questionnaire only), and representing only a portion of the items mentioned:

Flexibility

Size

Responsiveness

Ability to recover quickly

Crankiness just before menstruation

Smile

Strength

I like my body when I am making love (the sensations of my body)

Freckles on my back

The inner sense of my presence

Grace

The way I can express my sexuality

I don't like my body when I feel sluggish

Healthy

Facial lines

Sagging skin

Varicose veins

Facial hair

My genitals - they are erotic looking and aesthetically pleasing

Expressiveness of my face

Acne scars

Metabolism and muscle strength which makes me active and strong

Co-ordination and sense of balance

I hear very well

Allergy

Moles

Poor eyesight

Pubic hair

Body hair

Cellulite

Strong vaginal odour

Ability to move with co-ordination, to be able to learn to dance and do sports

The amount I sweat

Endurance

Eye-hand co-ordination

Liking the ability to give birth

There were many more items, but these suffice to make the point. The obvious conclusion here is that the Body-Cathexis Scale is much less comprehensive in addressing the issues then is the author's Questionnaire. This supports the researcher's decision to create a new and, hopefully, more complete as well as more subtle Questionnaire. This conclusion is not without some reservations, however. These statements were written before the Workshop, but after the women had completed the Questionnaire. Thus the Questionnaire itself might have sensitized the women to certain issues which they might not otherwise have referred to in answering the open questions. To counter this reservation, the women covered many areas which were not included in the Questionnaire. As well, the Questionnaire merely reminded the women of certain items; it in no way indicated that these areas were necessarily important. Should these open questions be included in future Questionnaires, it would obviously be preferable to place them before the other more structured questions. It might also prove enlightening to expand this area of research and administer both the Questionnaire used in this study and the Body-Cathexis Scale to women and see if one would correlate with the other. Any further research on the Questionnaire would help refine it more and make it an even more useful tool.

A second, but less important reason why the open questions were included was in an effort to get at certain information about which it was difficult to ask direct questions. For example, such questions as "Are you concerned with your health?" might consistently get the response of "always" and would thus lead to overall scores which might

be misleading. Everyone wants to be healthy, even if some respondents are really more concerned than others. Also, the researcher wanted to see if there would be increased tendencies (in the posttest compared to the pretest) to appreciate or be concerned with certain areas (such as health, strength, flexibility). In this respect the open questions appear not to have been suitable. There was, moreover, such great variability of length and kind of response from one woman to another, and even with the same woman from the first Questionnaire to the second that it would have been inappropriate to quantify these data or make comparisons over tests or groups. An attempt was made to compare the number of women in each group who made reference to particular issues on Questions 51 and 52, but the numbers for individual issues were small, and no obvious trends were apparent. Again, this was not the main purpose for the questions (which was the comparison with the Body-Cathexis Scale discussed above). However, tables were included in the Results section in case these might be of interest to researchers in the field.

Conclusions

Many women in North America hate their bodies. Until now, little has been done to encourage women to accept their bodies as they are, rather than to change them to fit into the current fashion of what is considered beautiful. This intervention has shown that it is possible for women who dislike their bodies to come to accept and even like those bodies, without changing them.

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Appendix I

Outline of Workshop Sessions

This Appendix details the ideas covered in each Workshop session. Each session was comprised of: information from the leader; discussion; sensory awareness exercises(s); and xeroxed handouts. In addition, prior to the session, every woman received a "Homework" sheet, which helped her prepare for the next meeting. The "Homework" sheet for each topic can be found following the description for that session. As well, as abbreviated resource list is included with the description of each session. Complete citations can be found in the thesis bibliography and reference sections.

WORKSHOP I--INTRODUCTION AND MEDIA INFLUENCES

Introduction

A. Outline of Procedures: How each session will be organized.

B. Names game.

C. Exercise

Sensing each body part - from Gunther, 1968.

D. Information from leader

1. Invitation to think about their bodies in new ways.
2. Confidentiality.
3. Women's dissatisfaction with their bodies is epidemic and taken for granted. Women are taught to hate their bodies, and even "beautiful" women suffer body-hatred.
4. Women's attention to their bodies has been trivialized, yet this topic must be taken seriously for any change to occur.
5. The way a woman feels about her body affects her self-esteem.
6. In order to combat the pressures which lead women to dislike their bodies, they must first see the negative influences which are operating.
7. Issues concerning body-dissatisfaction are different for men and women.
8. Some factors which may lead to body disliking are:

(a) Many women are conditioned to rate their bodies according to the standards of others.

(b) Often doctors have negative attitudes towards women's bodies.

(c) Some religions teach us to revile or subdue the body.

9. The current ideal of physical beauty for North America women is artificial and unattainable.

10. This unattainable ideal is particularly destructive to minority races.

E. Goals

Each participant was encouraged to set realistic goals for the Workshop. They were reminded that disliking of their body had developed over many years, and would not be completely undone in only seven weeks.

F. Break

Media Influences

G. Information from the leader and the film

1. The film Killing Us Softly (Kilbourne et al., no date) was shown.

2. Advertizing is a socializing force which shapes and creates attitudes.

3. Advertizing influences how we feel about ourselves, and must be taken seriously.

4. Many advertizements suggest that women are dependent on the goodwill of men. Thus, women learn to see themselves in men's eyes.

5. Advertizing people direct most of their advertizing at women, yet have a a patronizing attitude toward them.

6. The diet, cosmetic, and fashion industries profit enormously from women's dissatisfaction with their bodies. For example: Expenditure on diet-related items in the U.S.A. is $16,000 per minute; Beauty and fashion are a $40 billion per year industry; One half a million dollars is spent hourly on cosmetics. While these statistics are for the United States, it is reasonable to assume that a proportional amount is spent in Canada.

7. Nothing in advertizing is unintentional. Each ad costs somewhere between $7,000-$10,000.

8. Emotions elicited by ads are envy, insecurity, shame, quilt. They are intended to undermine a woman's self-confidence and create discontent in order to sell products.

9. In our society, stereotypes exist which imply that what is beautiful is also good, and what is unattractive is bad.

10. Women's bodies are not acceptable in the natural state.

11. Advertizing encourages competition among women.

H. Discussion

Resources

Many of the ideas in this session were gathered from the following (all those citations marked with an * are found in the Reference list, those without an * are found in the Bibliography):

*Chernin, 1981

*Dispenza, 1975

*Fisher, 1983

*Friar Williams, 1976

*Friedman, 1979

*Harmon, 1973

*Kilbourne, date

*Komisar, 1971

*Kullman, 1978

*Kurman, 1978

*Sontag, 1972

Dear Workshop Participant,

The first session of the Workshop--My Body, Can I Like It Without Changing It?--will meet at 7:30 P.M. in room C305 of the Clearihue building at U.Vic. (Clearihue is the first building on your left after the library, and has four wings.) We will meet in C wing, in the staff lounge at the end of the corridor on the third floor (follow the signs). You are allowed to park in the Clearihue lot but not the library lot. It might be a good idea to come earlier to locate the room, and find parking, etc. If for any reason you have decided not to attend the Workshop, please let me know immediately. Although I would be disappointed, I do have people waiting, and I will want 12 people for my research.

In order to make the Workshop as meaningful and useful as possible for you, I have some suggestions of a couple of things you might want to do before our first meeting. These aren't necessary to your participation, but I think they will be useful and enjoyable and will enrich the experience of our first meeting:

1. It might be useful for you to begin to think about your goals for this Workshop. Keep in mind that your negative attitudes about your body have developed over a very long period, and it will take time to counter years of conditioning. Try to make goals that can realistically be achieved in the seven weeks.

2. MEDIA WATCH--Our first session examines advertizing influences on body-hatred. I would like to suggest that you begin to examine advertizements (T.V., radio, newspapers, magazines, billboards, etc.) closely, rather than taking them for granted or ignoring them. As you look at the ads, ask yourself the following questions, particularly those ads for women (cosmetics, fashion, diet, etc.):

    A. Who is selling the product? Who is the authority? Is it a man or woman; how old is she/he; what is

she/he doing; is she/he attractive; is she/he fat or thin; what is the tone of voice used (e.g., warning, cajoling, conspiratorial, threatening)?

B. What is the message of the ad (both obvious and implied). For example, Oil of Olay ads imply that if you are a woman and use their product people will be unable to guess your age and you can convince them that you are younger than you are, which is a desirable thing to do. In other words, it's bad to be old. Or the Oxydol ad which states that while Oxydol makes clothes whiter, that mothers who use Oxydol and provide those white clothes are to be approved of. That is, women who do not wash clothes, or indeed make them white for others, are somehow falling down in their duty.

C. What is your emotional reaction to the ad? Do you feel humiliated, guilty, inadequate, etc.?

3. I would like to suggest that you purchase a notebook or journal to use during the course of the Workshop. It may help you keep track of ideas and thoughts or feelings which come up about your body. It will be especially useful to jot down points which were meaningful to you from the session, or which arise as a result of the suggested assignments for time between groups.

I am very excited about beginning this workshop, and I sincerely hope you are too. I look forward to our first meeting.

P.S. Please bring the fee with you on the 17th.

WORKSHOP II--HISTORICAL PERSPECTIVE ON WOMEN'S BODIES

A. Review of names

B. Exercise

Sensing our body--from Gunther, 1968.

C. Information from leader

1. Attractiveness is important and has implications for romance and success. To deny this would be foolhardy.

2. People who are perceived to be attractive are also seen to have more attractive personal traits (i.e., personality, intelligence, etc.).

3. If a woman believes that she is attractive, she will be able to affect how attractive others perceive her to be.

4. While it is important to a woman to be thought attractive, most women want, at the same time, to be seen in their entirety, and not merely as another "pretty face."

D. Discussion in triads

E. Information from leader

1. Women can start to challenge the current ideal. They begin by asking the question, "Who says?" in relation to what is or is not beautiful or attractive.

2. The ideal has changed across the centuries in Western society.

3. 20,000 years ago, the goddess was "fat." The ancient Greeks favoured a much fleshier silhouette than today.

4. Between 1400-1650 A.D. , the ideal was tummy-centred, with women attempting to give the illusion of pregnancy. Fat was equated with health, and health in turn with fertility. The possibility of fertility was seen as erotic.

5. From approximately 1650-1900 the ideal was more maternal, with the emphasis being on breasts, laps and buttocks. Fleshy and fat women were seen as beautiful. In the 18th century, women began to diet and wear corsets to have narrow waists which accentuated their buttocks and breasts. There was more emphasis on warmth and less on sexuality. Pallor, delicacy and languor (attitudes only possible to the affluent) were prized. Plumpness was still associated with fertility.

6. At the beginning of the 20th century, plumpness was still in vogue, as see in the Gibson Girl and the Floradora Girls. As well, at this time the parallel trend of the Femme Fatale began. The Femme Fatale was sexually free, childless, dangerous, and <u>thin</u>.

Women began to expand their physical activities. They began to prize a silhouette which indicated that the female body could function and move as well as look attractive. Dresses were no longer made for the individual, mass production began. Women started to try to change their bodies to fit the manufactured clothes, rather than having a seamstress tailor their clothes to

fit the individual body. The flapper was in vogue. She was a later, and less sinister version of the Femme Fatale. Socially and sexually free, she had a linear and sometimes androgynous physique, with bound breasts and bobbed hair. She was no longer maternal, but independent. Unfortunately, leanness quickly moved from a statement of liberation to an oppressive fashion requirement.

7. In this examination of the ideal in female beauty, as portrayed by Western artists, we have seen that the ideal over the centuries changes dramatically. Therefore, it is reasonable to conclude that there is no natural ideal.

8. Presently there are two parallel, but incompatible, ideals--the skinny ideal of high fashion, and the more rounded ideal of Playboy and other such men's magazines. Over the last 30 years the ideal woman has gotten thinner and thinner.

F. Break

G. Information from leader

1. Women are expected to be beautiful, and pressures are exerted by media, schools, family, friends, and partners.

2. For some women, their greatest goal in life is to be beautiful.

3. Strategies for discouraging people from commenting on women's bodies were discussed.

H. Discussion

1. Reaction to and thoughts about information.

2. Sharing of personal histories of body-dissatisfaction.

Handouts

Harmon, L.W. (1973) . . . And soma [sic]. Counselling Psychologist, IV, pp. 87-90.

Komisar, L. (1971) The image of woman in advertising. In V. Gornick & B.K. Moran, Eds. (1971), Women in sexist society. New York: Basic Books, pp. 2007-217.

Resources

Many of the ideas in this session were taken from the following:

*Dion, Berscheid, & Walster, 1972

Berscheid, Walster, & Bohrnstedt, 1973

*Bennett & Gurin, 1982, Ch. 2 The century of svelte

*Garner, Garfinkel, Schwartz, & Thompson, 1980

*Douty, Moore, & Hartford, 1974.

"HOMEWORK" SUGGESTIONS--WEEK TWO--HISTORICAL PERSPECTIVE

In our second session we will be looking at the changing ideal of female beauty over the centuries. As well, we will be examining our own personal life history of our relationship with our own bodies. I am suggesting several activities which are directly related to next week's session, and which I hope will make the time most valuable for you. I am also including ideas which aren't as directly related, but which might be fun and useful. Please try to do the ones related to the session, and any of the others which appeal to you, and which you have time for.

1. I would like you to try to write (or think about) your own life history of your relationship with your body. When was the first time that you began to dislike your body or to feel uncomfortable with how your body was? What was happening? Who was there? What were they saying? How did that make you feel? What did your mother say to you about your body? How did she feel about her own body, and being a woman? What did your father think about your body? What is his relationship to his body? How do your parents think about your body now? What do they say, do? Answer these questions in regard to anyone who was or is important in your life (your siblings, friends now and when you were a child, sexual partners, spouses, doctors, etc.). Think about how you were as an adolescent, how you felt about your body, how your friends felt about your body, and their own. What are people saying about your body now (both verbal and non-verbal messages)? What is your emotional reaction to them? Do you respond? When do you dislike your body the most? When do you like your body the best? Who is there at these times? How do they contribute to what you are feeling? If you are receiving negative messages, is there any way you can stop people from speaking negatively about your body? The reason for looking at this personal history is to begin to become clearer about the sources of negative messages about our bodies (as well as positive ones) and to begin to explore this rather than take it for granted.

2. Look in art books for pictures of nude women over the centuries. Notice the changing ideal of female beauty. How does it compare to the current ideal?

3. Go to some public place where you can observe women's bodies either naked or with little clothing (e.g., swimming pools). Look at the bodies, and notice the enormous variety. Compare these bodies to the ideal society sets forth for women, and notice how many actually look like the ideal. Are there ways that some women look which do not conform to the ideal, but which you personnally find attractive?

4. At home, set aside a Dump Cup, and every time you make a remark that is disparaging about your body, put in a penny. This will help you to begin to notice how often you put yourself down. If you are really negative, you will have enough money soon to do something nice for yourself!

Suggested Readings

American Beauty--Lois Banner.

The Century of Svelte--a chapter in The Dieter's Dilemma, by Bennett and Gurin.

WORKSHOP III--PHYSICAL STRENGTH--CONTROL OVER OUR BODIES--PREGNANCY

A. Information from leader

1. Whose body is it?

2. Women are encouraged to control their bodies through dieting, tight clothing, etc.

3. Women's range of movement is limited. Only certain gestures are "feminine."

4. Important decisions about women's bodies are often made in arenas in which women have little or no power, such as legislatures, the courts, the medical and legal professions. The major areas affected are birth control, abortion, and rape.

5. Doctors often have negative or paternalistic attitudes towards women and women's medical issues. Women's ignorance of the working of their bodies permits these attitudes.

6. Women need to claim their bodies aesthetically, legally, medically, and see their body as a source of their own pleasure and not merely that of others.

B. Discussion

C. Information from leader

1. Women can begin to see their bodies as an instrument, not merely as something aesthetic. Being feminine need not mean being

physically weak. A woman who can depend on her body can go more places in safety, and do more interesting things.

2. There has been a negative stereotype of women athletes which has discouraged women from becoming strong. Only certain sports are considered proper for women (those which are aesthetically pleasing, and which do not have strong body contact).

3. Self-defense courses can change a woman's attitude about her body and her ability to defend herself.

D. Exercise

Self-defense exercises were performed by the whole group. The women were taught to balance their bodies with centering. They learned the proper way to holler, punch, and kick.

E. Discussion

F. Break

G. Information from leader

1. Pregnancy can engender both positive and negative feelings about a woman's body, often reflecting the attitudes of others. A woman may wear clothes to hide her pregnant shape for several reasons. Some women feel that pregnancy is a statement that she has been sexual. In addition, pregnancy is often associated with fat, and women do not want to be seen as fat. However, some women

are proud of their big bellies and see them as proof of their ability to create. Most women do not think of themselves as sexually attractive when they are pregnant, despite the fact that some men find the pregnant shape erotic.

2. Many people see childbirth and pregnancy as illness, abnormal. The pregnant woman is often seen as deformed.

3. Women often lose control over their bodies during pregnancy and delivery. For some women, the experience of pregnancy is creative and powerful. For many, however, pregnancy is a time of fear and pain.

4. There is a double standard about exposed breasts in our society. For many, decolletage is completely acceptable, as is nude pictures of women in magazines, yet for these same people, a mother breast-feeding her baby in public is indecent.

H. Discussion

Handouts

Edmonton Women's Health Action Network (1980) Health action: A conference on health and women: Proceedings. No place: Health Promotion Directorate, Health and Welfare Canada--Taking charge of yourself, pp. 79-80; and What makes women run?, pp. 82-83.

Hunnisett, R. (no date) Self-defence for women. Victoria: Unpublished manuscript. Excerpts.

Nunes, M. & White, D. (1972) The lace ghetto. Don Mills, Ont.: General Publishing Co., pp. 112-119. (Chapter on pregnancy).

Resources

In addition to those mentioned above, ideas came from:

Beller, 1972

*Chernin, 1981

*Harmon, 1973

*Leslie, Leith, 1984--Personal communication

*Snyder & Kivlin, 1975.

HOMEWORK FOR WEEK THREE

This week we will be talking about physical strength in women and what it means to be physically strong. We are also going to look at the issue of control (both in terms of who has control over your body and in terms of how we are controlled through our preoccupation with our bodies). We will also discuss pregnancy.

1. Begin to notice how people around you react to your body. What do they say? What do they do?

2. Ask yourself whose body is your body? How often do you make decisions about your body for yourself? How often for others?

3. Do you feel physically strong? When do you feel strong? Do you feel physically weak? When do you feel weak? What are the consequences of feeling strong/weak? What are the benefits and drawbacks? Think about the consequences of your physical strength in terms of your physical well-being, your emotional reaction, and the behaviour you can and cannot participate in.

4. If you can, sometime during the course of this Workshop (or oftener if you want), get a massage, either from a friend or from a professional massage therapist. B.C. Medical will pay for almost all of a half-hour (or a great portion of an hour) of massage if you get a referral from your doctor. Most doctors will give a referral merely for the asking, or you can say you want a massage for relaxation or for some ache you have. This is one way of telling yourself that your body is O.K., it is self-loving, self-nurturing, and feels great. It is also beneficial both physically and psychologically. Most women do not take this advice from me, but I cannot urge it strongly enough.

5. Often women are pitted one against another in competition about our bodies. This is destructive both to women's self-esteem and to the relationship between women. As long as we are kept isolated from each other, we cannot break down the myths surrounding women and their body-hatred. This course is an attempt to break just such isolation, and to combat body-hatred. In light of this issue of competition, ask yourself how often you compare yourself to other women. Do you feel inadequate when you judge them to be more attractive? Do you feel smug when you judge yourself more attractive? Are you doing this with other women in this Workshop? Are you saying to yourself, "Oh, I can see why she came," or "What does she have to complain about?" Is it possible to just see other women's bodies without judging and comparing? How does this affect your relationship to other women? And how does this attitude snap back on yourself?

6. How is your life affected by your preoccupation with your body? How much of your life is controlled by how you feel about it? How are you restricted by your negative attitudes?

7. In preparation for the session on Menstruation, I would like you to begin to become aware of how you are during different points in your menstrual cycle. Begin to plot your emotional states, physical state, psychic state, energy level, sexual level, relationship highs and lows, plot your dreams, eating behaviour.

8. Think about how you did/would feel about your body when/if you were pregnant.

Suggested Readings

For Her Own Good--Ehrenreich and English.

Against Our Will--Susan Brownmiller.

WORKSHOP IV--MENSTRUATION

A. Discussion

As it was the mid-point of the Workshop, the participants were asked to share some of the changes which were taking place for them in terms of their body-satisfaction. How were they reacting to the Workshop? How were family and friends reacting to them?

B. Exercise

Walking warm--from Ernst & Goodman, 1981.

C. Information from leader

1. Menstruation is a part of women's physical processes, and is another place where they feel negatively about their bodies. This Workshop was an attempt to see menstruation as a more positive experience.

2. Menstruation is hidden in our society; it is taboo in polite conversation. Nevertheless, for half of the population, it is a natural occurrence, happening to each physically adult woman 12 times a year.

3. Menstruation seems to have been given little attention in North American scientific literature until around 1969, and even then studies have focused on the negative aspects.

4. In the 19th century, women's normal physical state was seen as sick. Female functions such as menstruation, pregnancy, and

menopause, were seen as abnormal. Femininity was viewed as a disease. Some of these attitudes still persist today.

5. Most women have internalized the negativity surrounding menstruation. Menstruation is not seen as a normal, healthy function. Rather, the unpleasant aspects of menstruation have been emphasized. Few mothers tell their daughters that menstruation is a positive occurrence. Indeed, some mothers do not prepare their daughters for menarche at all. The result is that most girls anticipate menstruation with anxiety, fear, and dread.

6. The menstruating woman has been seen, in this and other cultures, as dirty, unclean, taboo, mysterious, and contaminating. Today, the remnants of these attitudes undermine the self-acceptance and confidence of women in relation to their bodies.

7. Pre-menstrual syndrome (PMS) has been seen negatively as well, and most studies have focused on <u>physical</u> changes pre-menstrually rather than <u>psychological</u> changes. Studies have shown that a change to positive attitudes concerning PMS can alter the physical experience of PMS. Just as new attitudes toward childbirth have dramatically altered many women's experience of delivery, it has been postulated that new approaches to menstruation could also transform it into a more positive experience.

8. It is possible to see the menstrual cycle as an unexplored positive resource. PMS can be viewed as pre-menstrual energy (a time when a woman is most creative, personally aware, and has high psychic energy). Thus PMS could be seen as a time for growth.

9. In some cultures a woman's power as a shaman is revealed to her at menarche, and menstruation is seen as a time of great magical powers for women. Many cultures have elaborate rituals for menarche and the time of menstruation, both positive and negative. This "magic" of women has been both worshiped and feared.

D. Discussion

Handouts

Ehrenreich B. & English, D. (1979) For her own good. Garden City, N.Y.: Anchor Books. Excerpt (p. 4).

Steinmen, G. (no date) If men could menstruate.

Delaney, J., Lupton, M.J., & Toth, E. (1976) The curse: A cultural history of menstruation. New York: E.P. Dutton & Co. Introduction, (pp. 1-2) What every girl should know (pp. 93-97): Lifting the curse (pp. 236-242).

Harrison, M. (1982) Self-help for premenstrual syndrome. Cambridge, Mass.: Matrix Press. List of symptoms, p. 10.

Resources

In addition to those listed above:

Bardwick, 1971

Shuttle & Redgrove, 1978.

HOMEWORK SUGGESTIONS--WEEK FOUR

This week we will be talking about menstruation and women's natural bodily functions. In preparation for our meeting, I would like to suggest that you think about the following things.

1. Make a list of all the words you can think of which refer to menstruation (i.e., euphemisms such as "the curse" or "my friend") and which are used in place of the word menstruation. What is the attitude expressed by the use of these words? We will be comparing lists in the meeting.

2. What is your own personal history with menstruation? How did you find out about menstruation? Who told you, and what were you told? What was the attitude of the person telling you? What did your mother tell you about menstruation. Are these still the attitudes you hold about menstruation? Have they changed? How did those changes come about?

3. Were you prepared for your first period? Who prepared you? How did you feel? What was your mother's attitude at your first period? Your father's?; sibling's?; friends'? Did you have cramps? Was there any family recognition of this event? Was it a time of open celebration? Was it a secret? Was it merely matter-of-fact, etc.?

4. If you have worn tampons, can you remember the first time you used them? Who told you about them? Did anyone give you advice about wearing tampons? Were you nervous about breaking your hymen? Were there any other aspects of this which you remember as interesting or important?

5. What is the attitude towards your menstruation in your house right now, if you are presently menstruating?

6. Can you imagine or create a ritual which would celebrate a girl's first period? What is your response to this idea? Is it exciting? Is it absurd? What does this say about your attitude toward menstruation?

7. Give yourself a 20 minute foot massage with cream or oil, in order to do something nice for yourself and your body.

8. Do you have pre-menstrual symptoms? Check this out with the list I have handed out.

Suggested Readings

The Wise Wound--Penelope Shuttle & Peter Redgrove.

The Curse: A Cultural History of Menstruation--Janice Delany, et al. This book is out of print unfortunately. If you get a copy and are willing to sell it, I would be immensely grateful if I could buy it.

No More Menstrual Cramps and Other Good News--Penny Wise Budoff, M.D.

Self-Help for Premenstrual Syndrome--Michelle Harrison, M.D.

WORKSHOP V--FEAR OF FAT

A. Tuning into your body.

B. Exercise

Head tapping--from Gunther, 1968.

C. Information from leader and discussion

1. Virtually every woman fears becoming fat.

2. Northern American society tends to make value judgements about fat people. The fat person is seen as having flawed character, lacking self-discipline and self-control.

3. Most of what we are told about how fat is gained is misleading, wrong, or meaningless.

4. There are no accepted medical standards for helping people lose weight. Caloric measurement is inaccurate, as is the measurement of energy expended. When weight is lost it can be fat, muscle, or water. Thus measurement of weight loss in relation to fat is also inaccurate.

5. 98% of those who lose weight gain it back, and 90% gain back more. Even though diets do not work, diets are still promoted because there is a powerful economic incentive to do so. $16,000 is spent each minute on diet-related products in the United States.

6. Chronic dieting is seen as dangerous both physically and psychologically.

7. Setpoint theory postulates that the body itself demands a certain amount of adipose tissue. A complicated mechanism controls how much fat each person takes on. Weight gain cannot be explained merely by the number of calories consumed. Fat people eat normal amounts of food, or even slightly less than thin ones.

8. When fat people are seen not as overeaters but as chronic dieters, behaviour and results of dieting make more sense.

9. The setpoint is affected by composition of diet and amount of exercise taken.

10. While most literature focuses on the negative aspects of fat, there are some benefits which come with being fat. The body is more likely to be able to withstand disease with an extra supply of fat. Fat is needed for women's normal reproductive functioning. Peripheral fat converts androgen into estrogen, and thus the post-menopausal fat woman is less likely to develop osteoporisis (which is thought to develop after estrogen supply diminishes).

11. Desirable height-weight charts are based on methodically flawed research. According to more recent studies on mortality rate, the lowest rates have been among those who were 24-38% overweight. Thus, researchers have concluded that heavier is healthier, or no less healthy. Many negative medical attitudes toward fat appear to have no true bio-medical basis, but merely reflect cultural attitudes.

12. The causal relationship between fat and such diseases as high blood pressure, diabetes, and heart disease has not yet been

clearly established. In fact, what is known is only that there appears to be a correlation between such diseases and fat, without any indication concerning which way the cause and effect relationship flows.

13. It has been suggested that exercise lowers the setpoint and can be very useful for fat reduction. In addition, exercise has been useful in the treatment of just such diseases associated with fat mentioned above.

14. Some psychological theories have indicated that the fat woman is poorly adjusted, using fat as a wall against sexual encounter. Other psychological issues are obscured with her preoccupation with fat. Other theorists see this as merely another way that the fat woman is stigmatized, and that fat women are indeed quite healthy mentally given what they have to endure in a society which discriminates against the fat woman. In all probability, fat can be best understand using a combination of biological and psychological theories and insights.

15. Our relationship to food is a highly complex issue which has not yet been thoroughly studied.

16. Most fat women resent having to be thin to be acceptable.

Handouts

Reed, K. (1975) The food farm. In Sargent, P.Ed. Women of wonder. New York: Vintage Books, pp. 125-136.

Ritenbaugh, C. (1982) Obesity as a culture-bound syndrome. Culture, Medicine and Psychiatry 6, pp. 347-361.

Resources

The author is aware that the ideas and attitudes described above are controversial. In order to fully understand the thinking which formed these opinions, it is recommended that readers consult the two major sources for this session which are:

*Bennett & Gurin, 1982

*Ritenbaugh, 1982

In addition, the following resources should prove useful:

*Chernin, 1981

*Flack & Grayer, 1975

*Garner, Garfinkel, Schwartz & Thompson, 1980

*Graves, 1982

Orbach, 1978.

HOMEWORK SUGGESTIONS--FEAR OF FAT

1. Please try to read the handout Obesity as a Culture-Bound Syndrome by Ritenbaugh. It's an excellent article and answers so many questions about the whole issue of obesity and health.

2. If you had a friend who was fat, and you needed to describe her to someone who was to meet her at a busy public place, what words would you use to describe her (e.g., plump, chunky, fat)? Why would you use one word rather than another? What is the tone of words used to describe fat people?

3. Do you think there are stereotypes about the sort of people who are fat? Are certain characteristics of personality associated with fat people versus thin people? Do you have preconceived ideas about the willpower and self-discipline of fat people or thin people? Do you apply these stereotypes to yourself (whether or not you are fat or thin)? How does that affect you?

4. Do you really think that fat people are unattractive and that thin people are attractive? Have you ever felt attracted to a fat person? Is it possible to see the shapes of fat people as pleasing aesthetically once you stop judging them to be unattractive? How much of your response to fat is conditioning and how much is aesthetic reaction?

5. If you have dieted, was it successful? Did you keep the weight off? How did you feel in relation to yourself; the others in your life; food, when you were dieting? Did you feel apart, denied, outcast, etc.? How do you feel when you aren't dieting? Which feels better, dieting or not dieting (when you judge yourself to be overweight). Do you feel that you are accomplished when you can diet and stay on it? Do you feel superior to others who can't stick to a diet? Does this attitude snap back at you when you slip off your diet or gain weight back?

6. If you consider yourself overweight, how do you know you are overweight? Over what weight? Who has told you? What does it mean to be overweight? Who has decided what your weight should be? On what basis was that judgement made? Are ideal weights and heights really based on solid evidence about health and life expectancy? Have you ever questioned people who tell you what your weight should be? (Read the article mentioned in #1 for insight into these questions).

7. Have you ever postponed activities in your life until you were thin, or your body was "acceptable"? Did your body get to the acceptable place or were you never able to let yourself do or have the things you had postponed? How does that make you feel?

8. This one may be difficult for you to consider doing; many women have found this an emotionally difficult exercise, but think about giving it a try. Stand in front of a full-length (or 3-way) mirror and look at your body. Now, without judging it, describe it as if you were trying to communicate to a blind person. For example, my thighs are large, rounded, tapering to my knees, and the flesh is dimpled. Do not say, "I have nice thighs," merely try to see your body without rating it, either positively or negatively.

Suggested Readings

The Obsession: The Tyranny of Slenderness--Chernin.

Fat is a Feminist Issue (both original and II)--Orhback.

The Dieter's Dilemma--Bennett & Gurin.

WORKSHOP VI--SEXUALITY

A. Business

Discussion of ideas for an ending ritual, and for a group party.

B. Exercises

1. Shake out each body part.

2. Imagine a person touching a part of your body which you like. Imagine a person touching a part of your body which you do not like. What's the difference in your reactions?

C. Photographs of female genitals were shown

D. Information from leader and discussion

1. Good sex requires: information; practice; communication; and co-operation.

2. How a woman feels about her body will likely affect her ability to enjoy sexual contact. Satisfaction appears to be related to positive body image.

3. Attitudes of modesty have led to the ignorance of women concerning their genitals.

4. Many women find their genitals repugnant, and assume that their sexual partners feel the same way. The Freudian notion of penis envy has contributed to this attitude.

5. In addition, many women are embarrassed by their sexuality. Women believe that they are not supposed to say that they like sex.

6. The whore/madonna contradiction exists where women's bodies are simultaneously described as temples and/or dirty. Women receive conflicting messages. It is acceptable for them to be sexy, or sex-objects, but unacceptable for them to be sexual or lusty.

7. Until very recently, women's sexuality has been defined in male terms. This situation has led to such destructive and erroneous notions as nymphomania, frigidity, and the clitoral/vaginal orgasm controvery (which has no basis in actual fact--all orgasms are clitoral). As late as the 19th century, it was believed that healthy women had no sexual feelings at all.

8. Many women do not have orgasms with penetration alone, but need direct clitoral stimulation.

9. Sexually, many women ignore their own needs, and see their bodies as existing only for the pleasure of others.

10. Until recently, most sex manuals were written by men. Women were seen as passive, and a woman's body was described through its use to a male partner.

11. Some women have been caught in a "romantic" idea of sex. They believe that the "right lover" will know exactly how to please them without being told. They think that sex isn't "good" if they have to instruct their lover in what pleases them. This places undue and unrealistic pressure on the partner, and it is unlikely to bring about sexual satisfaction for either party.

12. Sex must be taught, and one of the best ways for a woman to find out what she enjoys is through masturbation.

13. Masturbation is not a second-rate sexual activity, but rather a pleasurable experience in itself. In addition, masturbation need not be in competition with intercourse.

14. Two-thirds to three-quarters of all women masturbate and reach orgasm 95% of the time.

15. Masturbation is a good way to become familiar with our body and learn to appreciate it more.

16. Each women deserves sexual pleasure in her own unique way. Women have to begin to take responsibility for their own sexual satisfaction. As well, women have the right not to enjoy sex or have orgasms, without feeling guilty or being judged.

Handouts

Demeter, K. (1977) Women's sexuality; Myth and reality. Palo Alto: Up Press. Chapter 4, Masturbation: Knowing ourselves, pp. 21-25.

Ernst, S. & Goodison, L. (1981) In our own hands. Los Angeles: J.P. Tacher, Inc., pp. 141-142.

Hite, S. (1976) The Hite report. New York: Dell, pp. 13-21, 179-182.

Resources

In addition to those mentioned above:

*Barbach, 1975

Dodson, 1974

*Friedman, 1975

*Leiblum, 1980.

HOMEWORK SUGGESTIONS--SEXUALITY

1. This one I recommend the most, as I think it will prepare you for our meeting. One of the handouts is the Questionnaire from the Hite Report. Read it and think about the questions which apply to you. I think it will give you lots of information about yourself.

2. Which parts of your body do you hide? Which parts do you accentuate? What does this say about your liking of those parts? How does the liking of these parts enhance/interfere with your sexual pleasure? How does your overall feelings about your body interact with your sexuality.

3. What messages have you received about your genitals from: your mother; father; siblings; friends; sexual partners; the media? What are your own attitudes about your genitals?

4. What was/is the attitude of your family and friends about your sexuality? Is it openly discussed or is it a taboo topic? Are you expected to be sexual, or not at all? How do these attitudes affect your sexual behaviour or enjoyment?

5. What were you told about masturbation as a child (by your mother; father; friends; siblings; etc.)? What are your attitudes about it as an adult? Is masturbation merely something a woman does when she doesn't have a sexual partner, or is it an enjoyable activity on its own? Did your mother ever talk to you about masturbation? What did she say? Did she masturbate? Could you talk to her about it now? Would you?

6. Have you looked at your genitals carefully? Look at your genitals in a mirror. To do this, find a moment when you can have some privacy. Take a hand mirror and hold it in front of your genitals while you are seated and your legs are apart (a hand mirror which can stand up by itself is best as it leaves both hands fee). Hold a flashlight and shine it into the mirror. The mirror then will flash the light back onto your genitals and your genitals will be well illuminated and you can see them in the mirror. Either draw your genitals, or describe them in works, in a non-judgemental way, as if you were telling someone who had just become blind, but who knew about colour and texture. Most women have never seen their genitals this clearly. Remember, everyone's genitals look different, and there is no right colour, shape, size, texture, or conformation. There is an enormous amount of differences between women. If you are really daring, you can do this with a friend, or several friends, and compare. Do what feels comfortable for you.

7. To experience genital feeling, and to know where your vaginal muscles are, tighten and relax your genital muscles. If you don't

know where those muscles are, stop mid-stream when you are urinating. The muscles which stop the urine flow are your vaginal muscles. Practise feeling them when you can, for a few seconds each time. Strengthening these muscles can increase your sexual pleasure.

8. Make love to yourself. Take a hot bath or shower to be lovely for yourself (use scented oils or bath salts if you like). Use candles, or incense. Wash and touch yourself all over, tenderly. Explore your body as if you were your own lover and were encountering your body for the first time and you adored it. Try singing or humming, or put on some particularly sensual music (please, no radios or stereos too near the tub--electrocution is not a turn-on). Relax. Think erotic thoughts. Take your time. When you are done, dry yourself in a clean, fluffy towel, gently. Massage yourself with oil or cream, all over. Love yourself.

Suggested Readings

The Hite Report--Shere Hite.

For Yourself--Lonnie Garfield Barbach (Subtitle: The Fulfillment of Female Sexuality).

Liberating Masturbation--Betty Dodson.

Women's Sexuality: Myth and Reality--Kass Demeter.

WORKSHOP VII--AGING AND MENOPAUSE

A. Exercise

1. Bend over and have your partner slap your back--from Gunther, 1968.

Aging

B. Information from leader

1. We live in a youth-oriented society, where the aged are stigmatized, disenfranchised, and invisible. This is particularly true for women.

2. In a society that has used 10-year-old models as the ideal for women's fashions and cosmetics, women are constantly urged to deny their age. Beauty for women has become synonymous with youth.

3. The cosmetics industry has a strong economic incentive to perpetuate women's denial of age.

4. The young ideal for women is smooth, soft, hairless, unlined, and unmuscled. There are only a few years in a woman's life when this is physiologically possible.

5. Age exaggerates sex-role differences. Men not only are permitted to show their age, but they are considered "old" much later than women. As men age, they generally gain status (money, position). As so much of women's status has been based on their physical appearance, as women age, they lose status. The popular

notion is that the man should be older than the woman. This, coupled with their increased status, means that the older man is far liklier to be able to find a partner than the older woman.

6. If a woman is prized mainly as a breeder of children, she will lose much of her status when she is no longer able to conceive.

C. Discussion

Menopause

D. Information from leader and discussion

1. Like menstruation, menopause has been a taboo subject and little information has been available until very recently. Again, the menopausal woman is not seen as "normal."

2. Some doctors are inclined to use menopause as an excuse for a whole panoply of unrelated problems. Medical magazines tend to show the menopausal woman as neurotic, complaining, depressed, erratic, or nagging.

3. Menopause is best understood in the threefold context which includes physical, psychological, and social issues.

4. Menopause is a natural body occurrence, not an illness.

5. Menopause is a complex issue, and women should be wary of simplistic statements about it.

6. Some of the inaccurate myths about what happens to women in menopause include: excessive weight gain; excess facial hair;

depression; nervous breakdown; insanity; sexual maladjustments. In fact, women may experience some of the following: hot flashes; night sweats; dryness of the vagina; headaches; palpitations; lapses of memory; weight gain; changes in eyesight; skin changes; breathlessness; swollen hands or feet; irregularity; sleeplessness or restless sleep; irritability; nervousness; joint pain; vertigo; hot feet. It is important in analysing the cause of these problems that the whole woman be taken into account. The cause of such occurrences are, most likely, an interaction of the following: hormone imbalance; less active lifestyle; eating habits; and emotional problems.

7. Menopause need not be seen negatively, in spite of the difficulties that the older woman encounters mentioned above. This time in a woman's life can be an exciting adventure full of challenges. It is usually at this time that a woman has more time and freedom for herself. In response to the woman who said, "But I would be 50 before I received my degree!" the answer is, "Yes, but you will be 50 anyway, whether you get your degree or not!"

E. Final business: Party: Research Questionnaires

F. Future plans of participants concerning continued growth toward body-satisfaction. All women present intended to continue meeting as a leaderless group.

G. Each woman made a statement to the group about herself, her body, the Workshop, etc.

H. Closing ritual

Part 1--Casting out

Fashion magazines were examined and pages with offensive statements or pictures were shared with the group and then torn up.

Part 2--Claiming

A final candlelit ceremony took place in which each woman wrote out one positive wish or thought about her body on a piece of paper. Each woman placed the paper in a silver bowl, choosing whether or not she would share it with the group. The notes were collected, sealed in pretty paper, and ritually burned at the final party.

Handouts

Posner, J. (1977) Old and female: The double whammy. Essence 2, pp. 41-48.

Budoff, P.W. (1981) No more menstrual cramps and other good news. New York: Penguin Books, pp. 192-217.

Resources

In addition to those above:

Bell, 1975

Francher, 1973

Moger, 1980

Sontag, 1972.

HOMEWORK SUGGESTIONS--AGING AND MENOPAUSE

1. How do you feel about your body aging? Are you most aware of the physical changes and the limitations which may accompany them (such as strength, energy, ability to perform certain tasks); or are you more concerned with beauty and acceptability. If old people were venerated, respected, and admired, would your thoughts and feelings be different? How much of your attitudes would change if you were a man?

2. We often see pictures of old men with very little clothing on. For example, there is a particularly famous photo of Pablo Picasso on the beach at the age of 90 wearing nothing but shorts and sandals. Can you imagine a similar picture of a 90-year-old woman? We see Picasso as completely acceptable, but most people would not see the woman as acceptable. What does this say about the double standard of aging for men and women in our society?

3. Look at advertisements which feature old people. What are they doing? What are they concerned about? What does the ad industry tell us about the activities of old people? What is the message?

4. What have you thought about your own menopause, or menopause in general? What facts do you know about menopause? What are current attitudes and myths about the menopausal woman? What are the implications of jokes about the menopausal woman? How do the attitudes of the society around you affect how you will feel about your own menopause?

5. Try to imagine a beautiful old woman. Not a woman who is beautiful because she doesn't show her age (dyes her hair, has had her face lifted, etc.) but a woman with grey hair, wrinkles, lines. Can you see an old woman like this as beautiful, or at least interesting? Try to find an old woman and attempt to see her this way. Say to yourself, "This woman looks beautiful even though she does not look young." Who says that the only beauty is youthful beauty? Do you believe that?

6. Create your own fantasy about you and your body, where you are accepting and pleased with your body, and perhaps everyone around you feels the same way. Be as wild and imaginative as you want to. Create a scene where you love your body and are completely at ease in it. Where are you, what are you doing, who else is there, etc. Could this fantasy every happen in real life? Could you come closer to it than you are now? If you would like to share this fantasy, we can do so in the final group.

7. Remember the sensing exercise we did in our first meeting, where you checked in with every part of your body. Try to do that once a day, to become more aware of your body, and feel it from inside.

8. How have your goals about your body and your relationship with it changed (if at all) from the beginning of this Workshop to the end? What goals do you have now for continuing your work on the acceptance of your body? What plans have you made? What would you like to do after the Workshop finishes? Can you arrange to get what you want?

Suggested Readings

Natural Menopause--Susan Moger and Prime Time in Victoria.

The Stone Angel--Margaret Laurence (a novel).

No More Menstrual Cramps and Other Good News (ch. on Menopause)--Penny Wise Budoff.

Women of a Certain Age--Lillian B. Rubin.

Appendix II

Questionnaire

The Questionnaire was scored on a five-point scale, with A=5; B=4; C=3; D=2; E=1. All questions were scored this way with the exception of the following: 1, 2, 4, 8, 10, 15, 16, 19, 20, 22, 23, 28, 44, 36, 50. These questions were scored in reverse order (i.e., A=1; B=2; C=3; D=4; E=5).

QUESTIONNAIRE

CONFIDENTIAL

This Questionnaire measures attitudes to women's bodies in general, and your feelings and attitudes about your own body.

There are no right or wrong answers. I am very interested in what you are thinking or feeling, so try to answer the questions in a manner as true to your experience as possible. I am interested in your thoughts or feelings at this moment in time, rather than in the past or in the future.

The information in this Questionnaire will be kept completely confidential and will only be seen by me.

Take all the time you need to make your answer really reflect your attitudes, feelings, or behaviour.

The more information I have about women's attitudes to their own bodies and those of other women, the more likely it will be that I can create an effective Workshop.

If you find any of the questions unclear or hard to understand, would you please note that beside the question, and if possible, will you elaborate on your difficulties in answering the question.

Thank you very much. This will be very helpful.

PLEASE MARK YOUR ANSWER ON THE COMPUTER SHEET ENCLOSED

Important: Please fill out the computer sheet beginning with number 1 and not number 121, which is on the other side of the computer sheet. The number of the questions correspond to the number on the computer sheet. Please use the enclosed pencil, and please return it.

****

THE SCALE FOR THE FOLLOWING QUESTIONS IS:

A. Strongly Disagree

B. Moderately Disagree

C. Undecided

D. Moderately Agree

E. Strongly Agree

e.g. If you strongly agreed with the following statement:

"Children deserve good schools"

you would make an E. next to the number on the computer sheet.

1. My own sense of the attractiveness of a woman generally reflects how closely she resembles the currently accepted ideal of female beauty (as represented by models in such magazines as Vogue, Glamour, Cosmopolitan, etc.).

A. Strongly Disagree

B. Moderately Disagree

C. Undecided

D. Moderately Agree

E. Strongly Agree

2. Women who do not resemble the current ideal of physical attractiveness should wear clothes which cover their bodies rather than reveal their bodies.

3. It is important for a woman to be physically strong.

4. Developed strength and muscles are unattractive in women (this question refers to muscles which are developed and appear as a result of regular common activity, such as sports or physical labour, and <u>does not</u> refer to muscles developed through body building where the purpose is to create muscle shape or size for such events as the female equivalent of a Mr. Universe Body Building Competition).

5. I think a moderately fat woman can be physically attractive (here fat refers to women who would be described as fat, but who are not extremely obese).

A. Strongly Disagree

B. Moderately Disagree

C. Undecided

D. Moderately Agree

E. Strongly Agree

6. I think a moderately skinny woman can be physically attractive (here skinny refers to a woman who would be described as skinny, but who is not anorexic or cadaverous).

7. I think a pregnant woman can be physically attractive.

8. In the last few months of pregnancy, when a woman's stomach is very large, it is not appropriate for her to be in a job where she is in the public eye (e.g., Receptionist, T.V. Interviewer, Store Clerk).

9. Pregnant women should wear clothing which accentuates their stomachs.

10. Generally speaking, I consider a woman more attractive at age 25 than at age 45.

11. Older women (over 65) can be sexually attractive.

A. Strongly Disagree

B. Moderately Disagree

C. Undecided

D. Moderately Agree

E. Strongly Agree

12. Old women who look their age, (e.g., wrinkles, etc.) can be physically attractive.

13. Many aspects of women's menstrual cycles are positive occurrences.

14. Many aspects of menopause are positive experiences.

15. At the present time, if I could change my appearance in any way (including very big changes like becoming taller or shorter, or changing the shape or size of my breasts) by <u>just wishing</u>, I would do so.

16. At the present time, if I could change my appearance in any way (including very big changes like becoming taller or shorter, or changing the size of my breasts) by <u>surgery</u>, I would do so.

IMPORTANT

THE SCALE CHANGES FOR THESE QUESTIONS

The Scale for These Questions Is:

A. Almost Never

B. Seldom

C. Occasionally

D. Often

E. Almost Always

For example, if you did almost all of your shopping at Thrifty's Food Store you would answer this question by Marking E. on the answer sheet.

"I shop at Thrifty's Food Store."

****

17. I am pleased with my body.

18. When people compliment me about my physical appearance I tend to believe them.

A. Almost Never

B. Seldom

C. Occasionally

D. Often

E. Almost Always

19. When others judge my body negatively, I tend to agree with them in my mind.

20. If and when I look in a full-length mirror, I see my body part by part.

21. If and when I look in a full-length mirror, I see my body as a whole.

22. If and when I look in a full-length mirror, I tend to look at myself from the neck up.

23. If and when I look at my body in a full-length mirror, I concentrate on my physical faults.

24. If and I look at myself in a full-length mirror, I concentrate on my physical assets.

A. Almost Never

B. Seldom

C. Occasionally

D. Often

E. Almost Always

25. When I get the opportunity, I look at my body in a three-way mirror.

26. I like looking my age (in this question I am trying to find out how willing you are to look your chronological age rather than older or younger).

27. My body is a source of pleasure for me (this includes appearance, physical sensations, and sexual sensations).

28. My body is a source of shame and humiliation for me.

QUESTIONS 29 AND 30 ARE NOT MEANT TO BE AN EITHER/OR CHOICE. IT IS PERFECTLY REASONABLE TO ANSWER "ALMOST ALWAYS" TO BOTH (OR "OCCASIONALLY" TO ONE AND "ALMOST NEVER" TO THE OTHER, ETC.)

29. If I chose to swim, I would feel comfortable going to a public swimming pool when only women were there.

A. Almost Never

B. Seldom

C. Occasionally

D. Often

E. Almost Always

30. If I chose to swim, I would feel comfortable going to a public swimming pool when men were there.

31. I am fond of my body.

32. When it is relevant to the conversation, I indicate to people close to me that I like my body.

33. When it is relevant to the conversation, I indicate to people who are not close friends or family, but merely acquaintances, that I like my body.

34. I like close, intimate friends to touch my body.

35. I delight in my body (this includes appearance, physical sensation, and sexual sensation).

A. Almost Never

B. Seldom

C. Occasionally

D. Often

E. Almost Always

QUESTIONS 36-40 DEAL WITH MENSTRUATION. IF YOU DO NOT MENSTRUATE, TRY TO IMAGINE HOW YOU WOULD ANSWER IF YOU DID.

36. When it is relevant to the conversation, I am comfortable (or would be) telling close female friends or female family that I am menstruating.

37. When it is relevant to the conversation, I am comfortable (or would be) telling close male friends or family that I am menstruating.

38. When it is relevant to the conversation, I am comfortable (or would be) telling female acquaintances that I am menstruating.

39. When it is relevant to the conversation, I am comfortable (or would be) telling male acquaintances that I am menstruating.

40. Aspects of menstruation are a positive experience for me.

A. Almost Never

B. Seldom

C. Occasionally

D. Often

E. Almost Always

41. Although there may be things about my body that I do not like, I am happy enough with what I've got to accept my body.

42. I like the way my genitals look.

43. I like the way my genitals smell.

44. I am embarrassed by my vaginal odours.

45. I enjoy the sexual sensations of my body.

46. I would be reluctant to approach a possible sexual partner because of my physical appearance (this refers to the situation where you do not have a regular sexual partner but might be seeking a new partner. If you are presently in a regular sexual relationship, try to imagine that you are looking for a new sexual partner when answering this question).

A. Almost Never

B. Seldom

C. Occasionally

D. Often

E. Almost Always

47. Generally, in terms of my physical body, I think of myself as an attractive sexual partner.

48. If someone were to tell me that she/he thinks my genitals are attractive, I would tend to believe her or him.

49. I am comfortable when someone touches my genitals during a sexual encounter.

50. Often women are anxiously thinking about their body, <u>even when they are engaged in other activities</u> (e.g., when walking or talking to a friend you may be worried about how your trousers fit and reveal your body, and how someone may be judging your body). This kind of thinking I would describe as "anxious" thinking. The question here is: I engage in "anxious" thinking about my body.

THE FOLLOWING ARE OPEN QUESTIONS. USE THE SPACE PROVIDED ON THESE SHEETS TO ANSWER THEM. IF YOU NEED MORE SPACE, TURN THE PAPER OVER. THEY WILL NOT BE ANSWERED ON THE COMPUTER SHEET.

51. What I like about my body is: (Please be specific).

52. What I <u>do not</u> like about my body is: (Please be specific).

In this question I am trying to see what your ideal relationship to your body would be:

I would like to know how much time you spend on different aspects of your body at the present time, and also what amount of time you would ideally spend. I will ask you to determine the percentage of your time for each item, both at present and ideally.

		% of time at present	% of time ideally
A.	I spend time on my physical appearance.	_____	_____
B.	I spend time on my health.	_____	_____
C.	I spend time on my physical tone (strength, flexibility, stamina, etc.).	_____	_____
D.	I have negative thoughts about my body.	_____	_____
E.	I have positive thoughts about my body.	_____	_____
F.	Other (please specify)	_____	_____
	Other (please specify)	_____	_____
	Other (please specify)	_____	_____

If you need more space, please turn over.

54. To what extent do you think that taking the first Questionnaire has caused you to change your thoughts or feelings about your body?

55. Comments about the Questionnaire in general, or certain questions in particular.

I WANT TO THANK YOU VERY MUCH FOR TAKING THE TIME TO ANSWER THIS QUESTIONNAIRE.

56. Circle the answer that applies.

Since taking the Questionnaire the first time, my overall acceptance of my body has:

A. Increased quite a lot
B. Increased somewhat
C. Remained the same
D. Decreased somewhat
E. Decreased quite a lot

57. Circle the answer that applies.

Now that you have completed the second Questionnaire, I would like you to think back upon the issues and concerns about your body which prompted you to want to take the Workshop--"My Body--Can I Like It Without Changing It?" Of the issues which were relevant for you, the Questionnaire included:

A. All of them
B. Most of them
C. Some of them
D. Few of them
E. None of them

If you did not answer A. All of them, and not all of your concerns were covered in the Questionnaire, would you describe what areas, issues, or concerns might have been added to the Questionnaire? Please use the space provided, or turn over if more space is required.

58. I would appreciate some biographical information about you.

Age: _____

Occupation: _____

Marital Status: _____

If you are not married, are you living with a partner: _____

If you are married or living with a partner, for how long have you lived together: _____

Education (last completed): _____

THIS IS THE END OF THE QUESTIONNAIRE

Again, thank you so very much for taking the time to answer the questions.

Appendix III

Topics Relating to Body Image Found in the Scientific Psychological Literature

Body image and perception. This area concerns itself with distortion in body image perception, and a person's ability to assess accurately her body size (particularly with anorexic or obese women) (Ben-Tovim et al., 1979; Gray, 1977; Slade, 1977; Thompson, 1978; Wingate & Christie, 1978).

Body image and self-esteem. This has been discussed above.

The importance of physical development to self-esteem. McLean, 1976.

What body parts related to self-esteem. Mahoney & Finch, 1976a, 1976b.

What body parts are considered important in our society. Clifford, 1971.

Psychosomatic disorders. How dislike of certain body parts relates to certain psychosomatic disorders. Clifford, 1971.

Which body types are preferred. Rerers to preference to ectomorphs, endomorphs, or mesomorphs. Kirckpatrick & Sanders, 1978.

Relationship of body types to personality traits. Mentioned above.

In addition, Brenner & Hinsdale (1978); Douty et al. (1974); Staffieri (1967).

Body awareness and relationship to emotional health. Armstead (1977); Kramer (1978).

Body boundary issues. Body barriers, personal space, penetration issues. Fisher in Douty et al. (1974); Haft (1975).

Development of body image. Mentioned above.

Appendix IV

Feedback Form

In preparing future workshops like this one, I would like to build on, or enhance those elements which you found useful, valuable, or helpful. Your reactions will be very useful for me when I come to design my next workshop. Therefore, I would like to get some feedback from you.

Each session included several elements:

1. Information from the leader (film, talk)
2. Group discussion
3. Xeroxed readings
4. Homework suggestions
5. Body-awareness activities.

Now I would like you to think about each of the sessions listed below, and tell me which element or elements (as many as apply) you found to be useful or valuable to you.

SESSION 1--MEDIA INFLUENCES ON WOMEN'S BODY-SATISFACTION

SESSION 2--HISTORY OF CHANGING IDEALS IN BODY TYPES AND PERSONAL HISTORIES

SESSION 3--CONTROL OF OUR BODIES, STRENGTH, OWNERSHIP, PREGNANCY

SESSION 4--MENSTRUATION

SESSION 5--FEAR OF FAT

SESSION 6--SEXUALITY

SESSION 7--AGING AND MENOPAUSE

Suggestions for activities you might like to see included in future workshops of this kind.

Vita

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Title of Thesis:

BODY-DISSATISFACTION IN WOMEN: THEORY, GROUP COUNSELLING INTERVENTION, AND MEASUREMENT.

Author: [redacted]

Susan Linda Slatkoff