Oppression through obsession: A feminist theoretical critique of eating disorders

Jesse Carin Christopulos

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OPPRESSION THROUGH OBSESSION:
A FEMINIST THEORETICAL CRITIQUE OF EATING DISORDERS

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

By
Jesse Carin Christopulos
June 1995
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Approved by:

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6/9/95 Date
ABSTRACT

This research project focused on the problem of eating disorders in young women. Feminist critical theory provided a framework from which to examine the indoctrination of women with an obsession with weight, diet, and exercise by a patriarchal society. This perception places the responsibility for the problem in the hands of an oppressive community, where it belongs.

The research sample consisted of sixteen tenth-grade females from a San Bernardino high school. They responded to questionnaires containing inquiries about self-esteem, body image, knowledge of eating disorders, value of women, and the impact of the media on their thinking. Ten members of the sample were given a presentation about restructuring one's thinking to rebel against the patriarchal indoctrination by society and the media, while the other six members served as a comparison group. This project shows that the administration of a similar presentation to all high-school age females will reduce, if not obliterate, the prevalence of eating disorders.

Although most of the respondents scored better on the post-test than on the pre-test, the group of respondents that received the intervention did much better as a group than did the group that did not receive the intervention. Those who received the intervention had an improvement in
their scores of 220% over those respondents whom did not receive the intervention. This suggests that perhaps similar types of interventions need to be administered to all high-school females to possibly help to obliterate the patriarchal wrath of eating disorders.
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INTRODUCTION

This research project asked how obsession with weight and body image preoccupies women and adopted an ideology which suggests that such obsession renders women powerless. The ideological position of this critical theory study is that eating disorders in women, brought on by the oppression of women and confusing messages delivered to women by society and the media, can be eliminated by resocializing women's perspectives at the high-school level. Feminist critical theory suggests that indoctrinating women with the misconception that success is measured only by body size and the worthless pursuit for an unattainable "ideal" body is a method in which the patriarchy attempts to control women (Meadow & Weiss, 1992).

PROBLEM STATEMENT

The United States is referred to as both the land of the free and the nation of plenty. This freedom allows the media to squelch a woman's true freedom to think for herself (Wartik, 1995). It also communicates the societal message that women must adhere to an unrealistic regimen which dictates that women maintain a near-skeletal figure while also partaking in the bounty of irresistible advertised
products (Seid, 1989). This "Land of the Free" has millions of women imprisoned by eating disorders.

As related by Charles and Kerr (1986), society makes complicated and confusing demands upon women, most of which include food in some way. Society places unrealistic requisitions on women through a number of messages (Squire, 1981). This is partly the basis for women's problematic relationship with food. Complicating the attempt for the ideal body, a woman is further overwhelmed with inaccurate research on what is a healthy body size. In addition, women's relationship with food lies on a continuum where eating disorders are the extremes and moderate concern about diet, weight, and body image lies in the middle. This affiliation is a product of women's structural position in society (Charles & Kerr, 1986). According to White (1992), as the current preference in America for an extraordinarily thin body has become associated with a preoccupation with weight and shape for women, many women, whether officially diagnosed with an actual eating disorder or not, view themselves as larger than they really are.

According to Seid (1989), five to ten percent of adolescent girls and young women suffer from anorexia nervosa. Anorexia nervosa came to the attention of the medical field, as a disorder in itself, about one hundred years ago. The first differential diagnosis was focused toward distinguishing between anorexia nervosa and
tuberculosis (Bruch, 1973). Ninety-five percent of anorexics are women (Seid, 1989). Some behavioral characteristics of anorexia include spending considerable time around food, preparing elaborate meals for others (yet insuring one’s own food intake includes only a narrow selection of low-calorie foods), hoarding or concealing food, and breaking food into small pieces prior to eating it or throwing it away (Malowald, 1992).

According to Sours (1980), the primary signs and symptoms of anorexia nervosa include a "deliberate and increasingly adamant refusal of food, and elective restriction of eating with a desperate pursuit of thinness as the ultimate pleasure in itself." The desire is to lose weight and attain control over the body and its functions, with behavior indicating food avoidance and a preoccupation with eating. An anorexic’s stress on self-effacement, unworthiness, and gaining love and power through body size are all exaggerations of what the majority of American women perceive, experience and do on an everyday basis (Perimenis, 1991). According to Seid (1989), estimates show that between five and nineteen percent of diagnosed anorexics die from the disease. Anorexia nervosa is an addiction like any other addiction, except thinness is the obsession and losing weight is the fix (Way, 1993).

Another disease which is closely related to and sometimes connected with anorexia is bulimia. Thirty to
sixty percent of adolescent girls suffer from bulimia, otherwise known as "the binge-purge syndrome" (Seid, 1989). This syndrome refers to a pattern of gross overeating that is followed by purging (vomiting, using laxatives, or overexercising), stomach pain, or sleep (White, 1992). The age of onset of bulimia is usually sixteen to twenty years old, and other clinical features include preoccupations with food, weight, and shape, fluctuations in weight, an irrational fear of becoming obese, and feeling a lack of control over eating (Mitchell & Pyle, 1985).

Media plays a very strong hand in the triggering of eating disorders. Psychologists have considered for a long time that media imagery of women that equates beauty with rail-thinness has some responsibility for the growing rate of eating disorders such as anorexia and bulimia. Various studies performed have demonstrated that women who have been exposed to popular media report higher incidences of stress, depression, and body dissatisfaction that those women not exposed (Wartik, 1995).

Further, the problem of eating disorders (with the major focus being on anorexia nervosa and bulimia) is increasing and strikes women many times more than men. The reason why women are more at risk is due to existing in a patriarchal society that inherently emphasizes perfection. For women, perfection is defined in terms of a perfect body. Due to this oppression, women seek out and are more
susceptible to external validation than men are (White, 1992).

To sum up, fifty percent of women between the ages of ten and thirty have an eating disorder (Seid, 1989). Anorexics and bulimics are both overly concerned with body weight and have an overwhelming fear of becoming fat. Both diseases are deadly and are killing the women of our society physically, mentally, and emotionally (White, 1992).

**Feminist Theory**

The paradigm used to conduct this research project was the critical theory paradigm, from a feminist theoretical perspective. As stated by Wetzel (1986), the essence of the feminist world view involves three organizing principles: 1) unity of all living things, circumstances, and knowledge, 2) the diversity of the individual, and 3) personal power and responsibility. These need to be explored in connection with the pervading problem of eating disorders among women.

The first principle is that there needs to be a unity of all living things, circumstances, and knowledge. This emphasizes a concept of combining energies to become something finer and stronger and more enduring. By putting efforts together, rather than competing against one another, we as a society can spiritually advance in positive ways. Unfortunately, most of society's focus is on how to excel oneself at the expense of everyone else. This brings forth the concept of not good enough, as one cannot achieve
perfection unless one is surrounded by those who are less than perfect. If the individuals of society would work together, instead of against each other, the viciousness of competition and the feeling of low self-worth resulting from losing the competition would not exist. Also, there would not be the need to control another group of people, such as women, and render them powerless. This patriarchal need to control gives birth to the media's mania with food, diet, and exercise. This fanaticism provokes women to an unrelenting, restraining obsession, forbidding self-empowerment.

The second principle is the uniqueness of the individual. This translates to mean a general respect for personal rights and a consideration of differences. Under this principle, each person's specific characteristics are accepted and even appreciated. One person is not regarded as better than another based on gender, appearance, race, sexual orientation, weight, body size, etc. Women would not only accept themselves, regardless of weight, but they would also realize that there are more valuable commodities about themselves than just their bodies.

The third principle is that of personal power and responsibility. This principle is action-oriented and refers to the allegiance to a single standard system where all human beings have personal power. This power allows each individual to be and to become, while no one sex, race,
sexual orientation, or body size group has power over another. This would mean that people currently defined as "overweight" would not be defined in the same way, would not be given special privileges (as privileges would not be necessary), nor would they be discriminated against in any way. Similarly, women would not have the pressure to conform to some ideal body size as the emphasis would not be on what a woman looks like, but on who she is.

Feminist theory is both a method of visualizing a philosophical perspective and thinking about events and a changing set of theories attempting to explain the various phenomena of women’s oppression. At its most basic level, feminism is a recognition and critique of patriarchy and sexual politics, as well as their relation to other class oppressions. Also, it is a set of beliefs, values, and ideas about the desired direction for change (Collins, 1986).

Feminist theory strives to help women make sense of their lives by supporting the study of how intersecting systems of oppression affect our experience. The goal of supporters who advocate feminist theory is to improve women’s status in society and to foster community and empowerment. When approaching issues from this world-view, it is important to integrate diversity and teach about the experiences of different groups of women. This would include an awareness of issues of race, class, age, sexual
orientation, and difference based on size and ability (Lee, 1993).

The feminist orientation suggest that a patriarchal society is a masculine society, its belief systems embodying the masculine principle. Society's primary emphasis on the instrumental masculine, whether individual or societal, invariably requires estrangement from the totality of life and being, while feminist theory places a high priority on understanding women and women's lives because so much of what is known about men, women, society, politics, morality, spirituality, and consciousness itself has been distorted by androcentrism. As the feminist perspective creates new questions and new approaches, there is the potential to provide an understanding of women's oppression, and, eventually, a rendering of all theories pertaining to humans and society (Collins, 1986).

There are four major points to be addressed regarding the prevalence of eating disorders from a feminist theoretical orientation. First of all, as man is the valued gender in society, the more "masculine" one appears, the greater chance of attaining success and respect. By "masculine," it is highly advised that one's body be thin and toned, as is stereotypically a man's build. In addition, there is the denial of "feminine" attributes, such as breasts and curves. Second, women are taught to deny themselves pleasure - whether it be sex or hunger related.
Third, being large and feeding oneself are both ways in which women break the rules against personal power. Last, "science" reports, extensions of patriarchy, allow the misconceptions about weight to prevail.

The More Masculine, The Better

As related by Chernin (1980), what is generally labeled as fat in women are those attributes that make the body of a woman different from that of a man. The thighs, often "too large for an adolescent boy," are appropriate for a woman. According to Meadow and Weiss (1992), as men are successful in the corporate world, women need to emulate men in order to be successful. It is narrated that a woman has to be "lean and mean" and that thinness is representative of status, power, and control. Connected to this is the idea of low self-esteem being common among women in our society, due largely to the universal experience of the oppression of women in a male-dominated society. Low self-esteem lies, as with any addiction, at the core of eating disorders (Way, 1993).

No Nurturing for Women Allowed

Food is often used as a reward and comfort. It is seen as connected with nurturing. Women desire nurturing. They are told not to nurture themselves, not to need nurturing, and not to listen to their bodies’ needs. Part of the problem is that the vast majority of American women have long-ceased paying attention to their bodies’ signals
(Squire, 1981). Women are expected to not partake in that nurturing of self. By depriving themselves of food, women become experts in self-denial (Charles & Kerr, 1986). A paradox exists as in order to be loved, a woman believes she must deny and deprive herself of her most basic needs (Meadow & Weiss, 1992). As expressed by Meadow and Weiss (1992), women have a passionate longing for the delights of the "forbidden" - food. They adhere to spartan regimens and deny temptation. Fat women break the cultural rules against powerfulness in women in that they feed themselves, thus nurturing themselves.

**Space Reserved Only for Men**

A fat woman is often considered ugly and bad because she is visible and takes up space. A large woman, by society's standards, breaks the fundamental rules set-up by society; fat is an expression of personal power as the owner occupies space (Meadow & Weiss, 1992). Millions of women no longer know when they are hungry or satiated for fear of this occupation of space, this unacceptable expression of power (Squire, 1981).

**Medical Reports Not Accurate**

In support of the patriarchal indoctrination concerning the need for women to be slim, medical reports state that the slimmer one is, the healthier one is. What had been discovered is that many studies have been done that contradict that "fact." As discussed by Chernin (1981),
although Samoan women possess extreme girth, they do not suffer from heart disease or high blood pressure. Therefore, is it the mechanical fact of being fat which causes disease, or is it the experience of being stigmatized? Seid (1992) also relates various studies done that demonstrate that those who are twenty to thirty percent overweight by the current standards of "ideal" are actually healthier and have the lowest mortality. Ironic, we never hear about these studies, of which there have been many.

The Resocialization Process

The obvious need is to eliminate this self-punishing attempt to reach some unattainable goal that really is quite insignificant. The way to do this is by resocializing young women, preferably at the age of thirteen or so, as that is the onset of puberty and hormonal changes. This resocialization process can best be done by intervening in high school physical education classes (as all females must take physical education) at the freshman, sophomore, junior, and senior levels. During this intervention, it must illustrated that women are worth more than their weight and society's desire to have women preoccupied with their weight is society's attempt to render women powerless. By supplying young women with an alternative perspective, the intervention encourages them to increase their self-esteem and regain some of their deprived power. In this way, these women can further educate other women, as well as the next
generations of women, eventually leading to the elimination of this self-destructive obsession.

The Role of the Social Worker

Social workers, who currently are beginning to acquire more positions within high schools, can intervene at an administrative level by supporting the need for this type of program. With support of this study, as well as other studies that have been done, the social workers must lobby for changes in the policies of high school to allow the inclusion of this curriculum. It is as important, if not more important, than the traditional material. It is imperative that social workers come together to help to eradicate the devastation and self-doubt, manifested as eating disorders, pronounced by a patriarchal, oppressive society on young women as a futile attempt at control. Without the information many women will continue to starve themselves to death.

The foregoing discussion led the researcher to the following question: What does the impact of an educational intervention have on invalidating the messages which lead to a women's negative self-image and lack of self-respect? The hypothesis of this research project was that by countermanding women with accurate research, women will begin to think about themselves and their status in society differently.
METHODS

Purpose and Design

The purpose of this study was to illustrate how the indoctrination of weight-obsessive information in combination with a patriarchal society oppresses and controls women, as well as renders women powerless. This study further aimed to elucidate that an intervention program provided to high school girls restores some of the self-worth that has been stripped from young women by re-educating them about what is truly valuable about them, their minds, hearts, souls, and spirits, and not just their bodies.

The design was a single subject design. A total of sixteen subjects, who were divided into two groups, participated in this study. The first group of six girls received no intervention. The second group, consisting of eleven girls, was given the intervention. The first group was a comparison group and the second group served as an experimental group.

Sampling

Sixteen females selected from two different sophomore English classes at a San Bernardino high school participated in this study. This was a non-probability convenience sample. The majority of the young women in this study were
Hispanic and African American. There were only two Caucasian females in the sample.

Data Collection and Instruments

Using a single subject design, data was collected by giving an identical pre-test and post-test to all sixteen participants, ten receiving the intervention, and six serving as the control group.

The pre-test/post-test questionnaires included a variety of questions relating to body image, self-esteem, value of women, the media, and eating disorders (see Appendix A). In two of the questions, the subject ranked the importance of thinness in relation to other properties, while two other questions pertained to the subject’s perceived body image as well as their perceived ideal body image. In addition, there were questions referring to a Likert scale in which the participant demonstrated a level of happiness with appearance, a level of acceptance or rejection that is felt from friends, family, boyfriends, and society, as well as scales reflecting the importance of this acceptance to each participant. Following the Likert scales existed six multiple choice questions about issues ranging from eating disorders to height/weight charts. Last, there was a true/false question pertaining to the degree of similarity between eating disorders and the eating habits of the majority of American women. These questions were all
addressed in some fashion in the intervention that was administered to the subjects in the form of a presentation.

As previously mentioned, the presentation, or independent variable, focused on four main areas: 1) society's devaluation of women, 2) the impact of the media on the perpetuation of the oppression of women, 3) education about anorexia nervosa, bulimia, and some of the not-widely known dangers of each disorder, and 4) what the real issue is and how to begin to solve the problem. The presentation lasted forty minutes, including questions, and was delivered in a discussion format so that the participants would listen and stay involved as much as possible. Magazines were used to illustrate the bombardment of messages upon women by the media. Also, a chalkboard was utilized in order to document statistics and when necessary to emphasize a point.

The intervention and post-test were given exactly one week following the administration of the pre-test. The teacher's roll sheets were used in order to verify that the same participants completed the pre-tests and post-tests of the same identification numbers. In this way, the teacher was not aware of the responses of her individual students, and the researcher was unaware of who the collected responses belonged to. The data was all collected by the researcher and kept confidential.

All human subjects requirements were strictly abided by. Each potential participant was sent home with a
"Consent for Child to Participate" form (Appendix B) and debriefing statement (Appendix C). Only those that returned the consents were allowed to participate. At the time of the pre-test, the potential participants were each given a "Consent to Participate" form (Appendix D) and debriefing statement (Appendix C). Only those participants who signed and turned-in the self-consent forms were allowed to participate. These strict measures were followed due to the participants' ages being under the legal age of eighteen.
RESULTS

There were nineteen variables examined. These variables were the following: for question 1, being thing and being happy; for question 2, being thin, self-esteem, and intelligence; for questions 3-16, the variables were the responses to the questions themselves.

In order to score each subject's responses, the variables were grouped into three different categories. The three categories that the variables were grouped in were self-esteem/body image, one's own value of women/society's value of women, and eating disorders/the media. This last category consisted of all of the multiple choice questions, instead of a scale of numbers, except question 15 (included in the value of women category), therefore requiring a specific answer of "1," "2," "3," or "4." If the respondent answered correctly, a point was given. An incorrect response added nothing to the participant's score.

In the first category, self-esteem/body image, the scores for the variables being thin (question 1) and being thin (question 2) were combined with the scores from questions 3, 5, 6, 7, & 9. For this category, a response of a low score was valuable, so in order to facilitate this scoring technique, the responses to questions 5, 6, 7, & 9 were flipped (i.e. a response of "1" would become a "9," a response of "7" would become a "3," etc.). An optimal
cumulative score for this category would be a "7," with the subject having responded to each of the seven questions with a "1." This score of "1" suggests a healthy self-esteem or body image, while a score of "9" suggests an unhealthy self-esteem or body image.

In the second category, one's own value of women/society's value of women, the scores for the variables being happy, self-esteem, and intelligence were combined, with the scores earned for questions 4, 8, and 15. For this category, a response of a high score was valuable, except for question 15, which required a specific answer of "4." If the respondent answered "4," she received one more point. If she did not answer "4," no additional points were awarded. In order to facilitate consistent scoring for the second category, the response to question 8 was flipped, as explained above. An optimal cumulative score for this category would be a "45," with the subject having responded to variables 2, 4, and 5 with an "8" or "9" (since variables 4 and 5 are both in question 2, thus using the same scale, only one can have a response of "9") and questions 4 and 8 with a "9." All of the questions asked the participants for a personal evaluation of one's own value of women, except for questions 8 and 15, which refer to society's value of women. For question 8, a score of "9" meaning "negative" is ideal, as that is the feedback women receive from the media. The third section has the multiple choice
questions 10, 11, 12, 13, 14, and 16. Each of these questions was scored with one point, with a total possible score of "6."

When evaluating the subject's outcome, quantitatively, the scores for the three sections of the subject's pre-test (baseline) were compared with the scores of the three sections of the subject's post-test (outcome). For the first score, since a low score was valuable, if the subject earned a lower score on the outcome than was earned on the baseline, the difference was scored as a negative number, which was a negative outcome. For the second and third scores, since a high score was valuable, if the subject earned a higher score on the outcome than was earned on the baseline, the difference was scored as a positive number, which was a positive outcome. If the subject earned a lower value on the outcome than was earned on the baseline, the difference was scored as a negative number, which was a negative outcome.

Participants Without Intervention

Subject 1 received the pre-test and post-test without an intervention. On the pre-test (see Table 1), she scored "44" on the self-esteem/body image section (ideal being "7"), "28" on the value of women/society's value of women section (ideal being "45"), and "4" on the eating disorder/media section (ideal being "6"). On the post-test, her
## TABLE 1

### INDIVIDUAL AND OVERALL SCORES FOR RESPONSES OF PARTICIPANTS WITHOUT INTERVENTION

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<td>24</td>
<td>NO</td>
<td>22</td>
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<td></td>
</tr>
<tr>
<td>2</td>
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<td>27</td>
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<tr>
<td>3</td>
<td>2</td>
<td>NO</td>
<td>1</td>
<td>-1</td>
<td></td>
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<td></td>
<td></td>
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<td>Overall=+4</td>
</tr>
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</table>
score for self-esteem did not change, but she lost four points in the value section and one point in the media section. Her overall score was "-5," an overall negative outcome.

Subject 2 received the pre-test and post-test without an intervention. On the pre-test, she scored "34" on the self-esteem section ("7"), "26" on the value section ("45"), and "2" on the media section ("6"). On the post-test, she gained six points for the self-esteem section, two points in the value section, and zero points in the media section. Her overall score was "+8," an overall positive outcome.

Subject 3 received the pre-test and post-test without an intervention. On the pre-test, she scored "36" for self-esteem, "24" for value of women, and "1" for media. On the post-test, she gained ten points for self-esteem, six points for value of women, and one point for media. Her overall score was "+17," an overall positive outcome.

Subject 4 received the pre-test and post-test without an intervention. On the pre-test, she scored "17" on the self-esteem section, "27" on the value section, and "1" on the media section. Her overall score was "+2," an overall positive outcome.

Subject 5 received the pre-test and post-test without an intervention. On the pre-test, she scored "29" on the self-esteem section, "24" on the value section, and "3" on the media section. On the post-test, she gained two points
in the self-esteem section, two points in the value section, and zero points in the media section. Her overall score was "+4," an overall positive outcome.

Subject 6 received the pre-test and post-test without an intervention. On the pre-test, she scored "24" on the self-esteem section, "24" on the value section, and "2" on the media section. On the post-test, she gained two points for the self-esteem section, three points for the value section, and lost one point in the media section. Her overall score was "+4," an overall positive outcome.

Participants With Intervention

Subject 7 received the pre-test, post-test, and intervention. On the pre-test (see Table 2), her answers to the first five variables were not useable due to inconsistency with the directions. Therefore, those five variables were not used in scoring the pre-test or the post-test. On the pre-test, she scored "32" on the self-esteem section, "7" on the value section, and "2" on the media section. On the post-test, she gained three points in the self-esteem section, five points in the value section, and three points in the media section. Her overall score was "+11," an overall positive outcome.

Subject 8 received the pre-test, post-test, and intervention. On the pre-test, she scored "36" on self-esteem, "17" on the value section, and "3" on the media
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<thead>
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<td>Subject 8</td>
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<td>+1</td>
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TABLE 2 (Continued)

INDIVIDUAL AND OVERALL SCORES FOR RESPONSES OF PARTICIPANTS WITH INTERVENTION

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<td>YES</td>
<td>4</td>
<td>+3</td>
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<tr>
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<thead>
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<tr>
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<tr>
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<td>+3</td>
</tr>
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<td></td>
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<td></td>
<td>3</td>
<td>1</td>
<td>YES</td>
<td>2</td>
<td>+1</td>
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<td></td>
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<table>
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<tbody>
<tr>
<td></td>
<td>1</td>
<td>34</td>
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<td>Overall=+15</td>
<td></td>
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</tr>
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</table>
section. On the post-test, she gained six points on the self-esteem section, nine points on the value section, and one point on the media section. Her overall score was "+16," an overall positive outcome.

Subject 9 received the pre-test, post-test, and intervention. On the pre-test, she scored "24" on the self-esteem section, "27" on the value section, and "3" on the media section. On the post-test, she gained one point for self-esteem, five points for value, and lost one point for media. Her overall score was "+5," an overall positive outcome.

Subject 10 received the pre-test, post-test, and intervention. On the pre-test, she scored "30" on the self-esteem section, "29" on the value section, and "2" on the media section. On the post-test, she gained two points in self-esteem, lost one point in value of women, and gained three points in the area of the media/eating disorders. Her overall score was "+4," an overall positive outcome.

Subject 11 received the pre-test, post-test, and intervention. On the pre-test, she scored "30" for self-esteem, "16" for value of women, and "3" for media. On the post-test, she gained five points for self-esteem, four points for value of women, and lost one point for the media section. Her overall score was "+8," and overall positive outcome.
Subject 12 received the pre-test, post-test, and intervention. On the pre-test, she scored "29" for self-esteem, "30" for value of women, and "1" for media. On the post-test, she gained ten points for self-esteem, lost two points for value of women, and gained three points for media. Her overall score was "+11," an overall positive outcome.

Subject 13 received the pre-test, post-test, and intervention. On the pre-test, she scored "35" for self-esteem, "22" for value of women, and "4" for media. On the post-test, she gained six points for self-esteem, fourteen points for value of women, and one point for media. Her overall score was "+21," an overall positive outcome.

Subject 14 received the pre-test, post-test, and intervention. On the pre-test, she scored "33" for self-esteem, "28" for value of women, and "1" point for media. On the post-test, she gained nine points for self-esteem, three points for value of women, and four points for media. Her overall score was "+16," an overall positive outcome.

Subject 15 received the pre-test, post-test, and intervention. On the pre-test, she scored "33" for self-esteem, "18" for value of women, and "1" for media. On the post-test, she gained three points for self-esteem, lost one point for value of women, and gained one point for media. Her overall score was "+3," an overall positive outcome.
Subject 16 received the pre-test, post-test, and intervention. On the pre-test, she scored "34" for self-esteem, "29" for value of women, and "0" for the media. On the post-test, she gained thirteen points for self-esteem, lost one point for value of women, and gained three points for the media. Her overall score was "+15," an overall positive outcome.

In order to best show group differences between those that received the intervention and those that did not, the following procedure was done: The final outcome scores were combined for the members of each of the two groups. The two group scores were then divided by the number of people in that particular group. The comparison group, those that did not receive the intervention, had a total score of "30." This score divided by the six participants in that group gives a group average of "5." The experimental group, those who did receive the intervention, had a total score of "114." This score, divided by the ten participants in that group, gives a group average of "11." Those subjects who received the intervention had an improvement in their scores of 220% over the comparison group.
DISCUSSION

Participants Without Intervention

Subject 1, a Hispanic student, received an overall score of "-5." This score implies that this subject had a decrease of personal value of women or perceiving a more positive value of women by society, or of knowledge of the media or eating disorders, as Table 1 displays there was no change in the area of body image/self-esteem. As this individual did not receive the intervention, she was not supplied with any tools to counteract society's ongoing messages to women. Her diminishing score could be due to having a conversation with someone about weight, seeing a commercial or movie on TV that caused her perceptions to shift, or from picking-up a magazine portraying an anorexic model proclaimed to be beautiful.

Subject 2, a black student, received an overall score of "+8." As she did not receive the intervention, she had nothing to contrast with her previously perceived ideas relevant to the areas being studied. She increased in all areas except for the eating disorder/media section. It is possible that this participant received some other outside input that reinforced for her the value of women and of herself.

Subject 3, a Hispanic student, received an overall score of "+17." She increased her scores in all three
areas. Like subject 2, since she did not receive the intervention, it is possible that she received some positive input about herself or women in general in the week that lapsed in between the pre-test and post-test.

Subject 4, a hispanic student, received an overall score of "+2." This individual had a lower score in the area of self-esteem/body image, possibly due to a media advertisement she may have viewed which resulted in a decrease in her satisfaction with her own body. Her personal opinion of women, or her perception that society does not value women, increased in the week’s time, possibly due to witnessing a female role model in her life get promoted at a job, or maybe receiving some positive feedback from a respected person. Her amount of knowledge about eating disorders or the media did not change.

Subject 5, a hispanic student, and subject 6, a black student, both received an overall score of "+4." They both increased their body image/self-esteem (according to the scores), as well as their personal value of women or perception that society does not value women. Subject 5 did not change in her knowledge about eating disorders or the media, while subject 6 decreased in her knowledge of eating disorders/ the media. This lack of change in the last area could be due to receiving wrong information from somewhere about the media or eating disorders, unlucky guesses, a misunderstanding of what the question was asking, or no real
knowledge about either area, as neither of these participants received the intervention.

Although it is difficult to speculate on the reasons why most of the participants who did not receive the intervention scored an overall positive outcome, the researcher will make an attempt. It is possible that the experience of taking the pre-test provided them with some knowledge, or led them to do some research on the issues in question. It is also possible, but highly unlikely, that a positive media advertisement was broadcast the week after the pre-test, resulting in an increase in the respondent's self-esteem. However, although they did score primarily positive overall outcomes, the group that received the intervention scored 220% more positively.

Participants With Intervention

Subject 7, a white student, received an overall score of "+11." She increased her scores in all three tested areas. This was not too surprising, as she received the intervention. Most of the subjects who received the intervention either increased in all three areas or decreased by only "1" in one of the areas. Although this could be due to lucky answers, such a trend is most likely due to a learning process that took place for all of the subjects who received the intervention.

Due to similarities apparent throughout the rest of the participants' results, they were grouped in order to best
illustrate the trends. Subjects 8 (black, +16), 13 (hispanic, +21), and 14 (hispanic, +16) were the other subjects whose scores increased in all three areas. Of the other subjects, 9 (black, +5) and 11 (hispanic, +8) lost only a point in the eating disorder/media section, 10 (white, +4), 15 (hispanic, +3), and 16 (hispanic, +15) lost only a point in the value of women section, and 12 (asian, +11) lost only two points in the value of women section, increasing their scores in the other two sections. All individuals who received the intervention increased their scores in the body image/self-esteem section. This is quite important to bring attention to because self-esteem and body image are two very critical areas when dealing with eating disorders. Women with eating disorders quite frequently, if not always, have a low self-esteem.

The next step for social workers is to bring attention to the potential perpetuation of eating disorders by a patriarchal, oppressive society as described in this study. Further studies need to be conducted to demonstrate the prevalence of this problem on a larger scale. This issue needs to be examined and further education must be done as it would be much more effective and compassionate to give this information to young women on a preventative level rather than waiting until the patriarchal society of the United States has oppressed women in the imprisonment of eating disorders.
APPENDIX A
QUESTIONNAIRE

1) Rank the following in order of importance to you, 1 being least important, 9 being most important:

- finishing high school
- dressing fashionably
- getting married
- being popular
- being thin
- making a lot of money
- being happy
- having guys like you

2) Rank the following according to how important they are for a woman to be successful in her career, 1 being least important, 8 being most important:

- college degree
- self-esteem
- being attractive
- fashionable attire
- assertiveness
- being thin
- intelligence
- hard-working

Using the numbers in the chart below, answer question 3 & 4:

3) Which of the above do you most look like? __
4) Which of the above do you ideally want to look like? __
For questions 5 to 9, circle the number on the scale that most directly reflects your opinion:

5) How happy are you with the way you look?
   1  2  3  4  5  6  7  8  9
   not very happy
   happy

6) The feedback you get from your friends, family, and boyfriend about the way you look is:
   1  2  3  4  5  6  7  8  9
   not very happy
   happy

7) The opinion of your friends, family, and boyfriend matters to you:
   1  2  3  4  5  6  7  8  9
   not very happy
   happy

8) The feedback you get from the media (T.V., magazines, radio, etc.) about the way you look is:
   1  2  3  4  5  6  7  8  9
   negative positive

9) The opinion of the media (T.V., magazines, radio, etc.) matters to you:
   1  2  3  4  5  6  7  8  9
   yes, no, all the time never

For questions 10-15, circle the one answer that is most correct for each question:

10) What is anorexia nervosa?
    1) when a woman is thin
    2) a condition where a woman is thin because she is very skilled at dieting
    3) a disease of obsession that kills 2% of the females population
    4) a disease when a person wants to eat, but has no appetite

11) What is bulimia?
    1) a skill that allows people to eat what they want without gaining any weight
    2) a disease that erodes the teeth enamel and diminishes ability to have children
    3) when a woman eats out of control
    4) a disease when a person never feels full
12) A woman who has a very feminine figure (large breasts, large hips):
   1) is admired by other women.
   2) is thought of as successful.
   3) is fat by today's media standards.
   4) is seen on the covers of magazines.

13) The diet industry:
   1) targets men and women equally.
   2) targets women slightly more than men.
   3) targets women tremendously more than men.
   4) targets women slightly less than men.

14) Standard advice on appropriate weight for individual heights illustrates:
   1) what is healthiest, as it is based on well-tested medical research.
   2) weights that are ten to fifteen pounds lighter than what is healthiest.
   3) weights that are five pounds lighter than what is healthiest.
   4) one of the most important things in life - being the right weight.

15) To receive nurturing:
   1) women will often turn to their husbands.
   2) women will often turn to their children.
   3) women will often turn to their careers.
   4) women will often turn to food.

For question 16, circle T for true or F for false:

16) Anorexia and bulimia are simply exaggerations of the majority of American women's eating habits.

   T   F
APPENDIX B

CONSENT FOR CHILD TO PARTICIPATE IN RESEARCH

I consent for my daughter to be a subject in the research project entitled "Oppression Through Obsession," a study on the effects of societal messages on the manifestation of eating disorders in young women. This study is being conducted by Jesse Christopulos under the supervision of Dr. Teresa Morris, professor of Social Work. This study has been approved by the Human Subjects Committee of the Department of Social Work, which is a subcommittee of the Institutional Review Board of California State University, San Bernardino.

I understand my daughter will be in one of two groups of students. Depending on which group she is in, she will either a) fill out one questionnaire and, a week later, fill out a second identical questionnaire, or b) fill out one questionnaire and, a week later, see a presentation and fill out another identical questionnaire.

I understand that my daughter’s participation is voluntary, she is free to withdraw at any time, all information is confidential, and that my daughter’s identity will not be revealed. Any questions that I or she have about the project will be answered by the researcher listed above. For additional information, I will refer to the accompanying page.

On the basis of the above statements, I agree to allow my daughter to participate in this project.

Parent’s Signature/Daughter’s Name

Date
APPENDIX C
DEBRIEFING STATEMENT

In connection with participation in the research project entitled, "Oppression Through Obsession," if you are interested in obtaining further information for any reason, please consult the following sources:
1) *Eating Disorders* by Hilde Bruch, M.D.
2) *Never Too Thin* by Roberta Pollack Seid, Ph.D.
3) *Women's Conflicts About Eating and Sexuality* by R. Meadow and L. Weiss.

or call:
1) California State University, San Bernardino Counseling Center  (909) 880-5569
2) Charter Hospital Corona  (800) 533-4673

Thank you for your help and participation in this research project.

School of Social Work
5500 University Parkway
San Bernardino, CA  92407
(909) 880-5501

Jesse Christopulos
M.S.W. Candidate

Dr. Teresa Morris
Research Advisor
(909) 880-5561
APPENDIX D

CONSENT TO PARTICIPATE IN RESEARCH

The study in which you are about to participate is designed to demonstrate the relationship between societal expectations and eating disorders. This study is being conducted by Jesse Christopulos under the supervision of Dr. Teresa Morris, professor of Social Work. This study has been approved by the Human Subjects Committee of the Department of Social Work, which is a subcommittee of the Institutional Review Board of California State University, San Bernardino.

I consent to be a subject in this research project, entitled "Oppression Through Obsession." I understand that I will be in one of two groups of female students. Depending on which group I am in, I will either a) fill out one questionnaire and, a week later, fill out a second identical questionnaire, or b) fill out one questionnaire and, a week later, see a presentation and fill out a second identical questionnaire.

I understand that my participation is voluntary, I am free to withdraw at any time, all information is confidential, and that my identity will not be revealed. Any questions that I have about the project will be answered by the researcher listed above. For additional information, I will refer to the accompanying page.

On the basis of the above statements, I agree to participate in this project.

__________________________________________
Participant’s Signature

Date
REFERENCES


