Comparison of Interventions for Women Experiencing Body Image Problems

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In this study, we investigated the effects of three counseling interventions on women's body image and self-concept. The interventions used were cognitive therapy techniques, cognitive behavior therapy techniques, and reflective therapy techniques. Women experiencing body image problems (N = 79) completed Second and Jourard's (1953) Body-Cathexis and Self-Cathexis Scales and were classified into either moderate or severe body image disturbance groups. Participants were randomly assigned to a therapy or the control group. Those assigned to the therapies participated in three structured interviews and did homework. Cognitive techniques emphasized changing self-statements, and reflective techniques explored feelings. A double repeated measures multivariate analysis of variance was performed on pre- and postscores on the Body-Cathexis and Self-Cathexis Scales, which had been found to be correlated. All participants improved in body image and self-concept. Therapy was better than no therapy. Cognitive therapy techniques were more effective for body image, and cognitive therapy techniques and cognitive behavior therapy techniques were most effective for self-concept. Participants in both classifications improved significantly on body image.

Women in our society undergo a socialization process that may teach them to value appearance over accomplishment (Rodin, Silverstein, & Striegel-Moore, 1985). A negative body image, in women, is often associated with a poor self-concept. A brief look at the popular literature reveals such books as Such a Pretty Face (Millman, 1980), Fat is a Feminist Issue (Orbach, 1978), and The Obsession: Reflections on the Tyranny of Slenderness (Chernin, 1981). The scholarly research supports the popular press and suggests that women exhibit mild body image disturbance and that men do not (Calden, Lundy, & Schlafer, 1959; Gray, 1977; Miller, Coffman, & Linke, 1980). Women and girls who misperceive their body size consistently consider themselves heavier, but men who misperceive their body size consider themselves lighter (Gray, 1977). Gray also found that women and girls diet more than men even though they are more likely to be underweight. Women's misperceptions about their body size sometimes lead to the often fatal disease of anorexia nervosa. Interestingly, Casper, Halmi, Goldberg, Eckert, and Davis (1979) found no difference in the degree of body image disturbance between normal control subjects and anorectic women. Both overestimated the size of their body parts yet were able to correctly estimate the size of a block of wood.

Women's nonacceptance of their bodies generalizes to almost every aspect of their lives (Worsley, 1981), including self-concept. Many of the cognitions related to self-image and self-concept are irrational (e.g., I am fat; therefore I am worthless). Cognitive therapies that dispute irrational beliefs may be helpful in overcoming disturbed body image and related negative self-concept. Cognitive therapy has been used with success in the treatment of depressed people describing cognitions of negative self-worth (Kovacs & Beck, 1978). Cognitive therapy is a treatment that works on attacking irrational beliefs and self-statements and changing these beliefs and self-statements into more positive ones. Used alone, cognitive therapy appears effective but no more effective than behavioral or nondirective techniques (Rachman & Wilson, 1980). When cognitive therapy is combined with behavioral techniques such as reinforcement and imagery, a more powerful and effective therapy appears to emerge (Kazdin & Mascitelli, 1982; Margolin & Weiss, 1978; Taylor & Marshall, 1977).

We conducted the present study (a) to compare the effectiveness of cognitive therapy techniques, cognitive behavior therapy techniques, reflective therapy techniques, and a waiting list control group in increasing satisfaction with body image and improving self-concept of women experiencing body image problems; and (b) to investigate the three techniques' effectiveness for women experiencing moderate body image problems and for women experiencing severe body image problems.

Method

Participants

This study was limited to women because the literature suggests that body image as a determinant of self-esteem is more of an issue for women than it is for men.

The participants in this study represented a broad range of college-age women from a midwestern university who considered body image to be a problem; that is, they considered themselves overweight or unattractive. Most were education majors receiving research credit for their participation as partial fulfillment of the requirements for
an educational psychology course. Qualifications for this study included (a) feelings of dissatisfaction with their body image to the extent that this dissatisfaction affected other areas of their lives, (b) no physical disabilities, and (c) weight falling within ±20% of the weight ranges on the 1953 Metropolitan Insurance tables for their height and frame. (This requirement eliminated extremes of body size. Given the attitudes of our society, women who strongly deviate from the average might be suffering from severe body image problems and need more than short-term therapy.)

Eighty-five women volunteered for the study. Two were eliminated from the study (but offered a referral for counseling) because their scores on the pretest (described later) indicated satisfaction with body image, and 4 dropped out. Seventy-nine completed the study. A median split on the pretest scores on the Body-Cathexis Scale determined the classification into those who had moderate body image problems and those who had severe body image problems. The mean score for the moderate group was 3.27 and for the severe group was 2.65. Both mean scores were lower than the mean score of 3.46 found by Secord and Jourard (1953) in their normative sample of college women.

Counselors

Five master's level students and one beginning doctoral student, all of whom had completed at least one practicum, served as the counselors for the study. All were women, ages 28 to 34 years, and were similar in physical appearance within each therapeutic intervention. (The two counselors for reflective therapy had red hair and were slightly heavy, and the two counselors for cognitive therapy were thin and had dark hair.) There were two counselors for each of the three therapeutic interventions. Each counselor saw 10 women experiencing severe body image problems and 10 women experiencing moderate body image problems, for a total of 20 women. Counselors were blind to the classification of subjects as well as to the variety of treatments and remained so throughout the experiment. (All counselors were asked not to discuss the experiment until afterwards.)

All the counselors were individually trained. Training consisted of a discussion about the therapeutic technique that the counselor was to use; the protocol that the counselor was going to use, including the homework assignment; and role-playing. It was explained that the protocols involved standard attending behaviors (eye contact and posture) and dress (neither highly professional nor casual). Training concluded with each counselor being videotaped with a confederate client.

Doctoral level students viewed the videotapes and rated all counselors on the short form of the Counselor Rating Form. We performed an analysis of variance (ANOVA) to detect differences among counselors. Two of the counselors were found to be different from the others, and these two women received further training in the cues determined to be producing score differences. Another videotaped session was done with the two counselors and a confederate client. A second evaluation revealed no difference between these two counselors and the other three.

Instruments

The dependent measure for this study was an instrument that consists of two correlated scales. These scales were treated as separate dependent measures. Participants in the three treatment conditions completed the Body-Cathexis and Self-Cathexis Scales (Secord & Jourard, 1953) as a pretest and a posttest.

The Body-Cathexis Scale consists of a list of 46 body parts and functions, and the Self-Cathexis Scale consists of 55 items representing conceptual aspects of the self (i.e., self-traits). Subjects rated each item on a 5-point Likert scale, with 1 representing the wish for change and 5, considering self fortunate. Scores were obtained by summing the ratings on items and dividing by the number of items. The reported reliability for women for the Body-Cathexis Scale is .83 and for the Self-Cathexis Scale, .89. Split-half reliabilities are reported at .81 for the Body-Cathexis Scale and .90 for the Self-Cathexis Scale. A modest correlation has been found between the Body-Cathexis and Self-Cathexis Scales; they covary in the same direction. Using a modified version of the Body-Cathexis scale, King and Manaster (1977) reported an internal consistency reliability of .83 (coefficient alpha). Jean (1982) also used a modified version of the Body-Cathexis Scale in her dissertation and reported an alpha coefficient of .86 for reliability.

The Body Image Beliefs Inventory, used as part of the treatment, is an inventory designed by the first author, on the basis of the literature, solely for use by the therapists. This instrument helped direct the participants' thoughts toward attitudes about their body image. The inventory was not statistically analyzed.

Procedure

Participants in this study first attended a group session in which they signed a consent form, completed some demographic information, were weighed to ensure compliance with weight requirements, and completed the Body-Cathexis and Self-Cathexis Scales of Secord and Jourard (1953). A median split of the scores on the Body-Cathexis Scale determined a woman's assignment to either the moderate body image disturbance group or the severe body image disturbance group. Participants from the high and low blocks were then randomly assigned to one of the following four sets of therapeutic techniques: cognitive therapy techniques (CT), cognitive behavior therapy techniques (CBT), reflective therapy techniques (RT), and waiting list control group (WL). Participants in this study attended three individual counseling sessions, each 30 min long. The second session was audiotaped.

CT focused on changing women's negative self-statements into more positive ones. Following a structured protocol, the counselor (a) administered a Body Image Beliefs Inventory; (b) demonstrated ways of changing the women's irrational negative beliefs into more positive ones; (c) taught the client to do it on her own; and (d) assigned homework consisting of completion of a daily homework sheet on which clients jotted down any automatic thoughts concerning negative body image; a more rational, positive belief; and any feelings that they had about either the positive or negative beliefs. They were to do this for a week. The second session involved reviewing the homework sheet, and the same homework assignment was given. In the third session, homework was reviewed; the session ended with how this technique could be used by the client in the future.

CBT was similar to CT for all three sessions except for the additional behavioral techniques of self-reinforcement and a fantasy exercise. In this condition, the counselor not only demonstrated changing the belief into a more positive one according to a structured protocol but also modeled self-reinforcement: "Now I'm going to reinforce myself for doing something good: 'That thought felt better, much better than the original thought.'" The homework sheet was the same as the one for CT, with the addition of a column in which the client was to note the self-reinforcement that she used after changing the negative body image thought into a more positive one. In the beginning of the second session, the counselor and client reviewed the negative, irrational thoughts; rational, more positive thoughts; and self-reinforcements and feelings surrounding the procedure from the homework sheet. Then the counselor led the client through a guided fantasy adapted by the researcher from exercises in Fat is a Feminist Issue (Orbach, 1978). The fantasy exercise had the
client envision herself as a confident, competent person with an acceptable body. At the end of the session, the counselor again assigned the homework sheet and also gave the client a copy of the body image fantasy with the instructions to do the fantasy exercise once a day and to reinforce herself for doing the assignment. The third structured interview was similar to the second session. Homework was reviewed, and the fantasy exercise was repeated.

In contrast to CT and CBT, RT did not include the technique of changing irrational, negative beliefs about body image into more positive, rational beliefs. Instead, the focus was on an exploration of feelings about body image during major developmental periods of the woman's life. During the first structured interview, the counselor and client explored the way that the woman felt about her body at present, these feelings' affect on how she felt about herself, and her childhood in relation to feelings about herself and her body. The counselor used the techniques of minimal verbal following, paraphrasing, and reflection of feeling. In this treatment condition, the homework assignment was to keep a journal of feelings. The second and third structured interviews were similar to the first, with the counselor's exploring the client's thoughts and feelings about her body image during adolescence and early adulthood and in various situations, such as work and social settings. During the third session, the counselor and client also explored what the client felt she had learned during the sessions and how her feelings toward her body image and self-image had changed. In the three treatment conditions, clients completed the Body-Cathexis Scale, the Self-Cathexis Scale, and the Counselor Rating Form immediately following the last session.

Participants assigned to WL completed the pretest and then were told that no counselors were currently available. They were assured that they would be contacted as soon as a counselor became available, about 3 weeks. After this period, these women were called and asked to come in for a meeting with the researcher. The researcher met with each one individually. None of the WL group had sought treatment or help from friends in the interim and admitted any awareness of the purpose of the study until debriefing. The women completed the posttest and then were debriefed about the study. They were offered the choice of one of the three therapies for treatment. The researcher did the counseling of the women in WL on an individual basis to check how the counseling was going and to attempt to ensure that the counselors remained ignorant of the purposes of the study. The first author's belief that counselors were ignorant of the purposes of the study was confirmed when counselors were debriefed at the end of the project.

Data Analysis

This analysis tested the effects of the four experimental conditions and the two levels of problem severity on the body acceptance and self-concepts of the participants. A double repeated measures multivariate analysis of variance (MANOVA) was performed on the pretest and posttest scores of the Body-Cathexis and Self-Cathexis Scales in accordance with the $2 \times 2 \times 4$ (Time $\times$ Severity Level $\times$ Treatment) design of the study and the modest correlation of the scales reported in the literature (Kurtz, 1969, 1971; Secord & Jourard, 1953). Where multivariate Fs were significant, univariate ANOVAs were performed. Where significant univariate Fs were found, Tukey honestly significant difference post hoc tests were performed on the means. Finally, Pearson correlation coefficients were computed on pretest and posttest scores on the Body-Cathexis and Self-Cathexis Scales.

A correlation coefficient was calculated on the Body-Cathexis Scale scores and the Self-Cathexis Scale scores for the pretest and the posttest to test the relation between these two variables.

Results

A Pearson correlation coefficient revealed a correlation of .73 ($p < .0001$) on pretest scores between the Body-Cathexis and Self-Cathexis Scales and .72 ($p < .0001$) on posttest scores.

Table 1 contains summary multivariate and univariate analyses of variance for the independent variables of level, therapy, and time.

Significant main effects were found for level of problem severity, approximate multivariate $F(1, 71) = 36.02, p < .001$, and time, approximate multivariate $F(1, 71) = 50.78, p < .001$.

The MANOVA for the interaction of Time $\times$ Level of Problem Severity was significant, approximate multivariate $F(1, 71) = 3.32, p < .05$. The univariate $F$ for the Body-Cathexis Scale for Time $\times$ Level was significant, $F(1, 71) = 5.91, p < .01$. Results of post hoc analyses on the univariate $F$ indicated

Table 1

<table>
<thead>
<tr>
<th>Source</th>
<th>Multivariate $F$</th>
<th>Body-Cathexis</th>
<th>Self-Cathexis</th>
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<tbody>
<tr>
<td></td>
<td>Between</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level</td>
<td>$F(1, 71) = 36.02^{***}$</td>
<td>72.06^{***}</td>
<td>30.29^{***}</td>
</tr>
<tr>
<td>Therapy</td>
<td>$F(1, 71) = 63$</td>
<td>1.01</td>
<td>0.86</td>
</tr>
<tr>
<td>Level x Therapy</td>
<td>$F(3, 71) = 1.83$</td>
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<td>1.36</td>
</tr>
<tr>
<td></td>
<td>Within</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>$F(1, 71) = 50.78^{***}$</td>
<td>96.82^{***}</td>
<td>76.02^{***}</td>
</tr>
<tr>
<td>Time x Level</td>
<td>$F(1, 71) = 3.32^{*}$</td>
<td>5.91^{*}</td>
<td>1.16</td>
</tr>
<tr>
<td>Time x Therapy</td>
<td>$F(3, 71) = 3.55^{**}$</td>
<td>6.03^{**}</td>
<td>5.50^{**}</td>
</tr>
<tr>
<td>x Level</td>
<td>$F(3, 71) = 2.12$</td>
<td>2.21</td>
<td>2.59</td>
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</tbody>
</table>

* $p < .05$.  ** $p < .01$.  *** $p < .001$.  

Where significant univariate Fs were found, Tukey honestly significant difference post hoc tests were performed on the means. Finally, Pearson correlation coefficients were computed on pretest and posttest scores on the Body-Cathexis and Self-Cathexis Scales.

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Table 1 contains summary multivariate and univariate analyses of variance for the independent variables of level, therapy, and time.

Significant main effects were found for level of problem severity, approximate multivariate $F(1, 71) = 36.02, p < .001$, and time, approximate multivariate $F(1, 71) = 50.78, p < .001$.

The MANOVA for the interaction of Time $\times$ Level of Problem Severity was significant, approximate multivariate $F(1, 71) = 3.32, p < .05$. The univariate $F$ for the Body-Cathexis Scale for Time $\times$ Level was significant, $F(1, 71) = 5.91, p < .01$. Results of post hoc analyses on the univariate $F$ indicated

Table 1

Double Repeated Measures Multivariate Analysis of Variance for the Body-Cathexis and Self-Cathexis Scales

<table>
<thead>
<tr>
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<td></td>
<td></td>
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<tr>
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<td>$F(1, 71) = 50.78^{***}$</td>
<td>96.82^{***}</td>
<td>76.02^{***}</td>
</tr>
<tr>
<td>Time x Level</td>
<td>$F(1, 71) = 3.32^{*}$</td>
<td>5.91^{*}</td>
<td>1.16</td>
</tr>
<tr>
<td>Time x Therapy</td>
<td>$F(3, 71) = 3.55^{**}$</td>
<td>6.03^{**}</td>
<td>5.50^{**}</td>
</tr>
<tr>
<td>x Level</td>
<td>$F(3, 71) = 2.12$</td>
<td>2.21</td>
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* $p < .05$.  ** $p < .01$.  *** $p < .001$.  

Where significant univariate Fs were found, Tukey honestly significant difference post hoc tests were performed on the means. Finally, Pearson correlation coefficients were computed on pretest and posttest scores on the Body-Cathexis and Self-Cathexis Scales.

A correlation coefficient was calculated on the Body-Cathexis Scale scores and the Self-Cathexis Scale scores for the pretest and the posttest to test the relation between these two variables.
that participants in both levels improved on the Body-Cathexis Scale over time. The univariate F ratio for the Self-Cathexis Scale for Time × Level was not significant.

As shown in Table 1, the MANOVA for the interaction of Time × Therapy was significant, approximate multivariate F(3, 71) = 3.55, p < .01. The univariate F test for the Time × Therapy interaction was significant for the Body-Cathexis Scale, F(3, 71) = 6.03, p < .01. Post hoc follow-ups revealed that at pretesting, the WL group scored significantly higher than the other groups. At posttesting, this was reversed, and the means of all sets of therapy techniques were significantly higher than that of the control group. The mean for CT was significantly higher than the other sets of techniques on the Body-Cathexis Scale, and there were no significant differences between the means of CBT and RT.

The univariate F ratio for the Self-Cathexis Scale, which was also a part of the significant overall multivariate Time × Therapy interaction, was significant, F(3, 71) = 5.50, p < .01. Post hoc follow-ups on the univariate F ratio revealed that at pretesting, the WL means were significantly higher than the means of the other groups. At posttesting, the trend reversed, and the means for all sets of therapy techniques were significantly higher than that of the control group. There were no differences between CT and CBT, and both means were significantly higher than that of RT.

Means for the eight cells of this double repeated measures MANOVA are reported in Table 2.

Discussion

This study supported Worsley's (1981) contention that women's nonacceptance of their bodies generalizes to almost every aspect of their lives, including self-concept. For participants in this study, body concept and self-concept were related.

Short-term therapy was effective in increasing women's body acceptance and also in increasing their self-esteem. This finding supports the studies of Clance, Matthews, and Joesting (1979) and Hutchinson (1982), who also found that negative body image was amenable to change with relatively short-term therapy. This study was similar to Hutchinson's study in the use of guided imagery and journals and to Clance et al.'s (1979) study in the use of guided fantasy and exploration of feelings about body image. Clance et al. also used relaxation techniques; we did not. In this study, we expanded on the current literature by using techniques that focus on cognition and by investigating the effectiveness of techniques for women with differing intensities of body image disturbance.

All the therapies were more effective than the control, but as revealed by post hoc tests, even those participants in the control group improved. That the women in the control group also improved may be related to the therapeutic effect of the focused awareness of the body and its functions after completing the Secord and Jourard (1953) Body-Cathexis and Self-Cathexis Scales, or simply regression toward the mean.

In the present study, we found CT to be more effective than CBT and RT in improving body image and equivalent to CBT and more effective than RT in terms of self-concept. This was a surprising finding for two reasons. First, the combination of behavioral techniques with cognitive techniques is purported to be a more powerful intervention than either alone, according to Meichenbaum and Cameron (1974). This has been supported by various studies (Margolin & Weiss, 1978; Taylor & Marshall, 1977; Woodward & Jones, 1980). Second, the high correlation between body cathexis and self-cathexis suggests that whatever is most effective with one is most effective with the other. That the cognitively based sets of techniques were more effective than reflective techniques was not surprising. The cognitive techniques in this study directed attacked the women's beliefs and forced them to analyze, evaluate and change these beliefs, and the homework assignment continued this process. Reflective techniques in this study lacked the depth and complexity of true client-centered techniques but still were more effective than the control condition. Reflective techniques helped the women bring their feelings about body image to greater awareness by exploring the feelings about their bodies at various stages in their lives. Because of brevity, this was originally considered an attention-control condition, but the relation aspects of the reflective treatment may have been therapeutically effective.

There are some possible explanations for the greater effectiveness of CT over CBT in women's body acceptance. CBT included a fantasy exercise in which participants actually imagined themselves growing larger; some participants commented negatively on this. The comments expressed by the participants to the counselors indicated that when women visualize themselves growing larger, the experience is too painful for them to assimilate anything positive that may also be happening. Another difference between CT and CBT was that CT used counselor reinforcement and CBT used self-reinforcement. Praise by counselors may have created positive relationship conditions that enhanced the therapeutic outcome. Therefore, an external reinforcement from the counselor may actually be a more powerful tool for change. These differences did not occur in effects on self-concept. CT and CBT were equally effective in improving self-concept. Here the fantasy exercise of CBT, which emphasized that the woman was competent, may have outweighed the negative body image temporarily presented.

The set of techniques in this study appeared to be powerful enough to alter body image even for those women with severe body image disturbance. That body concept and self-concept are correlated leads to the expectation that an improvement in one causes an improvement in the other; this was not the

Table 2

<table>
<thead>
<tr>
<th>Observed Cell Means</th>
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<tbody>
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<td>Cell</td>
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<td>8</td>
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</tbody>
</table>

Note. For levels, 1 = moderate, and 2 = severe. BC = Body-Cathexis Scale; SC = Self-Cathexis Scale; CT = cognitive therapy; CBT = cognitive behavior therapy; RT = reflective therapy; WL = waiting list control condition.
case in this study. Perhaps for self-concept to improve significantly, aspects of the self-concept besides the body concept need to be addressed.

The high positive correlation between body image and self-concept found in this study supports previous studies (Kurtz, 1969, 1971; Secord & Jourard, 1953).

The generalizability of the results must be considered in the light of the several limitations. The self-referral process used in this study means that results may be generalizable only to self-referred clients. Also, we did not incorporate a follow-up, so we do not know how stable the changes were. The use of two counselors in each therapeutic condition may have confounded the effect of the treatment. Only the second session was audiotaped, and counselors were aware of this; this might have affected the manipulation check because counselors could be expected to adhere more closely to the experimental protocol during that session. In spite of these limitations, the following implications for counseling can be drawn:

1. Brief counseling can help women increase body acceptance and self-acceptance. Cognitive therapy techniques may be the most effective for body acceptance, and both cognitive therapy and cognitive behavior therapy techniques are effective for self-concept.

2. Counselors often see clients with low self-esteem. When these clients are women, counselors might question these women about their body image. The findings of the present study indicate that work on body acceptance including brief therapeutic interventions with an emphasis on cognitive techniques can help increase self-acceptance as well as body acceptance.

3. Counselors working with women who have eating disorders might use cognitive therapy to work on body image. Other techniques may be useful for other components of this complex psychological syndrome.

4. When working with clients who have body image problems, counselors should be careful about the types of fantasy exercises considered.

A further consideration related to this study concerns counselors as agents for change. Too often counselors maintain the status quo, reinforcing dieting instead of body acceptance. Counselors need to be up-to-date on the latest research—the dangers of dieting (Polivy & Peter, 1985) are just beginning to be explored—and to suggest the existence of a biological set point, an explanation why most diets fail (Rodin et al., 1985). An analysis of how “looksism,” the societal belief in one ideal body type, contributes to poor self-concept and body image might help women be more accepting of themselves. The first step that counselors might take is to explore their own irrational beliefs about body image and to change these beliefs to more rational beliefs fostering acceptance of women of all shapes. Then they can help not only their clients but perhaps all of society move toward greater body acceptance.

References


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