DESIGNING AN ADULT EDUCATION PROGRAM FOR WOMEN WITH EATING DISORDERS

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MASTER OF ADULT EDUCATION

By

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ABSTRACT

This study examines the design factors in a distance psychoeducation program for women with eating disorders, and describes a pilot test of such a program in eight British Columbia communities. The design factors were determined by conducting two independent focus groups comprised of women with eating disorders (WWED) and health educators; individual consultations with experts on eating disorders; and individual interviews with 20 women who had recovered from an eating disorder (WRED). The results of the pilot test indicate that a distance education model based on adult education theory and women's literature can successfully deliver an outreach psychoeducation program that fosters transformative learning in women with eating disorders. Conclusions and recommendations may assist other health professionals in designing health education programs for women with eating disorders.

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TABLE OF CONTENTS

ABSTRACT i

ACKNOWLEDGMENTS ii

CHAPTER Page

1. INTRODUCTION 1
Background Information 2
The Problem..5
Purpose of the Study..6
Scope and Limitations..7
The Assumptions of the Study..9
Definition of Terms..10
Plan of Presentation 12

2. REVIEW OF THE LITERATURE 14
Eating Disorders 14
Psychosocial Development of Women 17
Women's Ways of Knowing...21
Psychoeducation 23
Transformative Learning 25
Facilitation Transformative Learning.......................................30
Distance Education and Education at a Distance 34
Designing Distance Education 36
Instructional Media 40
Using Media to Facilitate Learning...43
Summary of Literature...45

3. DESIGNING AND PILOT TESTING THE PROGRAM 47
Assessing Content and Format Needs...48
The Women with Eating Disorders (WWED) Focus Group...48
Conducting the WWED focus group..........................48
Key findings of the WWED focus group.....................50
Focus Group of Health Workers..53
Conducting the focus group of health workers..........53
Key finding of the focus group of health workers.......55
Consultation with Experts on Eating Disorders..................57
Key ideas 58
Identification of six themes of content topics 59
Interviews With Women who had Recovered from Eating Disorders (WRED) 59
The interview process 60

Starting the recovery 62
Overcoming dieting mentality 64
Recovered healthy eating patterns 65
Emotional triggers in eating disorders 66
Healthy body image 67
Enhancing self-esteem 68
Designing the Program Materials 69
Developing the Videotape Models 69
Overall format decisions 69
Guidelines used for presenting the stimulus material 71
Developing the Facilitators' Manual 74
Choice of lesson plans for the six modules 74
Organization of nine instructional events into each module 75
Accompanying handouts 78
Testing the Program at a Distance 79
Selecting Pilot-Test Sites and Participants 79
Pilot Testing Process 80
Feedback on Program Design 81
Learner relevance 81
Format appropriateness 82
Reflection and discussion questions 82
Instructional strategies 83
Videotape modules 84
Usefulness of handouts 85
Outcome Measurements 86
Administration of the Questionnaires 86
Pre-Test/Post-Test Results 86

4. DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS 89
Eating Disorders and Distance Education 89
Fostering Learning in Women With Eating Disorders 90
Psychological Development of Women 91
Women's Ways of Knowing 92
Facilitating Transformative Learning in Psychoeducation 93
Developing an Appropriate Technology for Women with Eating Disorders (WWED) 96
Designing Education 96
Changing Attitudes and Behaviours 97
Conclusions 99
Recommendations for Practice 102
Suggestions for Further Research 103

REFERENCES 105

APPENDIX A: LEARNING OBJECTIVES OF THE SIX MODULES 113

APPENDIX B: READING LIST 116

CHAPTER 1

INTRODUCTION

Eating disorders are serious health problems that affect women psychologically, physically, nutritionally, and socially. Conventional medical treatment of these problems typically includes biological and psychological procedures such as hospitalization, nutritional rehabilitation, medications, and psychotherapy. However, no single approach has been identified as the treatment of choice in the health literature. In a review of the various therapeutic approaches used in these disorders, Yager (1988) identified important issues relating to treatment, which include the nature of the disorder (such as the type of disorder, severity of malnutrition, and level of personality disturbance); the person's attributes (such as her age, motivation, affective state, family situation, and ability to engage in treatment); and the resources available for treatment. Garner, Rockert, Olmsted, Johnson & Coscina (1985) reported that many health professionals in the field of eating disorders believe that there are many advantages in replacing the "medical model" with an educational one. These advantages include the ability to offer services to more people without a proportional increase in professional experts; greater public acceptance and utilization; less stigmatization; and a better conceptual and a more proactive framework for problem prevention. In this thesis I examine the design of an

educational approach that may be useful in promoting the recovery of women who currently do not have easy access to treatment for eating disorders.

Background Information

Eating disorders (i.e., anorexia nervosa, bulimia nervosa and related disorders) have become a serious problem affecting young women in Western culture (Tonkin & Wigmore, 1989). Strong social pressure concerning diet and exercise, plus a cultural obsession with thinness, has rendered many women vulnerable to developing an eating disorder. Severe disturbances in eating behaviours affect approximately 5% of adolescent and young adult women in Canada. Significantly, 95% of the individuals affected by eating disorders in Western culture are female (British Columbia Ministry of Health, 1991).

In 1989, the Government of British Columbia commissioned a Task Force on Eating Disorders in order to evaluate the extent of this problem and to provide recommendations. The Task Force's report substantiated the magnitude of the issue and urged a number of actions, which included the establishment of programs in various regions of the province and improved education for health care professionals (McCreary Centre Society, 1989). The Task Force's recommendation for focusing education on health care professionals is consistent with Mitchell et al.'s

(1988) finding that current treatment of individuals with these disorders is most likely to be effective when provided by professionals with special expertise. Similarly, Garner and Garfinkel (1985) report that programs which address the core physical, nutritional, and psychological features of the eating disorders have produced the best results.

Treatment interventions for eating disorders range from in-patient treatments, to psychoeducation and cognitive group psychotherapy on an out-patient basis, to intensive longer term psychotherapy. Although some individuals with eating disorders have such severe illness that in-patient hospital treatment is necessary, most can benefit from programs based on out-patient treatments (Goldner & Leung, 1989). Statistics reported by Toronto Hospital, one of the largest eating disorders treatment centres in Canada, indicate that 85% percent of the patients treated in 1990 were in out-patient-based programs (Kennedy, Duncan, & MacKenzie, 1992).

A psychoeducational component forms an integral part of most formats for the treatment of eating disorders (Davis & Olmsted, 1992). Group programs have the advantage of cost efficiency and mutual support from group members who share similar experiences (Hobbs, Birtchnell, Harte, & Lacey, 1989). More specifically, group psychoeducation can produce significant clinical changes in favour of specific eating psychopathology, such as reduction of binge eating and vomiting (Davis, Olmsted, & Rockert, 1990). Fairburn and Cooper (1991)

explain that distorted or unrealistic cognitive beliefs concerning eating, body image and self-concept are almost universal among women with eating disorders. They claim: "These patients judge their self-worth or value almost exclusively in terms of their shape and weight" (p. 277). They emphasize that if individuals are to overcome their eating disorders, they must modify such distorted perspectives.

Despite the value of group psychoeducation programs, two serious problems interfere with delivery of them in British Columbia. First, there are few experts in British Columbia in this specialized area and, thus, it is difficult for many to access treatment. Second, most experts are located in city centres which may be considerable distances from those living in rural areas who need help. These problems have resulted in a lengthy waiting period. For example, a one year waiting period for treatment at Saint Paul's Hospital in Vancouver has become "normal" in recent years.

A promising possibility for change, given the geographic and demographic diversity of British Columbia, lies in an educational media delivery system. An outreach program utilizing video production technologies allows the transmission of experts' knowledge to any location where the program can be delivered, in turn, by local health professionals (Whiting, 1988). To promote the successful delivery of such a distance program, the design of the program should include content and an educational approach that are effective in helping women to

overcome their eating disorders. Furthermore, the program needs to provide health educators with a methodology to foster an interactive learning experience for the learners.

As an eating disorders specialist and an educator in nutrition, I was interested in finding an educational approach that would allow me to extend my knowledge and skills to help more women with eating disorders. In order to achieve this goal, a psychiatrist and I applied for funding from the British Columbia Medical Association to research and develop an outreach program for women with eating disorders. The research project received funding in 1993 for 2 years. I was the co-investigator and the project manager for the study.

The Problem

Psychoeducation programs that typically are designed in the traditional medical model to help women with eating disorders, usually provide information to learners about their distorted beliefs in a didactic manner (Davis et al., 1989; Garner et al., 1985; Weiss, Katzman, & Wolchik, 1985). The designers of these programs typically assume that transferring information about the nature of a disorder to the learners will somehow foster attitudinal and behavioural changes in them (Davis, Olmsted, & Rockert, 1990). However, adult education theory (e.g., Knowles, 1980) and the literature on women's learning (e.g., Clinchy,

Belenky, Goldberger, & Tarule, 1985; Tisdell, 1993) challenge the assumptions in this medical model. As a health worker and adult educator, the problem I asked was how can I design an adult psychoeducation program that can foster changes in women's psychological beliefs in British Columbia using adult education principles? This question raised other related questions: What are the distorted beliefs held by women who have eating disorders? How can this information help inform the psychoeducational program I construct? What educational approach might best promote the process of recovery for women with eating disorders? Finally, who can assist in finding answers to these issues? These questions guided me to design this study as part of the work I was doing as a project manager and consultant.

Purpose of the Study

The purpose of the study was to examine the usefulness of design factors in an educational program intended for women with eating disorders. The design factors were determined by (a) a needs assessment of both learners (women with eating disorders) and educators (professional health workers) and (b) consultation with content experts (a psychiatrist, 2 psychologists, 2 nurses, a social worker, and an educator) and 20 women who had recovered from eating disorders. In developing the program, I used videocassettes as the medium for transmitting

information. As well, I developed a manual for the health educators who would be facilitating the local groups. The educational program that I developed as part of this study was a pilot test used in eight communities by local mental health professionals. I collected feedback about the process and about changes in eating habits from both the health educators and the learners by means of questionnaires.

Scope and Limitations

This stuay is in the area of health education within the context of women's learning for dealing with eating disorders. It involved developing an educational program that could promote learning using a distance-based psychoeducation approach. The content development was based on data collected from two sources: (a) women's experiences with eating disorders and with their recovery processes, and (b) input from a group of experts on eating disorders. The format of the program was based on needs, as identified by a group of health workers in a rural community in British Columbia. The group of health workers represented typical health educators who could choose to use such a distance psychoeducation program in their community in the future. Changes in the learners' attitudes and behaviours were intended outcomes of the psychoeducation program.

The emphasis of the study is on the program design. The implementation of the pilot test was done by various mental health care workers. However, detail on the implementation process was beyond the scope of this study. Data collected by evaluative questionnaires before and after the implementation are used to assess the usefulness of the design factors.

A facilitator's manual was designed to provide the health educators with a course framework and instructional strategies for program implementation. All course content, namely the technical information about eating disorders, was contained in the videocassettes. The manual did not contain scripts of the videocassettes and therefore was not designed to be used independently of the videocassettes. A total of 14 reproducible handouts, containing supplementary information for the course, were developed. These handouts included reading lists for learners and facilitators, work sheets for group activities, and take home guidelines. These handouts were not designed to repeat content presented in the videocassettes.

The needs assessment data were collected from 6 Vancouver women who have eating disorders (the WWED focus group), 12 potential program facilitators in the rural community (the focus group of health workers), 20 Vancouver Lower Mainland women who had recovered from eating disorders (WRED), and 7 experts on eating disorders in

Vancouver. Thus, the needs identified may not be representative of all women with eating disorders nor of all health workers.

The program was field-tested in eight sites in British Columbia, both urban and rural, over a period of 6 weeks. Each pilot-test group consisted of three to eight women who ranged from 16 to 40 years in age. The feedback from learners and health educators was directly related to their immediate experience with the program. It did not reflect long term effectiveness of the program. It reflected the evaluation of the program design. The health educators subjectively evaluated the content and format of the manual. The usefulness of the handouts, as a teaching aid, was evaluated by the health educators, but learners were not asked to evaluate the effectiveness of the handouts. The experience level of health educators may influence their assessment of the usefulness of the design factors. The data are limited in the sense that behavioural changes in the learners were measured immediately after completion of the program.

The Assumptions of the Study

In designing the study I assumed that focus groups would be an effective source for collecting data from WWED and health workers. The focus group participants were open and uninhibited in sharing their experiences and needs. In the delivery of the pilot, I assumed that videocassettes as the media of instruction in the program design were

both essential and could be effective for delivery. The videocassettes had not been tested earlier in the field.

Definition of Terms

In this thesis, I use several key terms, which are defined as follows:

Anorexia nervosa is characterized by an intense fear of becoming obese, lack of self-esteem, and distorted body image. This results in self-induced starvation, serious weight loss, and amenorrhea in females (American Psychiatric Association, 1994).

Bulimia nervosa is characterized by recurrent binge eating episodes followed by self-induced vomiting, fasting, use of diuretics, purging with laxatives, and/or excessive exercise (American Psychiatric Association, 1994).

Compulsive eating is an uncontrollable consumption of a large volume of food associated with emotional stress and depression (Kano, 1989).

Distance education is the transmission of instruction or education through the use of media. The learner is physically separated from the instructor but they do communicate.

Education at a distance is commonly understood to mean forms of non-traditional education where essential course materials may be mailed or transmitted to learners and local facilitators may be utilized. In this instance, learner meetings may take place and several educators are typically involved in various capacities. This term allows for more program delivery variation than the term distance education.

Meaning perspectives are sets of expectations or assumptions that are based on past experience. Each meaning perspective is made up of sets of specific knowledge, beliefs, value judgments, feelings, and assumptions.

Meaning schemes are rules, roles, and expectations that govern the way a person sees, feels, thinks, and acts.

Perspective transformation occurs when sets of expectations or assumptions are changed as a result of new experiences.

Psychoeducation is education or training that promotes changes in the learner's beliefs and attitudes on subject areas that serve the goals of treatment and rehabilitation of a psychiatric disorder.

Transformative learning involves reflectively transforming the beliefs, attitudes, assumptions, opinions, and emotional reactions that constitute an individual's meaning schemes or transforming one's

meaning perspectives. Transformative learning occurs when, through critical self-reflection, an individual revises old or develops new assumptions, beliefs, or ways of seeing the world (Mezirow, 1991a; Cranton, 1994).

Plan of Presentation

Following this introductory chapter, in chapter 2 I review the most significant literature related to designing a distance psychoeducation program for women with eating disorders. The first part of the chapter provides an overview of eating disorders, women's psychosocial development, and women's way of knowing. The second part explores psychoeducational approaches in the treatment of eating disorders. The third examines the transformative learning process, and the last part discusses effective approaches used in distance education.

In chapter 3, I describe the assessment, development, implementation and outcomes of the distance psychoeducation program that I designed to facilitate women's learning and the recovery process from their eating disorders.

In chapter 4, I discuss the process and results of the study and compare them to the literature. I also summarize and draw conclusions from the study. I make recommendations for other health educators

designing distance psychoeducation programs for women with eating disorders and make suggestions for further research.

CHAPTER 2

REVIEW OF THE LITERATURE

This literature review examines four topic areas useful in planning an adult distance education program for women with eating disorders. The first section briefly defines eating disorders and discusses women's psychosocial development and women's ways of knowing as they relate to eating disorders. The second section explores psychoeducational approaches in the treatment of eating disorders. The third section examines transformative learning as a process in psychoeducation. The final section reviews relevant approaches for designing distance education programs.

Eating Disorders

Eating disorders, characterized by severe disturbances in eating behaviours, affect approximately 5% of adolescent and young adult women in Canada (British Columbia Ministry of Health, 1991). This suggests that at least 50,000 Canadians are afflicted. Eating disorders are classified into the two major categories: anorexia nervosa and bulimia nervosa. Anorexia nervosa is the refusal to maintain body weight over a minimum normal weight for age and height, leading to

severe malnutrition, for some, to death. Bulimia nervosa is characterized by recurrent episodes of binge eating followed by self-induced vomiting; use of laxatives, diuretics, enemas; fasting; or excessive exercise (American Psychiatric Association, 1994). These two forms of eating disorders are not mutually exclusive. Fifty percent of individuals with anorexia nervosa exhibit binge-eating episodes (Fairburn & Cooper, 1991). Some studies have shown that from 7.8% to as high as 19.6% of American college-aged women have symptoms of bulimia (Halmi, Falk, & Schwartz, 1981; Pyle, Halvorsen, Neuman, & Goff, 1983). The incidence of eating disorders in young women has reached epidemic proportions in North America (American College of Physicians, 1986).

Some researchers attribute the recent increased prevalence of eating disorders to social and cultural pressures on women in the Western culture (Wolf, 1990). The changing ideal for women from plumpness in the previous century to slimness in the present century may be a contributing factor (Garner, Garfinkel, Schwartz, & Thompson, 1980). Women in pursuit of an unrealistic body shape may find themselves feeling unworthy and inadequate. Jasper and Maddocks (1992) believe that "contemporary Western culture has unfortunately managed to make most women feel uncomfortable with normal female body size, to find problems with their bodies where there are none" (p. 181). Harper-Giuffre (1992) speculates that the increase in incidence of eating disorders are related to the fact that "women face multiple,

ambiguous, high-achievement-oriented, and often contradictory role expectations that have been precipitated by shifting cultural norms" (p. 4).

The disturbed eating patterns of women with eating disorders appear to be secondary to their overvalued ideas concerning their shape and weight. For most women, the onset of an eating disorder typically follows a period of restrictive dieting. However, only a small number of women who diet develop eating disorders. It is the position of the American Dietetic Association that individuals who develop eating disorders "are emotionally and psychologically vulnerable when they develop the self-destructive behaviours characteristic of an eating disorder" (American Dietetic Association, 1994, p. 902).

Initiating factors of an eating disorder are not specific and may be biological, psychological, or socio-cultural (Goldner & Leung, 1989). However, there are individual traits that may predispose women to eating disorders. These include problems with autonomous functioning, self-esteem deficits, drives for perfectionism and self-control, and fear of maturation (Davis et al., 1989). Bruch (1978) asserts that eating disorders develop as a result of multi-determined and self-perpetuating problems in the perception and expression of how an individual sees herself in the world. Similarly, Harper-Giuffre (1992) believes that cognitive distortions (e.g., dichotomous reasoning, personalization of situations, and overgeneralization) about one's self and one's

environment are salient in anorexia nervosa. Therefore, examining the psychosocial development of women may bring greater understanding of women's vulnerability to eating disorders and their way of knowing.

Psychosocial Development of Women

The two main groups of adult development models that emerge from the psychological literature include the age/stage model and the life events model (Peck, 1986). The age/stage theory conceptualizes a linear lifespan progression through various age-related stages of development (Erikson, 1970; Levinson, Darrow, Klein, Levinson, & McKee, 1978). In each stage, the individual must master particular developmental tasks before moving on to the next stage. Contrary to this approach, the life events model is based on timing of events rather than chronological time and age. The individual's perception and subjective reaction to the aging process and its events are indices of growth and maturation (Neugarten, 1976).

According to Courtenay (1994), there are four characteristics common to both groups of psychological models of adult development. These include (a) emphasis on self-identity and growth; (b) the presence of hierarchical stages that range from the simple to the complex, from rigidity to flexibility, and from narrow to compressive perspectives; (c) human development occurs throughout the lifespan; (d) and the goals of autonomy, separateness, and independence.

Some researchers support these earlier models of development in investigating the psychosocial development of women. Sales (1987) upholds the age/stage theory in her description of women's development. She assumes that for women, as well as men, the primary goal of development is achieving autonomy or separateness. Simpson (1977) and Labe (1982) echo similar ideas in the process of individuation and separateness. Simpson, however, asserts that women spend more time in certain developmental stages than do men and speculates that some women remain at a particular stage as a form of escape. In comparison, Labe proposes that women tend to complete an individuation process between 30 and 40 years of age which is later than men.

In the feminist literature, however, there is general agreement (Belenky, Clinchy, Goldberger, & Tarule, 1986; Boyce, 1985; Gilligan, 1982; Miller, 1986) that current developmental theories do not reflect the realities of woman's experience. The earlier models have been criticized for their incompleteness and their lack of biological and social-cultural perspectives (Rossi, 1980). In addition, the research contributing to the development of traditional models is male-centred and does not consider the differences in men and women's psychological development (Gilligan 1982; Peck, 1986).

Miller (1986) proposes that a distinguishing feature in women's development is their sense of connection with others. She believes that "women's sense of self becomes very much organized around being able

to make and then to maintain affiliations and relationships" (p. 83). Boyce (1985) similarly finds that "a woman's perceptions of herself and her life are not separated from the network of relationships in which she is connected" (p. 7). The framework of Boyce's model of female psychosocial development illustrates the context of commitments in which females develop and connect throughout their lives. Boyce presents development crises as overlapping circles in order to emphasize the aura and complexity of the process of female development.

Crises contribute to developmental growth (Gilligan, 1982). Boyce (1985) suggests that women deal with more than one developmental crisis at a time throughout most of their lives, in contrast to the linear (one crisis at a time) developmental models based on men's experiences. Gilligan conducted interviews with women before and after crises they had experienced, and found that past conflicts contributed to a new way of thinking about the future. Miller (1986) presents conflict as inevitable in life and as the source of all growth. She distinguishes between productive and destructive conflicts; productive conflicts include a feeling of change, expansion and joy, whereas destructive conflict "often involves a feeling that nothing can change or enlarge" (p. 129). The ability to engage in productive conflict can be a source of growth for women because conflict is part of any relationship.

Peck (1986) echoes the centrality of relationships and attachment to women's development in a model of women's adult self-definition. As

seen in Figure 1, the flexible outer wall represents the changing social-historical time dimension within which a woman lives her adult life. The social-historical time level also subsumes chronological time and physiological aging to reflect how women may experience the aging process within the social context. The next layer of the model, the sphere of influence, consists of relationships of varying degrees of closeness in women's lives. The two critical characteristics, flexibility and elasticity, of the sphere of influence represent the quantity and the quality of those relationships. Emerging in a spiralling funnel-shaped force through the centre of the sphere of influence is the woman's self-definition. Self-definition is depicted as largely dependent on the sum of the socio-historical forces and the elasticity and flexibility of the sphere of influence. The spiralling motion indicates that self-definition is a dynamic process in which women constantly monitor their growth and change. It also indicates how growth and change can make an impact upon the relationships they value. The widening of the funnel suggests increasing clarity of self-definition with the passage of time. The model in its entirety shows the complexities characteristic of women's experiences.

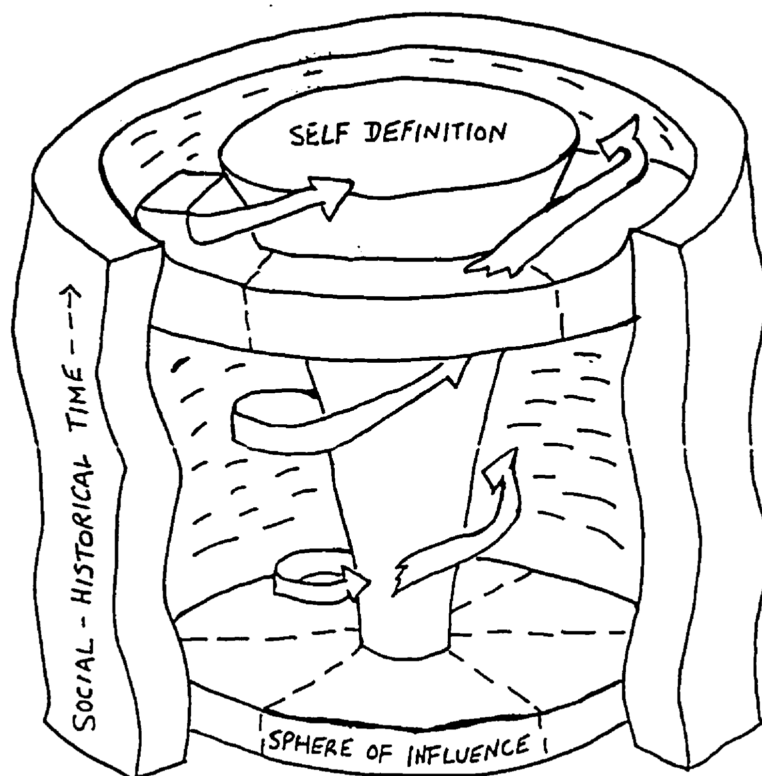

Figure 1. A model of women's self-definition in adulthood
(Peck, 1986, p. 278).

From the feminist perspective, women's development is closely related to culture and social processes. Consequently, women's life experiences influence their ways of knowing.

Women's Ways of Knowing

Tisdell (1993) offers three interrelated insights for adult learning from a feminist perspective of emancipatory education. First, she states, women may have different learning needs from men. Second, gender-based power imbalances in the socio-cultural context affect women's learning. Third, adult educators need to alter the nature of gender-based power relations in the learning environment.

Belenky et al. (1986) conducted in-depth interviews with 135 women to explore their experience and problems as learners and to review their past histories for changing concepts of self and relationships with others. Women's perspectives on knowing are categorized as silent, received, subjective, procedural, and constructed. Silent Women, as they refer to them, see themselves as mindless and voiceless and subject to the power of external authority. Women with the received knowledge perspective feel capable of receiving knowledge from external authorities but not capable of creating knowledge on their own. According to Belenky et al., subjective knowing occurs when women conceive knowledge subjectively and intuitively, whereas procedural knowledge is a perspective from which women apply objective procedures for acquiring and communicating knowledge.

Women with the constructed knowledge perspective are capable of creating knowledge and view all knowledge as contextual (Belenky et al., 1986). They value a subjective and an objective approach of knowing. The data collected from Belenky et al.'s study indicate that women's life experiences and development determine their perspectives on learning. This study concludes that women can shift from one mode of knowing to another; however, the data are inadequate to suggest a hierarchical sequence in these five ways of knowing. Although it is not known why and when the shift of perspectives occur, Belenky et al. confirm a relationship between women's self-concept and their learning styles and

that the transformation of self can generalize and affect how women learn.

In the context of education, Clinchy, Belenky, Goldberger, and Tarule (1985) suggest that women need to know that they are capable of intelligent thoughts; women want validation of their existing knowledge; most women prefer contextual learning with firsthand observation; and they wish to consider their own experiences in the context of new learning. This distinctive learning style has implications for designing effective educational programs for women with eating disorders.

Psychoeducation

A variety of approaches with no consistent educational framework have been called psychoeducation in the psychological literature (Barter, 1984; Davis & Olmsted, 1992; Gingerich et al., 1992; Hayes & Gantt, 1992; Housley, 1992). Goldman (1988) attempts to clarify the concept of psychoeducation with his definition: "education or training of a person with a psychiatric disorder in subject areas that serve the goals of treatment and rehabilitation" (p. 667). This may include increasing patients' acceptance of their illness, encouraging active co-operation with treatment and rehabilitation, and developing coping skills in dealing with the disorder. Goldman formulated his definition of psychoeducation on

the basis of psychotherapeutic techniques which exert their influence through arousal of affect, cognitive mastery, and behavioural regulation.

Goldman (1988) asserts that education is an integral part of psychotherapy and says it has an ameliorating effect on some symptoms of severe, persistent mental illness. Furthermore, rehabilitation is as important as treatment and depends heavily on education for its success. Goldman differentiates psychoeducation from psychotherapy in that psychoeducation emphasizes cognitive mastery rather than arousal of affect. However, behaviour regulation is often a feature of both psychotherapy and education. Many practitioners of psychoeducation seem to agree that the psychoeducational approach should foster attitudinal and behavioural change in the learners (Davis, Olmsted, & Rockert, 1990; Hayes & Gantt, 1992). In addition to these dimensions, Dinkmeyer (1991) suggests that mental health counsellors should focus on the affective and interpersonal nature of the learning process.

Psychoeducational programs are typically conducted in a structured group setting and they tend to be more didactic than process oriented. For example, Davis, Olmsted, and Rockert (1990) describe their psychoeducation program for bulimia nervosa as: "a didactic process whereby the practitioner thoughtfully distills and summarizes relevant scientific information about a disorder to address such questions of the patients as, 'Why did I develop this problem? What can I do to get better?'" (p. 882).

Most mental health practitioners of psychoeducation take a traditional disease-oriented approach and place emphasis on the pathology and teaching of the pathology rather than on the individual's experiences or the perspectives which may have contributed to a disorder (Ciliska, 1990; Davis & Olmsted, 1992). They assume that individuals will change their attitudes and behaviours with information provided by experts. The use of this traditional educational model in psychoeducational groups has been criticised by Ettin, Vaughan, and Fiedler (1987). They stress that participants have a need to react, discuss, and personalize the material presented to them. Ettin, Vaughan, and Fiedler suggest that educators should use group processes to enhance the nature and applicability of psychoeducation.

Mezirow (1991a) views the psychoeducational process as one which helps adults learn to overcome ordinary existential psychological distortions. Such psychological distortions have to do with presuppositions that may generate unwarranted anxiety and inhibit action. According to Mezirow, challenging and correcting distorted assumptions is central to the concept of transformative learning.

Transformative Learning

Mezirow's (1991a) theory of perspective transformation provides a theoretical basis to understanding transformative learning. He argues

that all human beings function within structures of habitual expectation which, in turn, are made up of specific knowledge, beliefs, value judgements, and psychocultural assumptions. These sets of habitual expectation mediate the activities of perceiving, comprehending, and remembering. Hence, the interpretation of the information is influenced by the individual's sets of habitual expectation. The process of perspective transformation, as defined by Mezirow involves:

> becoming critically aware of how and why our assumptions have come to constrain the way we perceive, understand, and feel about our world; changing these structures of habitual expectation to make possible a more inclusive, discriminating, and integrative perspective; and, finally, making choices or otherwise acting upon these new understandings. (p. 167)

The concept of changing a frame of reference which gives new meaning to one's experience is not unique to Mezirow's theory of perspective transformation. Freire (1970) describes the similar concept of "thematic universe" in his theory of conscientization. Unlike Mezirow's theory which focuses on personal development in adulthood, Freire emphasizes social change through transformative learning.

Transformative learning is an integrative process of adult development (Mezirow, 1991a). According to adult development theory, adults evolve new ways of constructing meaning as they go through life's transitions. They often revise a frame of reference and change behaviour patterns and attitudes in the process of growth (Daloz, 1990). However,

developmental struggles can occur when people cannot adapt to current reality with appropriate adjustments because that adaptation is mired in internal conflict. Gould (1990) refers to the resolution of a conflict resulting in change in behaviour pattern as a unit of adult developmental work. He has identified three stages in a unit of adult development work as: (a) a specific demand inherent in the situation requiring a new behaviour pattern; (b) sorting out the difference between current reality and past realities confused with the current situation; (c) a clearer and grounded understanding of current reality. Gould believes that it is from the strengthened position of the third stage that individuals become "more able to do psychological work which does not require sorting out past and present in the midst of confounding, negative affect experience" (p. 137).

The internal process of changing meaning perspective in psychological development is echoed by Nowak (1991) as a personal, intimate, and individual process which happens consciously within the individual in response to a particular set of stimuli and reflections that are right for that individual. Individual conscious transformations "prepare the individual for perspective transformation and encourage him or her to risk a total change in perspective" (Nowak, p. 7). According to Nowak, perspective transformation can be accelerated if an individual has reached the following three conditions: (a) really feeling experience -- getting in touch with original truth; (b) internalizing of six principles

(polarity, causality, force, reality, change, and responsibility); and (c) developing and using faith, courage, and freedom which make the principles operational.

Mezirow's earliest work on transformative theory (1975) was delineated from extensive interviews with women in college re-entry programs. He identifies 10 phases in the process of personal transformation (Mezirow, 1981):

> (1) a disorienting dilemma; (2) self-examination; (3) a critical assessment of personally internalized role assumptions and a sense of alienation from traditional social expectations; (4) relating one's discontent to similar experiences of others or to public issues - recognizing that one's problem is shared and not exclusively a private matter; (5) exploring options for new ways of acting; (6) building competence and self-confidence in new roles; (7) planning a course of action; (8) acquiring knowledge and skills for implementing one's plans; (9) provisional efforts to try new roles and to assess feedback; and (10) a reintegration into society on the basis of conditions dictated by one's new perspective. (p. 7)

This 10-step transformative learning process has been criticised as being conceptualized as a psychological process, rather being understood in terms of the social and political contexts in which learning occurs (Clark & Wilson, 1991). Clark and Wilson argue that Mezirow's focus is on the internal process with no regard for the historical and socio-cultural context that limits the interpretation of learning experiences. Mezirow (1991b) rebuts that the individual's meaning perspectives are

learned in a social context and are culturally assimilated. In Mezirow's own words:

> I have tried to show how the internal dynamics of adult learning operate within the cultural context, how critical reflection, discourse, and action can change culturally assimilated assumptions and premises which limit and distort understanding and give learners greater control over their lives. (p. 190)

The lack of emphasis on the social environment is also a major area of criticism in Mezirow's transformative theory. Collard and Law (1989) assert that Mezirow's work lacks "a coherent, comprehensive theory of social change" (p. 102). In his response to Collard and Law, Mezirow (1989) clarifies his position on social action by acknowledging the importance of social change but emphasizing that the learner, rather than the educator, must make the decision to take social action. Tennant (1993), who examined the developmental process intrinsic to transformative learning, is in support of an integrative view of the learning process in a social context. He views adult development as both psychological and social.

Wildemeersch and Leirman (1988) provide a sociological interpretation of transformative learning in their theory of life-world transformation. Their theory attempts to clarify the inter-relatedness of the action, reflection, person, and context dimensions of the socialization processes inherent in adult learning. Wildemeersch and Leirman refer to a taken-for-granted societal reality which governs one's action as the self-evident life-world. According Wildemeersch and Leirman, the self-

evident character of the life-world is maintained by a narrative communication pattern which, in turn, affirms the existing social and cultural order. Even problematic events can have a taken-for-granted character. However, when an external event or stimulus causes the individual to engage in an anxiety producing and uncomfortable reassessment of existing values, a change in the self-evident life-world can result. This stage is called the threatened life-world. People can be inhibited or facilitated to either fall back upon the taken-for granted aspirations and actions, or move forward by exploring new perspectives and initiatives through a transformation process.

In mental health, the professional "needs to see beyond individual change to deal not only with individuals but with all the variables in the system surrounding the individual" (Dinkmeyer, 1991, p. 37). Furthermore, the learner should be understood as a social, decision-making person whose behaviour has meaning in a social context. In planning psychoeducation programs, the adult educator needs to have an understanding of the transformative process in psychological, developmental, and sociologic terms, and to develop skills in facilitating learning that encourages a process of transformation.

Facilitating Transformative Learning

The facilitation of learning in women with eating disorders must address the distorted or unrealistic cognitive beliefs concerning eating, body image, and self-concept (Fairburn & Cooper, 1991). Helping

individuals to identify and correct faulty underlying assumptions to their psycho-cultural perspectives is the focus of the transformative learning process.

Central to transformative learning is critical reflection, where presuppositions of one's meaning perspectives are assessed, examined, and reformulated (Mezirow, 1990). Reflection, therefore, can enable individuals to correct distortions in their beliefs and errors in problem solving. Drawing on Mezirow's theory of transformative learning, Brookfield (1990) proposes three interrelated phases in the critical reflection process: (a) identifying the assumptions that underlie our thoughts and actions; (b) scrutinizing the accuracy and validity of these in terms of how they connect to, or are discrepant with, our experience of reality (frequently through comparing our experiences with others in similar contexts); and (c) reconstituting these assumptions to make them more inclusive and integrative. Based on these phases, Brookfield (1987) has suggested a number of techniques for identifying and challenging, unexamined, taken-for-granted, assumptions.

Critical questioning is one of most effective means to externalize "ingrained assumptions" (Brookfield, 1987, p. 92). This technique employs a specific form of questioning designed to elicit the assumptions underlying the learner's thoughts and actions. For example, in Gould's (1990) therapeutic learning program, learners are encouraged to focus on

"What is the real meaning of my fear response?" when errors in their thinking are inhibiting their action. Mezirow (1991a) posits that:

> content and process reflection are the dynamics by which our beliefs - meaning schemes--are changed, that is, become reinforced, elaborated, created, negated, confirmed, or identified as problems (problematized) and transformed. Premise reflection is the dynamic by which our belief systems--meaning perspectives--become transformed. (p. 111)

Cranton (1994) delineates critical questioning within 3 types of reflection. These are: content, process, and premise questioning as defined by Mezirow. The "what?" questions serve to stimulate content reflection which raises the awareness of the content or description of a problem. When learners ask how they have come to have a particular belief, they have engaged in process reflection. "Why?" questions engage learners in premise reflection where they question the problem itself. The critique of premises is problem posing, as distinct from problem solving. It poses questions concerning the validity of a taken-for-granted situation. According to Mezirow (1991a), perspective transformation occurs when meaning perspectives are transformed.

Brookfield (1987) suggests that critical questioning should be specific and focus on easily identifiable specific events. People tend to be more comfortable with questions regarding the details of a particular incident rather than generalized, abstract questions. Learners' assumptions and general themes about issues of concern should emerge

from their answers. To be effective, adult educators should communicate informally and avoid the use of jargon with learners.

Challenging assumptions is an essential step in the process of perspective transformation. According to Brookfield (1987), asking learners to critically examine the values and personal beliefs that are central to their self-concept can cause discomfort, fear, and anxiety. The facilitator, therefore, needs to be a skilled helper who has earned the trust of the learners. Rice and Faulkner (1992) suggest a professionally trained leader is important to provide continuity, consistency, and stability to group members. However, he or she does not necessarily have to be a professionally trained therapist, counsellor, social worker, or educator (Brookfield, 1987). The facilitator should be provocative but not intimidating (Cranton, 1994). Some authors see the helper acting as a role model in the facilitation process (Brookfield; Marsick, 1990). Modelling openness, honesty, and integrity can encourage an atmosphere of trust. One technique Brookfield (1990) uses is to disclose his idea on a subject and then ask people to explore with him, and each other in the group, the discrepancies between their own experiences and Brookfield's own insights. Helpers should be able to critically reflect on their own assumptions and meaning perspectives before asking others to do so (Brookfield).

As seen in my study in chapter 3, facilitating transformative learning at a distance can present additional challenges. The next

section examines distance education as a form of adult education program delivery, and explores the relevant approaches used in designing education programs for education at a distance.

Distance Education and Education at a Distance

Looking at the distance education literature, Knox (1991) defines distance education as "any formal approach to learning in which a majority of the instruction occurs while an educator and a learner are at a distance from one another" (p. 9). This method of education has provided educational opportunities where they had previously been unavailable, and has reduced the impact of limited resources, such as few or no classrooms, education materials, or teachers (Dwyer, 1990). Knox (1991) characterizes distance education in the following ways: (a) flexibility of time and place of programs; (b) affiliation with continuing education and extension of colleges and universities; (c) adults are the principal market in distance education programs; and (d) successful study at a distance requires adult traits such as self-directedness and internal motivation. Dwyer described distance education more generally as "serving learners physically separated in space and time from their primary sources of information" (p. 221).

Wagner (1990) sees the value of distance education in the delivery of educational programming to individuals and groups that are dispersed geographically. The separation of the learner and teacher in the delivery of traditional distance education presents unique challenges. Specialized course design and instruction are required to facilitate learning under such circumstances. Moore (1990) asserts that "distance education emphasizes the integration and utilization of all types of instructional technology to enhance the assimilation and integration of provided learning experiences" (p. 221).

Holmberg (1989) outlines two constituent elements in distance education: a pre-produced course and non-contiguous communication between students and tutors. The pre-produced courses are usually in print and often supplemented by audio and/or visual recordings. The role of non-contiguous communication (two-way traffic), whether in writing, via telephone, on audio tape, by computer, or in any other way, will vary greatly. In some distance-education systems, various technologies are basic elements. In others, technologies are periodically replaced by face-to-face sessions. Although course materials typically are produced centrally, Moore (1989) believes that local instructors help learners gain individual understanding of the materials, and develop critical responses to them.

Keegan (1980) defines distance education with six required elements; however, it is significant that four of the six do not apply in my

education at a distance study to be discussed in chapter 3. The first is the separation of a teacher and learner. In my study, a team was involved. I was the designer working with three groups who provided input on content: one was a WWED group, another was a WRED group, and the third was a group of medical experts. Several decentralized local facilitators with general knowledge of mental health comprised the complete educational team for this study. There was no influence of an educational organization, no two-way communication media, and learners were in groups, not working alone. These elements deviated from Keegan's definition of distance education. My education at a distance program involved facilitators and used a technology medium, so it might be seen as meeting only two out of six of Keegan's requirements.

It is for these reasons that I speak of education at a distance through this thesis. I believe this study helped to break new ground in the adult distance education area of study and practice since a team worked effectively at a distance from each other. The definition in chapter 1 helps address this approach. Otherwise, the basic design, media, and learning components of the classic distance education literature remain relevant to this thesis.

Designing Distance Education

Moore (1989) describes two approaches to designing distance learning materials: the course team and the author-editor. The team approach, which has immediate relevance to the study discussed in this

thesis, utilizes many specialists including subject authors, instructional technologists, illustrators, television workers, recording and other media specialists, librarians, photo-librarians, and an editor. Their purpose is to structure academic content in a form suitable for distance learning. Holmberg (1989) refers to such team approach as the "industrial" approach because it is commonly applied by large distance-education organizations. He believes that high quality is achieved by the division of the work among specialists into individual tasks. By contrast, the author-editor approach relies on one academic to write the course content which is subsequently edited into a teaching program by professional editors. When electronic media is used, the content is contributed by an expert and produced by telecommunications experts. The major weakness Moore sees in such author-editor arrangements is that neither expert is an instructional designer.

The design of learning experiences is critical to the effectiveness of an education program, including those involving distance. Dwyer (1990) asserts that:

> the role of the designer of effective learning experiences, to be used either for conventional-type instruction or distance education, is one of manipulating the instructional environment so that learners will act on information in short-term memory initially and long-term memory subsequently in ways that will enable them to process information at levels commensurate with that which is necessary for them to achieve the different types of educational objectives. (p. 223)

If distance programs are to be designed effectively, it is helpful to understand some of the fundamental learning theories. According to Gagne (1985), the information-processing model of learning and memory proposes that a single act of learning involves several stages of internal process. These stages include: (a) reception of stimulation; (b) transformation of stimulation into features for short-term storage; (c) rehearsal of items in short-term storage to prepare for long-term storage; (d) semantic encoding for long-term storage; (e) search and retrieval of previously learned material; (f) response organization to produce an appropriate performance; (g) feedback about performance provides reinforcement; and (h) executive control processes select and activate cognitive strategies appropriate to the learning task. Gagne posits that these internal learning processes can be influenced by a series of events external to the learner which makes instruction possible. Table 1 lists the "events of instruction" and their relation to the processes in an act of learning.

Table 1. Events of Instruction and Their Relation to Process of Learning (Gagne, Briggs, & Wager, 1988, p. 182)

	Instructional Event	Relation to Learning Process
1.	Gaining attention	Reception of patterns of neural impulses
2.	Informing learner of the objective	Activating a process of executive control
3.	Stimulating recall of prerequisite	Retrieval of prior learning to working memory
4.	Presenting the stimulus material	Emphasizing features for selective perception
5.	Providing learning guidance	Semantic encoding; cues for retrieval
6.	Eliciting the performance	Activating response organization
7.	Providing feedback about performance correctness	Establishing reinforcement
8.	Assessing the performance	Activating retrieval; making reinforcement possible
9.	Enhancing retention and transfer	Providing cues and strategies for retrieval

The order of the events of instruction is approximate and may vary with the learning objective. More importantly, not all events are employed in every lesson. Older and more experienced learners may supply most of these events by themselves (Gagne, 1985).

Bonner (1982) suggests that some characteristics of the adult learner should determine the need for providing certain instructional events. For example, the event "stimulating recall of prerequisites," may be extended to "stimulating and assessing recall of related learning" in

order to allow adults to use previous learning and life experience to facilitate learning new content. Other characteristics of adult learners to consider in designing instructional events include learner sophistication, motivation and expectations for participating in a learning experience. The value placed on incidental learning, personal experience, and learning strategies is also important (Bonner). When the events of instruction are not supplied by the learners themselves, they must be supported by the teacher, instructional materials, or other media (Schramm, 1977).

Instructional Media

According to Gagne et al. (1988), one of the most important decisions that must be made in instructional design is the choice of media as a vehicle for the communications and stimulation that make up instruction. Moore (1989) believes that media selection, particularly in distance education, is an issue of major consideration because each technology alters the role of instructors, affects learners, and influences the appropriateness of instructional design in a different manner. Media of instruction can range from oral communication, printed materials, actual objects, and computers, to moving pictures (Johnson & Foa, 1989; Schramm, 1977). In the selection of a medium, Schramm argues that it is what a medium can do and not what it is like technically that is important. In other words, the type of medium is not as important as how the selected medium can enhance the effectiveness of instruction.

For example, to teach a desired behaviour, an educator can choose any medium, such as pictures, slides, video recording, or computer images, that demonstrates the action.

Gagne (1985) categorizes instructional media into language media and non-verbal media. Language communications may be in the oral or the printed form. According to Gagne et al. (1988), the different instructional media have different capabilities of providing the various events of instruction. Oral communications can be effective in directing motivation toward instructional aims, informing learners of the learning objective, providing learning guidance, eliciting performance, and providing feedback. Although printed media, such as books, pamphlets, and leaflets, can communicate the same language content, they are seldom designed to support the processes involved in each learning phase. Consequently, oral and printed language, when used alone, may not be sufficient in accomplishing all instructional functions. Non-verbal media include the use of the actual object, or representation of objects in the form of pictures or diagrams. Objects or pictures provide the learner with a visual image which enhances encoding and storage in one's memory (Gagne, 1985). When the learner retrieves the stored image, it would likely be the same specific image that was originally perceived. Without the use of a picture, the learner is left to construct an image.

In instructional settings, pictures are often combined with oral communication to support the learning process. Ellis (1992) asserts that

learning can be significantly enhanced by combining print with pictures and sound. When verbal communication and pictures are used in combination, such as in television, for example, the rapid changes of scenes and unusual visual stimulation are highly effective in gaining attention.

Salomon (1979) has a different conception of media. He argues that "it is not a medium of communication that makes a difference in learning, but rather a specific attribute it potentially entails" (p. 14). Each attribute of media, such as structure, colour, concreteness, pace, difficulty, belongs to a class of such attributes. Salomon categorizes these classes of media attributes into (a) contents; (b) medium-specific symbol systems in which the contents are structured; (c) technologies used in gathering, encoding, sorting, and conveying the contents; and (d) situations in which the media typically are used. Every medium consists of all four classes of attributes, but not all attributes have the same effects on learning. Although contents and situations may facilitate learning from a medium, they are generally independent of any medium. The technology accounts for the availability and accessibility of information, but it does not affect learning directly without symbol systems. Every object, mark, or event can serve as a symbol, provided that the learner can extract knowledge pertaining to other entities. In Salomon's view, the symbol system is the most critical in defining a medium.

Understanding the nature and the characteristics and the media is essential in the selection of appropriate instructional media.

Using Media to Facilitate Learning

The choice of media depends on the needs and abilities of the learners, the nature of the learning events, and the media coding system most likely to bring about the learning events (Schramm, 1977). The complex nature of media and the interaction of elements involved in learning make it difficult to fit a given medium to a given learning task (Schramm). In a general approach, Gagne et al. (1988) outline a systematic method of media selection for achieving the intended learning outcome. Their model for media selection provides a set of exclusion rules for media that are unsuitable for learning and a set of inclusion rules for characteristics of media that support learning. Pictures, for example, are particularly effective in promoting attitude learning and attitude change. Pictures can portray images of the human model's behaviour in choosing a course of action within different situations, as well as the reinforcement that follows such choice (Gagne, 1985).

Schramm (1977) argues that learning and achievement are more affected by the techniques employed in the instructional act than by the medium chosen to deliver instruction. Similarly, Simonson (1980) suggests that there is no best medium for producing attitudinal outcomes, but there is probably a best approach for maximizing desirable outcomes in a specific situation. His review of over 200

experiments studying the relationship between instructional media and attitude change shows no definitive conclusion concerning their relationship (Simonson). However, Simonson found that some techniques of using media were successful in producing intended attitudinal outcomes. He provides the following guidelines for promoting attitudinal outcomes in learners. First, Simonson suggests using a mediated instruction that is realistic, relevant to learners, and technically stimulating. Second, educators should include the presentation of new information about the topic in mediated instruction. Third, presenting persuasive messages in a credible manner is important. Fourth, involving learners in the planning, production, or delivery of mediated instruction is a valuable step. Engaging learners in post-instruction discussions and critiques is also encouraged. Finally, providing learners with a purposeful emotional experience or arousal during instruction will likely change their attitudes in the direction advocated by the mediated message.

Instructional media can have an impact on learning when selected carefully and used properly. Instructional designers need to consider the use of media not just as a means to deliver information but as a technique in the act of instruction (Wilkinson, 1983). Integrating the selected or produced media into the lesson plan is essential for achieving instructional outcomes (Gueulette, 1988; Wilkinson).

Summary of Literature

The development of an eating disorder may be related to biological, psychological, and/or socio-cultural factors. Distorted beliefs about eating, body image, and self-concept are common among women with eating disorders in Western cultures. Education addressing these potentially harmful beliefs is essential in the recovery from an eating disorder (Davis & Olmsted, 1992; Fairburn & Cooper, 1991).

Psychoeducational programs found in the psychological literature (Davis, Olmsted, & Rockert, 1990; Hayes & Gantt, 1992) emphasize subject-oriented learning rather than emancipatory learning. In the medical model, the focus is typically on didactic teaching. According to Mezirow (1990), the psychoeducational process should be one that is transformational. Mezirow's perspective transformation theory provides a framework for understanding the transformative learning process in psychoeducation. Critical reflection, central to Mezirow's theory, can help women assess, examine, and reformulate their distorted beliefs concerning eating, body image, and self-concept.

Since eating disorders affect mostly women in Westernized cultures, adult educators need to understand women's learning in a social and cultural context; consider the interrelationship of women's adult development and their learning styles, and; emphasize connection

over separation of women's relationships with others. The connected teaching model described by Clinchy et al. (1985), in which the teacher is encouraged to trust each learner's experience and to connect with each learner's perspective, can increase the effectiveness of instruction.

In addition to an understanding of the learner and the learning process, the selection of instructional techniques and the effective application of media to educational setting are essential, particularly in distance education and education at a distance. Media have the power to achieve learning outcomes if they are well produced and carefully selected to support the instructional events and to meet learning objectives. In designing such education programs for women with eating disorders, adult educators must face the challenge of integrating the theory of transformative learning and women's learning styles with instructional techniques that are effectively integrated with media technology.

The next chapter focuses on a study I conducted in British Columbia in 1993 where these factors were all considered in designing and delivering an educational distance program for 23 women in a successful pilot project.

CHAPTER 3

DESIGNING AND PILOT TESTING THE PROGRAM

This chapter describes the process and results of the distance psychoeducational program I designed for WWED. The program was designed and pilot tested in British Columbia over a 2 year period during 1993-1995. The process comprised three phases. The first phase consisted of assessing the content and format needs of health care professionals as the educators, and women with eating disorders as the learners. The needs assessment on content included focus group sessions with both WWED and health workers. It also included consultations and interviews about program format with two other groups, (a) health and education experts and (b) WRED. The second phase was designing and developing the program materials, including a facilitators' manual and six videocassette modules. The third phase involved pilot testing the program with selected mental health care workers in eight communities across British Columbia. Verbal and written feedback as well as pre- and post-test questionnaires were used for interpreting outcomes.

Assessing Content and Format Needs

Assessing the content and format needs of the two groups, learners and facilitators, represents the focus of this study. First, I assessed content needs from a focus group of women currently suffering from eating disorders and then from a focus group of health care professionals. After establishing the nature of the content that might be useful, I consulted with seven health and educational experts using an interview methodology to assess an appropriate format for the program. Six themes emerged from these interviews. I then used these six themes to elicit further program format ideas by interviewing 20 WRED.

The Women With Eating Disorders (WWED) Focus Group

In order to develop a program that meets the needs of women with eating disorders, I wanted to understand the personal experiences of these women and investigate some of the self-knowledge they have concerning their problem and recovery. This was the beginning point of my study.

Conducting the WWED focus group. On July 26, 1993, I conducted a 2-hour focus group with 6 women who were at various stages of eating disorders including anorexia nervosa, bulimia nervosa, and compulsive eating. I selected these women from among clients in

my private practice as a nutritionist working in Vancouver. They represented a cross-section of eating disorders and ages among women who suffer from this problem in Canada. These women ranged in age from 16 to 40. Other selection criteria included their emotional stability, and their comfort and ability in speaking about their problems. I contacted all 6 women by telephone and explained my project to them before inviting them to participate.

I also invited a video script writer to be an observer and to take notes for me. It provided him with the opportunity to learn about the intended audience. I did not want to use a tape recorder because I feared that it could inhibit the group discussion. Since the script writer was the only male in the focus group, I sought verbal permission from the participants for his attendance. All six women said they were comfortable with his presence. He sat quietly in the background and took notes with a pen and note pad. None of the women knew each other prior to this meeting. I started the focus group meeting with a self-introduction and asked the women to say only what was comfortable for them. I facilitated the focus group in a collaborative, non-judgmental manner, and encouraged input from all participants.

I explained to them that I wanted to collect information and learn about real life experiences of women suffering from eating disorders. I was particularly interested in learning about effective treatment approaches and recovery processes from their perspective. I asked 10

focus questions of the group: (a) What motivated you to get help for your eating disorder? (b) What did you need to know to start your recovery? (c) What key areas of knowledge were most important in your recovery process? (d) What changes did you need to make in your thinking about weight and food? (e) What helped you to begin to recover a healthy eating pattern? (f) What emotional issues related to your eating disorder were important for you to address in your recovery? (g) What skills did you need to learn in order to deal with underlying emotional issues? (h) What did you need to know and do about your body image in order to recover? (i) What was helpful in changing your body image? (j) What was effective in improving your self-esteem?

I asked each question in sequence, and allowed approximately 10 minutes for the women to discuss each question before posing the next question. Once the women warmed to each other, they shared their experiences and expressed their ideas freely. The input provided by each person depended on the amount of insight she had about her eating disorder. For example, I observed that the amount of insight had a positive correlation with the duration of the person's treatment. The longer the person had been in treatment, the greater her insight into her eating disorder. Only half of these women had what I perceived to be considerable insight into their problems.

Key findings of the WWED focus group. Using the notes taken by the script writer, I compiled the statements into similar categories.

For example, all comments related to body images were grouped. I also tabulated the number of times that a similar statement was made. I noted agreements and disagreements on topics. For example, body image dissatisfaction was common, but the nature of psychological problems were not. From this analysis, I identified nine themes: imprisonment, isolation, need for support from others, distorted thinking about food and weight, mistrust of their bodies, body image concerns, emotional association with food, socio-cultural pressures, and low sense of self-worth.

Although the women shared many common experiences, most were surprised to hear that others felt the same way. "Having an eating disorder is like being in prison," said one woman. Others told me that they felt ashamed, trapped, isolated, or that they believed most people did not understand their struggles. Many of the participants talked about how their eating disorder was a deep secret that nobody should know. They did not feel the freedom to enjoy things that most people take for granted. For example, they did not feel free to eat what they wanted, which limited them from participating in numerous social events.

Most of the women in the focus group reported seeking help when they felt they had the support of friends, family, or health professionals. None began to seek help without this first level of support. They told me that they needed to feel "worthy" of recovery. Self-hatred was a common

theme. They said it was motivating for them to know that others also felt they needed to be worthy of recovery. Recovery has been a long slow process for all of them. The average length of illness for these women was 3 years. "It's like taking three steps forward and one step back," was how one woman described her journey of recovery.

All the women agreed that the societal pressure to be thin and the idealized images of women portrayed in the media contributed to their problem. They told me they needed to know that people would like and accept them even if they were not thin. Their self-image was tied to their body image. One woman said, "I weighed myself every morning. If my weight went up, that would ruin the day for me." All the women in the group shared similar experiences. They said that they had allowed their lives to be ruled by the weight scale.

"Knowing is not doing when it comes to food. I may know that I should be eating better, but I don't seem to be able to do it," said one woman. Most women said that they were knowledgeable in nutrition. However, they no longer remembered how to eat normally. All the women in the group had distorted ideas of healthy eating and had developed fears of eating regular meals. Most sustained themselves on "diet" foods and a limited variety of other food such as bran muffins, salad, and fruit. Fifty percent of the WWED group had engaged in eating binges. The eating binges would include large quantities of high calorie foods, such as ice cream, bread, and butter. These women associated

their eating binges with their emotional state. "When I feel depressed, I turn to food to numb my feelings," was how one woman described the way she used food to cope with her emotions. When I asked about emotional issues, most women told me they were not aware of exactly which emotional issues in their lives were related to their eating disorder. However, all of the women agreed that they have personal psychological issues which needed resolution. For example, one woman disclosed, "I was sexually abused by my baby sitter when I was young and it still affects how I interact with men." Another woman told the group that she has never felt loved by her parents. The psychological traumas shared by these women were diverse and disturbing.

Focus Group of Health Workers

In order to determine the perspectives of professionals who work with women with eating disorders, I conducted a focus group with 12 health workers in Campbell River. I selected Campbell River because it is representative of many smaller communities in British Columbia, with a population of approximately 25,000. It has one mental health centre, which is the major source of mental health education and treatment programs.

Conducting the focus group of health workers. I sought the assistance of the mental health therapist at the mental health centre to plan the focus group of health workers. She coordinated a group of health workers who have contacts with eating disorders clients in the

community. We selected 12 participants for the focus group, who represented a range of knowledge levels and disciplines, including family services, counseling services, crisis line, parenting programs, youth programs, women centre, art therapy, social work, and nursing. I conducted a 2-hour focus group on August 19, 1993. My primary purpose was to determine the knowledge and skill level of these potential facilitators and to identify what format and components were needed to support the delivery of an outreach eating disorders program from their perspective.

The six questions for the focus group of health workers were: (a) What types of eating disorders do you see in your community? (b) What programs are currently available to individuals with eating disorders in your community? (c) How comfortable are you in providing treatment to individuals with eating disorders? (d) What knowledge and skills do you need to feel more competent in treating individuals with eating disorders? (e) What resources would help you to provide improved eating disorders treatment? (f) If you were to deliver a group program, what support materials (e.g., background information, audiovisuals, handouts) would you like to have in order to help you implement the program?

Most of the health workers knew each other and were ready to talk about their needs for an eating disorders program. I used a more direct facilitation style than the one used with the WWED focus group. I was not as concerned about sensitivity of the topic, because the discussion

was less personal and emotional. However, I ensured that each person had enough time to provide adequate input and to express his or her individual thoughts. The health workers regarded me as an expert in the field of eating disorders and tended to ask for solutions to problems they were experiencing in the community. Ultimately, I had to re-focus the group by emphasizing that their input would guide the development of an outreach program, which in turn would be available to them. I left the focus group with the perception that they had basic knowledge of eating disorders and good teaching skills. However, their questions during the discussion indicated that they needed more expertise and confidence in working with WWED groups and individuals.

Key findings of the focus group of health workers. During the focus group meeting, the participants described the general population of WWED in their community as young women, ages 14-30. The types of eating disorders included anorexia nervosa, bulimia nervosa, and compulsive eating, with bulimia nervosa being most prevalent. Major issues they identified included body image, self-esteem, and preoccupation with food and weight.

I also was told that there were no specific community programs available to women with eating disorders in Campbell River. All of the health workers expressed their lack of confidence in providing eating disorder programs; they told me they needed more training and regular

contact with a resource person for consultation if they were to deliver an eating disorder program. Although they reported that they were interested in learning more in the area of eating disorders, they said frankly they could not allocate time to do so in their current work setting. The social worker said, "Working in a small town, we have to be generalists to address the diverse needs of a small population." However, in addition to basic health knowledge, everyone in the group had group facilitation and counseling skills. The health workers expressed greater confidence as facilitators than as instructors in the field of eating disorders. For example, a nurse said: "I don't know enough nutrition to teach it, but I can share the resources in the program and support women in making changes."

When I presented the idea of using media technology as a component of the program design, the group received it well. Many of the health educators liked the choice of videotapes as the instructional medium because clients could learn directly from the experts on the videotapes. Furthermore, the health workers believed they, too, would learn about eating disorders from the videotapes as they deliver the program. However, the health workers advised me that they would like the program format to be flexible so that they could adapt the program to suit their individual work settings. They said they would like to have some guidelines for delivery, but the guidelines should not be overly structured. They wanted minimal background reading so preparation for

each lesson would not take too much time. In addition, they requested that I develop a facilitator's manual, which could serve several purposes including: to support the videotapes, to guide the facilitator, and to provide discussion questions. Furthermore, some of them suggested that I develop handouts to supplement materials presented in the program. A few of the participants said they would need to set up a resource library in their own town so that reference materials could be easily accessible. They also requested that I include a reading list in the program which they could use as a guide in stocking their local library.

Consultation with Experts on Eating Disorders

After the first two focus group sessions, I consulted a group of experts on eating disorders, including 1 psychiatrist, 2 nurses, 2 psychologists, 1 social worker, and 1 education consultant in order to create program content from the acknowledged experts. The consultations occurred individually with each expert between August and October, 1993. Each expert was consulted on the content of the program, the development of the video script, and the best use of language. These experts were staff at an Eating Disorders Clinic in Vancouver, where each of them had worked extensively with eating disorders and conducted WWED groups. The members of this advisory group were selected for their recognized expertise in eating disorders and for their diverse representation of health disciplines.

Key ideas. The experts identified a few key considerations in the program development. These included their concern that the language and tone of the instruction needed to be respectful of women's experiences and self-knowledge. To minimize the psychological barriers that may interfere with learning, the advisory group suggested that the narrator in the video should use a third person voice to avoid guilt-producing comments. These experts also advised that women would learn best from others who have had the same problem rather than from a health professional.

They said the content of each module must be informational as well as motivational. The facilitators who would conduct the outreach program may not be knowledgeable of the topic, thus, the video modules must be self-contained in presenting the information to the learners. The video should help women be empowered to take action towards overcoming their eating disorders. To minimize guilt and shame that are typically experienced by women who have eating problems, the psychologist suggested that the program should help women externalize their eating disorder and treat it as an "enemy." He explained that their low self-esteem perpetuates their problem and makes recovery difficult. However, if women could view the eating disorder as an external entity, against which they need to battle, they may feel more empowered and worthy of recovery.

Identification of six themes as content topics. As a result of the advice I received from the advisory group, in combination with ideas gathered from the literature (Davis et al., 1989; Rice & Faulkner, 1992; Weiss, Katzman & Wolchik, 1985), I identified six content topics for the program: (a) Starting the recovery; (b) Overcoming dieting mentality; (c) Recovering healthy eating patterns; (d) Emotional triggers in eating disorders; (e) Healthy body image; (f) Enhancing self-esteem. These six topics encompassed the themes which had emerged from the WWED focus group. I decided that each topic area should constitute one learning module.

Interviews With Women who had Recovered from Eating Disorders (WRED)

I now had the needs identified and considerable information from the experts, but I wanted to gain an understanding of the process of recovery from the viewpoint of the WRED in order to help identify effective instructional strategies that might facilitate learning. Furthermore, I wanted to use the voices and images of WRED in the video modules. To accomplish this, I interviewed 20 women who had fully recovered from eating disorders. In July 1993, I contacted 20 of my clients, located in the Vancouver Lower Mainland area, who had recovered from an eating disorder and invited them to participate in this project. I selected women ranging from ages 14-40, with 80% of them between ages 20-30. They had suffered either anorexia nervosa, bulimia

nervosa, compulsive eating, or a combination of eating disorders. The duration of their illness varied from 1-10 years.

The interview process. I explained my purpose for the proposed interview in the initial telephone contact with these women, and explained how I would use the information to help other women with similar problems. All the women I contacted agreed to participate because they wanted to help others with the same problem. When I explained that the interviews would be videotaped and used in an educational video program for sufferers, a few women told me they would be nervous speaking in front of a camera. I assured them that the camera could be switched off at any time upon their request and that they could preview the final edited video program before its release. This assurance seemed to alleviate any reluctance they had about being on camera.

I arranged the video-taping of the interviews at the studio of a company I contracted with to produce the video series. I conducted the interviews over 3 consecutive days in August. Privacy was important to ensure that women were comfortable in discussing their personal and emotional experiences. The camera operator and I were the only people in the studio with the interviewee. The camera operator had great sensitivity to the topic of eating disorders because he had a friend who was a sufferer.

At the beginning of each interview, I expressed my appreciation to the interviewee for her participation and contribution, introduced the camera operator, and asked the interviewee to sign a release form. I emphasized that the interview could be terminated at the interviewee's request. I sought to conduct the interview in a very informal style, to establish rapport and trust, to acknowledge their replies to my questions without judgment, and to convey empathy when they shared their struggles in recovery.

Although each woman's stories were different, they communicated many of the same messages. Their stories were extremely interesting and their experiences were painful. It was clear to me that these women turned to a preoccupation of food and weight to avoid dealing with their personal problems, and that they had struggled long and hard to battle their eating disorders. Through the interview questions, I tried to draw out their experiences, changes in their beliefs and self-concept, the "secret" of their success, and their insights as derived from their recovery. I wanted the voices of these women to form the key messages in the program. Each interview took approximately 1 hour. I designed the interview questions to address the six topics (modules) of the program.

In the next six subsections, I outline the questions asked and key messages communicated by the interviewees. The interviews did not always follow the order of these questions and did not always include all

the questions. I wanted each interviewee to feel free to direct the emphasis of the interview to issues that were most important in her own recovery. As the significance of each topic was variable for each interviewee, I spent more time on issues of greatest importance. I did, however, cover all the broader topics with every woman I interviewed.

Starting the recovery. The first topic in the program, starting the recovery, was a critical topic. The remaining topics would not be very meaningful if this module was unable to initiate the learners' recovery process. To capture the experiences of women's lives with, and lives without, an eating disorder, I developed 10 questions: (a) In what ways has the eating disorder interfered with your life? (b) How was your emotional state when the eating disorder was in charge? (c) How was your physical state when your eating disorder was in charge? (d) Tell me about the pain and suffering that you felt during the course of the eating disorder? (e) Did the eating disorder interfere with any plans or goals that you had in your life? (f) Did the eating disorder rob you of any interests or habits, friends or family? (g) What helped you to shift into the recovery mode? (h) How has your life broadened and improved with the advances that you have made against the eating disorder? (i) What are the joys and victories you experienced in your recovery process? (j) What are the biggest sources of joy and happiness that are present in your life?

I was told by the interviewees that the eating disorder robbed joy and happiness from their lives. One woman said, "When I had an eating disorder, I didn't have a life." They recounted how they experienced little pleasure in doing anything. Many women, especially those with anorexia nervosa, said they isolated themselves. I was told that their eating disorder had seriously damaged them emotionally and physically during the most serious stage of their illness. When the eating disorder was in charge, most of the women were preoccupied with thoughts of food and weight. They were withdrawn socially because of their depressed mood and their weak physical status. They avoided situations where they were confronted with food, such as parties. Such social isolation kept these women trapped in their eating disorders. They felt that reaching out for help was very difficult but necessary for the recovery process to begin. One woman said, "It was a leap of faith. I met someone who I could trust and confide in. I took one step at a time as I tested the water." For some of the WRED group, the recovery process itself was healing. One woman conveyed that she has grown personally from having an eating disorder. "I'm not the same person that I was before. Not one cell in my body is the same," she said. Most women have gained wisdom from the recovery process. They recognized the danger of dieting and how it can take over their lives and lead to a life-threatening eating disorder. As one said, "If I knew what I know now, I would have never fallen into the trap of an eating disorder."

I noted that the common denominator in their recovery was breaking the secrecy of their eating disorders and sharing their struggles with others. It was helpful for them to view the eating disorder as an enemy rather than a friend, because it made them angry. It also motivated them to relinquish their behaviour of eating disorders.

Overcoming dieting mentality. To gain information of how dieting relates to the development and continuation of an eating disorders, I asked 5 questions (a) How did dieting start for you? How did you fall into the dieting trap? What pressures did you feel? (b) What effects did dieting/bingeing /purging have on your mind and body? (c) Why didn't dieting/bingeing/purging work for you? (d) What changes in your thinking about food were important in your recovery? (e) What changes did you have to make in order to begin to eat normally?

Dieting led to an eating disorder for all the interviewees. They told me that they felt trapped by dieting. As one woman described it, "At first, it was to get some attention by dieting. Then it became a way of life." One woman described how dieting/bingeing/purging became a perpetuating cycle for her: "Whenever I ate something that I wasn't supposed to, I felt guilty so I ate more. Of course, after that, I had to throw it up so I wouldn't gain weight." Some women graphically described the damaging effects of an eating disorder, such as losing clumps of their hair, fainting, and lethargy. All the women communicated that dieting contributed to their eating disorder and that

it was essential for them to relinquish dieting in the recovery process. However, normalizing eating was an extremely difficult step. For most of the women, learning to eat normally was an on-going process. To begin eating normally, they had to challenge their irrational thoughts about food, such as "I will gain 10 pounds if I eat a cookie." Some used positive self-talk to overcome any guilt associated with eating "forbidden" foods, such as telling themselves, "I can eat a hamburger. The meat is rich in iron and my body needs it." Some women watched how other healthy people ate and tried to learn from their observations.

Recovering healthy eating patterns. To identify the barriers women had to overcome in the process of changing their eating behaviours and patterns, I developed 6 questions: (a) What was your eating pattern like when the eating disorder was at its worst? (b) What thoughts and beliefs did you have about food that made eating difficult for you? (c) What were the beginning steps for you in normalizing eating? (d) What changes did you make in your eating pattern that were important in your recovery? (e) How did normal eating behaviours help you overcome your eating disorder? (f) What would you tell people who are afraid to eat normally because they are afraid of weight gain?

The eating patterns described by the interviewees varied greatly, but they all had similar dichotomous thoughts about food. A food was either "good" or "bad." Their distorted beliefs about food made eating normal meals difficult. The interviewees who had nutrition counseling

seemed to have more insight into the recovery of a healthy eating pattern. For example, one woman said, "Eating regular meals decreases the urge to binge." Another said, "I look at food as fuel and essential nutrients. If I didn't eat any fat, how would I get my vitamin A, D, E, and K!" The fear of eating normally had kept a few women from recovering fully from their eating disorders. Women who have resumed eating normally started by eating meals mechanically to reestablish a pattern, replacing diet foods with regular foods, and allowing themselves forbidden foods so they did not feel deprived. Many interviewees told me that each small victory in eating had helped build their confidence in making more changes.

Emotional triggers in eating disorders. To identify the relationship between emotional problems and eating disorders, I asked 3 questions: (a) What emotional issues in your life opened vulnerability for the eating disorder? (b) How did you disconnect your emotional issues from eating problems? (c) What strategies have you found helpful to you in dealing with your emotional problems?

The emotional issues in the women's lives included: perfectionism, family problems, abandonment, and sexual abuse. From the interviews, it was clear to me that eating disorders were not caused by a uniform set of emotional problems. Although their problems were individualized, they were consistently linked to the eating disorder. The eating disorder was a way for women to cope with or distract from their emotional

problems. One woman said, "Restricting, bingeing, and purging numbed my feelings and thoughts." Recognizing the emotional triggers for food and then disconnecting them from bingeing was an essential step that most women learned in their recovery. One woman told me, "One of the most important factors in my recovery is to identify and face emotional issues and problems." In general, the strategies that these women used in dealing with their emotional problems included professional counselling, support group, and consoling with friends.

Healthy body image. To determine factors affecting women's body image and how they improved their body image, I asked 5 questions: (a) How is the perception of your body image related to the eating disorder? (b) How did your feelings about your body keep you trapped in the eating disorder? (c) What changes did you have to make to improve your body image? (d) How does feeling better about your body help your recovery process? (e) How do you perceive your body now as compared to before?

All the interviewees had a poor body image, which led them to dieting. Their body image was not related to their actual weight but more closely related to their self-esteem, such as "feeling fat when things didn't go well in my life." These women said they derived self-esteem from their physical appearance and they over-emphasized the value of being thin. It was essential in these women's recovery process to decrease the emphasis on their body weight and to focus on other positive attributes. In order to do so, the women, who previously weighed themselves

multiple times daily, stopped weighing themselves. Some set more realistic standards for judging their bodies and others stopped judging their bodies completely. As they came to recognize that they were overly critical of their own bodies, they asked trusted friends and family members to provide positive feedback on their body size.

Enhancing self-esteem. To gain women's insight into their self-esteem and their recovery, I developed 5 questions: (a) What were some experiences in your life that negatively affected your self-esteem? (b) In what ways was your self-esteem connected with the eating disorder? (c) How has the eating disorder affected your self-esteem? (d) How has your self-esteem changed as you recover from the eating disorder? (e) What are some ways that were helpful to you in improving your self-esteem?

Although poor self-esteem was common for all interviewees, they shared very different experiences in their lives which contributed to their negatively feelings about themselves. Some of the factors which threatened their self-worth included unemployment, feeling vulnerable or rejected, being handicapped, physical/verbal/sexual abuse, and stressful life events. Their sense of self-worth fluctuated depending on the opinion of others and their own changing weight and shape. However, they all expressed how they were self-critical and tended to be perfectionists. The majority of the WRED said that having an eating disorder had worsened their self-esteem and made them feel even less worthy. One woman said, "My eating disorder destroyed my self-esteem; things that

other people can do with no problem, I found very difficult." Another woman told me that she believed that she deserved the eating disorder because she "was a worthless shell of a person." However, most women were able to improve their self-esteem by focusing on their accomplishments and their positive attributes. One woman acknowledged, "I have learned to be kinder to myself."

Designing the Program Materials

Using the input from sufferers, experts, and the recovered, I designed the program to have three components. A videotape formed the core instruction; a facilitator's manual assisted health professionals to make the instruction interactive; and educational handouts supplemented the videotape information.

Developing the Videotape Modules

The video portion was designed to provide expert information to help women discover how to change an eating disorder lifestyle into a healthier one. In this section I describe decisions concerning the overall format and the guidelines I used for presenting the stimulus materials.

Overall format decisions. I designed the videotapes to be independent of each other for program flexibility. In this way, program facilitators could use them in other teaching contexts as well. The videos presented information on each topic. Following Whiting's (1988)

recommendation for the best length of educational videotapes, each video module was 10-15 minutes. The instructional content was limited to the time available and geared to the learner's level of experience. The content was presented in three ways to facilitate the learning process. First, video clips from the interviews with the women provided personal experiences. Second, the narrator of all six modules acted as a mentor for the program learners. She (Sharon) appeared confident, knowledgeable and possibly could have recovered from an eating disorder. Lastly, the dramatic scenarios, in which actors performed scripted life situations, provided demonstration of behaviours and new skills.

To personalize the program, as suggested by the focus group of health workers, each of the program modules followed the progress of a fictional character, Debra (a professional actor), through her initial steps on the road to recovery from an eating disorder. This view through a window on Debra's life was supported by factual information provided by the narrator, Sharon. To heighten the emotions of the viewers, each video module was peppered with video clips of interviews with WRED telling their own experiences of success and failure. The effect was powerful and personal.

The script was developed by the script writer who had attended the earlier WWED focus group. I worked closely with the script writer in the development stage, as did the experts. The script was reviewed and

revised by the eating disorders experts on three occasions. For the video production, I was actively involved in casting actors for the dramatic scenarios to ensure accurate portrayal of characters. On production days, I was on-site to oversee that the production was meeting the educational objectives. I ensured that the director was guiding the actors to act out the script in a realistic and believable manner.

Guidelines used for presenting the stimulus material. In designing the video modules, I followed Simonson's (1983) instructional media design guidelines for promoting attitudinal change among the learners. I also remained sensitive to the fact that these would be used at a distance from me but would have local facilitators to lead discussion. In this, I needed to anticipate problems in advance that might arise in the future. Here I explain how I adapted these guidelines for the video.

Guideline 1: Make mediated instruction realistic, relevant to learners, and technically stimulating. In keeping with women's ways of learning (as identified by Clinchy et al., 1985), I used the stories of women and images portraying women's experiences with eating disorders as the foundation of the video modules. These were intended to validate the learners' experiences. To promote contextual learning with firsthand observation, actors were used to dramatize choices in behaviors and the corresponding outcome. For example, when a woman chose to use her

friend for support, she did not binge; however, when she isolated herself, she engaged in what is called "binge-eating" in the field.

Guideline 2: Present new information about the topic. Each module presented new information on the designated topic to the learner. I developed new information based on what women in the WWED focus group said they needed to know to start their recovery process. For example, the nutrition information was designed to challenge the learners' cognitive beliefs about caloric requirement and healthy food choices.

Guideline 3: Present persuasive messages in as credible a manner as possible. I designed the program to foster a combination of subject-oriented and emancipatory learning (Cranton, 1994). There were some facts and problem-solving strategies that needed to be communicated to the learners. As mentioned, I chose to use a female narrator, who acted as the educator on the video program, to communicate the information. In keeping with Tisdell's (1993) feminist emancipatory educational approach, the narrator took a neutral power position to minimize any power disparities. She was not portrayed as an expert or a health professional. She presented herself as a poised, confident, intelligent person who may have recovered from an eating disorder herself. Her language in addressing the learners was in the third person to promote information sharing, rather than giving advice. For example, she said, "It's possible for someone to be freed of an eating disorder and claim a

healthy life," rather than saying, "You can free yourself of an eating disorder and claim a healthy life." For casting this actor, I used the criteria that the actor had to be able to portray a friendly, trusting, and caring image.

Guideline 4: Involve the learners in planning, production, or delivery of mediated instruction. I used the input from the WWED focus group to help me in designing messages that would promote attitudinal changes in learners of similar needs. I developed discussion questions which involved learners in analyzing scenarios presented in the video module. For example, in module 3 where the actor, Debra, refuses to eat, one of the discussion questions was, "Why does Debra think that her body doesn't require much food?"

Guideline 5: Using post-instruction discussions and critiques seem to develop favorable attitudes toward the delivery method and content. I designed each module to lead into a discussion among the learners following the viewing of the video. On the advice of a psychologist, who was one of the experts on eating disorders that I consulted, I used an externalizing approach in the question design for post-instruction discussion. To externalize, I worded the questions in a way that would position the problem related to an eating disorder as an outside enemy rather than an internal flaw. For example, instead of asking "How does being secretive and isolated perpetuate an eating disorder lifestyle?" the question was phrased as: "In what ways do you

think that secrecy and isolation help to imprison a person in an eating disorder lifestyle?" By externalizing secrecy and isolation, the person was no longer being secretive and isolated but instead, secrecy and isolation were external problems which the person needed to overcome.

Guideline 6: Provide a purposeful emotional involvement or arousal during instruction. I selected video segments from the 20 WRED interviews which conveyed messages with various emotional expressions. I intended the personal stories of these women to provoke emotional arousal of the learners. For example, one of the WRED was on the verge of tears as she communicated how she struggled to overcome her problem. Another sufferer expressed great joy in her voice and facial expression as she talked about the freedom and fulfillment she has had since her recovery.

Developing the Facilitators' Manual

My purpose in designing a facilitator's manual was to provide a suggested program framework and facilitation tips for the program facilitators. I structured the manual into lesson plans that corresponded with the six videotape learning modules.

Choice of lesson plans for the six modules. I followed Gagne-Briggs' (Gagne et al., 1988) design model, which includes nine instructional events: gaining attention, informing the learner of the

objective, stimulating recall of prerequisite, presenting the stimulus material, providing learning guidance, eliciting the performance, providing feedback about performance correctness, assessing the performance, and enhancing retention and transfer. Each lesson consisted of an introduction, group reflection, video presentation, group discussion, self-learning activities, and a wrap-up. Each activity had a suggested timeline to guide the facilitator. I intended the manual to be flexible for the purposes of delivery and as a resource for facilitators in their work settings.

Organization of the nine instructional events into each module. This section describes how I organized the nine instructional events into each module.

Gaining attention. For the written manual, I used reflection questions as a way to guide the attention of the learners to the topic of each module. The questions were intended to help learners examine their own experiences, assumptions and beliefs. I used the critical questioning approach to stimulate critical reflection in the learner (Brookfield, 1987). In the first module, for example, one of the questions asked was, "In what ways do people's lives change when an eating disorder enters their life?" As a group, the learners could decide from the list of suggested questions which ones to discuss. They could also add additional questions to the list.

Informing the learner of the objective. The identified needs of the WWED group provided the basis for the learning objectives (Appendix A). For example, one of the objectives in module 1 was to examine the impact of their current behaviours on their eating disorders. The objectives of each module were clearly defined and related to the reflection questions posed to the learners. I intended that facilitators explain the objectives prior to showing the video modules to prepare the learners.

Recalling prior related experience. I tried to accomplish this instructional event through the reflection questions. I designed the questions to stimulate learners' recall of related learning. In module 1, for example, one of the reflection questions was, "What things does an eating disorder rob from a person's life?"

Presenting the stimulus material. The videotape modules were the stimulus materials. The facilitators were advised to show the videotape following the discussion of the reflection questions in each module.

Providing learning guidance. As a support and learning technique (Belenky et al., 1986), I integrated group interaction into the program design to foster learning guidance and mutual support. Through homework assignments, the learners who would use the program would review their weekly learning with the group and share their experiences with each other at the beginning of each session. In order to encourage learners to reflect on their learning journey, I recommended that the

future learners be asked to use the common adult education strategy of journaling. One of the weekly assignments for the learners was to make journal entries about their experiences as they practiced new learning strategies and made changes toward their recovery. The process of journaling would allow learners to examine their thoughts and beliefs on weekly topics of the program and to reflect upon their learning (as recommended by Cranton, 1994).

Eliciting performance. The opportunity for learners to practice the newly acquired knowledge and skills was an important component of my program design. It was a critical aspect suggested by my WRED focus group. I developed self-learning activities for each module. These activities served as homework and were related to the content of each topic. Learners were encouraged to practice them between each session. For example, in Module 3, where normal eating activities were demonstrated, one of the homework assignments for the learners was to practice one or two activities which would help them in establishing a normal eating pattern. An example of an activity was to discard all diet foods and start introducing what they previously considered were forbidden foods.

Providing feedback. In the design, I suggested to facilitators that, at the beginning of each session, they should invite learners to discuss the previous session's self-learning activities. My purpose was to encourage facilitators and learners to provide feedback to each other. I

cautioned facilitators to acknowledge learners' self-learning experiences positively and not to display obvious judgment. This approach was intended to help validate women's existing knowledge and to affirm that they were capable of intelligent thoughts.

Assessing performance. In this type of program. where each learner could be at a different level of knowledge, I knew individual progress could vary greatly. Therefore, I advised facilitators to have learners review their journal weekly as a way to monitor and to assess their own learning during their recovery. Learners were asked to keep a record of their goals and their changes in attitudes and behaviours in their journal. The achievement of their goals was a way for learners to assess their own performance.

Enhancing retention and transfer. I encouraged the facilitators to summarize the key points at the end of each session and then to review them again at the beginning of the next session. This could help learners keep their focus on the learning objectives of each session and reinforce their learning.

Accompanying handout. Based on input from the focus group of health workers, I developed 14 handouts to supplement information presented in the video module. These handouts provided program outline, group guidelines (rules on commitment, confidentiality and safety), weekly worksheets for group reflection questions, references information (for example, alternative activities to binge-eating and

sample menu). For convenience, these handouts were designed to be reproducible with a photocopier. Each handout was numbered and referenced to each module in the facilitators' manual. As a part of these handouts, I compiled a reading list for group participants and a professional reading list for group facilitators to broaden their learning on each topic of the program. The group facilitators could use the reading lists (Appendix B) as a guide if they want to start up a resource library in their community. All the references on the reading lists were available on loan through the British Columbia Eating Disorders Resource Centre in Vancouver.

Testing the Program at a Distance

I pilot tested the eating disorders program in eight communities in British Columbia. The purpose of the field-test was to obtain feedback from facilitators and participants on the program design and to evaluate the effectiveness of the program.

Selecting Pilot-Test Sites and Participants

The eight communities I chose were Courtenay, North Vancouver, Surrey, Campbell River, Victoria, Cranbrook, Chilliwack, and Maple Ridge. They represent both urban and rural populations. I contacted the mental health worker at the regional mental health center in each community by telephone to elicit their participation in the pilot test.

Only two of these test sites (North Vancouver and Victoria) had any eating disorders program available to women in their communities. All of the mental health workers welcomed the opportunity to participate in the pilot test as program facilitators.

The facilitator at each Mental Health Centre recruited the learners in their own communities. Each group consisted of 3 to 8 women. All group sessions, except one, were conducted at the local mental health centre. At that site, the facilitator worked in the Child and Youth Division and conducted the group in a high school.

Pilot Testing Process

The video modules, a final draft of the facilitator's manual, and a set of pre- and post-test questionnaires were sent to all test sites in August, 1994. Prior to sending the program materials to the test sites, I contacted the facilitators by telephone and explained the field test procedures, and I followed up with a letter. I explained that all information on the questionnaires would be confidential and used for research purposes only. I asked them to distribute the pre-test questionnaires to learners in the first session and the post-test questionnaires in the sixth session of the program. I asked the facilitators to follow the program outline as detailed in the manual and to critique the program design and the facilitator's manual. To ensure the facilitators' feedback was clear, I requested that they write their

comments on the manual and return it with the completed post-test questionnaires.

Each pilot test group met weekly for 6 weeks during September and October, 1994. The facilitators followed the program structure as outlined in the facilitator's manual. All eight test sites completed the delivery of the program. The facilitators returned the facilitator's manual with their comments and feedback on the program design. In the next section, I describe the feedback I received from the facilitators.

Feedback on Program Design

As instructed, the facilitators wrote their comments and feedback on the facilitators' manual as they delivered each session. The areas in which I solicited input included learner relevance, format, and program design. I did not asked specific questions about each aspect of the program design; rather, the facilitators' feedback was allowed to be unstructured and subjective.

The amount of feedback received varied greatly. Learners in Courtenay, East Kootenay, and Chilliwack provided the most feedback. I compiled and categorized all the comments written in the manuals and summarize the finding in the following subsections.

Learner relevance. The learners of the program included women with anorexia nervosa, bulimia, and compulsive eating. The compulsive eaters, who tended to be overweight because of binge-eating behaviours, wanted more help with weight loss. The body weight of the women with

eating disorders varied greatly; it was clear that the compulsive eaters were a non-homogenous group.

The Chilliwack group, conducted in a high school, did not provide an appropriate setting. The group met after school in a classroom. The learners said, "It was hard to leave the student role." Twelve women enrolled in the program but only 6 attended the first session and the number of members decreased each time they met. The facilitator reported that some group members did not admit to eating disturbances, which made it difficult for self-disclosure. The facilitator suggested, "This program would work well if it was held at the mental health centre with clients referred by mental health workers, physicians, or other health professionals."

Format appropriateness. The feedback on the format was all positive. "The layout of the modules is easy to understand and follow," said the facilitator of the Courtenay group. The larger groups needed more time in each session. The suggested time in the program was 1 1/2 hours per session, but some group leaders needed 2 hours to complete their sessions. The group reflection questions took 20-30 minutes, and the post-video group discussion needed 30-45 minutes. The facilitators did not comment on the flexibility of the program, as they were instructed to follow the suggested format for the pilot test.

Reflection and discussion questions. Most of the facilitators said the wording of the questions was confusing to learners. The

questions which used an externalizing approach were not easily understood by some learners. For example, instead of asking "Why do sufferers hide their emotional issues?", the externalizing question was worded: "How does it happen that certain emotional issues may have remained hidden in a person's life?" The facilitator in Maple Ridge, who had previous training in this approach, said she "liked the externalizing approach to questions." She understood the externalizing approach and was able to address the questions to the learners in a manner that facilitated learning.

In general, the facilitators agreed that discussion questions were an important component of the program design. One facilitator said, "It was very helpful in assisting my thinking and to help me focus in on the specific issues." The Cranbrook leader said the questions "drew out considerable discussion."

Instructional strategies. In keeping with emancipatory education, one of the empowering strategies the program suggested was to encourage learners to undertake an anti-dieting action. The Courtenay group showed a very positive response to this strategy. "Two of the participants in the group were especially keen to boycott dieting and the promotion of perfectionism in media," the Courtenay facilitator reported. Some of the anti-dieting actions discussed by the group were: lobbying for anatomically correct Barbie dolls, banning dieting scams, mass education on dieting myths, promotion of healthy eating

behaviours, and acceptance of different body shapes as beautiful in our society.

Many of the facilitators found journal-keeping a valuable tool for learners to reflect on their thoughts and beliefs. Through group discussions, some learners were able to legitimatize these thoughts and feelings or to identify irrational ones that require challenging. The learners kept track of their progress in their journal and monitored changes and difficulties between sessions.

Video modules. The feedback on the video was extremely positive from both the facilitators and their participants. "The role plays were very well done-- believable," commented the facilitator at Courtenay. The video segments from the interviews of the recovered women "really hit home with the group," said the Courtenay facilitator. She reported that one participant told her, "It was nice to hear other women express emotions and thoughts similar to mine."

The Cranbrook group identified with the image of being in jail and agreed that the first step to recovery was the need to talk to others. There was some negative feedback on the physical size of the characters on the video. One learner said, "The women in the video were all skinny thin women. I had a slight problem with that . . . a lot of women with disordered eating are normal to large in size."

For convenience of space and to control cost, all 6 modules were on a single videotape. Although each video module was spaced, there

was no title bar separating each module. The facilitator at Cranbrook wanted "clearer identification of the beginning and the end of each weekly video segment."

Usefulness of handouts. All the facilitators found the handouts useful. Some of them wanted more handouts to reinforce information presented. Suggestions included adding Canada's Food Guide, information promoting self-esteem, and more learning activities.

In general, the feedback on the program design was highly positive. I incorporated the suggestions into the final program design where possible. For example, I lengthened the program to 2 hours, providing more time for group reflection questions and post-video group discussion. To minimize the confusion for the learners, I simplified the wording of some of the reflection and discussion questions to clarify their meaning, but still maintained their externalizing quality. In addition, I suggested that the program be used with individuals who have anorexia and bulimia nervosa, especially those who have not had previous treatment. This addressed the problems that the overweight women raised. Unfortunately, the cost of video production prohibited any major changes to the video itself. The only change to the video was when I inserted a clear lead with a title bar before each module to identify the beginning of a new lesson. Since the suggestions on the video were very few, this was not seen as a limitation.

Outcome Measurements

I conducted several measures of evaluation on this project and report on them here.

Administration of the Questionnaires

The facilitators were instructed to distribute the pre-test questionnaires at the beginning of the first session and the post-test questionnaires at the end of the last session. In order to accomplish this, the facilitators asked the participants of the program to arrive half an hour earlier on Week 1 and to stay half an hour extra on Week 6. The facilitators stressed the confidentiality of the questionnaires to the participants. The administration of the questionnaires went smoothly and no problems were reported.

The pre-test included a general information sheet, a health information questionnaire (HIQ), an eating disorders inventory (EDI), and a body attitudes questionnaire (BAQ). The post-test included the same questionnaires except that a client satisfaction index replaced the general information sheet. These questionnaires were intended to measure the participants' changes in attitudes, feelings, and behaviours in areas of food, eating, body image, and self-concept.

Pre-Test/Post-Test Results

In total, 41 learners participated in the pilot study and completed pre-program questionnaires; 23 learners completed the 6 week program and completed the post-program questionnaires. The ages of participants ranged from 17 to 55 years, with a mean of 27. The mean age of problem onset was 13.6, with a range of 4 to 25 years age at the onset.

The questionnaires did not show significant changes. Using the standard tests, eating disorders inventory (Garner, Olmsted, & Polivy, 1983), body attitudes questionnaire (Ben-Tovim & Walker, 1994), and health information questionnaire (Geller, Johnston, & Madsen, 1997), all widely recognized tests in the eating disorders field for measuring cognitive and behavioral dimensions of eating disorder symptomatology, the only significant improvement observed was the health information questionnaire symptom intensity score, $t=-3.02$, $p<.01$. Statistically, this indicates that the presence and severity of specific disturbed eating practices were significantly reduced. At the completion of the program, there was a 50% reduction of the number of participants who met the diagnostic criteria for bulimia nervosa. That is, 3 of the 6 women among the 23 participants in the study with bulimia nervosa reduced their frequency of purging to the point where they no longer met the diagnostic criteria for bulimia nervosa.

The eating disorders inventory (EDI) subscores, body attitude questionnaire (BAQ) subscores, and the health inventory questionnaire (HIQ) compulsive eating subscore did not indicate changes due to treatment. However, learners stated they were generally satisfied with the program. They indicated that the quality and effectiveness of the program was fair to good, but not excellent. The majority of people said that they would participate in a similar program again and that they would likely recommend the course to a friend in need of similar help.

The results of this study show a promising future for the delivery of psychoeducation for women with eating disorders at a distance. However, due to the scope and complexity of eating disorders, and the variety of individual treatment needs, any education program designed to treat individuals with eating disorders must clearly define its audience. In the next chapter, I analyze the design and results of this study and provide some recommendations for educators designing distance psychoeducational programs for women with eating disorders.

CHAPTER 4

DISCUSSION, CONCLUSION, AND RECOMMENDATIONS

The purpose of this study was twofold: (a) to examine the design factors in a distance education program intended for women with eating disorders; and, (b) to pilot test a program design that was based on the needs assessment of learners (women with eating disorders) and educators (professional health workers). In this chapter, I briefly discuss the process and outcomes of the study I conducted in British Columbia and then I discuss the congruity between the literature and my experience with this project. In the final section, I make recommendations for practice and offer suggestions for future research.

Eating Disorders and Distance Education

The findings of this study indicate that distance education is a promising model for the delivery of health education to women with eating disorders. Furthermore, to be successful, this project has shown that the design of distance education for these women must consider women's ways of knowing in combination with adult learning principles. Taken together, well designed distance education delivery processes and materials which are sensitive to women's needs, and which take the principles of adult education as their foundation, hold considerable

promise for women who face limited access for treatment of eating disorders in their community.

According to Wolf (1990), Garner et al. (1980), and Davis et al. (1989), socio-cultural factors and individual traits contribute to women's vulnerability to eating disorders. The personal information from the WWED focus group in this project was consistent with these researchers' findings. The women I involved in this study all felt that the pervasive societal pressure to be thin and the idealized images of women portrayed in the media contributed to the development of their eating disorders. They also felt that their self-image was tied to their body image. They recognized that there were elements in their personalities--elements of perfectionism--that made them prone to the relentless pursuit of thinness. The literature and my own findings were congruent in these respects.

Fostering Learning in Women with Eating Disorders

The concept of fostering learning with this special group in society requires both sensitivity and knowledge.

Psychological Development of Women

The research conducted by Belenky et al. (1986) suggests that women's psychological development influences how they learn throughout the lifespan. By interviewing a group of WRED about their recovery process, I was able to gain an understanding of their psychological development as it relates to their course of illness. The account of their life changes was in support of Peck's (1986) model of women's self-definition in adulthood. It was clear that relationships and attachment with others were central to their development, their trauma, and their recovery. As mentioned in chapter 3, one woman's relationship with a trusted friend was the initiating force for her recovery. Women's self-definition was clearly affected by social-historical forces. For example, most of the WRED reported that they became more flexible, sociable, confident, and trusting as they healed from their eating disorders. These interviews supported the research by Miller (1986) and Gilligan (1982) which indicates that women's development and sense of self are related to intimacy and connection with others.

In the delivery of a program to a WWED population in this study, I found it was essential to foster self-esteem and create a renewed sense of connectedness, not more isolation, for the learners. In this respect, conducting the eating disorders program at a distance using a group setting with a local facilitator provided a learning environment that fostered connectedness both with other learners and with a caring

facilitator. The women felt supported and empowered to make changes. Therefore, the principles of women's psychological development and learning needs are congruent with the principles of collaboration and support seen in the feminist adult education literature (Clinchy et al., 1985; Miller, 1986).

Women's Ways of Knowing

Tisdell (1993) recommends that educators should avoid power disparities and alter the nature of structured power relations in the teaching setting to promote emancipatory learning. Consistent with this recommendation, the video modules in my project utilized a peer group of women with eating disorders and a female actress speaking in the third person to address the learners, thus minimizing any sense of power disparity. Furthermore, the local instructors at the pilot test sites were not eating disorder experts but were facilitators with some knowledge of the relevant mental health issues. This power-sharing approach challenged other traditional psychoeducation programs where the instructors must be health professionals and experts in the subject (Davis & Olmsted, 1992; Hayes & Gantt, 1992).

The data from Belenky et al.'s (1986) study suggests that women's life experiences and development determine their perspectives on learning in adulthood. The interviews with the WRED confirmed this. Women having had this experience had various perspectives on learning that were dependent on their maturity, the duration of their eating

disorder, and their relationships with others. Further, the reflection questions at the beginning of each group session encouraged the learners to reflect on their own thoughts and life experiences. Proceeding in this way built a successful program and was consistent with the literature on women's needs and learning styles.

According to Clinchy et al. (1985), women prefer contextual learning and wish to validate their existing knowledge. In using the video segments of interviews with recovered eating disorders sufferers in the learning modules, learners were able to identify with other sufferers, learn from other sufferers, and consider their own experiences in the context of such new learning. The instructional activities such as reflection questions, post-video discussion questions, goal setting, and journal writing were essential in providing contextual learning to the group participants. In this respect, the project was entirely supportive of women's literature and adult education principles.

Facilitating Transformative Learning in Psychoeducation

Although there is no consistent approach in the design of psychoeducation, there is agreement in the psychology literature that psychoeducation programs should foster attitudinal and behavioural change in learners (Davis, Olmsted, & Rockert, 1990; Hayes & Gantt, 1992). The adult education literature, such as work by Gould (1990)

seen in chapter 2, also supports the contention that psychoeducation can help adults overcome psychological conflict and can bring a change in behaviour. However, as seen in chapter 2, much of this literature assumes that a disease-oriented, medical approach is to be used. The results of this study challenge the disease-oriented, medical model advocated by Ciliska (1990), and Davis and Olmsted (1992). The emphasis should not be on the pathology of a disease, the focus should be on the learners' experiences or perspectives which may have contributed to a disorder.

In support of Mezirow's (1991a) theory of perspective transformation, the eating disorders program I developed employed a transformative learning approach to help learners examine and challenge underlying assumptions about their eating disorders so they could achieve a new perspective and act on new understandings. Through the fostering of critical reflection with, for instance, journal writing, the learners were able to recognize their habitual and personal expectations and begin to critically see and monitor changes in both their attitudes and behaviours. As seen in chapter 3, the learners kept a journal for a 6-week period during the program and were able to use journal writing as a tool for reflection. The results seen were consistent with Mezirow's (1990) theory that critical reflection is central to transformative learning.

The design of the program took learners through three phases of a reflection process. As discussed in chapter 3, the learners were asked in

the beginning of each session to identify the assumptions underlying their thoughts on the topic of that session. This design step supported Brookfield's (1987) view that critical questioning is an effective means to bring out ingrained assumptions. Likewise, the video content was designed to reflect and help validate learners' critical questioning by allowing them to see the experiences of WRED. The discussion questions and homework phase provided the opportunity for individuals to reconstitute their own assumptions, make these more inclusive, and integrate them into a new perspective on self and their relation to others.

However, in my pilot test some learners found the reflection and discussion questions confusing. The process of critically questioning personal values and beliefs was unfamiliar and possibly intimidating to a minority of these learners. This is consistent with Brookfield's (1987) finding that critical questioning can cause discomfort, fear and anxiety. Many researchers (Brookfield; Cranton, 1994; Marsick, 1990; Rice & Faulkner, 1992) suggest that a facilitator for such work must be trained, but should not necessarily be a health or education professional. The facilitator should be provocative, not intimidating, and should be a role model. On this point, the inconsistent results and feedback from the heath workers at various test sites confirmed that the quality and experience of the facilitator can affect the success of the critical questioning process. As seen in the Recommendations for Practice later

in this chapter, it was evident that the facilitators needed enhanced training on techniques of critical reflection.

Developing an Appropriate Technology for Women with Eating Disorders (WWED)

This study involved a team of educators and the lessons learned are of value to health and adult educators.

Designing Education

The principles of women's ways of knowing and adult education were confirmed in this project, as were the principles of adult education program design in relation to the needs of women with eating disorders. However, one may still ask if distance technologies are compatible with such a highly personal, deeply felt, disorder?

According to Holmberg (1989), a team approach to designing distance education can produce high quality programs because the work is divided among specialists for individual tasks. Moore (1989) suggests that a course team should include professionals in the content area, technology, and editing. In this project, in addition to content experts, media technicians, and a writer, the eating disorders program design team included learners (WWED) who provided much of the content and many of the learning strategies. These women were also consulted as experts of their own experiences. They represented the needs and

knowledge of similar learners. The pilot test results showed that learners found they were able to relate to the feelings and thoughts of women through education at a distance. In this respect, my study confirms the promise of education at a distance for this group but it also challenges Holmberg's and Moore's assertions on "experts" by arguing that learners can be considered content and facilitation experts.

Changing Attitudes and Behaviours

The results of the pilot test supported Simonson's (1983) instructional media design model for promoting attitudinal change. Most learners found the videotape modules realistic, relevant, and technically stimulating. The learners identified with the similar profiles of WRED and found the videotape modules most relevant. As seen in chapter 3, the overweight compulsive eaters who were not represented in the focus group felt the information was less relevant to them. The discussion questions following the video modules promoted positive attitudes toward the videotape as a method of delivery for both facilitators and learners.

As seen in chapter 3, the results from the empirical instruments, EDI subscores, BAQ subscores, and the HIQ compulsive eating subscore did not show significant changes due to this eating disorders program. These self-reported psychological instruments are designed to measure attitudes, personality features, and eating disorder symptoms thought to be relevant to anorexia nervosa and bulimia nervosa. In a 6-week health education program, the health field would agree that it would be

unrealistic to expect ingrained attitudes about food and body image, and entrenched personalities to change significantly. However, the fact that the HIQ symptom intensity score showed a significant improvement is promising. It means that some learners reduced the presence and severity of disturbed eating practices. I was not surprised that only a few of the learners' needs were met in regards to recovery of eating disorders symptoms. The program did not attempt to substitute comprehensive eating disorder treatment programs; rather, this 6-week psychoeducational program should be utilized as an aid for support groups or an adjunct to psychotherapy involving individuals who are just beginning to admit and cope with their eating disorder. The empirical data indicate distance education utilizing instructional media has the potential to reduce eating disorders symptoms of some participants. This finding supports Goldman's (1988) view that education is an integral part of psychotherapy and can even ameliorate some symptoms of sever mental illness. It is also congruent with Davis, Olmsted, and Rockert's (1990) finding that group psychoeducation can produce significant clinical changes in favour of specific eating psychopathology, such as reduction of binge eating and vomiting. This project has challenged the disease-model approach and has opened the door to reaching one of society's least visible, least served, and least understood groups whose very lives are often at risk.

Conclusions

A psychoeducation program, using transformative and adult learning principles, showed promise as an initial treatment for eating disorders. A distance delivery model reached learners in locations where eating disorder expertise was limited. In chapter 1, I posed some questions relating to program design for an outreach program for women with eating disorders. Here, I explain how this study provided answers to the problem situation. The first question posed was, "How can I design an adult psychoeducation program that can foster changes in women's psychological beliefs in British Columbia, using adult education principles?"

A transformative learning approach can help women identify, examine, and change their perspectives on food, body image, and self-image. This finding concurs with Fairburn and Cooper's (1991) views that if individuals are to overcome an eating disorder, treatment must address the distorted cognitive beliefs concerning eating, body image, and self-concept. By understanding women's ways of knowing and using adult education principles, adult educators can develop a learning environment and educational materials that can foster connectedness and contextual learning. Using an education at a distance model for delivery, I found I could reach women throughout British Columbia.

The second question I posed was, "What are the distorted beliefs held by women who have eating disorders?" The women of this project reported that they felt trapped by their eating disorders. Their disordered eating behaviours prevented them from participating in social events, yet, they felt they needed to connect with supportive people to make the first step towards recovery. They had dichotomous thoughts about food. They believed if they vomited the "bad" foods, they could control their weight. They believed that their self image was determined by their body weight. They also thought that food could help them cope with their emotional difficulties.

I also asked, "How can this information help inform the psychoeducational program I construct?" This project formed the content and format for a program that can be used widely across any province or state. The women's distorted beliefs formed the topics of the 6 weekly lessons: Starting the Recovery, Overcoming Dieting Mentality, Recovering Healthy Eating Patterns, Emotional Triggers in Eating Disorders, Healthy Body Image, Enhancing Self-Esteem. I found that women like to learn in a collaborative way from others who have had similar experiences. Learning environments that promote connectedness are more suitable for women than isolated learning settings. Furthermore, the disease-oriented model did not provide a learning approach women needed to examine, challenge, and correct their distorted perceptions.

In chapter 1, I asked, "What educational approach might best promote the recovery process for women with eating disorders?" I found that women want to validate their knowledge. They need to recognize how their assumptions about their world are preventing them from action. The disease-oriented approach to health education, in which learners are taught about the "what" and "how" of their disease, fails to address the individuals' perspectives that underlie their disorder. To counter the approach advocated by Garner et al. (1985), women need an educational approach that can help them examine their beliefs and come to the realization that they need a new perspective. The results of the study showed that a transformative learning approach can initiate the recovery process of women with eating disorders because it encouraged them to examine and challenge their underlying distorted beliefs.

Finally, I asked, "Who can assist in finding answers to these issues?" Although eating disorders are a complex mental health problem that require a multidisciplinary team approach, psychoeducation for women can be delivered by distance methods if the program design adequately addresses the needs of the learners and facilitators. As seen in this study, the groups who can assist in finding answers to the design issues should include the educators, the health experts, and the learners themselves. In this sense, all are experts.

Recommendations for Practice

Based on these conclusions, I offer the following recommendations.

1. Changing cognitive beliefs about eating, body image, and self-concept requires learners to undergo a process which was defined in chapter 1 as perspective transformation. For this reason, I recommend that health educators use an adult education model that employs a transformative learning approach rather than a medical approach that is disease-oriented.

2. In light of the influences that women's psychological development and their ways of knowing have on their learning needs, I recommend that adult educators use instructional strategies that foster connectedness and contextualized learning as found in the adult education and women's literature.

3. Designing a distance program for women with eating disorders not only requires a team of health professionals, an adult educator, and media production experts, but also WWED. Therefore, I recommend a team approach rather than a singular teacher-student approach, but further research is needed on this, as seen in the next section. I also recommend that WWED be consulted for their experience and expertise with the problem. To achieve learner relevance, these sufferers should represent the demographics of the target audience.

4. Given the escalating incidents of eating disorders in Western

society and the limited availability of treatment in most of Canada and the United States, it is my view that distance psychoeducation should be used as the first step in the continuum of treatment for women with eating disorders. To ensure consistent quality and effectiveness of program delivery, I recommend that all facilitators be trained to foster transformative learning.

Suggestions for Further Research

This study brings new approaches and raises new challenges in providing eating disorder treatment to women. The following are areas for further research in this field.

1. Although accessibility to resources on eating disorders has increased with this project, it is still limited by the availability of trained facilitators. A self-directed program with greater emphasis on women's ways of knowing would further increase the availability of resources to women with eating disorders. Therefore, I suggest that researchers study the design of self-help programs for treatment of eating disorders.

2. The effectiveness of an eating disorders education program can be greatly affected by the readiness of the learners. Therefore, I suggest that more research be conducted to determine the appropriate criteria for learner selection and to develop screening tools for program participation.

3. There is a general need to study the retention issues of WWED in psychoeducation programs. More specifically, future research needs to assess the retention impact of psychoeducation program based on adult education principles for the WWED population. Therefore, I suggest a follow-up study of participants who completed a psychoeducation program similar to this one.

4. More research is needed in the design and evaluation of health education for the prevention of eating disorders using women's literature and the adult education literature. Therefore, I suggest the nature of team approaches be compared to tutor-mentor or teacher-learner pairing.

This study should be a challenge both for adult educators and health educators and it is hoped that the two fields might work more closely in the future to address the vital issue of eating disorders in our society.

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APPENDIX A

LEARNING OBJECTIVES

OF THE SIX MODULES

Modules Objectives

Module 1:

- To identify how food and weight preoccupation interferes with academic endeavours, career, social, and familial pursuits
- To recognize the eating disorder as an enemy
- To examine the impact of their current behaviours on their eating disorders
- To experience hope in recovery

Module 2:

- To accept a "natural" weight
- To realize the physiological and psychological effects of starvation, bingeing and purging
- To recognize dieting and purging behaviours as ineffective methods of weight control

Module 3:

- To recognize food rules and unhealthy eating patterns
- To learn the mechanics of normal eating
- To take steps towards healthy eating

Module 4:

- To recognize the diversity of emotional issues that are related to eating disorders
- To identify possible individual issues that are related to the eating disorders
- To begin to separate emotional issues from eating behaviours
- To develop strategies to deal with identified emotional problems

Module 5:

- To recognize the socio-cultural pressures influencing body dissatisfaction
- To examine thoughts and beliefs about body image
- To identify internal feelings and sensations associated with perceived body image
- To develop skills in establishing a positive body self-image

Module 6:

- To recognize the relationship between self-worth, self-concept and body image
- To identify cognitive patterns which affect self-worth
- To take steps to improve self-worth

APPENDIX B

READING LIST

Suggested Reading List for Professionals

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