Community Reflections in the House of Mirrors Pilot Project

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Abstract

Researchers have identified the need to explore the context in which disordered eating is a reasonable response to violence and socio-cultural expectations, and the need for prevention programs that link fat phobia with other forms of oppression (Burstow, 1992; Herman, 1997; Orbach, 1994; Piran, 1999; Sesan, 1994; Steiner-Adair, 1994, Thompson, 1992). To date, the House of Mirrors Community Development Pilot Project (the "HOM") is the only community-based program in Canada that addresses these issues. The HOM is a visual arts installation of twenty-six full-length mirrors onto which women, girls and artists of various cultures, ages, and body types portrayed how violence and fat phobia have impacted their lives. The purpose of this multiple method study was to assess the efficacy of the HOM as a facilitator of working relationships between the health, business, art, and education sectors in Campbell River, B.C. The process was documented in two focus group interviews with five members of the HOM Subcommittee and in a survey of the HOM subcommittee and the Eating Disorder Program Advisory Committee. Evaluating the project's effectiveness distinguished different levels of community involvement as connections, relationships, and partnerships. The evaluation highlights differences between prevention and community development initiatives and the need for an emphasis on partnership building in social work. This knowledge will be used to inform future policy and practice decisions.

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Definitions

Disordered Eating: "The term disordered eating acknowledges that a continuum of eating behaviours exist that includes anorexia, bulimia, compulsive eating, binge eating or any range of experience where individuals feel they have issues around food, weight and body image. For example, at one end of the continuum is body image preoccupation and dieting, and at the other extreme is the development of a diagnosable eating disorder, with many different identifiable points along the way" (Association for Awareness and Networking around Disordered eating, 2000). The term also conveys the idea that disordered eating is a social construct that is rooted in societal beliefs and attitudes.

Violence: Violence includes any or all of the following: sexual assault, emotional, physical, and sexual abuse, violence that results from substance misuse, various social determinants of health such as poverty, and various forms of oppression and "hate literature" including the distorted and unrealistic media images of women.

A Community Development Approach to Disordered Eating: A community development approach to disordered eating actively involves all community sectors in collaborative work to problem solve around disordered eating support issues.

Community Connections: Connections are a form of networking that involve engaging or reaching out to community sectors without necessarily building a relationship or actively engaging them in an organized way. Connections range anywhere from asking for a donation to eliciting subcommittee volunteers.

Relationships: Relationships involve active interactions that go beyond networking to form a deeper association that may develop into a mutually beneficial partnership.

Partnerships: Partnerships are deeper commitments that include an understanding of each other and active involvement of all partners in building a mutually beneficial relationship.

Social Determinants of Health: The social determinants of health are functional ways in which our society implicitly condones oppressive behaviours such as racism and sexism. The term (the social determinants of health) is often bandied about as something that we should deal with in practice, but sadly most organizations do not. This lack of consideration perpetuates oppression and is a form of violence. One example of how this relates to disordered eating is reflected in the experiences of women living in poverty, who are often forced to buy the cheapest foods. These are usually foods that are high in sugar and fat. Not surprisingly, many women report compulsive eating or overeating as a way of dealing with their poverty issues (Association for Awareness and Networking around Disordered eating, 2000).

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Never doubt that a small group of thoughtful, committed people can make a difference; indeed it is the only thing that ever has.

Margaret Mead

Note to the Reader

This research was conducted with the support of the Association of Awareness and Networking around Disordered Eating ("ANAD"). ANAD is primarily dedicated to the provision of disordered eating support services for women and girls. This thesis and research reflects ANAD's mandate and therefore focuses primarily on the experiences of women and girls, while recognizing that there is also a small and growing number of boys and men struggling with disordered eating.

Chapter 1 Formulation of the Issue

This Chapter outlines the context for disordered eating/eating disorder ("disordered eating") work in British Columbia and the need for a policy that addresses the needs of service users. Following a description of the purpose of the research and my interest in this topic, I will consider disordered eating issues and their importance, similarities and differences in practice philosophies in the field, along with their context in the current health care climate. Examining the health care climate will provide a framework to delineate and analyze the underlying issues in the disordered eating field and suggestions for the development of a policy that supports an inclusive approach to care. The House of Mirrors Community Development Project piloted in Campbell River in February 2000, will be introduced as an example of a practice model that promotes a community development approach to disordered eating issues.

What is the purpose of this study?

The Association for Awareness and Networking around Disordered Eating ("ANAD") co-sponsored the creation and exhibition of the *House of Mirrors* ("HOM") with community partners in 1998. As the proprietor, the Association for Awareness and Networking around Disordered Eating ("ANAD") piloted the HOM project with a local 'BC Coalition to End Disordered

Eating' member in Campbell River in February 2000. The art installation and accompanying educational manual were used as a community development tool. The intent of the pilot project was to assess the HOM project's usefulness in dealing with disordered eating from a social action perspective. With ANAD's support, I evaluated the HOM project 's effectiveness as a community development tool and social change agent (Appendix F).

The questions I wanted to answer in this study were:

a) To what extent, if any, does the HOM project facilitate the development of working relationships between the health, business, art, and education sectors of the Campbell River community?

b) What influence, if any, does the HOM project have on community connectedness at local, regional and provincial levels?

c) To what extent, if any, does the HOM project create awareness of disordered eating as a social issue in the community's health, business, art and education sectors?

d) What influence, if any, does the HOM project have on the reallocation of funding resources to support dealing with disordered eating issues?

Situating Self

Feminists openly question the ability to be neutral or free of bias and have stressed the importance of individuals identifying their social location along with their values and beliefs in research and practice (findlay, 1991; Harding, 1997;

Kirby and McKenna, 1989; Rigor, 1992). As a feminist, I believe that my personal values, beliefs, and experiences inform and affect the lens with which I view the world. Since my experiences will naturally inform and shape all aspects of the research process, I believe it is essential for me to clearly identify my location in this work. Situating myself identifies my own biases and power in the research process (Harding 1997; Reinharz, 1992; Ristock and Pennell, 1996,). Consequently, I am aware that I approached this research as someone with professional and personal experience with disordered eating.

For the last four years, I have volunteered and worked in disordered eating organizations as a support group facilitator, board member, and coalition builder. During this time, I completed undergraduate degrees in both art history and social work, and developed an interest in the use of art to strengthen and build community. During this time, I found that most disordered eating services focused on providing individual support in the form of prevention or treatment, while each year the support and funding declined.

I became increasingly aware that little work focused on wider societal change. Unlike other areas of social work, the disordered eating field was without a community development language or framework. Through my work with the Association for Awareness and Networking around Disordered Eating ("ANAD"), I realized that creating change involved encouraging disordered eating workers to work collaboratively.

The concept of collaboration has not been widely explored in disordered eating practice or literature. For example, the disordered eating literature does not currently include a focus on the community development principles of inclusion and alliance building outside of prevention and treatment frameworks. However, my work with the BC Coalition to End Disordered Eating continually reveals the daily experience of isolation and the lack of support workers face. The collective experiences of workers and individuals fighting for the cause speaks to the need to work together to facilitate support services, service provision, and resource development. As coalition members, we have often talked about our isolation and how the coalition meetings provide us with an opportunity to share and debrief practice issues. Individually, however, our experiences indicate difficulty working collaboratively and building relationships in our own communities. This difficulty stems from the lack of a framework to guide or facilitate this kind of relationship building. Thus, my interest in doing this research stems from my own experiences, and I believe my research will provide others with an opportunity to explore new ways to increase disordered eating support and resources in their communities.

The HOM project is of particular interest to me because it links my interest in community work, my love for art, and my own experience with disordered eating. I was a participant in the creation of the *House of Mirrors* and also surveyed participants in 1998 to document the personal benefits they gained from being involved in the exhibit's creation. Participants unanimously agreed

that working on the creation of the *House of Mirrors* was a valuable and empowering way to give voice to their experiences. As an individual who struggled with disordered eating and participated in the *House of Mirrors,* I bring insider knowledge and a curiosity about community development to this evaluation.

Additionally, I am aware that I conducted this research as an ANAD volunteer who believes the organization's assumptions that:

> a) disordered eating primarily affects women and girls;
>
> b) disordered eating is not an individual problem - it arises from a combination of how individuals respond to family dynamics, community support structures and societal structures that actively work to oppress various groups of people;
>
> c) a healing relationship to our bodies and self-acceptance is the basis for individual, community, and societal change around this issue;
>
> d) environments that support individuals to make personal change will facilitate change in communities and foster environments that enable communities to change society, and
>
> e) ANAD will work towards societal change by creating partnerships (ANAD, 2000).

A combination of feminist and social change philosophies along with my experiences as a member of ANAD informed this research process and literature review. The perspective that I bring to this research defines disordered eating as a social issue that is multi-determined and rooted in societal inequities. This perspective does not negate individual responsibility and supports larger societal change through community involvement that facilitates consciousness raising

and the development of support structures that challenge oppressive practices in the field.

The Problem

There is no formal policy for disordered eating in British Columbia, and the absence of a formal policy hinders treatment accessibility and practice. Treatment issues are a concern for individuals seeking services and for practitioners who are providing services to a growing number of individuals effected by disordered eating. Recent reports acknowledge that increasing numbers of individuals are struggling with disordered eating, and indicate the need for a continuum of care services that is respectful, and appropriate, for all individuals (BC Coalition to End Disordered Eating, 1998; Moore, 1998; Feminist Research, Education, Development, and Action Centre, 1999, Niblock and Anderson, 1998).

Disordered eating treatment services are currently provided in British Columbia at a tertiary or acute care level. This is not surprising given that virtually all medical research on disordered eating focuses on the description, classification, and elaboration of pathology (Bordo, 1993). This research focus links eating disorders to biological, psychological, and familial dysfunction, along with established categories of psychological disorders. Disordered eating research views the causes of eating disorders to be multi-dimensional, and to include: individual factors, such as low self-esteem and control issues, familial factors, such as boundary confusion and high parental expectations, and cultural

factors, such as the thin aesthetic and the changing roles of women (Anderson, 1998). These approaches ignore larger societal issues.

Because of the focus of medical research disordered eating is labelled as a mental health issue. Treatment services are provided through hospitals with governmental funding provided as a matter of course, while early intervention and support services struggle to obtain any funding at all (Niblock and Anderson, 1998). Presently, mental health service provision is split between the Ministry of Children and Families, which services children and youth, and the Ministry of Health and the Ministry Responsible for Seniors, which services adults (the "Ministries"). Representatives from these Ministries meet at Provincial Eating Disorder Steering Committee and they acknowledge that there is a need for counselling services, however, disordered eating services are not discussed in their policies.

Queries from individuals requiring disordered eating support services are referred to B.C. Children's and St. Paul's Hospital Eating Disorder Programs. These two tertiary programs provide services for individuals with a diagnosable eating disorder (Appendix A). Women who do not meet the criteria for a diagnosable eating disorder can not access these services. While some other counseling services may also be available through local health units, advocacy organizations and private practitioners are left to fill the gaps in the present service provision. Advocacy organizations and private practitioners also provide most of the province's prevention programs: "disordered eating is being

addressed in a patch-work fashion, driven by individuals dedicated to the cause but usually off the side of their desks" (McKay, 1998: 2).

An adequate number of support and treatment services, however, are not the only concern in the disordered eating field. The current approach to treatment in the hospitals is also troublesome. B.C. Children's and St. Paul's Hospital Eating Disorder Programs use a "bio-psycho-social" approach to care. The bio-psycho-social approach to care was adapted from a practice model in the alcohol and drug field, and postulates that all substance misuse, including disordered eating, results from a complex interaction between biological, psychological, social, and spiritual determinants (Adult and Drug Services, 1996).

The bio-psycho-social approach, however, is problematic and further exacerbates disordered eating treatment issues for two reasons. First, while the bio-psycho-social theory proposes a multi-dimensional approach to care --which includes biological, psychological, social and spiritual components in treatment-- current practice only addresses the biological and psychological aspects of an individual being treated in the British Columbia health care system. Rather than viewing the individual holistically, medical practitioners continue to segment individuals by concentrating only on their mind and body with treatment practices that focus almost exclusively on disordered eating symptoms. This is evident in the focus on nutrition, feeding, counselling, and psycho-educational group work in both of the above programs (British Columbia's Children's Hospital, 1997; VISTA, 1998).

Secondly, the bio-psycho-social theory lacks a critical analysis of the oppressive aspects of the disease or medical model components of this theory (Ball, 1996; Barber, 1994; Kasl, 1992; Truan, 1993). For example, the Diagnostic Statistical Manual IV (the "DSM IV") lists the fear of becoming fat as a required diagnosable criteria for anorexia, and similarly an over concern with body shape and weight as a required criteria for bulimia (Appendix A). However, recent research indicates that disordered eating impacts women across class, sexual, racial, and cultural lines (The Feminist Research, Education, Development and Action Centre, 1999) and that not all of these women identify with this emphasis on appearance or dread of fat. As a result of these fat-phobic criteria, many women are either late to be diagnosed or excluded from treatment programs (Thompson, 1992; Katzman and Lee, 1997; Steiner-Adair and Vorenberg, 1999). Professionals are often reluctant to treat women when their problems violate expected societal stereotypes (Steiner-Adair, 1994), or when their behaviour falls outside of "the norm". For example, while I was a support group facilitator, a woman in an Ontario support group attributed her difficulty accessing care in Vancouver to the fact that she was a lesbian in her mid-forties without finances, who had a past history of using speed to control her weight. Similarly, a Vancouver area woman in her late thirties reported being turned away from services including nutritional counselling and support groups, because service providers were not skilled enough to handle her "difficult" personality and her "acting-out" behaviour. These women do not conform or "fit" well into the

expectations of current service provision and can not access care. For this reason, the bio-psycho-social model may not recognize or provide appropriate treatment for many women, seniors, aboriginal people, members of ethno-cultural groups, and people with disabilities (BC Ministry of Health and Ministry Responsible for Seniors, 1999). The focus on tertiary care and current treatment approaches, then, is problematic for individuals requiring care.

Importance of the Issue

The above treatment and accessibility issues are further intensified by the fact that support services are not governed by a disordered eating policy. A disordered eating policy is important because there are very few services available in communities across British Columbia for a large number of individuals who are struggling with disordered eating issues. As discussed above, an identifiable range of women is not considered, or is late to be considered, for treatment due to misperceptions about the relationship between disordered eating and fat phobia, which are often based on racist and heterosexist assumptions (Thompson, 1992).

Service providers in British Columbia also state that individuals are being released from hospital programs back into the community in increasingly poor health, and the community is consequently forced to deal with medically unstable individuals (BC Coalition to End Disordered Eating, 1998; Niblock and Anderson, 1998). For these reasons, service users and providers state that there

is a need for a broader definition of eating disorders and a greater range of support services along the continuum of care (Niblock and Anderson, 1998; BC Coalition to End Disordered Eating Winter Meeting Minutes, 1998). The need for more comprehensive service is also supported by the Feminist Research, Education, Development and Action Centre's ("FREDA") 1999 report which outlines the increasing number of individuals affected by disordered eating, the lack of a comprehensive system of care, and the need for financial support for family violence and disordered eating programs in Canada.

However, despite the increased reports of disordered eating, the actual prevalence of disordered eating is not known because of the stigma and shame associated with the issue. Various research problems in the field also contribute to the lack of information about prevalence. However, researchers and clinicians agree that 90-95% of those affected by disordered eating are girls and women and 5-10% are boys and men (Burstow, 1992; Bordo, 1993; Eating Disorder Awareness and Prevention Inc., 1999; Moore, 1998). Moreover, modest estimates suggest that five to ten percent of postpubertal females are affected by disordered eating (5% anorexia, 2% bulimia and 4% atypical), and experience significant misery and disruption in their lives (Levine, 1996).

Eating disorders are reported as the third most common chronic illness among adolescent females (The Canadian Paediatric Society cited in FREDA, 1998). Conservative estimates based on Canadian prevalence rates point out that there are at least 4, 000 cases of anorexia and 12,000 cases of bulimia among

females' aged 14-25 in British Columbia alone. Adolescent health surveys conducted in the 1990s also indicate that other forms of disordered eating are much more prevalent (Prevention Project Advisory Committee, 2000). Needless to say, the statistics in these reports are not conclusive, but they do help to identify the prevalence of anorexia and bulimia in Canada.

The absence of a disordered eating policy further aggravates the issues by facilitating the development of institutional treatment services that focus only on tertiary or micro level intervention. As we will see in the next section, disordered eating is classified as an individual problem and the development of micro level intervention services merely provides 'band-aid' solutions. The definition of disordered eating as an individual problem is reinforced in the absence of a value driven policy that uncovers the structural roots of disordered eating.

History of Disordered Eating

Disordered eating, however, is not a new issue. Anorexia nervosa was first diagnosed as a medical illness in France by Lasegue in 1874, in Britain by Gull in 1873, and in Canada by Inches in 1895 (Brown and Jasper, 1993). However, anorexia remained a rather obscure illness until the 1970s, when anorexia and bulimia became practically epidemic among women. Many feminist authors describe the increase of disordered eating as a response to the widespread

communication of the thin white beauty ideal (Bordo, 1993; Brown and Jasper, 1993; Poulton, 1996; Sied, 1989).

Recent findings also indicate that anorexia and bulimia affect all sections of the community and all families (The Anorexia and Bulimia Nervosa Foundation of Victoria Inc., 1998). Modest estimates suggest that ten to twenty percent of individuals that struggle with anorexia will eventually die from related complications (National Eating Disorder Information Centre, 1985), and ninety percent of these individuals are girls and women (Gagnon cited in Moore, 1996). In light of the increasing recognition of individuals affected by disordered eating, the lack of support and funding is a growing concern.

As mentioned above, the absence of a formal policy facilitates the government's default position of providing only tertiary or micro level intervention services, and further perpetuates the individualization of disordered eating issues. Treatment services are available only for women who meet the criteria outlined in the DSM IV, and the underlying belief in these hospitals is that disordered eating is primarily the result of biological and psychological factors. The individual is blamed for disordered eating and little attention is given to social factors in treatment practice.

Feminist Perspectives

Situating the Issue

Since hospital treatment facilities concentrate on providing tertiary care, only women who meet the DSM IV criteria for eating disorders are treated, and as a result eating disorders are primarily defined by this medical definition (Appendix A). Disordered eating is often minimized or excluded from discussions and is considered an individual problem. In contrast, feminist and trauma-based research critiques these practices and reveals how disordered eating treatment perspectives pathologize eating disorders and justify the provision of few services. As mentioned above, most hospital-based treatment programs embrace a disease or medical model of disordered eating. Supporters of these models claim that disordered eating is a psychiatric illness with strong genetic links. Not surprisingly, medical models are often characterized by disease treatment responses, and focus on responding to the predictable phases, stages, signs and symptoms (Ball, 1996) of disordered eating. Treatment perspectives do not consider disordered eating as a social issue or the resounding contributions of social and environmental factors. As a result, disordered eating is individualized or minimized as a young girl's issue in medical treatment facilities. In this respect, the medical system is not dealing well with disordered eating (Niblock and Anderson, 1998; Thompson, 1992), and

this may be largely due to practitioners' resistance to acknowledge disordered eating as a social issue.

These traditional perspectives pathologize disordered eating and identify anorexia, bulimia, and binge eating as the only true eating disorders, following specific criteria outlined in the DSM IV. However, the widespread body dissatisfaction and dieting that affects many women in Western industrialised countries remains unrecognized in these models. Feminist researchers have questioned the identification of eating disorders as a pathology, and have highlighted the medical model's professional, economic, and philosophical stake in the designation (Bordo, 1993; Poulton, 1996). Their analyses also highlight how an individual focus embraces, rather than challenges, the dominant structure of sexism in our patriarchal culture. Through a feminist lens, medical definitions of eating disorders do not accurately reflect the experience of girls and women. Anorexia and bulimia are points on a continuum of weight preoccupation and disordered eating that is prevalent among women and girls, and is considered by many to be a normative female experience (Anderson, 1998; Brown, 1993a; Bordo, 1993; Burstow, 1992; Kitchener, 1999; Orbach, 1999; Women's Therapy Centre Institute, 1994). For this reason, many feminists reject the medical eating disorder label and recognize the need for a broader definition: "troubled eating", "eating problems", and "disordered eating" are some alternative terms used in the literature.

Additionally, a feminist cultural perspective reconstructs the role of culture and gender as a primary cause of disordered eating and forces the reassignment of disordered eating to social causes rather than individual dysfunction (Bordo, 1993). Feminists recognize that most girls and women are affected by disordered eating to some degree, and most disordered eating sufferers are girls and women. As a result, it is more accurate to describe disordered eating as a reflection of the position of girls and women in society rather than as a pathology.

Today girls and women are increasingly encouraged to focus on their appearance in order to attain success and happiness. This focus on appearance is examined in the recent Globe and Mail's story entitled "Girls under the Knife" (January 13th, 2001). This article reports the growing popularity of cosmetic surgery (for youth) as a lifestyle enhancement or a quick fix solution for low self-esteem and a lack of self-confidence. Younger and younger girls are looking to purchase perfection in "the thin white ideal" in much the same way they would buy the latest fashion fad. In addition to the demand for breast implants and nose jobs, many Asian women attempt to combat racism by having surgery to create double eyelids. Re-framing these issues reveals disordered eating as a reflection of the prevalence of fat phobia in western society and the reality of violence in women's lives.

A great deal of the disordered eating literature makes connections between emotional, physical and sexual abuse (Brown, 1993; Burstow, 1992;

Thompson, 1992; Women's Therapy Centre Institute, 1994). FREDA (1999) also corroborates the links between violence and disordered eating. In its October 1999 draft report: *Swallowing the Hurt: Family Violence, Anorexia and Bulimia: a review of the literature and information gathered from Canadian practitioners,* FREDA made links between violence and the seriousness of anorexia and bulimia in communities across Canada. The report identified a relationship between family violence and disordered eating, and suggests that the particular experiences of individual girls and women will shape the likelihood, nature, and personal meaning of disordered eating.

There is also a considerable body of feminist literature that examines the "thin aesthetic", fat phobia, and fat oppression in Western culture (Bordo, 1993; Brown, 1993a; Burstow, 1992; MacInnis, 1993; Schoenfielder, Wieser, and Mayer, 1983). Feminist research has excelled in this area of analysis. However, a fat phobic analysis has also contributed to the stereotype of disordered eating as a young, white, middle class, heterosexual, female issue (Orbach, 1986; FREDA, 1999; Thompson, 1992). This "golden girl" stereotype has been perpetuated by a focus on these young girls and women in research studies, sensationalized media coverage, and by " medical and government" practice responses, like the use of the DSM IV.

A growing body of trauma-based theory literature illustrates how the "golden girl" stereotype and fat phobic criteria, has excluded many women from being diagnosed (Thompson, 1992; Steiner-Adair, 1999). Trauma-based theories

also suggest that disordered eating is a survival strategy or coping mechanism, which is used by many women to deal with various forms of oppression, such as racism, and various social determinants of health, such as poverty. (Moore, 1998; Thompson, 1992; Schoenfielder, Wieser, and Mayer, 1983). In light of the issues, many researchers have identified the need to explore the context in which disordered eating is a reasonable response to violence and socio-cultural expectations and the need for societal change (Burstow, 1992; Herman, 1997; Orbach, 1994; Piran, 1999; Sesan, 1994; Steiner-Adair, 1994, Thompson, 1992). In a review of prevention programs, Steiner-Adair (1994) specifically identifies the need for prevention programs to link fat phobia with other forms of oppression. Needless to say, the "golden girl" stereotype also works to negate the experiences of the many women whose disordered eating is an internalized response to violence, abuse, and oppression (Jasper, 1993; Kasl, 1992).

Some Common Ground

Like the feminist philosophies mentioned above, community organizations such as the Association for Awareness and Networking around Disordered Eating ("ANAD") and the British Columbia Eating Disorder Association ("BCEDA"), encourage a client centred approach that considers the context in which disordered eating issues occur. Community perspectives also incorporate feminist principles that value individual voices and knowledge with respect for diversity (Burstow 1992; Rhodes 1989, Ristock and Pennell, 1996),

while re-framing disordered eating as a community issue that requires community solutions. For example, ANAD's community development approach encourages practitioners to create bridges between community sectors and begin a dialogue around the issue that encourages community accountability and social change.

Most feminist and community perspectives, then, recognize disordered eating as a continuum that acknowledges anorexia, bulimia, compulsive eating, binge eating, or any range of experience where individuals feel they have issues around food, weight, and body image (ANAD, 1999a). These perspectives also state that there is no one cause of disordered eating (Brown and Jasper, 1993), and that anyone can develop disordered eating (ANAD, 2000). Generally speaking, disordered eating is viewed as the result of multiple factors including social, familial, psychological, and biological issues. And for many (women) it is the result of the internalization of violence in their lives. Health professionals and researchers refer to this internalization as trauma-based theory, and acknowledge that many, but not all, women who struggle with disordered eating have experienced forms of violence in their lives (Brown, 1993b; Burstow, 1992; Thompson, 1992; Women's Therapy Centre Institute, 1994).

FREDA identifies the importance of an integrated approach to care which incorporates feminist principles and recognises the unique needs of each individual. In this respect, FREDA's report draws together much of the thinking of service providers and consumers in the disordered eating field from the last

few years. The thoughts of service providers and consumers are documented in the meeting minutes of several committees which have formed to deal with some or all of the current provincial, treatment, and advocacy needs and issues. Despite the variously focused medical and feminist philosophies, service providers and users seem to agree that there is a continuum of disordered eating and a need for appropriate care services along the continuum. Agreement, however, ends there: there is no consensus on what the disordered eating continuum includes or what services are needed.

History of Policy Attempts

The following section of this chapter will provide an overview of the climate in British Columbia's health care system, and explore the present "policy work attempts" at a provincial level in the disordered eating field.

Where does disordered eating fit in current health care practices?

Climate

The mental health care system in British Columbia is currently in a process of reform. Since 1998, British Columbia's health care system has shifted to a process of regionalization. Services are shifting from a centralized institutional care system to a more decentralized and regionally integrated system. This means that the responsibility for the planning, delivery and evaluation of mental health services is shifting. As a result, tertiary care facilities,

enhanced acute care services and expanded community-based services are being transferred to communities (B.C. Ministry of Health and Ministry Responsible for Seniors, 1998: 8). Coinciding with this process, in November 2000, the MOH began the implementation of the 1998 Mental Health Plan in order to bring policy and service delivery in line with the North American guidelines of Best Practices in Mental Health Care (B.C. Ministry of Health and Ministry Responsible for Seniors, 1999).

As a seemingly supportive measure during the implementation of the Mental Health Plan, the MOH set up a number of working groups and committees to facilitate and inform the transition process. One of these supports is a provincial committee mandated to develop a mental health advocacy framework to support the implementation of the Mental Health plan in British Columbia. The committee is composed of representatives from health authorities, advocacy groups, service users, family support, and the MOH along with the Mental Health Advocate. This working group intended to develop Mental Health Advocacy Policies and align advocacy contracts and funding accordingly. The main objectives were to:

1) inventory advocacy services in B.C. and in other jurisdictions by type, outcome and cost;
2) recommend advocacy services to support the implementation of the Mental Health Plan for B.C.; and
3) develop an implementation plan to facilitate necessary service transitions (B.C. Ministry of Health and Ministry Responsible for Seniors, 1999; B.C. Ministry of Health and Ministry Responsible for Seniors, 2000a).

The Committee findings were reported to the Mental Health Steering Committee B.C. Ministry of Health and Ministry Responsible for Seniors, 2000b).

The Advocacy Framework Committee, however, is also part of a larger government initiative that is currently questioning the funding of advocacy services in the province. As part of this larger initiative, the Advocacy Framework Committee surveyed B.C. community members to assess the need for advocacy funding. The survey was developed without incorporating feedback from the advocacy community and therefore was not well received. Outrage in the advocacy community led to a decision by the government to use some but not all of the survey results, and ultimately to keep the present advocacy funding in place. This means that no new monies will be designated to disordered eating community groups. Not surprisingly, there is a lack of available funding for disordered eating community groups and a concern about future funding. This also means that the expansion of much-needed community support services beyond micro-level intervention is unlikely.

Policy Attempts

History of Governing Bodies

For a number of years, the main provincial decision making body in the disordered eating field was the Provincial Eating Disorder Steering Committee ("PEDSC"), which currently operates as an advisory committee. PEDSC was initiated by the Ministry of Health's Acute Care Division, as a response to the

regionalization of the tertiary care hospitals. This response stemmed from the medical system's concerns about the funding practices of this MOH branch. At this time, the MOH had decided that there was a need for a provincial medical outreach team. The outreach team was set up at St. Paul's Hospital in Vancouver, and PEDSC was created to inform the team about what was going on in the province. The team was composed of a full time director and a full time nurse position with some additional administrative support. PEDSC's global budget is currently $250,000, with $80,000 for the position of director, and $50,000 for the position of nurse. The remainder of the funds are spent on travel and accommodations (McKay, 2000a).

PEDSC was developed to give the impression that the regional programs and the hospitals had a voice in determining where the service needs were greatest at any one time. Government membership included the MOH, the Ministry of Children and Families, the Women's Health Bureau staff, and a chairperson from the MOH's Acute Care Division. The province was also arbitrarily divided into six regions, and six people were asked to attend to represent and report the needs of those regions. There was also representation from the Association for Awareness and Networking around Disordered Eating ("ANAD") and the British Columbia Eating Disorder Association ("BCEDA"), with a view to providing the committee with a consumer perspective. Additionally, a medical health officer was asked to represent prevention activities in the province. Finally, representation included the two tertiary care

hospitals. With the exception of the tertiary care hospitals, all the members were appointed and did not have any decision making power. Only the hospital representatives (doctors and nurses) had power at the table (McKay, 2000a).

In this form, PEDSC commissioned a provincial needs assessment, increased funding to the hospitals by giving $60,000 in funding to the two regional hospital programs, and hosted some conferences. The committee was more or less a place to get provincial funding issues vetted in an effort to bandage holes in the present health care system. At this time, the group dynamics were such that hospitals were given the money, regional representatives complained, advocacy groups were relatively quiet, and the prevention person was always silenced at meetings (McKay, 2000a). Therefore, the committee did not initiate change in terms of addressing the systemic, prevention, or medical issues around disordered eating.

After the MOH staff member left in 1998, the chair was passed to the Ministry of Children and Families representative, and the power structure shifted. The regional people provided better representation and were listened to, the advocacy groups began taking a more active role, and provincial initiatives were discussed. Thus, the committee moved away from being a place to vet funding issues and became a place to work together to affect change in the system (McKay, 2000a).

However, with a change in the director of the outreach program, the committee shifted again and moved from a steering committee (PEDSC) to an

advisory committee. In this advisory role, PEDSC became the Provincial Eating Disorder Advisory Committee ("PEDAC"), which presently exists as a forum for consultation and as a test site for the viability of the director's ideas. Needless to say, PEDAC has no power to create change inside the system or to affect funding (McKay, 2000a).

History of Initiatives

During the history of PEDSC and PEDAC the committee was presented to the public as a regulating body that aims to provide consistency in service provision throughout the province. The underlying assumption of those with power on the committee is that the medical community and service providers in the field already know how to treat disordered eating. As "change agents", then, the medical community casts themselves in the role of working *on* rather than *with* service users who are viewed primarily as passive service recipients. Typically change in the medical community begins with assessment and is followed by goal selection (Wharf and McKenzie, 1998: 24).

Not surprisingly, the main initiative developed during the history of PEDSC was the *Needs Assessment of Disordered Eating Services in British Columbia* (the "Needs Assessment"). In 1997, PEDSC hired two researchers to conduct a needs assessment. The purpose of the needs assessment was to profile an exploratory view of disordered eating issues and to determine who needed

services in B.C., what types of services were needed, and where services were needed. The researchers identified the following twelve themes:

1) the continuum of disordered eating;
2) limited access to services: the trickle down effect and the revolving door of treatment;
3) support for children and families;
4) the needs of service providers;
5) providers on the margins;
6) tertiary centres and regionalization;
7) usage of scarce resources;
8) continuity of care;
9) transitional services from medical to community environments;
10) fostering connection: longer term care to address underlying issues;
11) broader determinants of health, and
12) community development: creating resources in the community (1998).

Unfortunately, the researchers were bound by time and resources, and were unable to access a large number of service users and providers. The small sample size reduced the generalizability of the data and prevented PEDSC from formally generating policy from this research. While the statistics may not be quantitatively generalizable, the richness of the qualitative data provides unique insights into treatment and service issues.

Following the Needs Assessment, PEDSC's new projects' sub-committee detailed recommendations for actions related to the needs assessment's findings. This document will be discussed in the Policy Proposal Section below.

In addition to completing the needs assessment, PEDSC also decided to develop a provincial prevention framework for disordered eating. The "Best Practices" Youth Suicide Prevention Framework developed by the Ministry of

Children and Families was put forth as a potential model that could be developed for disordered eating prevention. This manual was funded by the Ministry for Children and Families and includes a discussion of: a) the problem of youth suicide, b) a youth suicide model, c) best practice strategies for youth suicide prevention, and d) a community-wide approach to suicide prevention. The manual incorporates an ecological systems approach as a way to understand youth suicide prevention (White and Jodoin, 1998).

A member of PEDSC suggested that the prevention sub-committee might use this manual as a framework to assist in the development of a co-ordinated approach to prevent disordered eating in British Columbia adolescents. Early drafts of the disordered eating prevention framework suggested that an ecological model was adopted with provisions that paid lip service to social or structural factors.

In my view, the essence of the disordered eating prevention framework derives in part from the youth suicide ecological model and is problematic for two reasons. The first problem is the manual's focus on adolescents. While a disordered eating prevention plan for youth is needed, the singular focus simultaneously dismisses the need for prevention services for adults. Unfortunately, a generic approach to disordered eating prevention is likely to fail in much the same way as the current medical treatment approach has, because the needs of all girls and women are not homogeneous. While the importance of respecting diversity and individual needs may be acknowledged to a certain

extent in the document's guiding philosophies, there is no follow through in the suggested practice strategies.

Secondly, an ecological systems approach presumes that societal structures work fairly well as they are and may sometimes need additive solutions that will enhance the system. This liberal philosophy is problematic because it reinforces the belief that disordered eating is an individual problem. This is evident in the philosophy itself, which encourages a "goodness of fit" between individuals and our current systems (Coates, 1994; Gould, 1987, Payne, 1991). In the youth suicide prevention model, youth are taught a variety of social skills, coping strategies, and warning signs so that they can take personal responsibility for an issue that is structurally based. Similarly, teachers are taught how to assess youth at risk of suicide. With this approach, the onus is on the individual to adapt and take responsibility for problems that are rooted in societal structures, and no action is encouraged to change the societal structures that are the root cause of these problems. Similarly, in the disordered eating prevention framework, a portion of the document refers to the work of relational theorists like Carol Gilligan and Jean Baker Miller and their theories about the psychological development of women and girls (Prevention Project Advisory Committee, 2000). Within this context, Gilligan and Miller discuss resiliency along with risk and protective factors that determine an individual's ability to cope with adversity.

The incorporation of resiliency into the prevention framework further supports an individual focus and raises additional concerns. For example, Sheila Martineau (1999) questions the focus on adversity in advocacy policy and practice for its links to historical ideologies such as heroism, stoicism, and rugged individualism. Martineau states that resiliency research and rhetoric however unintentionally, may actually trivialize trauma and pathologize vulnerability. In the winter 2001 B.C. Institute against Family Violence Newsletter, Martineau describes resiliency as a euphemism for academic achievement and "teaching resilience" as a euphemism for social conformity. The article indicates that this terminology often targets disadvantaged groups, and often represents mainstream standards of children staying in school, getting good grades, having non-disruptive behaviour, and being (or becoming) members of the dominant society.

It is also important to note, that Gilligan and Miller's ideas are used to frame the issue of disordered eating, and that their work is often described as a form of essentialism. Essentialism is described as "a belief in true essence -- that which is most irreducible, unchanging, and therefore constitutive of a given person or thing" (Fuss in Kemp and Squire, 1997: 250). Essentialism is often criticized for: a) tendencies to overgeneralize, universalize, and catagorize problems; b), beliefs in a hierarchy of oppressions, and c) beliefs in an objective reality. In feminist theory, Fuss states that essentialism is articulated in appeals to a pure or original femininity, a female essence, outside the boundaries of the

social and thereby untainted although likely repressed by a patriarchal order (Fuss in Kemp and Squire, 1997). Defending Gilligan, Bordo states that criticisms of Gilligan's work are often "(mis) interpreted as a simple celebration of traditional femininity rather than as a critique of the sexual division of labour that assigns "female" values to a separate domestic sphere while keeping the public, male space a bastion of autonomous selves" (Bordo 1993: 48).

In any case, an acknowledgement of larger societal issues is included in the disordered eating framework discussion, but the suggested intervention strategies remain individually focused, with no mention of how to incorporate efforts to address issues such as violence and oppression, and encourage wider societal change. For example, this plan suggests incorporating a community development component into prevention work that proposes actions that create awareness, train community members, and directly involve youth in prevention efforts (Prevention Project Advisory Committee, 2000). In other words, the societal context is incorporated only as it relates to the individual's immediate environment. Authors of the framework also intend to use the House of Mirrors Community Development Project as an example of best practices in prevention, but do so within a written context that focuses on individual change, where individuals are taught how to accommodate and conceal underlying structural issues. This line of thinking is in tune with the medical approach, which currently pathologizes disordered eating and blames the individual. A provincial prevention plan based on this framework, then, will merely provide a

wide-scale band-aid intervention that reinforces the structural problems which foster disordered eating.

Policy Funding

As mentioned above, PEDSC implemented a needs assessment and proposed the use of the already widely accepted Ministry of Children and Family's Youth Suicide Prevention Framework for disordered eating. It is important to note that both the ministries described above fund such initiatives. Not surprisingly, these policy initiatives alleviate the system of responsibility and reinforce medical and governmental values, philosophies, and approaches to health care. The proposed prevention framework, for example, fits well with the medical system's approach to disordered eating because it individualizes or pathologizes the issue. Similarly, a pathology framework is perpetuated and reinforced in the current bio-psycho-social approach to care, which in practice only addresses the biological and psychological aspects of treatment, and may fail to provide appropriate treatment for many individuals (BC Ministry of Health and Ministry Responsible for Seniors, 1999).

Critical Analysis of Policy Attempts

Recent "Policy" Initiatives

An examination of the underlying devaluing of women will be explored below in terms of the recent disordered eating initiatives from PEDAC, FREDA, and the B.C. Centre of Excellence for Women's Health.

PEDAC's Recommendations

Following the publication of the needs assessment, PEDAC (1999) produced a report entitled the "Executive Summary and Policy Recommendations for the Needs Assessment," which summarized the needs assessment's findings into four thematic clusters:

1) The continuum of disordered eating: the truncated continuum of services;
2) Resources: limitations, allocation and location;
3) Systems of support: support for families, professionals, and community "stakeholders", and
4) Service delivery: standards and protocols (1-2).

From these thematic clusters, PEDAC generated a list of policy recommendations to address the issues raised in the needs assessment. A few of the strengths of the recommendations include acknowledging the need for a continuum of care, a broader definition of "eating disorders", and an emphasis on prevention as the preferred intervention. The weaknesses of these recommendations are that they are individually focused, and do not address structural issues such as sexism. For example, most of the recommendations are "individually" focused interventions that brand disordered

eating as a young girl's issue. There is no question that many individuals seeking services reach out to agencies and clinics when they are in a "victim place", and there is certainly a need to provide services that support girls and women to reclaim their personal power. Focusing on individuals may be a necessary in term measure. Working at an individual level, however, is only a small part of addressing disordered eating issues. To create change, organizations must recognize disordered eating as a community issue and take action collaboratively to create community-generated solutions that address the underlying devaluation of women in our society and create societal change.

The Feminist Research, Education, Development, and Action Centre (FREDA)

The underlying debasing of women is also evident in the work of feminist organizations in the disordered eating field. As mentioned above, the FREDA Draft Report (1999) linked violence with anorexia and bulimia. In this study, Canadian practitioners commented on ineffective treatment approaches and stressed the importance of an integrated approach to care which incorporates feminist principles and recognises the unique needs of each individual. The proposed integrated approach stresses the importance of treating girls and women holistically to improve lasting and effective treatment outcomes (1-30).

The report does promote a holistic approach to care that addresses the diverse needs of women across a continuum of care. However, FREDA's focus on anorexia and bulimia is problematic and reinforces the medical focus on a

DSM IV diagnosis of eating disorders. While the report includes a discussion of anorexia and bulimia across race and class, there is no mention of a disordered eating continuum. The FREDA Draft Report essentially reinforces the medical model's focus on diagnosable "eating disorders", which excludes the reality of many women who experience disordered eating and do not meet the DSM IV criteria. In the report, FREDA addresses structural issues in some respects, but by dismissing the disordered eating continuum, they perpetuate the underlying medical assumption that eating disorders are the result of individual dysfunction. FREDA's exclusion is potentially harmful as it reinforces oppressive medical stereotypes and dismisses the need for services for women without a DSM IV label.

The B.C. Centre of Excellence for Women's Health

Similarly, the B.C. Centre of Excellence for Women's Health (COEWH) published a report entitled *Hearing Women's Voices: Mental Health Care for Women* in 1999, which considers mental health issues for women. The COEWH states the impetus for it as the lack of goals, actions, and consideration of women in the B.C. Mental Health Plan (Morrow and Chappell, 1999). Their report focuses on the challenges and barriers women face with mental health issues. They stress the importance of considering a "social-psycho-biological" approach rather than a "bio-psycho-social" approach to health care given the impact of the social determinants of health on women. The "social-psycho-biological"

approach is presented with an outline of a women-centred approach to mental health care that acknowledges that women have different needs. The approach incorporates a focus on wellness, promotion, social environments, equity, and social justice.

The report is important because many of the care issues raised by disordered eating community groups and FREDA's report are raised and supported. Nevertheless, the report raises some concern, because "eating disorders" are only briefly mentioned as a young woman's issue. Disordered eating is not acknowledged as a social issue or as an issue that can affect all women and girls.

A focus on eating disorders in adolescents is also found in the Centre's most recent report, *Consuming Identities: Young Women, Eating Disorders and the Media* (Hoskins and Dellebuur, 2000). Undoubtedly studies on adolescent women and the media are important. However, to date the Centre's funding choices and focus are on adolescents or young women. A primary focus on adolescents or young women is troubling, as it further supports the "golden girl stereotype" of disordered eating, dismisses disordered eating as an issue of concern, and belittles the impact of disordered eating on women of all ages.

Policy Proposal

This section discusses the need to develop a disordered eating policy that values women and girls while supporting anti-oppressive social work practice

philosophies. A policy that incorporates anti-oppressive practice philosophies is important because it will encourage practitioners to examine how they are impacted by society, so that they can work to eliminate rather than reinforce oppression (Gil, 1998). Practitioners would not only be encouraged to become aware of the numerous ways individuals are oppressed in our society, but also to examine their own power and privilege and how it impacts others.

In this paper, the incorporation of anti-oppressive practice philosophies starts from an understanding of sexism as a paradigm of all oppression (Milner and O'Bryne, 1998; Reinharz, 1992). This approach is different from some feminist and anti-racist approaches because it involves a consideration of all forms of oppression or "isms" (ableism, ageism, classism, heterosexism, racism, sexism, and weightism). In practice, these philosophies encourage an examination of how the "isms" reflect social constructions, and work as filters to oppress and isolate individuals, and how many individuals experience multiple forms of oppression (findlay, 1991; Gil, 1998; Milner and O'Bryne, 1998). A disordered eating policy reflecting feminist and anti-oppressive philosophies, then, is a shift from past and current approaches and moves beyond the recognition and acknowledgement of oppression to support societal change.

The Proposed Use and Implementation of the Needs Assessment

As indicated in the above history section, PEDAC's prevention sub-committee drafted a plan for the implementation of the needs assessment

findings. The *Proposed Use and Implementation of the Needs Assessment for the Provincial Eating Disorder Advisory Committee* (the "Proposal") outlined two major issues apparent in all of the needs assessment themes: 1) the need for a single co-ordinated system of care for adults and children around disordered eating, and 2) the need for an agreed upon definition of what constitutes the continuum of care for disordered eating (McKay, 1998: 3).

Based on their own experience and the needs assessment findings, the committee proposed that PEDAC develop a disordered eating policy from the following philosophy statement:

> We believe eating disorder services should address the continuum of disordered eating from self-esteem and body image disturbance to chronic life threatening eating disorders. In accordance with this belief, we assert that 25% of a community's resources for eating disorders should be allocated for prevention programs and services.
>
> We believe care should be offered in the most non-intrusive manner possible, and should be client driven. We believe care should be based on the principles of respect and trust, and that programs should operate based on a continuity of care model.
>
> We believe clients should have the ability to make choices in the manner in which services are provided to them. Thus, we recommend a broader scope of services be covered by the Medical Services Plan (i.e. clinical counsellors, clinical social workers).
>
> Programs and services need to be flexible in time, location and types of services offered. Programs should address emotional, physical, spiritual, and psychological aspects of eating disorders, and should acknowledge the influence of culture on the development and maintenance of disordered eating behaviour.
>
> Programs should offer various levels of care that clients may access at different points during their recovery, and transitions between levels of care should be supported.
>
> The value of peer support (both one on one-peer programs and peer support groups) should be acknowledged and promoted as an

effective and necessary part of the provision of services (McKay 1998: 3-4).

Along with this philosophy statement, the proposal included a continuum of care model. The intent of the proposal was to provide the foundation for a discussion paper that explores these issues further. The proposal addresses real issues in the disordered eating field, and could easily be adapted into a discussion paper that expands on the above issues and directly addresses the need for services that respect diversity. This paper could then be used to create a disordered eating policy. Unfortunately, PEDAC has not accepted the proposal. To date, committee members report that the work is still "on the table", but no movement has been made to draft the document into policy.

I believe the proposal is currently being "shelved" for process and content reasons. The process reason concerns the parties involved in writing the proposal. While several members of PEDAC were involved in the process work around the proposal, the proposal was written from a predominately community perspective, and largely reflects community needs and values. Policy makers, however, do not necessarily share or acknowledge these community values or needs.

Policy makers tend to be affluent, middle-aged men, while the individuals requiring services are women (Wharf and McKenzie, 1998: 5). As Wharf and McKenzie state: "In a very real sense, policies are initiated, planned, and implemented by people who will be unaffected by the programs or services"

(1998, 4). In the disordered eating field, the medical system, the government, and their employees are key stakeholders and individuals with power. For example, some would argue that there is a conflict of interest and abuse of power in Dr. Laird Birmingham's role as the Provincial Director of the Eating Disorders, the Director of Bariatric Surgery at St. Paul's Hospital, and as the Principal Investigator for several obesity research studies funded by the pharmaceutical company Hothman La-Roche (Gingras, 1999). Since the key stakeholders or individuals who have the power to develop policy are men who profit from disordered eating and the oppression of women, they will likely resist adopting a policy that questions current mainstream values and exposes their power and privilege. For these reasons, the proposal or "draft policy" would not be considered economically grounded or politically popular.

Similarly, the content part of the proposal implicitly positions disordered eating as a social issue and endorses a community development approach. The proposal puts forth the belief that societal structures, not individual dysfunction, are a root cause of disordered eating, and that disordered eating should be viewed as a community issue rather than a woman's or girl's issue. In supporting a community approach, the proposal also begins to expose societal structures that cause and perpetuate disordered eating.

To support this approach, the proposal encourages two main structural actions. The first action involves shifting to a community development approach that would encourage collaborative work between regions in British Columbia

and support the process of regionalization described above. Regions would be encouraged to develop Regional Disordered Eating Advisory Committees ("REDACs") that would hold PEDAC accountable, provide consumers with a voice, and connect and provide support to workers at a regional level. The purpose of each REDAC would be to provide a regional representative with an avenue to ensure that the region and PEDAC are informed of the issues and activities of each region. Ideally, a diverse cross-sector of regional, grass roots, and mainstream health authorities and consumers would be on each REDAC to encourage inclusiveness at decision-making levels (McKay, 1998).

The proposal also encourages the use of the needs assessment as an organizing tool for this community development work and ideas about how to support the development of REDACs. Service providers and users are encouraged to build alliances and to work together in their communities to deal with disordered eating issues. Therefore, a loose community development framework is provided as a guide to make practice relevant to each community.

The proposal's second action involves setting up a system of MSP coding and coverage. This action item calls for provincial support to:

a) set up a coding system that will enable the true extent of disordered eating to be documented;
b) provide MSP coverage;
c) develop guidelines and standards for treatment;
d) develop program and system evaluation; and
e) encourage research that considers different needs and assesses prevention programs.

The underlying assumption in both proposal actions, then, is that current government responses to disordered eating are not working well, and that each community needs to have an opportunity to communicate its needs in terms of services and support in order to better deal with the issue of disordered eating. The proposal suggests that there are problems in the system's current approach and indicates that adding services to the existing system is not going to adequately or effectively address these issues. The proposed solution involves seeing individuals as unique and promotes finding ways to support individual and community solutions. It suggests that we adopt a community development approach in order to begin dealing with disordered eating at an individual, community, and societal level.

Reflections on the House of Mirrors Community Development Project

The proposal discussed above lays the groundwork for an anti-oppressive disordered eating policy which identifies the structural causes of disordered eating and calls for action that begins to address and dismantle certain societal structures. These societal structures, such as heterosexism, racism and sexism, are the same ones that give power and privilege to policy makers, so the proposal threatens the power and privilege of policy makers. The province's current-cost cutting climate also presents some challenges in acquiring support for this initiative.

At this point, it is difficult to say whether or not PEDAC will support the implementation of the proposal. However, social workers can work individually and collectively to support the proposal by supporting the proposal's two key principles: inclusiveness and alliance building, identified by Wharf and McKenzie as the essence of effective policy making (1998, 127-134).

At a practice level, social workers and practitioners in the disordered eating field can begin work at a local level to address their support and funding issues with projects like the House of Mirrors Community Development Project (the "HOM project "). The HOM project is a community art project that was funded by the Canada Council's "Artists in Community Project," in 1998. The project used the arts to develop existing relationships between artists and their communities. In Vancouver, collaborative work between community organizations, artists, and one hundred and fifty women and girls created a twenty-six-piece art installation entitled the *House of Mirrors*. Using mirrors as a canvas, artists, women, and girls from various cultures, ages, and body types explored the illusions and distortions projected into the psyches of women and girls. The impact of the media, diet, fashion and cosmetic surgery industries were revealed through this collaborative art process (ANAD, 1998a). ANAD co-sponsored the creation of the *House of Mirrors* with Kiwassa Neighbourhood House, Pacific Immigrant Resources Society, and the Vancouver Roundhouse Community Centre. The *House of Mirrors* was exhibited at the Roundhouse

Community Centre from July 23 to August 2, 1998 and will travel throughout British Columbia as a community development tool.

The travelling exhibition encourages a community development approach to disordered eating, modelling the above principles of inclusiveness and alliance building. The community development approach to disordered eating presented in the HOM project will be illustrated in the following chapter, along with the need for this approach in the broader context of the disordered eating field.

Chapter 2 The House of Mirrors Community Development Project

Situating the Association for Awareness and Networking around Disordered Eating ("ANAD")

ANAD is a non-profit grass roots service provider that receives funds from the provincial and regional health authorities. ANAD is primarily a volunteer driven organization that has educated, informed, and advocated for services and prevention around disordered eating in communities of British Columbia since 1981. Because of the lack of disordered eating services in the province, ANAD's services are stretched out along the continuum of care to include individuals requiring services from acute care to early intervention. ANAD attempts to narrow the service gaps by providing support groups for women and educational sessions on body image, self-esteem, and the impact of attitudes and beliefs on youth service delivery. Currently, ANAD is mandated to support individuals affected by disordered eating and advocates a community development approach to disordered eating at a local, provincial, and national level. The latter part of ANAD's mandate led to my interest in community work and involvement in the HOM project.

Why did ANAD get involved in the House of Mirrors*?*

ANAD members became involved in the creation of the *House of Mirrors* because the HOM project was a good way to promote a community development

model of social change around the issue of disordered eating. At the local level, the HOM project enabled ANAD members to:

1) raise the organization's profile;
2) bring together different sectors of the community;
3) educate around disordered eating in the community at large;
4) start to work with a culturally diverse population; and
5) create a space for women and girls to share their experiences (ANAD, 1998b).

ANAD also saw the *House of Mirrors* as an opportunity to begin working on the provincial aspect of its mandate, which is to advocate around the issue of disordered eating. The intent of the HOM project, then, was also to produce a quality art show that would travel around the province to assist communities in raising awareness (ANAD, 1998b).

Work on the *House of Mirrors* coincided with ANAD's coalition work over the last couple of years. During this time, ANAD members brought together service providers and service users in British Columbia to form a coalition, with a view to developing a provincial voice and support network around disordered eating. During this process, service providers and service users identified the lack of support and insufficient funding for disordered eating in their communities as the two most substantial obstacles to their work (BC Coalition Meeting Minutes, 1998). These obstacles have not yet been addressed in the province.

With this in mind, ANAD continues to offer the *House of Mirrors* to communities as a community development tool to assist with support and

funding issues in the province. The creation of the *House of Mirrors* combined a belief in the healing properties of art and the power of art media to convey messages. After its initial artistic creation, the project was then promoted as a community development tool and a means of encouraging different sectors of the community to develop relationships and work together around disordered eating issues.

The emphasis on relationship and partnerships building stems from social change efforts in the field of social work and is described in more detail below. A community development approach is an innovative way to encourage responsibility and accountability in the disordered eating field, because most research and practice approaches including feminist ones fall under prevention and treatment initiatives (Levine, 1999) that tend to focus on providing individual support.

Disordered Eating Practices

Since most disordered eating practice falls under prevention or treatment initiatives these approaches are usually presented as polar opposites in the literature and in practice, with workers adamantly supporting one of the two perspectives. This tension is partly due to preferential government funding for treatment over prevention, and partly due to the belief that the two perspectives are fundamentally different.

However, despite the tensions between the prevention and treatment views, both stem from an individual or pathology premise; the main difference between the two initiatives is where they fall on the intervention continuum. As a result, the individual is the focus of change in prevention and treatment interventions, and little to no work is done at the societal level. For example, education is the primary focus of prevention programs and stems from the belief that the weightism prevalent in Western society results from prejudicial attitudes and beliefs. The individual focus in these interventions is based on the assumption that "isms" are the result of prejudice rather than societal structures, and can be changed through education (Adamson, Briskin, and McPhail, 1988; Popple, 1995). Such educational interventions, then, focus on changing attitudes. While attitudinal change is an important contributor to change, it does not necessarily translate into change at the societal level. Neither individual or attitudinal change sufficiently challenges societal structures or creates major social change (Adamson, Briskin, and McPhail, 1988).

When societal issues are acknowledged and addressed in these educational approaches, they usually take the form of peer, family, or school (institutional) interventions (Eating Disorder Awareness and Prevention Inc., 1999; BC Ministry of Education 2000; Friedman 1999; Levine 1999; Larkin, Rice, and Russel, 1999; Office on Women's Health 1999; Prevention Project Advisory Committee, 2000; Rice 1996). These interventions are consistent with the ecological systems approach discussed in Chapter 1, which commonly refers to

social issues as including the social context in practice. The social context refers to a person's immediate social environment or social milieu, and as a result, embodies relatively restricted ideas of how society influences people (Fook, 1993). For example, in family systems therapy the social context is defined as the family (Beecher, 1989). In an ecological perspective, then, the social context involves minimal awareness of larger social structures extending to include social, political, and economic factors, and ignores larger structural change endeavours (Beecher, 1989; Marchant and Wearing, 1989). The avoidance of wider societal change efforts is also apparent in other care initiatives like heath promotion (Addiction Research Foundation, 1996), that seem to incorporate social or community perspectives, but really only target the individual and his/her actions.

For this reason, ANAD focuses on the promotion of social change through community development work. ANAD's community development approach is based on the belief that different sectors of the community need to be involved in order to create larger scale changes. Community development, however, does not mean just working with likeminded groups. Whenever possible, this collaborative work involves engaging the art, education, health, and business sectors to work together outside of the current system to create societal change. Through community work, ANAD encourages relationship building that moves beyond the superficiality of networking, and strives to build bridges at the community level. Involving the whole community re-frames disordered eating

as a community issue. And, the community as a whole is encouraged to become responsible and accountable for dealing with disordered eating issues (ANAD, 2001).

Sponsorship of the HOM project is also intended to encourage community development and promote provincial connectedness (ANAD, 2001). ANAD members encourage and support individuals to use the art show in their communities to create awareness and raise funds, while connecting the art, education, health and business around disordered eating issues. The HOM project, then, is an approach to address the current problems that individuals and organizations have already identified in their own communities.

What is the House of Mirrors?

Content

The *House of Mirrors* is a visual arts installation of twenty-six full-length mirrors onto which women, girls and artists of various cultures, ages, and body types portrayed the numerous ways fat phobia and violence have impacted their lives. For those readers who have never been in one, a house of mirrors typically contains mirrors that have flaws, causing the reflections they cast to be distorted. The artistic director felt this to be the perfect metaphor for the distorted images reflected back to women and girls every day. It is very common for us to look in

Figure 1. Photographs of the House of Mirrors Exhibit

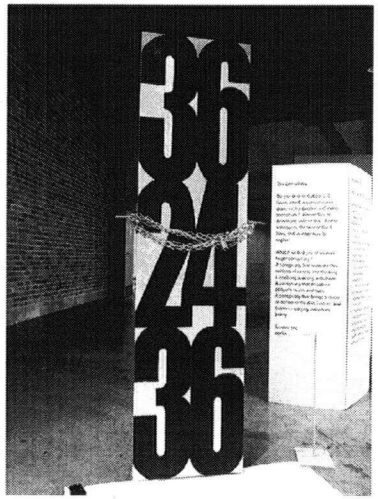
Theme 1: The Lies We Are Fed

"You can never be too thin or too rich"

Through research, discussion and exploratory exercises, the participants examined what they had been told all their lives about how they should look. The women and girls looked at the media, fashion, diet and medical industries in order to examine societal belief systems and to uncover the subtle and obvious messages that shape and impact their self-confidence.

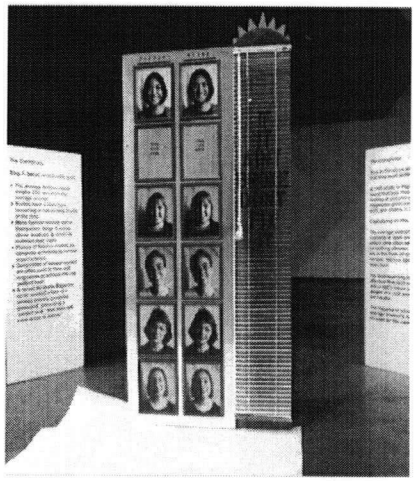
The Two Goddesses, 1998
Artist: Claudine Pommier with Ita Margalit

The Two Goddesses is the first piece and was situated at the exhibit's entrance and depicts the changes in the beauty aesthetic over time in a comparison of the modern day mannequin and the Woman of Willendorf figurine from c.30, 000 BC.



36-24-36, 1998
Artist: Sheila Norgate with Sally Holdsworth, Kathy Price, Sigrid Tarampi, Lynne Van Meer, Leah Van Meer, Kim Bruce and Jan Alexander

36-24-36 depicts the powerful and graphic symbol of the lies women are told about their bodies. Women are constantly asked to "measure up". And, the numbers are a metaphor for the notion that there's a perfect size. The barbed wire chain and padlock around the mirror aptly reflects these confinements. No other numbers hold this kind of meaning in our culture. However, by today's standards, 36-24-36 is too big. The modern ideal has been shaved down to 34-25-35.

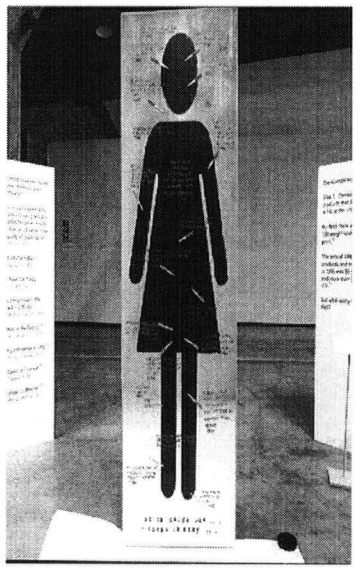


Don't Make Me Over, 1998

Artist: Sheila Norgate with Sally Holdsworth, Kathy Price, Sigrid Tarampi, Lynne Van Meer, Leah Van Meer, Kim Bruce and Jan Alexander

Don't Make Me Over, consists of 8x10 portraits of some of the group members. The portraits are arranged in a Before and After style. The point is, however, that there is absolutely no difference between the before and after shots - because they don't need improvement. The words before and after are mounted above the photos to urge the viewer to try and discern the difference between the shots. One set of frames has been left blank and set around eye level. The invitation for the viewer reads "your face here". The viewer is also invited to "turn the magic wand" to learn the secret of the miraculous "makeovers". By turning the rod of the small venetian blind viewers unveil the statement "if it ain't broke don't fix it".

In A Woman's Work is Never Done, participants literally took a logo of a woman off of a bathroom door and stretched her to make her thin enough to fit the dimensions of the mirror. This mutation is symbolic of the way women have to be altered to fit the ideal. Similarly, the red writing that surrounds the woman reflects the lies women have been told about their bodies in magazines, ads and books from the 1930s to the 1990s. The lies are connected to the corresponding body part under scrutiny with nail files. And, the choice of red is suggestive of lipstick and plays on the use of lipstick on mirrors (especially in film). The woman herself has been sanded to giver her a rougher more organic finish.



A Woman's Work is never Done, 1998

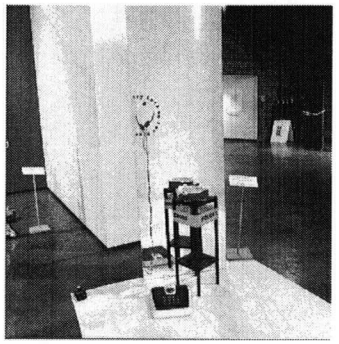
Artist: Sheila Norgate with Sally Holdsworth, Kathy Price, Sigrid Tarampi, Lynne Van Meer, Leah Van Meer, Kim Bruce and Jan Alexander

Figure 1. Photographs of the House of Mirrors Exhibit

Sticks and stones May Break My Bones reflects one woman's experience of growing up as a fat child. By the age of three--when the photo on the mirror was taken--this woman already knew she was fat and that fat was bad.

Here, the woman recalls how inadequate "sticks and stones may break my bones" was against the power of hurtful words and labels. Though the saying is meant to empower children the end result is that it denies the true experience of the pain inflicted. Children and adults of size are constant targets of demeaning comments, stereotyping, discrimination and ignorant blame. It is impossible to defend one's heart and mind against such an avalanche of socially condoned hatred. The viewer is invited to participate in the woman's birthday party and to play pin their head on the piggy etc., and experiment with all those fun word combinations.

Sticks & Stones May Break My Bones
Artist: Sheila Norgate with Sally Holdsworth, Kathy Price, Sigrid Tarampi, Lynne Van Meer, Leah Van Meer, Kim Bruce and Jan Alexander



My Mirror's Back & There's Going to Be Trouble, 1998
Artist: Sheila Norgate with Sally Holdsworth, Kathy Price, Sigrid Tarampi, Lynne Van Meer, Leah Van Meer, Kim Bruce and Jan Alexander

In My Mirror's Back and There's Going to Be Trouble, the viewer stands before a completely unadorned mirror, and steps onto an old bathroom weight scale. The words, "Your feet here" are printed on the scale. The viewer is invited to pick up the headphones, which will be suspended on the mirror at about eye level with the invitation, "Try this on for size". Beside the mirror is a wooden stand on which an open tin of shortbread cookies rests. There is a yellow "police do not cross" tape wound around the legs of the stand. This plays on the notion of cookies as forbidden. As viewers stand on the scale looking at themselves in the mirror, they listen to a two and a half-minute sound loop of the participants' voices. On this tape participants chant the kinds of self-admonishment they might hear in their own minds while standing in this place. The chant is written as a kind of nursery rhyme.

Too big, too small, to short too tall
Too thin, too fat, too dumpy, too flat,
Too low, too high, too bold, too shy,
Too pretty, too plain, too modest, too vain

Figure 1. Photographs of the House of Mirrors Exhibit
Community Reflections in the House of Mirrors Pilot Project
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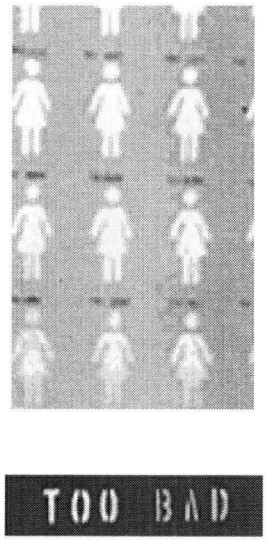
Along similar lines, Too bad plays with the bathroom symbol of a woman. Underneath each symbol is a quality, characteristic, or physical attribute. The idea is that women as they are, are too much i.e. too old, too black, too ugly, too sloppy etc.

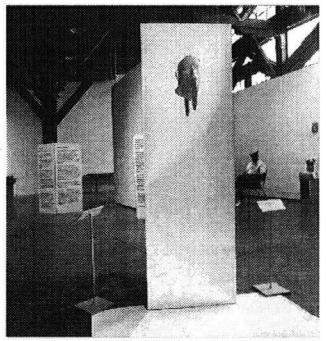


Too Bad, 1998
Artist: Sheila Norgate with Sally Holdsworth, Kathy Price, Sigrid Tarampi, Lynne Van Meer, Leah Van Meer, Kim Bruce and Jan Alexander

Theme 2: Swallowing the Lies

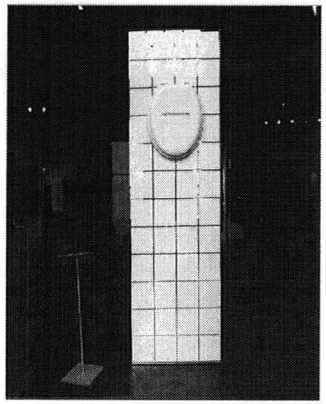
"I literally purged the lies I swallowed through my bulimia."

In this theme, participants explored the impact that fat phobic messages have had on their lives, how these messages were internalized and how these internalized thoughts manifested in their behaviours, belief systems, eating habits, relationships, and feelings about their bodies.



Puke, 1998
Artist: Merrell Eve Gerber with Ru Bechler and Lisa Wellbanks

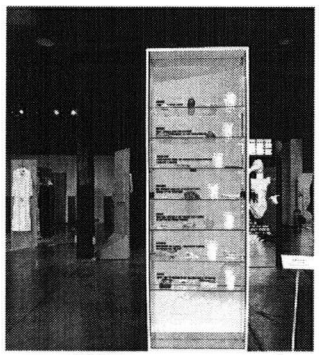
The face on this mirror was cast from one of the group participants. The viewer is encouraged to engage with the piece and pull out the three-foot long tongue. The tongue displays the negative thoughts and derogatory names associated with women like "slut, bitch, ugly, cow".



Going to Extremes to Escape the Misery, 1998

Artist: Merrell Eve Gerber with Lisa Wellbanks, Wanda Andrade and Ru Bechler

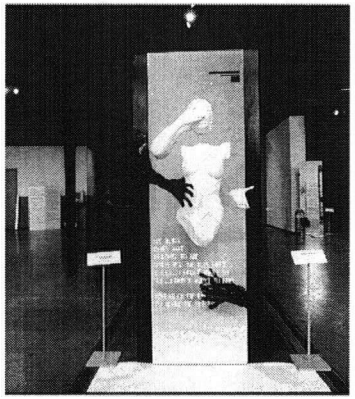
In Going to Extremes to Escape the Misery, the viewer is invited to lift the lid and see themselves disassembled in the mirror below and in the cracks between the tiles.



Untitled, 1998

Artist: Claudine Pommier with Roselle Healy

Untitled or the "the fridge" reflects the restrictive and regimented nature of dieting. This regimented diet depicts a food journal which offers up Monday as the best day to start a diet and symbolizes how food and exercise are used " to make up for yesterday's "mistakes". Here, food and exercise are not about health, they reflect our culture's obsession with thinness.



Body Betrayed, 1998

Artist: Claudine Pommier with Marie-Claire Bergman

Written on the mirror are the words:

"My body does not belong to me, What was me has been taken, I don't want to see, I don't' want to feel...Too much of everything to make me hurt"

Based on a personal experience, "Body Betrayed" reflects the personal and public issue of the hurt and pain women endure because of sexual abuse, violence, and hate literature. Body betrayed reveals the reality of violence in women's lives.

By-Pass, 1998
Artist: Merrell Eve Gerber with Susan Masterton

By-Pass is one woman's story of medical torture and self-loathing. She writes:

After years of self-loathing, size discrimination, put downs, numerous diets, diet pills, injections of the urine of pregnant mares, fasting, weight loss groups, etc. and at the urging of a doctor friend of mine, I decided to research the "last resort" --Surgery. I sought the advice of an "obesity specialist" who told me that I had two choices. The first was surgery, the second, do nothing. I chose intestinal bypass surgery where almost 3/4 of the small intestine was "bypassed' resulting in weight loss and chronic diarrhoea.

The first words I heard after the surgery but before I opened my eyes were, "God, I hate these big ones, watch your backs, fellahs." I thought, "bitch", even the medical profession was biased and cruel. Later, I awoke to the sound of my own moaning. I had been cut from "stem to stern" and was in excruciating pain. But lose weight I did, to the tune of about one pound a day. I lost 85 lbs. In 3 months, which put a tremendous strain on my liver. I was literally starving and very jaundiced when I was admitted back to the hospital and fed intravenously through my jugular vein. For two months every hour throughout the night a nurse would shine a flashlight on my neck to check that I hadn't bleed to death. The sleeping pills they gave me helped to keep me still. A bedside liver biopsy (apparently 1/400 patients bled to death during this procedure) revealed hepatitis and cirrhosis. My blood was sent to the Mayo Clinic for analysis and I received a unit of blood on two separate occasions. Fortunately the blood was not contaminated with hepatitis C or HIV but I was one of the people asked to be tested 12 years after the tainted blood scandal.

When I was strong enough to have the surgery reversed, my intestines were put back to their original configuration and my body breathed a sigh of relief. The surgery had been a sin against nature and it almost killed me. Others have not been so lucky. Some have died on the operating table, some have suffered from years of ill health and others suffer from chronic arthritis and diarrhoea and on and on it goes....

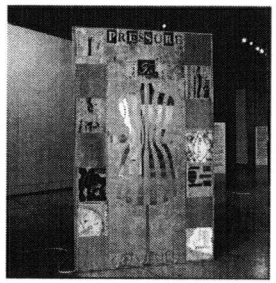
Theme 3: Telling Our Truths

"Women are so much more than the images that we see reflected to us through the media."

Under this theme, women and girls portrayed what is true for them about their bodies and the diversity and richness of who they are.

Mirror #1-6

The next six mirrors or panels are part of a process piece that reflects the different stages participants went through to move out of old negative beliefs around their bodies, which they had assumed from society, to new beliefs, which liberated them. They tried to reflect what their general experience had been, what they feel around their bodies today, and what their goals are around continuing to grow.



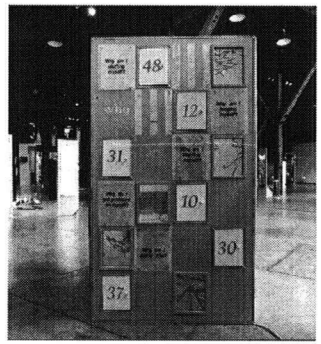
Mirror #1

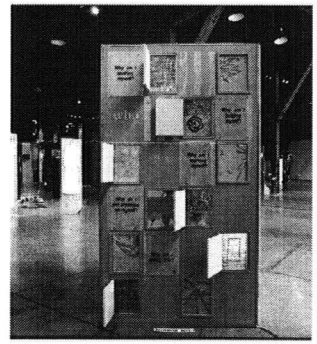
Artist: Patricia Murphy with Lucy Banic, Amelia Goodine, Lorrie Miller, Ahava Shira and Taylore Carsen

Mirror #1 reflects the common pressure from society to conform and what is internalized and what women continue to grapple with.

Mirror No. 2 depicts the participants' experiences and empahsizes their diverse ages. They smashed the mirrors symbolizing their rejection of the "pressures and shoulds" they face as well as the idea that all our power comes from our surface and looks. This panel reflects the questioning process we go through when we realize these beliefs around the body don't work for us.

The numbers on each door represent the ages of the women in the group. The viewer is invited to open the doors and read the women's stories.





Mirror #2, 1998

Artist: Patricia Murphy with Lucy Banic, Amelia Goodine, Lorrie Miller, Ahava Shira and Taylore Carsen

One woman's story:

I am forty-eight years old. On my forty-seventh birthday I gave myself the gift of sustenance --of freedom.
I have this history of deprivation, of trying to be invisible. I am so strong willed that for most of my life I have been able to keep my

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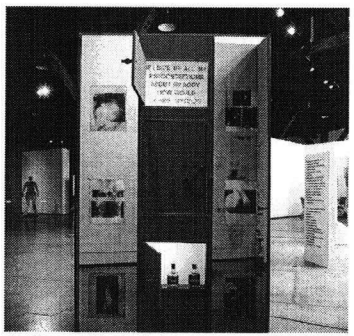
body close to the culturally acceptable size. But I have paid a price for this "safety".

How can a body dance and run and sing and create when it is half starved? When the fear of my mind and the ridicule of society is what occupies my thoughts. How is it possible to paint the pictures in my heart when I am not willing to feed it what it needs to be strong?

Sometimes I am still frightened by what I might have done to myself by engaging in this self-imposed torture.

But what is done is past. The present is what exists for me at this moment. But what this bit of writing is about is the second stage. The stage where I am just beginning to ask the questions. Just beginning to catch a glimmer of some hopeful answers.

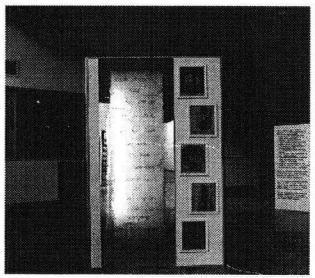
All I knew was that I was tired of being hungry. Tired of monitoring my hunger, thirst and desire. Tired of saying no. Tired of nod feeling full. Tired of being separate from the celebration. I wanted to eat some of my own birthday cake.



Mirror #3, 1998

Artist: Patricia Murphy with Lucy Banic, Amelia Goodine, Lorrie Miller, Ahava Shira and Taylore Carsen

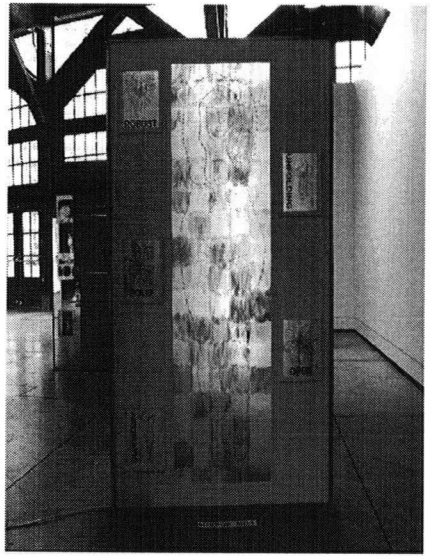
Mirror No. 3 is about looking for options, and perhaps beginning to see ourselves in a new way. The photographs are parts of the body that participants could accept as they are, and then some that they find difficult to accept as they are. The viewer can guess which are which. For the participants, this was a means of looking beyond what we're "supposed" to look like and being able to say, "Yes, this is who I am and I actually quite like it!" The young girls in the group pointed out that by looking for other ways to see ourselves, at first there is a nothingness, which confronts us. This is why the door is chained and what the blank inside is about. Then the next-door, the bottles labelled essence, wisdom and sensuality, are a hint that our identity comes from within, and perhaps is bottled up.



Mirror #4, 1998

Artist: Patricia Murphy with Lucy Banic, Amelia Goodine, Lorrie Miller, Ahava Shira and Taylore Carsen

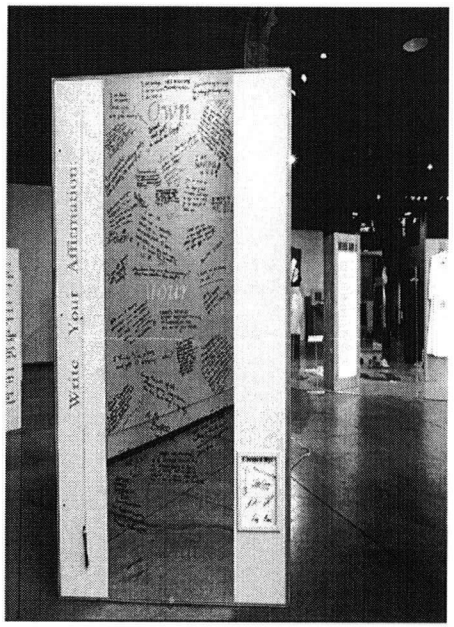
Mirror No. 4 extends this idea that it is our inner being which needs to be considered, rather than what we look like and what the size of our body is. The participant's used the notion of water to pose the question of what we're actually made up of, and to use it as a symbol of the many meanings that water suggests. The images are positive affirmations, which we all feel a need for (i.e. we all still need role models to remind us of our changed attitudes.)



Mirror #5, 1998
Artist: Patricia Murphy with Lucy Banic, Amelia Goodine, Lorrie Miller, Ahava Shira and Taylore Carsen

Mirror No. 5 continues the theme of positive affirmation but the individual writing of each person together creating an image extends the idea of community. By women talking or communicating together, we help and affirm each other. The flowers, a cliché symbol commonly used for part or all of the female body shifts the metaphor of beauty. The meaning here is that flowers are considered to be beautiful and are acclaimed for their uniqueness in shape, sizes, and colour. "If nature is perfect, then so am I." The labels used can be descriptive of both the flower and the body.

Mirror #6 is plain with only the words "Own your own possibilities" and is of course an invitation to the viewer to see herself or himself in a new light or from an affirmative position. Viewers are invited to add their own positive affirmation to the mirror.



Mirror #6,1998
Artist: Patricia Murphy with Lucy Banic, Amelia Goodine, Lorrie Miller, Ahava Shira and Taylore Carsen

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The Perfect Fit

The Perfect Fit is a "posh" dressing room with four mirrors and several designer-clothing labels. Each fashion label explores aspects of the fashion industry's impossible expectations and barriers women face in our society.

talk to my breasts: is a commentary on a woman's body as the object of the male gaze. The sexy black bra is given lips and teeth to talk back.

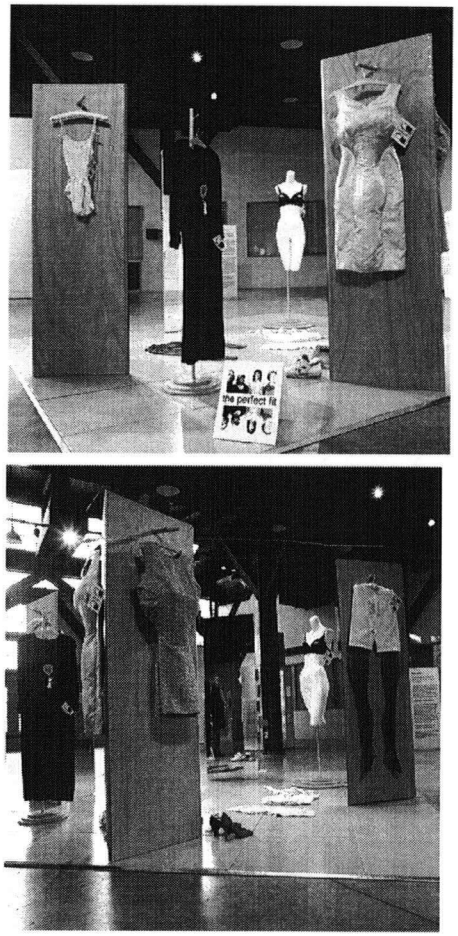
work: is a collection of single shoes that symbolize the numerous jobs women perform.

can I be happier than my mother: explores the struggle women face as they reconcile their own success.

who am I? This poem explores culture and its impact on women's identity and physicality. This is one woman's experience of freedom and self-expression as a Muslim woman in Canada.

size zero: is a parody on the size labelling of women's clothes. All the clothing under this label reflects the ridiculous demands of the fashion industry of women's bodies.

edible: plays on the societal expectations of women to look young, sexy and innocent and the social prejudice that (fat) women's sexual appetites will consume their partners.



The Perfect Fit, 1998

Artist: Claudia Cuesta with Lara Coutts, Farina Reinprecht, Ruth Tovim and Karen James

8Figure 1. Photographs of the House of Mirrors Exhibit
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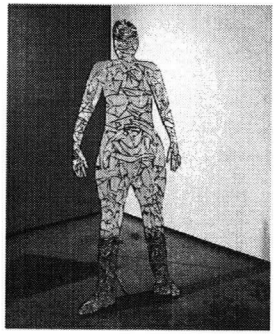


Breaking the Mold, 1998

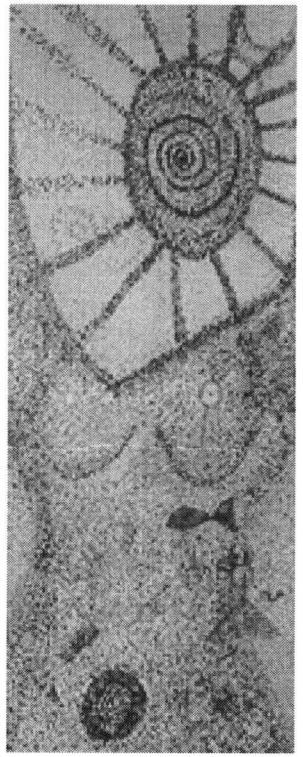
Artist: Sheila Norgate with Sally Holdsworth, Kathy Price, Sigrid Tarampi, Lynne Van Meer, Leah Van Meer, Kim Bruce and Jan Alexander

Breaking the Mold consists of a mirrored mosaic silhouette of one of the participants. To create this piece, participants broke up old mirrors that were tarnished around the edges, flawed and blemished - just like real women are. The act of breaking the mirrors was a way for the participants to reclaim the image of a woman as real, and as a way to make a reflection in their own image.

Chat Room, 1998

Recording and interviewing: Ita Margalit, Editing: Kevin Nimmo and Ita Margalit, Room Design: Ita Margalit, Sheila Norgate, Original Room Concept: Claudia Cuesta

The Chat Room represents a kitchen, the traditional center of women's lives and a forum where women can move. Exhibition viewers are invited to sit around the kitchen table and listen to girls and women share their tape-recorded stories and experiences about struggling to "measure up".



Celebration, 1998

Artist: Merrell Eve Gerber with Julie Thompson, *Wanda Andrade, Ru Bechler, Jeannine Poirier and Susan Masterton*

This piece is a celebration of women's diversity in a beautiful kaleidoscope of colourful dots. The exhibit's final piece also incorporates the viewer as they see their reflection cast amongst the colours.

Importance and Utility

Based on the above themes, the stories of one hundred and fifty women and girls presented disordered eating as being rooted in societal beliefs and attitudes with an aim to deconstructing stereotypes. Exhibition viewers are encouraged to observe and interact with the installation and to discover how the participants have challenged the distorted images of the female body and the discrimination against people who are fat. ANAD encourages using the term "people of size" as it models a shift in thinking about fat, body shapes, and sizes. Exhibition viewers are encouraged to consider this shift in language and begin to question how they think about body differences.

The exhibition's themes and accompanying educational panels explore the misinformation presented by the media, diet, fashion, and medical industries, while revealing myths about fat and violence towards women, and explore how we participate and perpetuate these prejudicial beliefs. Viewers are introduced to information that explains:

a) why diets do not work (Miller, 1999; Poulton, 1996);
b) how the diet, fashion and medical industries profit from diets that do not work (Bordo, 1993; Poulton, 1996; Seid, 1989);
c) how the endorsement of weight loss is a conflict of interest for some health care professionals (Berg, 1999; Brown and Jasper, 1993; Corgan and Ernsberger, 1999; Ernsberger and Koletsky, 1999; Miller, 1999; Poulton, 1996; Rothblum, 1999; Schoenfielder, Wieser, and Mayer, 1983), and

d) facts about fat (Brown, 1993; Brown and Zimberg, 1993; Burstow, 1992; Poulton, 1996) and how individuals can reclaim their bodies and change societal beliefs.

Community Development Intent

As mentioned above, the HOM project was piloted as a community development tool in Campbell River in February 2000, and provided Campbell River with an opportunity to create change and address the current lack of disordered eating service provision in the area. With this in mind, Campbell River was given three guiding principles to follow in the pilot project, which were intended to provide the community with ownership over activities while respecting ANAD's community development philosophy.

Based on this premise, Campbell River was required to:

1) Establish or have definite plans for a support group or some support structure for girls and women (for example, support groups or peer counselling).

ANAD members realized that the project would raise levels of awareness in the broader community. Raised awareness would present women and girls with an occasion to self identify around this issue, and consequently might lead to a want or desire for support in dealing with how this issue affected them. Therefore, the community as a whole was encouraged to become responsible and accountable, while providing some concrete support structures for individuals who identified with the issue. This was to persuade the community to help to solve the problem rather than create more frustration (ANAD, 1998b).

2) Involve at least three community sectors to host the project, and if possible to work at a regional and provincial level.

ANAD members hoped that encouraging involvement at a local, regional, and provincial level would help to create a support network and ensure that the burden of hosting the HOM project did not rest solely on one organization (ANAD, 1998b).

3) Organize two other community activities to accompany the HOM project.

The mandatory development of additional activities was intended as a way to help facilitate cross-sector work on the project. Campbell River, then, was encouraged to use the HOM project as a catalyst for divergent sectors of the community to raise its profile, and create alternative resources. By using the art show as an enticement, the Eating Disorder Program had something tangible to offer other community sectors to work collaboratively on. For example:

1) teachers could use the exhibit to augment their curriculum with a tour;
2) the arts community could develop workshops opening up an avenue of blending art and health;
3) the business community could sponsor the opening event, thus being seen as good partners in health prevention; and
4) the health authority could agree to match any funds raised during the "gala" opening of the exhibit (ANAD, 1998b).

Following the principle of empowerment, Campbell River was to take ownership of their work by choosing and organizing the accompanying activities most appropriate for their community's unique needs and characteristics.

The goal of the HOM project, then, was to provide the community with some programming funds or resource allocation. The hope was that the whole community would become more literate around the issue of disordered eating, and would be willing to work together to end disordered eating (ANAD, 1998b).

One of the main aims of the HOM project is to facilitate the development of more disordered eating services by encouraging geographic communities to work locally on the exhibit. The intent is not to define how communities work together, or to provide them with a recipe for change. Following the basic requirements presented above, the community will shape how they will work together to create awareness about disordered eating and critique structural forms of oppression. By hosting the HOM project, each community makes the choice to try out a community development approach in the short term to see if it fits with their beliefs and whether or not it will work well for their community.

The HOM project is unique because it asked the art, education, health, and business sectors of the community to work collaboratively and begin a dialogue around disordered eating. Through community building activities, collective decision making is used to plan the use of the art show as a focus for change. The project aimed to dissolve the boundaries our society has created between art, education, health, and business. Collaborative efforts, then, were used to problem solve disordered eating support and funding issues identified by interested individuals, service users, and providers in British Columbia over the last two years. The hope is that this research can be used to inform practice and

policy decisions in much the same way as Wang, Burris, and Xiang's (1996) photography exhibit of Chinese women's rural health issues. This study was used to improve their quality of life and encourage policy changes aimed at achieving social equity.

Historical Context of Community Work

Collaboration between community sectors is an essential component of the HOM project. Community development work is described in a variety of ways in the social work literature. Generally speaking, descriptions in the social work literature vary from non-directive voluntary participation approaches, to a profession that reinforces and operates within the constraints of imposed contemporary political structures and mainstream ideas (Payne and Campling, 1997; Twelvetrees, 1991). Dominelli (1990) states that identifying community work models is problematic because definitions are somewhat arbitrary and largely depend on what is deemed important by the theorist describing the model.

In any case, Popple (1995) describes the different kinds of community work as ranging on a continuum from pluralist to radical paradigms. Pluralist approaches strive to maintain balance between competing interests through small-scale changes. Radical models, on the other hand, encourage wider

political analysis and macro level changes that recognize and take action against structural inequalities.

Rothman (1995) describes the three main frameworks that function under these pluralist and radical paradigms as locality development, social planning and policy, and social action. Locality development is an approach that often draws on feminist principles and encourages wide involvement of community members in democratic leadership, (educational) goal setting, and action that benefits all community members. In contrast, social planning and policy approaches focus on problem solving that involves data assembly and analysis. In this approach, expertise, social science thinking, and empirical objectivity are considered essential components. Social action, on the other hand, is a more inclusive approach that strives to recognise disadvantage, and encourage community change that redistributes power, resources, and includes marginalized groups in decision making (Rothman, 1995). In practice, community work may incorporate characteristics of each of these approaches (Twelvetrees, 1991). Specific practice models include community care, organization, development, and class based action. Dominelli (1990) has subsequently modified the original class based action model, added feminist community action and community action from a black perspective to the above list of practice models.

Dominelli (1990) also critiques community work literature stating that some efforts enforce the status quo by hiding their agendas under the pretence of

being neutral. Many scholars, practitioners, and community members echo Dominelli's concerns about being neutral in practice, in much the same way as feminist therapists question neutrality. ANAD members share this unease and are very clear about encouraging a community development philosophy that strives to create change. ANAD members actively encourage a community development approach, which derives in part from some of the above models and is informed by newer approaches within the radical paradigm such as Ristock and Pennell's research as empowerment initiatives. In their work, Ristock and Pennell (1992) stress the importance of a critical analysis of power that results in a restructuring of power so that it can be uses responsibly. Power becomes a subject of analysis and a vehicle for change. These empowerment initiatives encourage the formulation of "alternative truths" and the creation of inclusive communities.

Drawing on these principles, ANAD members encourage a community development approach that aims to help facilitate larger societal change. Unlike other community initiatives, however, this does not mean that ANAD members are trying to control how the change happens or what the change will look like. With the HOM project, ANAD is providing communities with support to create an environment for change. In order to create larger scale changes, different sectors of the community need to be involved. Thus, the HOM project encourages communities to involve all sectors to work around disordered eating. Involving the community re-frames disordered eating as a community issue, for

which the community as a whole becomes responsible and accountable. Bringing the various community sectors together to work on the HOM project encourages the community to work together outside of the current system to meet their needs and to create societal change.

Community Development and the Arts

Along similar lines, other Canadian organizations are drawing on traditional practice and are experimenting with the idea of partnerships in the community as a way to begin addressing current oppressive practices such as sexism, racism, classism, heterosexism, and related "health" consequences. Local examples of such efforts include a theatre play by the World AIDS Group and art displays by the University of British Columbia Women Student's Office (UBC Women Student's Office, 1999; WAG, 1999).

Partnerships are becoming increasingly popular between community and arts organizations (Prokop, 1998; Larsen, 1997). These relationships are fostered by the use of community development approaches that link social work with art as a way to strengthen and build communities and begin to address oppressive societal structures (Larsen, 1997). The use of art in this manner stems from First Nations' community practice that values the artist as a key participant in community life. Artists demonstrate how to preserve, express, and renew cultural life while reflecting community spirit and value. Canada has a history of

artists working in community-based collaboration with neighbourhoods, social agencies, trade unions, schools, professions and many other "non-arts" groups and institutions (Canadian Conference of the Arts, 1997).

Drawing on the history of artists working in community based collaboration community workers are playing with the use of art as a way of communicating and creating awareness about social issues. When affected individuals are active participants in the creation of such projects, art becomes the visual embodiment of experience and knowledge (Hawkins, 1993; Lacy, 1995). Art is a powerful and effective way of engaging and connecting people with social issues (Hawkins, 1993). Communicating and creating connections is an essential part of relationship building and community work. Art and community collaboration also reflects feminist practice philosophies which promote the growth of community work and encourage a movement from outside intervention to internal strengthening and social action (Dominelli, 1990).

Acknowledging internal community resources and drawing from first hand knowledge is increasingly being recognized as essential to social work: consumers are a valued knowledge base. "When practice wisdom derives from collective reflection, it re-appropriates knowledge and promotes participation in the community" (Checkoway, 1997). Art becomes the medium to visually voice societal issues and to convey individual experience and knowledge. An interest and connection with art is also encouraged in this process, as art becomes the means of engaging the viewer. This connection provides the foundation upon

which relationships can be built and partnerships created (Lacy, 1995; Larsen, 1997).

Community work is essentially a form of relationship building which creates awareness, facilitates learning, and provides "empowerment" opportunities. Personal experience and knowledge are valued and voiced, which in turn facilitates social action. Thus, art, community work, and social action work together cyclically to inform and build community.

Philosophical Underpinnings

As indicated in the above sections, the HOM project was originally developed as a community development project and is intended to be used as a community development tool in the future. The HOM project is guided by the belief in the healing and connecting properties of art and community, as well as by social justice philosophies. Social justice philosophies were embodied in the creation and content of the HOM project and in ANAD's future community development vision. The social justice perspective can be described as focusing on social justice issues such as empowerment and the confrontation of structural disadvantage. This perspective seeks to create a better world, critique dominant social, economic and political structures, and draw on critical intellectual traditions such as feminism (Ife, 1995a). This means exposing power, rejecting narratives that universalize experiences, and taking a political stance that

encourages new ways of thinking which affirm the experiences and needs or real people (Ristock and Pennell, 1992). Empowerment is viewed as a process and a central component of social justice.

The development of the *House of Mirrors* exhibit encompassed the social justice concept of empowerment in the creative development process and in plans for future tours. The initial creation of the *House of Mirrors* empowered women and girls to use creative ways to tell their stories. Similarly, the exhibit will tour the province in the future and assist communities to develop emotional and financial support. The HOM project also empowers viewers to create change individually and collectively. Suggestions on how viewers can create change are included on the information panels in the exhibition and in the accompanying educational manual.

The content of the exhibit also promotes critical thinking as the information panels encourage the viewers to question societal beliefs and structures. Disordered eating is not presented as a mental health matter, but as a complex issue that needs to be considered in relation to larger societal problems such as violence, discrimination, and the social determinants of health. ANAD encourages a more holistic approach that recognizes that anyone can develop disordered eating, because oppressive western societal structures are a root cause of disordered eating. This analysis acknowledges that individuals are impacted by their immediate environment, which includes their family, peers, school, work place, and community (See Figure 2). In turn, the immediate environment

is informed by society at large, and its oppressive structures such as: ageism, ableism, classism, heterosexism, racism, sexism and weightism (ANAD, 2000). The accompanying educational manual, then, was provided to assist teachers and students to break down stereotypes and create awareness about the various forms of oppression: for example, fat phobia is used to draw parallels between the other "isms". Teachers and students are urged to participate in exercises that encourage self-awareness and an understanding of power, privilege, and oppression.

In March 2001, the HOM project will begin a northern tour to 100 Mile House, Prince George, and Smithers. As a travelling exhibit, the HOM project is being developed at the local level where the community's voice is valued and respected in shaping collaborative working relationships. Respecting and valuing the community's voice are identified by Wharf Higgins (1997) as the essential elements to foster citizen participation. The HOM project also encourages political development at a local, regional and provincial level. At a local level, communities are asked to raise awareness about disordered eating and to work together to organize the exhibit and two additional events. Communities are also strongly encouraged to organize at a regional and provincial level to create change. As stated in the HOM manual, ANAD members are willing to provide any support they can to facilitate this work. ANAD member's hope that community involvement throughout the province will create the foundation for an "ongoing and complex process of dialogue,

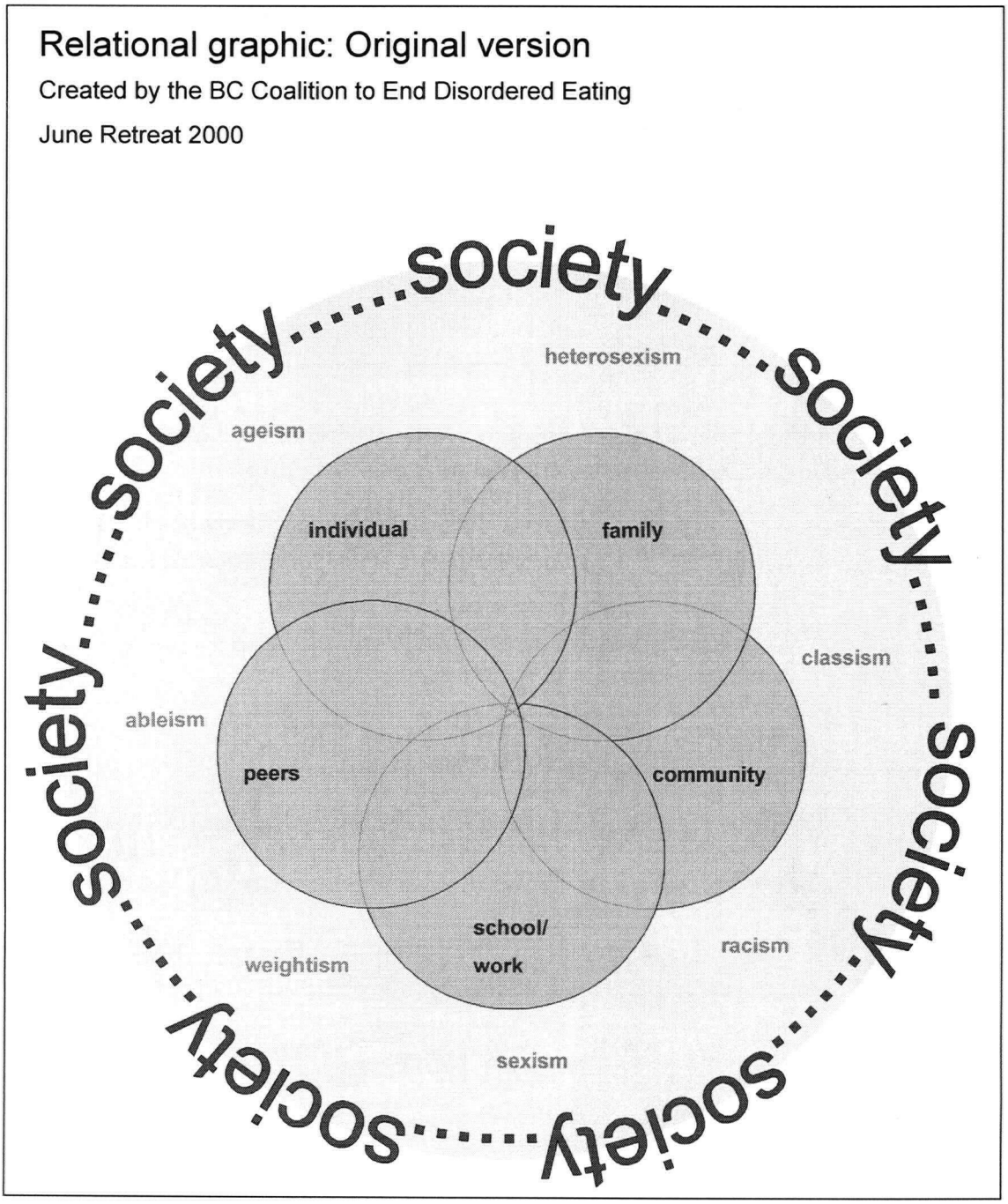
exchange, consciousness raising, education and action." (Ife 1995a, 93-4). The community development aspect of the exhibit is intended to create awareness around disordered eating issues and to involve different community sectors in order to facilitate such a discussion and encourage collective action (Ife 1995b, 138-139).

In economic terms, the HOM project can also be used to attract future funds and services. Communities are provided with an opportunity to use the HOM project to raise money. All funds raised by activities in the community will remain in the community for disordered eating work (Ife 1995b, 131). Similarly, by participating in project evaluations, Campbell River and other communities will be able to use the final report to secure funding for future collaborative initiatives.

Finally, the art exhibit itself encourages interest in art and culture. Communities are strongly encouraged to involve the arts community in the organization of the HOM project to further this dimension. Viewers are also encouraged to connect with the art pieces on a personal level and are offered suggestions about how they can become involved and create change.

Figure 2. Relational Graphic

Based on ANAD's research, the BC Coalition to End Disordered Eating created this diagram to illustrate a more holistic disordered eating perspective.



Expanding Collaboration Further

Thus far, the above sections have discussed how community work, art partnerships and social justice philosophies have informed the creative process, content, and community development aspects of the HOM project. In addition to the above influences, the HOM project was designed to actively support developing awareness and change at community and societal levels.

This kind of work has been described in the community development literature as a focus on the social learning and social mobilization aspects of social work practice. MacNeil (1997) describes social learning as an aspect of practice or group-work around an issue that helps to create awareness, facilitates individual healing, and teaches skills. Many community development projects promote the social learning aspect of practice, and this focus fits well with the aims of most disordered eating prevention programs (Shisslak and Crago, 1994; Steiner-Adair, 1994). Such efforts are valuable and provide support primarily on an individual level.

The HOM project incorporates the social learning aspects of social work practice with a focus that links structural issues with disordered eating and identifies how viewers can create change. The information panels also critique for-profit industries such as the diet, fashion, cosmetic, and surgery industries. Viewers are encouraged to consider how these industries profit from the exploitation of body dissatisfaction and self-loathing. Self-help solutions are

peddled in the form of books or products that essentially offer quick and ineffective solutions (Bordo, 1993; Poulton, 1996; Seid, 1989). Additionally, panels indicate how some weight loss schemes offer more permanent solutions or present life style choices that follow from current health care trends, but are not any more effective than their short-term counter parts (Corgan and Ernsberger, 1999; Berg, 1999). In either case, individuals are made completely responsible for their "condition" or "faults" along with the failure of products to help them lose weight (Poulton, 1996; Seid, 1989). Individuals are encouraged to view their "personal problems" narrowly without considering how societal conditions contribute to them.

The goal of the exhibition is to encourage viewers to question why they may be striving to measure up to unrealistic societal expectations (McKay, 2000b). Viewers are encouraged to critique weight-loss and self-help industries and examine how marketing strategies use misinformation, prejudice, and aspects of cultural socialization to sell products. These marketing strategies educate the public about "problems" or "diseases" such as weight and relationship dependency and market these accordingly in order to create a profit.

An example of this tactic is evident in co-dependency theories that became popular in the 1980s. The term co-dependency usually refers to a person in relationship with someone who misuses substances. However, the characteristics of co-dependency are strangely reminiscent of characteristics that are encouraged in girls and women such as caring, dependency, and valuing

relationships. An example of this kind of deceptive self-help literature is found in Pia Mellody's book *Facing Co-dependency: What It Is, Where It Comes From, How It Sabotages Our Lives ("Facing Co-dependency").* Mellody's book is a clever advertisement for her practice at the Meadows for-profit clinic in Arizona. In *Facing Co-dependency,* Mellody presents a theory of co-dependency that is very vague and could apply to almost anyone. Mellody claims that her book is rooted in her practice experience at the clinic (Mellody, Miller, and, Miller, 1989). Throughout the book, she attempts to establish theoretical credibility by borrowing many of the popular and familiar features of family systems theory like boundaries and relationship triangulation (Freeman, 1992a; Freeman, 1992b). The vagueness of her theory promotes the idea that the disease of co-dependency is common to most (women), which is undoubtedly a ploy to attract and maintain clientele. However, Mellody's work, along with other co-dependency theories, actually blames women for their socialization, the resulting desire to maintain or salvage an unhealthy relationship with their (substance using) partners, and in some cases for their partners substance use (Kasl, 1992). As a result traits usually associated with women such as caring, mutual dependence and support are deemed a liability.

Poulton describes this as an ingenious strategy to cover assets (1996). In the diet industry, the ideal weight for women has steadily declined over the last thirty years and today the ideal is unattainable for ninety-five percent of women. Therefore, most women are encouraged to diet and be concerned about their

weight. At the same time, the diet industry tells people that: "The program can't fail. Only you can fail (Poulton, 1996: 65)."

The effect of the above marketing strategy is two fold: the problem is presented as applicable to a wide range of people, and the individual is blamed for her failure to transform herself. This notion of personal failure shifts attention away from the structures and relations of power (Adamson, Briskin and McPhail, 1989) that profit financially from weight-loss products, thereby reinforcing fat phobia. By ensuring that their products appeal to a wide audience, and by blaming this audience personally for product failures, marketers profit in much the same way as the medical profession profits financially in the weight-loss and surgery industries (Poulton, 1996; Seid, 1989).

The HOM project presents a critique of various industries that have built a market on body dissatisfaction and self-loathing, and introduces a philosophy that promotes health at any size. A focus on health at any size encourages a paradigm shift away from the current dieting and weight loss focus approach to health (Corgan and Ernsberger, 1999; Miller, 1999). These lessons are drawn out further in the facilitator's manual that accompanies the HOM project.

The HOM project's community development approach also means moving beyond the social learning aspects of practice to create awareness and literacy in all community sectors and to build community accountability. As discussed in Chapter 1, disordered eating is often dismissed as a woman's or girl's issue. In order to create change, workers must be encouraged to see

disordered eating as a community issue that requires community solutions. Initiating an inclusive dialogue will help the community to identify the seriousness of this issue and the need to work together to develop a continuum of support services to reduce the number of individuals affected by disordered eating.

In order to address this issue effectively, community workers need to challenge the inherent assumptions our society makes based on these beliefs in all sectors of our community. This is a large undertaking, but ANAD believes that by using the HOM as a tool, individuals and organizations can bring together the various sectors of a community to start the process (ANAD, 1999b).

Each community has varying needs, levels of public awareness, and access to the full continuum of health, educational, and social services that are needed to deal with this issue. Consequently, for some communities the emphasis will be on getting the local or regional health authority to recognise the need for health care services. In other communities, this may involve school boards incorporating appropriate curriculum, youth serving organizations' providing supportive work environments, or the encouragement of local merchants to take some responsibility. Whatever the emphasis, supportive and collaborative action from other community sectors is essential (ANAD, 1999b). Active community involvement is necessary to create change and to effectively address structural inequalities, along with support and funding issues.

The emphasis on collaboration and partnership building in the HOM project differentiates ANAD's community development approach from other work and responses in the disordered eating field. As mentioned above, a community development approach is new in the disordered eating field and the concept of collaboration involves building partnerships with other sectors of the community.

How does the House of Mirrors project address current issues in the field?

To date, the HOM project is the only "community based program" in Canada that explores the social aspects of disordered eating, links fat phobia with violence and other forms of oppression, and encourages social change. Viewers are asked to critically reflect on the issues of pathology and ineffective treatment by examining stereotypes, while acknowledging a continuum of disordered eating and the social causes of disordered eating. While the art exhibit and accompanying educational manual facilitate these discussions, information panels also give viewers ideas about how they can become change agents.

In other words, the HOM project provides an alternative approach to dealing with current issues in the disordered eating field. An evaluation of the project expands and enriches our knowledge about the viability of a community development approach in building collaborative working relationships to deal

with health issues. This learning will be used to improve future tours of the HOM project.

How is an evaluation of the House of Mirrors project significant?

There is a dearth of social work literature on community development and social action efforts in the disordered eating field. Most social work contributions to the understanding of disordered eating concentrate on a variety of clinical practice issues, with a focus on family therapy (Skekter-Wolfson, Woodside and Lackstrom, 1997) and prevention initiatives (Brown, 1993a; Brown and Zimberg, 1993; Friedman, 1999; Friedman, 2000; Siegler, 1993). Skekter-Wolfson, Woodside and Lackstrom (1997) state that the breadth of knowledge and interest in disordered eating is also reflected in the minimal amount of social work literature devoted to this issue, and the literature lacks information about the larger societal context in the development of eating.

Adding a community action focus to the research literature will help to contextualize disordered eating issues and encourage critical thinking about pathology and medical treatment practices. A more inclusive view of disordered eating will also encourage health practitioners to question and challenge societal prejudices and draw attention to the exclusion of some women from treatment. Exploring the use of a community development approach to disordered eating

will also illustrate how communities can build partnerships to begin to establish support and awareness around the issue and create societal change.

Chapter 3 Methodology and Method

In this study, I examined the effectiveness of a community development approach in the context of disordered eating practices in British Columbia. The HOM project is the only community-based program in Canada that explores disordered eating as a reasonable response to violence and socio-cultural expectations, while linking it with fat phobia and other forms of oppression. My hope is that my research will contribute to an understanding of these issues in the disordered eating field.

Design and Rationale

This qualitative and quantitative study evaluated the HOM project 's effectiveness as a community development tool in Campbell River. A qualitative focus in the research format facilitated the development of a process evaluation that offers a rich view of community working relationships, disordered eating awareness, and funding reallocation.

Following the community development focus of the HOM project, this study draws on the complimentary philosophies of feminism and action research. As mentioned in Chapter 1, these approaches raise questions about the validity of the medical model's focus on individual pathology. They embody many of ANAD's beliefs and are described as empowering and reflexive. Action research

originates from community development principles and is described as research in which action and evaluation proceed simultaneously (Reinharz, 1992). An action research approach is described by Hart and Bond (1995) as a dynamic interaction of seven criteria: 1) education; 2) dealing with individuals as members of social groups; 3) a problem-focused, context-specific and future-orientated approach; 4) social change promotion; 5) improvement and involvement; 6) a cyclical process that links action and evaluation; and 7) collaborative research relationships with participants (37-38).

Additionally, Barnsley and Ellis (1992) describe a (participatory) action research approach as a systematic collection and analysis of information for the purpose of taking action and making change. These authors describe action research as a way for community groups to do research that will help to improve the situation of people in the community. Action research is used as a tool for empowerment rather than an end in itself, and focuses on learning how people actually experience an issue or problem, and how change can be created. In other words, real life experiences are used to develop strategies and programs. Action research approaches are also intended to strengthen and mobilize community groups by increasing their understanding of the issues they are working on and their connections with one another. This learning can then be used to inform advocacy work (Barnsley and Ellis, 1992).

Like action research, feminists stress the importance of starting from a women's experiences and describing women's ways of knowing (Reinharz, 1992).

Feminist philosophies put the social construction of gender at the centre of inquiry and support participants to participate in research that raises awareness, provides a vehicle for their voices, and creates social and individual change (Lather, 1992). Riger (1992) describes this as a feminist method that should produce studies about and for women that help to change the world. Applying feminist principles to group research is also described as a way to build connections, avoid alienation of the researcher from the research (Charmaz cited in Reinharz, 1992), and access a wider range of voices (Ristock and Pennell, 1992). In feminist research, the process becomes part of the product (Reinharz, 1992).

With these philosophies in mind, a multiple method approach was chosen for this evaluation that included two focus groups and a survey method. The focus group format was well suited to the exploratory nature of this study and was chosen to provide a "real life setting" that would elicit candid and spontaneous information about cross-sector relationships (Kreuger, 1994). This format addressed potential confidentiality problems in the writing and distribution of the final report. In keeping with action and feminist research philosophies, the focus group format also encouraged me to become part of the research and included me as an instrument in the data collection and analysis (Creswell, 1998; Kvale, 1997; Padgett, 1998; Stewart and Shamdsani, 1990). As a research instrument, I was encouraged to gather and analyze information, focus

on the meaning of participants dialogue, and describe the process in expressive and persuasive detail (Creswell, 1998).

Focus groups were held in March and April 2000, following the February exhibition and activities. Data from the focus groups provided a foundation for the survey component of the project evaluation conducted in May 2000. The survey component of the evaluation was chosen as a non-obtrusive method of triangulation that would facilitate feedback from other members involved in the HOM project, contextualize the focus group meetings, and further elaborate on the experiences of focus group participants (Cheetham, Fuller, McIvor and Pitch, 1992; Maxwell, 1996, Reinharz, 1992). The focus group and survey provided opportunities for participants to debrief while providing participants with a forum to share their reactions and feelings about community work. The use of multiple methods was also intended to ensure thoroughness and to enhance understanding by adding layers of information, and by using one type of data to validate or refine the other (Reinharz, 1992). To ensure anonymity, the names of participants were not included in the findings. At the participants' request, quotes were edited to encourage easier and more respectful reading (DeVault, 1990).

The evaluation results were disseminated in ANAD's fall newsletter and at their public annual general meeting in September 2000. Copies of the evaluation results are also available for the research participants and other interested parties courtesy of ANAD.

The method and design of my study was approved by the Behavioural Sciences Screening Committee for Research Involving Human Subjects at the University of British Columbia in March and April 2000. The Certificates of Approval are located in Appendix B and C.

Focus Group Interview Format

Following feminist and social justice principles, a semi-structured interview format was selected for the focus group portion of this study. The interviews contained a few guiding questions (Appendix G) which asked participants in Campbell River to reflect on their experiences with community relationships while working on the House of Mirrors Community Development Pilot Project (the "HOM" project). As the researcher, I facilitated a guided conversation about the experience of using the touring art exhibition to build community relationships (Kirby and McKenna, 1989; Kvale, 1997). The small number of interview questions allowed participants some freedom to shape the process and provided them with an opportunity to debrief their experiences. Working together in this way helped to reduce possible power differences, and to empower participants (Ristock and Pennell, 1996; Swigonski, 1993). Similarly, every effort was made to address power differences. Participants were informed about the purpose and objectives of the study, and I addressed and discussed my involvement with ANAD and the HOM. The evaluation was also framed as a

learning tool for future tours aimed at assessing how the project was working, rather than as an evaluation of their work.

Focus Group Sample

Following ANAD's HOM project guidelines, the Eating Disorder Program's Advisory Committee formed a subcommittee to organize the HOM project. The sub-committee was composed of five women volunteers who came from the art, education, and social service sectors, with one of the women working in two sectors. Invitations participate in the research were sent to these subcommittee members because of their unique insight (Maxwell, 1996) into cross-sector working relationships during the HOM project (Appendix D).

All five members volunteered to participate in the focus group interviews. A focus group of this size is consistent with the literature's recommended sample size (4 to 12 participants) and is now identified as a "mini" focus group (4-6 participants) in the literature (Carey, 1995; Kreuger, 1994). The mini focus group is considered easier for the facilitator to recruit and moderate, while being more comfortable for participants (Carey, 1995; Kreuger, 1994).

When the participants were first contacted, they were informed of all aspects of the research study, along with my background and interest in the research, and the four to five-hour time commitment. All participation was

voluntary and participants had the choice to withdraw their involvement in the research at any time without jeopardizing their relationship with ANAD.

Data Collection: The Focus Group Interview

Through discussions with the Eating Disorder Co-ordinator, the subcommittee determined a mutually convenient date, time, and location for holding the groups. The focus groups were scheduled at the end of March and April 2000 during weekday afternoons to accommodate the participant's busy schedules. Both groups were held in the family services office in Campbell River.

Participants were given the opportunity to talk informally and check-in with everyone before each session. During the first interview, I shared information about my interest and experiences in the disordered eating field, and my relationship with ANAD and the HOM project. After mingling and settling into the room, I reviewed the purpose of the evaluation, the planned use of the evaluation results, and suggested some ground rules for the meeting. On both occasions, participants were reminded that they could withdraw from the research process at any time. Participant consent forms were reviewed verbally and each participant was asked to sign a consent form. Participants were given a copy of their form before leaving (Appendix E).

Both focus group interviews were tape-recorded with participant consent as a relatively unobtrusive way of documenting the process (Kreuger, 1994). The

first focus group began by giving participants the opportunity to introduce themselves and respond to the icebreaker question (Kreuger, 1994; Reinharz, 1992): How did you become involved with the HOM project? This introductory question was intended to provide an opportunity for each member to talk and feel comfortable (Kreuger, 1994). This process helped group members ease into a dialogue about their experiences of community relationships. Following the initial opening round, the first question was introduced along with an open invitation to begin sharing. However, in the second session the opening round was less formal and participants were given a summary and copy of the first transcript for consideration. The interview was transcribed verbatim to facilitate a rigorous analysis (Kreuger, 1994), and participants were given an opportunity to review the transcript to ensure accuracy and to share any additional reflections or feedback. A transcript summary was used to initiate discussion in the second group and the remaining research questions were used when appropriate to further facilitate discussion.

The first focus group ran over the suggested time frame with participants eagerly sharing their experiences during the HOM project. The meeting time was extended to allow participants ample time for reflection. During the second focus group, the transcript summary and guiding questions were used to clarify and further explore the participant's experiences. This reliability check provided an opportunity to review key points and confirm or disconfirm their stories (Reinharz, 1992). Participants were content with this process and did not feel

they needed the opportunity for "prolonged engagement" at the end of the second group.

Following a semi-structured interview format (Bernard, 1994, Kvale, 1996), questions were used in both groups to facilitate a guided conversation about the experience of community relationship building (Kirby and McKenna, 1989). At times, the questions were anticipated by group members and integrated into the dialogue on their own initiative. Similarly, a number of the areas covered in the survey were brought up by group members prior to its distribution in the second group. I was pleased by the group members' interest in the "survey" topics and felt their comments confirmed the relevance of the chosen survey questions.

The transcription process was also interactive, as participants had the opportunity to provide "member checks" (Creswell, 1998; Kreuger, 1994; Maxwell, 1996; Strauss and Corbin, 1998) following both focus groups. As mentioned above, participants were provided with a summary of the first group and given the opportunity to comment and check on my understanding of their experiences during the second focus group discussion. A summary of the second group meeting and a transcript were also sent to participants to provide the same opportunity for reflection, and to further ensure accuracy. After the second clarification process, I sent thank you cards to the participants as a way of valuing their time and contributions to the research study.

Survey Sample and Format

In addition to the focus group participants, the survey was distributed to the members of the Eating Disorder Program Advisory Committee. Since four of the five subcommittee members were also on the Eating Disorder Program Advisory Committee, thirteen surveys were distributed in total.

The survey was designed to explore the area of community relationships, disordered eating awareness, and disordered eating resources (Appendix H). In keeping with the exploratory nature of the research, the survey's focus was primarily qualitative and used open-ended questions. The quantitative characteristics of the survey included yes and no questions and Likert scales. The quantitative component of the survey complemented the open-ended questions, and helped to make sense of the data by offering a simple means to compare and qualify responses (Cheetham, Fuller, McIvor and Pitch, 1992).

Respondents were asked to describe their experiences of cross-sector work and disordered eating initiatives before and after the HOM project. The survey asked respondents about their general experience of cross-sector work during the pilot, and included questions about community support, task distribution, collective work, and rewards and challenges. Respondents were also given an opportunity to discuss the activities that accompanied the exhibit and the HOM project 's impact at a local, regional and provincial level. Additionally,

respondents were asked about their future interest in cross-sector work and to give advice for future tours.

In terms of educational benefits, respondents were asked to rate and discuss their own learning and their perceptions about increased community awareness. Respondents were also asked to rate disordered eating resources in their community before and after the HOM project and to discuss their ability to raise the Eating Disorder Program's profile during the pilot. By completing the survey respondents were given an opportunity to debrief and comment anonymously on their experiences with the HOM project.

Data Collection: Survey Responses

As mentioned above, the evaluation survey was designed for the Eating Disorder Program Advisory Committee and the HOM Subcommittee. These thirteen committee members were given an envelope containing a copy of the survey and a self-addressed and stamped return envelope. The survey was distributed to the five focus group members at the second focus group. At this time, the Eating Disorder Program Co-ordinator was also given surveys to distribute at the Eating Disorder Program Advisory Committee meeting the following week.

Five of the 13 surveys were returned in June 2000. While I was hoping for a higher response rate, the focus group discussions indicated that most Advisory

Committee members were not as directly involved in the HOM project as initially anticipated. Needless to say, the lower than expected survey response rate was disappointing.

Data Analysis

Qualitative data analysis is described as a reflexive activity that occurs simultaneously with data inquiry (Kreuger, 1994), and should inform all aspects of data collection and report writing (Kvale, 1996). The analysis process involves: a) structuring the data, b) clarifying or distinguishing essential information, and c) analysis, which involves illustrating the participants' understanding and providing new perspectives (Kvale, 1996). Thus, analysis is a comprehensive and systematic process that is cyclical, reflexive, and transforms the data beyond a descriptive account (Coffey and Atkinson, 1998).

The data analysis in this study included considering the focus group and survey data separately and as a whole. Initially, focus group data was examined by listening to the interview tapes and reviewing the focus group transcripts several times, along with my field notes, in order to note pauses, laughter, non-verbal gestures, and voice inflection (Carey and Smith, 1994; DeVault, 1990; Kreuger, 1994; James cited in Reinharz, 1992). This process enabled me to familiarize myself with the data and to develop an understanding of each group member's experience (Creswell, 1998; Maxwell, 1996). I transcribed the tapes

verbatim (Kreuger, 1994; Maxwell, 1996) and also reviewed them to ensure transcription accuracy. Similarly, a transcript of survey responses was created to facilitate easy review. As mentioned above, my own reflections and thoughts were kept in a separate journal to document my journey and to facilitate reflection and analytical insight (Kirby and McKenna, 1989; Maxwell, 1998). This process allowed me to convert my thoughts into a form that could be coded and referred to for further consideration throughout the analysis process (Maxwell, 1998).

The data was analyzed by developing categories and coding concepts (Strauss and Corbin, 1998). Like other qualitative methods such as grounded theory, categorizing the focus group data involved fracturing the transcripts into concepts, and rearranging them in order to facilitate a comparison and to develop a greater understanding of the interviews (Coffey and Atkinson, 1996; Maxwell, 1996). A similar process was also used for the open-ended survey questions. I subsequently coded and separated the questions, and tried to assess what information was essential to understand the data. Additionally, the quantitative survey questions were tabulated using a computer program to facilitate easy reading and comparison of the data.

The survey and focus group questions were initially used as a way to organize the data (Coffey and Atkinson, 1996). Ten concepts emerged from the data through this process, and were examined further to identify categories or "big ideas" interconnecting both focus group discussions (Kreuger, 1994) and

survey responses. From this process, I developed the following coding framework.

Table 1. Coding Framework

Cross-sector Working Relationships	Community Development
Relationships *Challenges*	*organizational learning* *community connections*
Disordered Eating Awareness	Funding Reallocation
lack of awareness *developing awareness*	

The four categories and their subsequent dimensions are discussed in detail in Chapter 4.

The analysis process also included a consideration of the focus group data at an individual and group level. Consideration of the group context involved contemplating participant responses and behaviours as a means of countering the partial decontextualization of the data during transcription (Carey, 1995; Carey and Smith, 1994; Kreuger, 1994). To prevent decontextualization, consideration was given to the meaning and context of the participants' words (Morgan, 1995). The transcripts were reviewed in conjunction with my focus group notes to consider non-verbal cues (Carey and Smith, 1994; DeVault, 1990; Kreuger, 1994). Additionally, my thoughts were developed through a process of "memoing" (Creswell, 1998; Maxwell, 1996) and concept mapping (Maxwell, 1996) as a means of contextualizing and better understanding the discussions.

In addition to decontextualizing concerns, another consideration in focus group analysis is the likelihood of participants' censoring their thoughts and only expressing popular opinions. Initially, I felt that "censoring and group think" (Asbury 1995, Carey, 1995; Carey and Smith, 1994) issues were noticeable in the focus group discussions as participants were reluctant to discuss their working relationship as a subcommittee and their unique experiences. This may be because co-workers are more reluctant to express negative observations in front of each other (Kreuger, 1994). The group's reluctance may also have been the result of the subcommittee's history of task focused work (Payne, 2000), and some members' discomfort with "process issues" such as personality differences and difficulties that were evident while working on the project.

However, as the group became more comfortable, some members opened up and directly discussed their experiences. Other members used laughter and humour to indirectly discuss difficult issues and to relieve tension. In the second focus group, members continued to use humour, but expressed their unique experiences irrespective of previous comments.

A group level analysis helped me to better understand some of the subcommittee difficulties in terms of organization and communication. For example, on a few occasions some members' comments and questions indicated that they were unsure of who was supposed to be responsible for certain tasks. Similarly, statements and gestures in the second group indicated that the group had applied for funding from one of the organizations represented at the table

and that the group as a whole was harbouring unresolved feelings about the rejected proposal. Prior to the evaluation, the women had avoided talking about the unsuccessful grant in their meetings. One group member used the "safety" of the evaluation as an opportunity to introduce the subject and to explain to members why the committee did not get the funding. In any case, the group demonstrated the ability to put the disappointment aside and to explore alternative ways of dealing with resource issues. The level of openness and sharing in this discussion, however, further assuaged my concerns about censoring and conformity in the group.

Analysis involved consideration of the content and process of the focus groups to further understand what the data was telling me about the community development aspect of the HOM project. I also considered how the group members interacted, when group members were silenced and how this happened, and how the group interactions made sense in terms of the broader community development aspect of the project.

My analysis identified the subcommittee's experiences with community relationships during the HOM project and considered this data in relation to the broader survey topics. As mentioned above, the focus group participants initiated discussions about some of the survey topics on their own initiative. Therefore, the data collection methods and analysis seem to naturally overlap. An integrative analysis was a natural extension of this process.

Insuring Credible Findings

In order to insure credible findings, I transcribed the focus group interviews and journaled my own thoughts and observations separately to ensure that the women's experiences were accurately documented. The journal records and written documentation I completed throughout the project track my own thoughts and experiences during the research process and document my decisions regarding data analysis.

To indicate the subjectivity I bring to my interpretation, I also situated myself in the research and made my position visible. I used open ended questions and semi-structured focus group interview formats, allowed for prolonged engagement, and checked with participants to make sure that the transcripts and findings fit with their experience (Maxwell, 1996). The participants were provided with their own copy of each transcript and asked on two occasions if my analysis fit with their experience. This process ensured that I had clearly understood their comments. Similarly, I was able to supplement the focus group data with the survey data to further ensure credibility. I have also tried to make liberal quotes throughout the findings section to ground the analysis in the data.

Finally, I made sure any discrepant views were accurately portrayed in the findings (Kreuger, 1994). For example, participants disagreed about whether or not the project required too much work at the community level. Additionally, my review and critique of theoretical and practice literature, along with peer

reviews (Creswell, 1998; Padgett, 1998), minimzed the impact of my own filtering of differences and conflicts in the data. Consulting with peers who were familiar with the research topic and those who were not (Maxwell, 1996), helped to solidify my ideas, facilitate the analysis process, and identify parts of my findings that fit with similar practice experiences. For example, peer reviews were helpful in making sense of the community development practice issues, in addition to reading available community practice research. Every effort was made to ensure valid and trustworthy research results by including faithful descriptions and interpretations of the data that were immediately recognizable to the research participants.

Given the qualitative focus of this study, however, the generalizability of the data is limited. The data is not readily comparable across groups, as the data is specific to the context (Kvale, 1996) and membership of this research sample. The evaluation was considered to be a necessary dimension of practice and, therefore, was a useful means of documenting community development learning (Shaw and Lishman, 1999). However, the data is contextual (Kvale, 1996) and does reflect the reality of the participants in this community, and consequently may be relevant and informative in other settings (Carey, 1995; Kreuger, 1994).

Chapter 4 Findings

This chapter discusses the four major categories that surfaced from the data. The categories are apparent from the subcommittee's overall descriptions and in survey responses, and are set out with their respective dimensions in Figure 3. Figure 3 depicts the impact of the project on the community and the inter-relatedness of the subcommittee's experiences of cross sector relationships, community development, disordered eating awareness, and funding reallocation. These categories reflect the subcommittee's experiences of working on the HOM project, how their work had an impact on the community, and the thoughts of survey respondents. Each category is described in detail with its subsequent dimensions to illustrate the different facets of community work experiences. These findings will be considered in relation to community development and disordered eating prevention literature along with suggestions for future research in the following chapter.

Co-operative Working Relationships

This category describes the co-operative working relationships that developed during the project between various community sectors. The cross-sector relationships that were initiated during the HOM project are described

below along with the challenges subcommittee members faced as they developed these contacts.

Relationships

For the purpose of this evaluation, relationships are defined as involving active interactions that go beyond networking to form a deeper association that may develop into a mutually beneficial partnership. Focus group discussions and survey responses identified the art, education, fitness and social service sectors as developing co-operative working relationships during the project. As mentioned above, focus group participants identified themselves as working in the art, education and social service sectors and the five survey respondents identified themselves as coming from the art, business, health, education and social service sector of the community, with some respondents working in two or more sectors.

Cross-sector relationships, then, were forged with individuals and organizations in the above sectors and are outlined below. Each focus group description sets out 1) how the sector was engaged to work on the project, 2) whether the relationship was new or whether the groups had worked together in the past and had already established a relationship, and 3) the outcome of that contact.

Figure 3. Diagram of the Research Findings

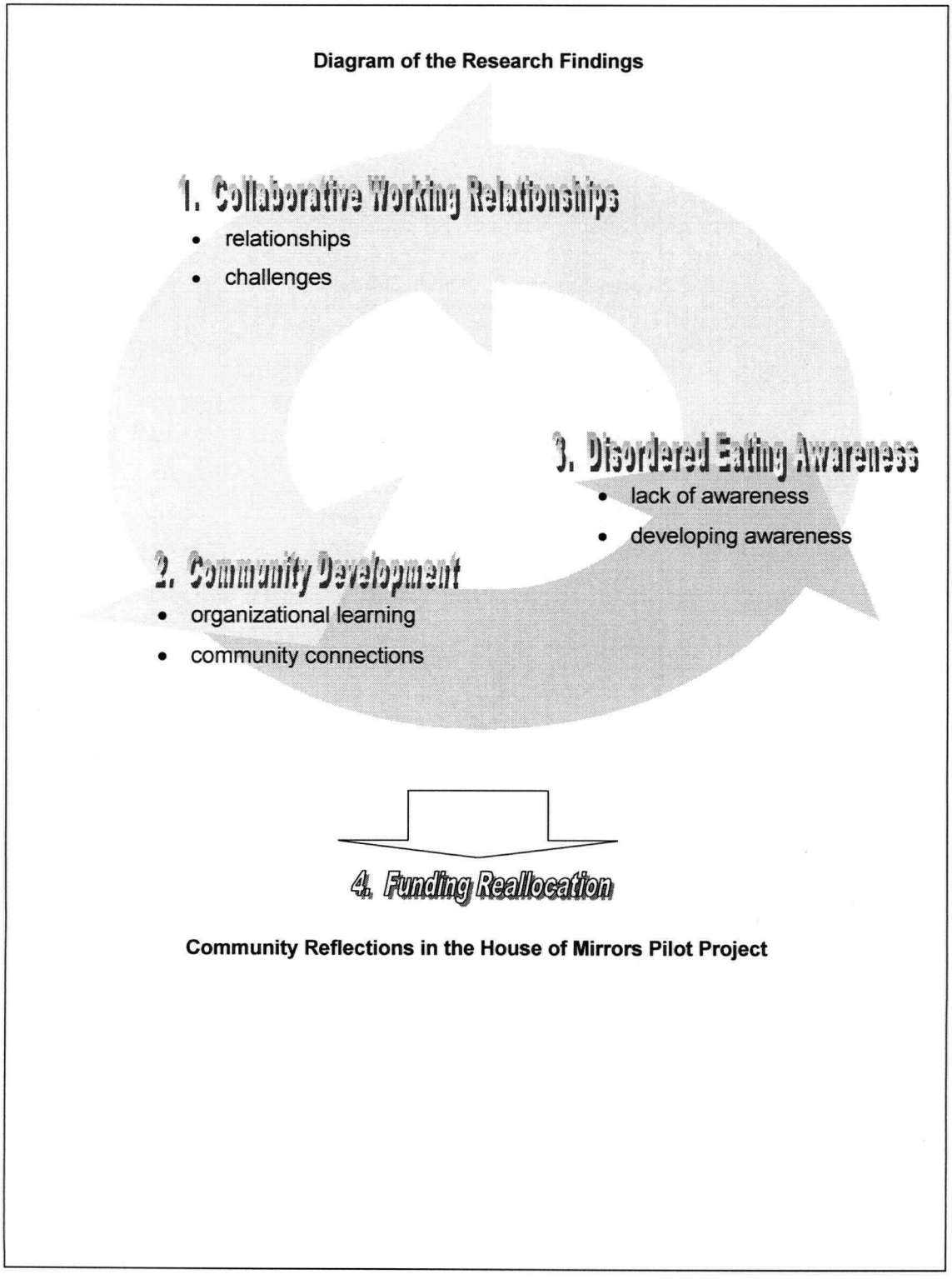


Table 2. Respondent's Cross-sector Relationship Experience

Dimension	Focus Group and Survey Responses
a) Art This dimension represents the link made between the Eating Disorder Program and the arts sector of the community. During the planning stages, the Eating Disorder Program Co-ordinator approached an arts organization that was interested in the partnership aspect of the project. This arts organization supported the project by providing a volunteer committee member for the HOM project subcommittee. The art contact was a new connection for the program that facilitated the recruitment of an exhibition space, project volunteers, and media coverage.	*Initially, I think the interest or the contact came because our organization has experience putting on arts exhibitions. We take care of exhibitions, for example, at the local theatre, and host other shows around town. But, our mandate is really to foster awareness of art and culture in the community and this was just an opportunity that in my opinion sort of killed two birds with one stone (focus group participant).*
b) Fitness A new connection was made with one of the fitness centres and resulted in the promotion of the HOM project in classes and advertisements in a local gym. Committee members felt this connection was significant in increasing awareness about the relationship between fitness and disordered eating, and could be developed further in future outreach work.	*There was one particular [fitness] instructor...who I just really badgered to come down...[and] every time she taught a class [after seeing the exhibit], she said that she didn't want to see anybody at the next class until they had seen the show. [The fitness centre] also used bulletin boards at the gym to point out the dates of the show and count down how many days were left...(focus group participant)*
b) Education One member of the working subcommittee came from the education sector, and others were engaged through invitations to view the exhibit. Invitations were mailed out to local	*...A counsellor [I know] at [one of the schools] who had been down maybe eight days before the end of the exhibit, went back to her school and said "Everybody needs to go down and see that." As a result of [her influence] and*

area schools that invited teachers, counsellors and school groups to tour the exhibit. Interested teachers were provided with an educational manual to encourage learning about disordered eating. The mail out of invitations to the education sector resulted in one counsellor taking a special interest in the project and organizing a number of school tours. Engagement of the education sector also resulted in a letter of support for the Eating Disorder Program to use for future funding proposals.	*a conversation she had with a colleague at a secondary school, I would say two hundred kids were through within the last four days... (focus group participant)*
c) Social Services Participants defined the next sector, social services, as involving organizations that focused on community work and employed social workers, and family service and mental health counsellors. Four members of the working subcommittee came from this sector of the community with representation from the Eating Disorder Program, Family Services and the Ministry of Children and Families. Their respective organizations supported the project through administration and meeting space. Additionally, committee members advertized the project in their organizations, brought clients to the exhibit, and encouraged clients to attend the exhibit. Other social service agencies also supported the HOM project by sending support letters.	*[A local men's group] wrote [two of the subcommittee members] a nice letter congratulating us and supporting our effort to bring the show to town and for bringing a variety of issues to the forefront which predominately affect women, but pertain to some men (focus group participant).*
d) Cross-sector Work In addition to the focus group reports described above, four out of five survey respondents also felt the HOM project encouraged cross-sector	Respondents commented that: *[the project encouraged work] between disparate groups with very dissimilar goals (survey respondent #1).*

work. However, there was less clarity from the respondents regarding cross-sector work on the project activities that accompanied the exhibit. One respondent identified the gala as the only cross-sector activity. A second respondent identified several cross-sector efforts including the contributions of the art, media, health, education, and business sectors. A third respondent identified the subcommittee members as a mixed sector group that worked on the project. Additionally, two of the respondents said they were unsure that any cross -sector worked took place.	*[the community] needed to [work together] in order to make the project the best it could be (survey respondent #3).* *[the] HOM project [sub] committee brought together the health, education, social services and art sectors of the community (survey respondent #4).*

Thus, the overall response from the community was very positive. Individuals from the art, business, health, education and social services worked together and demonstrated their support for the project in a number of ways. In some sectors, a "champion" promoted the HOM project after viewing exhibit. In other sectors, individuals were involved because the issue or project was related to their work. However, despite support for the project there seem to be general confusion about the meaning of community development.

Challenges

This aspect of the co-operative working relationship category explores the various challenges the committee faced as they tried to engage other sectors to work on the HOM project. Focus group participants identified ethical and

partnership challenges, while survey responses depict previous community work experience and future interest.

a) Ethical Issues

The dimension entitled "ethical issues" was named by participants and reflects the concern expressed by community members about the exhibition content. Focus group discussions and survey responses revealed community feelings of concern about the issue of disordered eating being presented in a public venue. This was the first time disordered eating was presented to the community in a public forum and the subject matter was considered controversial. Some community members stated that they did not know enough about the disordered eating issues to defend the exhibit against public criticism, which centred on concern about the appropriateness of exposing young people to subject matter such as lingerie, a bra with teeth, and bowels. Concern about ethical issues prompted a couple of community organizations to insist that the show be exhibited in a private location.

> *...almost immediately my board of directors...vetoed my choice [of a prime downtown location to display the exhibit] and made me get the show out of there and find some place else. It was subject matter related. Some of the words [used to describe the directors' feelings] were [that I would be] holding the audience hostage [and that] I wasn't giving them choice about what they would and wouldn't see...They said that they didn't care at all when it was in a private location but as soon as it became a public accessed event they wouldn't support it...(focus group participant)*

As a result, the exhibition location changed three times. To further alleviate concern, the HOM project subcommittee posted a disclaimer on the front door of the exhibition space to provide individuals with a choice about viewing the content.

b) Partnerships

The subcommittee members themselves made the distinction between relationships and partnerships, and the partnership dimension reflects the subcommittee's feelings about cross-sector work and thoughts about the potential for partnership building in future tours. Based on the focus group discussions and the survey responses, partnerships are defined as involving deeper commitments that include an understanding of each other, collaborative work efforts, and active involvement off all partners in building a mutually beneficial relationship. Relationships, on the other hand, involved these characteristics to a lesser degree and best describe the working interactions between subcommittee members.

To explore the concept of cross-sector work, survey respondents were asked about their previous community and disordered eating work experiences. Two of the respondents reported working on at least three previous cross-sector projects. One respondent reported working with a number of community groups on a regular basis. Another respondent reported involvement with a

number of projects in the education field, and one respondent had no previous experience.

Only one respondent reported previous work on disordered eating projects, which included various Eating Disorder Awareness Week activities over the last three years and the development of a local disordered eating support group. Other respondents listed the newness of the eating disorder program, the lack of opportunities, and a career in non-health related work as reasons for not working on prior projects.

The focus group discussions and survey responses indicate that there were several people working on the HOM project that had previous experience with community work. However, focus group members did not describe themselves as having partnership building experience. Focus group members also stated that their main goal in piloting the HOM project was to create awareness about disordered eating in their community. Since building partnerships was not the primary interest of the subcommittee, the committee focused on creating disordered eating awareness and establishing connections that promoted this goal. The concept of partnership building was understood as a time and energy-consuming endeavour that would be more easily facilitated with prior partnership building experience.

> *I would say where ever there was a place to develop a relationship that would be good to pursue. If you could use the House of Mirrors as a tool to develop those relationships, then [that would be] even better. [I would recommend] working more on [building partnerships] and I'm not sure what that would look like, but they would take time and conversation with your*

group so that you know what it is that you want to do and then who would do the work. We did not do that very much other than getting the donations that we did (focus group participant).

If [a future community] group had some experience establishing partnerships of all kinds, even if the [partnerships] were unrelated, or the [group] perceived them as unrelated to the subject matter of the House of Mirrors, if they could somehow find a use for that partnership [that] would be beneficial (focus group participant).

Additionally, the subcommittee discussed how a number of their experiences spoke to the necessity of establishing a partnership with the arts community to deal with problems requiring art expertise.

Finally, respondents were asked whether or not they had worked on any cross-sector projects as a result of the HOM project. Four respondents said 'No' and stated the lack of opportunities and the need to recuperate as reasons. One respondent said 'Yes' and stated that there was a project in the process of being developed. However, all the respondents stated that they were not currently working on any cross-sector projects in the disordered eating field. One respondent identified the current priority as program funding. There appears to be some interest in future cross-sector projects with one project currently being developed. There also seems to be funding issues that are a priority at this time.

Community Development

The community development category describes the subcommittee's organizational learning about community work and the local, regional and

provincial connections that were fostered during the HOM project. Levels of connectedness seemed to be strongest at the local level, with some information about the exhibit being shared with nearby communities. However, few or no connections were made at the provincial level.

Organizational Learning

This dimension explores the subcommittee's learning about the organizational aspects of community work. This learning is described in terms of organization, time and volunteer issues. Since organizing is a key part of the HOM project, participants found that these issues affected all facets of the project.

Table 3. Respondent's Community Development Experiences

Dimension	Focus Group and Survey Responses
a) Organization Organizational learning was recounted in focus group discussions. While the subcommittee members preferred not to discuss their own working relationships as a group, direct and indirect comments indicated that most of the work was carried out by two subcommittee members. This depiction was not refuted by the other subcommittee members, and was also indicated in a support letter presented	*There might even be some recommendations for the things that you are going to need to do, and the kinds of committees you might like to strike (i.e. the communications committee, the set-up committee etc.), so that all of these various sundry activities get accomplished. That might co-ordinate those efforts and the bodies a little bit more efficiently, so that the load gets spread out and people are aware of what they are*

to these two members, congratulating them on their work. Given the distribution of the subcommittee workload, and the time issues discussed above, subcommittee members felt that they could have organized the HOM project more efficiently by having a larger governing body and by spreading tasks and responsibilities more evenly amongst committee members and volunteers. A stronger organizational structure would likely reduce workloads and stress levels, while inducing more active participation from the community sectors at the table.	*committing to (focus group participant).* Survey respondents echoed the importance of organization in their advice for future tours as they suggested, communities: *Get lots and lots of diverse help! Thinkers, doers, planners, socialites, movers-shakers...(survey respondent #1).* *Organize well and distribute responsibilities (survey respondent #4).* Additionally, one respondent enthusiastically encouraged communities to: *Go for it! [This is a] <u>good</u> exhibit. [The] message gets out and networking with others is great fun! (survey respondent #2).*
b) Time Issues The time dimension encapsulates the time issues subcommittee members faced. Subcommittee members did not realize the amount of time involved in working on the HOM project. The time commitment (and subcommittee task distribution) resulted in an unsuccessful attempt to access financial support from one of the community sectors. Similarly, one subcommittee member described the unanticipated workload as prohibiting her from pursuing other funding sources.	*For me I didn't feel like [the time commitment] was a burden. [The time commitment] was stressful but it wasn't a burden. And, I never thought scrap [the HOM project] because of the time commitment, but my board was not committed to the reason that this exhibit was important. They were interested in the partnership aspect. And, I can't judge why they made the decision [not to provide financial support], but they saw too much time commitment, which cost [them] money (focus group participant).*
c) Volunteers The volunteer dimension reflects the individual support issues that arose	Additionally, one of the women who carried out a lot of the workload stated:

during the HOM project. Subcommittee members learned the importance of having access to a substantial volunteer pool. The subcommittee needed more volunteers than they anticipated to work on the committee and HOM project tasks. Some members felt that access to volunteers with flexible hours was important for some of the last minute subtasks related to the exhibition's installation.	*I guess my comment is that I don't think we had enough bodies. And, for me it was way too much [work]. It was hugely stressful and I think there's a better way of delegating that stuff, if you have enough bodies interested in being involved (focus group participant).* Two survey respondents also indicated that the HOM project could have used more volunteer support. One woman commented on the importance of thorough organization, stating that *As [we] discussed [in the focus group], the* HOM project *requires a lot of person hours to organize or operate. We could have used more help (survey respondent #4).*

Community Connections

Despite the organizational issues described above, the subcommittee did establish community connections. Community connections are defined as a form of networking that involves engaging or reaching out to community sectors without necessarily building a relationship or partnership. Connections range anywhere from asking for a donation to eliciting volunteers. This dimension explores the subcommittee's learning about community connections at a local, regional and provincial level.

a) Locally

At the local level, businesses and media were asked to support the HOM project through donations and advertisements or coverage. A number of local businesses agreed to provide monetary or in kind support for the HOM project. New connections were made with a law firm that donated space to house the exhibit, local bakeries and grocery stores that donated food for the opening gala, and offices and businesses that displayed poster advertisements. Support was also provided by media coverage of the HOM project. Two subcommittee members used existing contacts to send out press releases and set up interviews. Four stories were printed in local newspapers and subcommittee members were interviewed on radio and television shows. The exhibit was also advertised on the television community bulletin board.

The HOM project subcommittee also approached city council to expand the proclamation of "Eating Disorder Awareness Week" to "Eating Disorder Awareness Month". This contact formed a connection with the municipal government and February is now officially "Eating Disorder Awareness Month" in Campbell River. Not surprisingly, four out of five survey respondents stated that the HOM project was a very useful way to raise the organization's profile locally.

Locally,

[The HOM project] may help us with funding [at a local level] (survey respondent #4).

Numerous [local] groups toured the exhibition (survey respondent #5).

All the respondents agreed that there was enough local support for the HOM project in their community. One respondent commented that their group had built up support (for disordered eating) over the previous two years. Three of the four women who responded also felt the amount of work required by the community was reasonable. One woman was unsure. One woman commented that the workload was:

#2 Reasonable, <u>not</u> too much!

Additionally, two respondents thought that ANAD had provided support at the local level. Focus group participants felt that having a specific contact person at ANAD was very helpful in the first few months of the planning process, but that a direct contact person was also needed throughout the entire project. Focus group participants and survey respondents also stated that ANAD supported the HOM project by sending the project's artistic director up for the installation. Three survey respondents also felt that the supporting written documentation was not clear enough to install the exhibit without additional support. Another woman stated that the actual use of the exhibit was supportive. Additionally, two women remarked that there was a need for more continuity in the communication between ANAD, the subcommittee, and the

moving company. One woman also felt that the artistic director's presence was both helpful and problematic and that the exhibit installation would have been quicker without her. Finally, one woman mentioned how much she appreciated the opportunity to debrief during the evaluation focus group.

b) Working Group

Local connectedness was also described in terms of the work accomplished during the HOM project. Within the Eating Disorder Program, the working relationship between the Eating Disorder Program Advisory Committee and the HOM project subcommittee was also described by respondents. One respondent felt the working relationship went fairly well despite:

> *Some communication glitches and last minute [exhibit] moves [which] were stressful. [The] volunteers came through in the end! (survey respondent #2).*

Another respondent felt that:

> *There wasn't a close working relationship [as] the [HOM project] sub-committee was formed to implement the project (survey respondent #4).*

The third respondent stated the question wasn't applicable to her situation as she was only involved with the HOM project subcommittee.

The first response seems to hint more at the working relationships in the subcommittee. The last two responses suggest that there was not a close

connection between the two groups, and that the subcommittee was more or less independently functioning.

Survey respondents were also asked to comment on HOM project activities. Respondents listed the working group activities accompanying the exhibit as follows. All five respondents listed the opening gala. Additionally, four respondents listed the school tours. One respondent also listed the invitation mailouts, and local support groups. Another respondent included the Mayor's proclamation of "Eating Disorder Awareness Month", community displays and media coverage. A third respondent listed a weight watchers tour group. These responses indicate that there was some confusion between the task work, such as mailouts, and activities such as the gala opening. Additionally, some respondents listed the school tours that took place as a result of the subcommittee invitations but were not organized by the subcommittee. These responses reflect a general confusion about the organizational process that was also displayed in the focus group discussions.

Generally speaking, the accompanying activities were described as being well received by four respondents. One respondent was unsure about the community's reaction. Commenting on current activities, two respondents indicated that disordered eating support groups and individual counselling activities were still running in the community. Two respondents were unsure if there were disordered eating activities running. One respondent said there were no activities at the present time. The mixed response may be explained by the

lack of current programming directly resulting from the HOM project and possibly the respondents' lack of involvement in present programming.

However, three respondents reported the advisory committee would be interested in future disordered eating projects. One respondent was unsure, and one respondent stated that:

> *If they had an art-related project perhaps we'd consider it (survey respondent #1).*

Two respondents reported interest in future community development projects. One respondent said that the project provided:

> *Good experience meeting and working with other groups! (survey respondent #2)*

Three respondents were unsure, and one respondent stated that:

> *This was more work and hours than I, or my Board felt we had committed to. But once promised, did our best for the HOM project (survey respondent #1).*

The HOM project overall was described as rewarding by three of the five respondents. The rewards were described as the number of viewers, the amount of media coverage surrounding the exhibit, the dissemination of educational information in the community, the opportunity to network, and the supportive community responses. One respondent felt the exhibit could have been busier.

c) Regionally and Provincially

Respondents were less clear about the HOM project 's regional impact. Two respondents stated that it was somewhat useful, one respondent said it was not very useful, and one respondent did not know. One respondent stated that:

Surrounding towns were informed of our project! (survey respondent #2).

Two respondents commented that they did not know whether the HOM project was a useful way to raise awareness at the provincial level. The subcommittee obviously made an effort to advertise and invite nearby communities to attend the exhibit. It is difficult to determine whether or not the exhibit impacted the region. In all likelihood, regional and provincial connectedness would have required more organization at the local level and more support from ANAD.

Awareness of Disordered Eating

This category describes the HOM project 's ability to create awareness about disordered eating. Focus group discussions and survey responses indicate both the need for greater disordered eating awareness about disordered eating as a social issue, and the HOM project 's impact on community awareness.

Lack of Awareness

Focus group discussions in particular indicated that some community members believed disordered eating to be a matter of personal choice.

> *My husband works at the [community] district and he took one of the [HOM project] posters and put it up in the lunchroom in plain view of a woman he feels has an eating disorder. Someone came in and tore it down and said, "Those kind of issues don't really exist. If someone wants to eat, if they are hungry, they should just eat. And, if they chose not to eat, that's their own problem." The person who made the comments just basically had the opinion that we are all adults in this [engineering] department or field or whatever. As if nobody who had anything like that would be there...it was a small thing that my husband realized...that a perfectly well educated individual could have an opinion like that (Focus Group Laughter).*

As a result, some areas of the community such as the medical sector (public health, nursing, and physicians) and other individuals were difficult to engage around the issue.

> *We probably liaise more with the physicians in town than anybody else at the table, so I was very disappointed that no doctors came out, at least for the [Gala] opening. I know that [the physicians] are out there with their own set of beliefs, perceptions, and attitudes about the young women that we sometimes get as clients. And, it's very disturbing that they are not willing to educate themselves more, because I don't think they really understand what they are dealing with. [The physicians] deal with [disordered eating] only from a medical perspective and they often lose patience very quickly with the teenage girls, because they think [the clients] are just being insolent non-compliant teenagers (focus group participant).*

As mentioned above, these experiences indicate the need to develop more comprehensive strategies for involving misguided individuals in the HOM project.

Developing Awareness

In contrast, focus group participants and survey respondents described what they learned about disordered eating while working on the HOM project. One focus group participant stated that:

> *Certainly one of the misconceptions [I held] was that [a greater number of] younger women would be affected [by disordered eating]. But over the duration of the show, I certainly started to change my opinions about that. Although I knew there wasn't ever an exclusive category [of people affected by disordered eating], I started to learn more about the demographics. So, that [was] my benefit from it (focus group participant).*

Similarly, survey participants were asked to rank their levels of disordered eating knowledge before and after the exhibit. The respondents rated themselves from somewhat to very knowledgeable about disordered eating issues. This is not too surprising, given their interest and involvement in the HOM project. Responses also indicate that respondents who did not identify themselves as very knowledgeable about the issues indicated some learning about the continuum and societal aspects of disordered eating. Table 4 depicts these responses.

Additionally, survey respondents identified the disordered eating philosophy presented in the HOM project as:

You are fine-however you look-whatever your size (survey respondent #1).

The model image is unnatural and dangerous to our health! (survey respondent #2)

Women in particular are bombarded with unfair or poisonous messages that often result in destructive habits, behaviours, and low self-esteem. There is a more positive way of acceptance of life if you don't allow yourself to get sucked into this swamp (survey respondent #4).

Survey respondents identified learning new information about disordered eating and about prevention. Learning about disordered eating was listed as:

a) *[disordered eating] is still mostly a female concern(survey respondent #1);*
b) *disordered eating affects mental states of reasoning (survey respondent #1);*
c) *only two percent of us really look like the models (survey respondent #2);*
d) *how all-consuming the struggle to be thin can be (survey respondent #2);*
e) *the actual "model" measurements will create major problems with menstruating, child bearing, etc(survey respondent #2);*
f) *the history of concern for physical shape(survey respondent #5), and*
g) *the statistics about disordered eating (survey respondent #5).*

Prevention learning was identified as:

a) *moms and some dads brought their kids to learn (survey respondent #2);*
b) *art is a great way to communicate (survey respondent #5), and*
c) *people are attracted to different mechanisms for passing on information.*

In addition to their own learning, all five respondents' felt the HOM project had created disordered eating awareness in their community. Two of the respondents stated that:

> *[the HOM project] validated [the] existence [of disordered eating] (survey respondent #1).*

> *[I] have had several comments from various sources about how the exhibit impacted people (survey respondent #2).*

Community viewers also included their thoughts in a comment book at the exhibit. Some of the comments are included below.

> *[The exhibit] helped me to find more strength to keep trying to be positive and get better. Great exhibit and very informative. Thank you (exhibition viewer).*

> *I believe [this type of exhibition] is one of the best forms of bringing attention and focus to society. It is subtle enough to touch our hearts in a personal way yet strong enough to make a bold statement (exhibition viewer).*

> *A wonderful exhibit for young women [in particular] to explore the influences and pressures of society on them (exhibition viewer).*

> *As an art therapist, I'm so delighted to see this expression of what the "reality" is in our culture regarding images; art is a universal language (exhibition viewer).*

Table 4. Survey Respondent's Disordered Eating Knowledge Before and After

Knowledge of:	Before:	After:
the unattainable physical ideals found in fashion magazines	• 2 knowledgeable • 3 very knowledgeable	• 1 knowledgeable • 4 very knowledgeable
the impact of media images on girls and women	• 2 knowledgeable • 3 very knowledgeable	• 2 knowledgeable • 3 very knowledgeable
the problem with diet/weight-loss programs	• 4 knowledgeable • 1 very knowledgeable	• 3 knowledgeable • 2 very knowledgeable
Anorexia nervosa	• 2 somewhat • 2 knowledgeable • 1 very knowledgeable	• 4 knowledgeable • 1 very knowledgeable
Bulimia nervosa	• 2 somewhat • 2 knowledgeable • 1 very knowledgeable	• 4 knowledgeable • 1 very knowledgeable
Compulsive eating	• 3 somewhat • 1 knowledgeable • 1 very knowledgeable	• 2 somewhat • 2 knowledgeable • 1 very knowledgeable
fat prejudice	• 2 somewhat • 1 knowledgeable • 2 very knowledgeable	• 3 knowledgeable • 2 very knowledgeable

The above comments are encouraging as they indicate the potential for learning while working on the show, and the ability to reach viewers with a number of messages about support, prevention, and societal influences.

Funding Reallocation

The funding reallocation category represents the possibility for the HOM project to influence funding resources as an off shoot of the project. Focus group discussions briefly touched on this issue, stating that they hoped that bringing the HOM project to their community would assist them in finding funds for the next year. The Eating Disorder Program Co-ordinator was currently in the process of submitting a funding proposal for additional monies at the time of the second focus group.

Additionally, two survey respondents indicated that the program was currently in the process of fundraising for next year, so they could not fully comment on the success of new funding or funding reallocation at this time. However, as one respondent stated the HOM project had the potential to influence local funders and one respondent enthusiastically mentioned

> *At least, funders have heard more about what we're about now! (survey respondent #2)*

Similarly, another respondent stated that the HOM project was useful, because

> *any form of public awareness can only be helpful in securing funding (survey respondent #5).*

Responses suggest that the HOM project was a good way to raise the Eating Disorder Program's profile through community development, cross-sector relationship building, and raising awareness. At this time, it is difficult to assess the ability of the HOM project to help secure future funding.

Overview

Overall, the Eating Disorder Program successfully set up a working subcommittee of five people from three community sectors. The Eating Disorder Program focused on a partnership with the art sector while connecting with other sectors of the community. Partially for this reason, the bulk of the workload was distributed between two people on the subcommittee. The uneven distribution of tasks made the HOM project seem too demanding to the art sector, and for this reason they declined to provide additional grant money to support the HOM project. This learning indicated that while different sectors of the community may participate in the HOM project, their level of involvement will vary. This distinction revealed three levels of involvement in the HOM project that are described as connections, relationships and partnerships. This learning also indicated the importance of a strong organizational structure to plan and implement the HOM project and accompanying activities.

Despite the uneven workload, the working subcommittee did well to elicit interest and support from the various community sectors. Subcommittee members were able to engage individuals or "champions" who sold their sector on the HOM project. As mentioned above, school tours and promotion in a local fitness centre resulted from invitations and networking with contacts in these areas. In this sense, the subcommittee was able to form connections and begin to establish relationships. The HOM project gave the subcommittee the opportunity to begin establishing the foundation for future work with different parts of the community such as the fitness sector. This learning uncovered the importance of engaging dedicated individuals to promote the HOM project in their area.

Generally speaking, focus group participants and survey respondents described the exhibit as a good way to raise the Eating Disorder Program's profile in the community. The impact of the HOM project on funding resources could not be assessed at this time, but was considered to be part of the motivation for hosting the HOM project. Awareness about disordered eating and prevention was reported in focus group observations, survey responses, and in the exhibition comment book. Work on the HOM project also identified areas in the community that have lower levels of awareness about disordered eating issues and the need to develop better strategies to reach these audiences. Additionally, subcommittee members discussed their choice to focus on creating

awareness in the community and to use the HOM project as a prevention piece rather than as a community development tool.

The above findings will be discussed in relation to disordered eating research, teamwork, and partnership building literature in the following chapter along with specific project recommendations and suggestions for future research.

Chapter 5 Discussion

Relationship of Findings to the Literature

The purpose of this study was to evaluate the efficacy of the HOM project in facilitating cross-sector working relationships, community connectedness, disordered eating awareness, and funding resources. This section identifies the relevance of my study's findings to disordered eating research and literature related to practice, teamwork, and partnership building.

Prevention vs. Community Development

My study provides data indicating that there was a tension between the community's interest in prevention work and the HOM project's community development approach. Findings indicate that the subcommittee focused their efforts primarily on creating community awareness about disordered eating rather than on relationship or partnership building. This finding is understandable given the nature of the problem and the commitment of workers to challenge the status quo. The finding is also understandable in the context of other work in the disordered eating field. As mentioned in Chapter 2, work in the disordered eating field is currently split between prevention and treatment initiatives and there is usually a tension between these workers.

Not surprisingly, it is often a challenge to convince prevention and treatment workers to come together at the same table to discuss disordered

eating issues. For example, one of the HOM subcommittee members relayed a local health clinic worker's story about a doctor who made a rather dismissive comment about the project in her work place. This doctor actually threw out the gala notice in front of her, without sharing the invitation with other staff members. Enticing discussions between treatment and prevention workers certainly proved to be a challenge Campbell River faced when trying to engage the health sector to work on the HOM project.

Learning

As mentioned in Chapter 2, a community development approach is new in the disordered eating field, and aims to address oppressive societal structures. Therefore, workers may be unfamiliar and more comfortable with prevention or treatment focuses. This is likely part of the reason why Campbell River chose to use the HOM project as a prevention piece. Workers in Campbell River also identified consciousness raising as a priority. Creating awareness is most often associated with prevention work. Openness to a focus on prevention and education was indicated by candid examples of personal learning shared by the focus group and survey respondents. The concern (about displaying the exhibit in a public centre) expressed by some influential community members also indicated the need for greater awareness about the issue. This level of concern about the exhibition content was not anticipated. However, the subcommittee

members found a creative solution to dealing with these concerns by posting a disclaimer on the front door and finding a less central location to house the exhibit. While these kinds of reactions are consistent with the daily experience of many advocates working in the field, it indicates the need for greater awareness around the issue, and for strategies to reach such challenging individuals.

Relationship or partnership building, on the other hand, is associated with a community development approach. Given the focus group comments and the current practice dichotomy between treatment and prevention, the Campbell River workers seem to consider the different approaches to be mutually exclusive or the focus on relationship building to be less important. The mixed survey responses about cross-sector work also indicated a general confusion about the definition of community development.

Organization

The community's focus on prevention also helps to explain some of their project organization experiences. The time, volunteer, organization, and task distribution difficulties that were discussed during the evaluation seemed to be partly the result of the subcommittee's inexperience with the needs of a community development project. Generally speaking, most prevention projects do not require the same amount of co-ordinating as community development projects. Many prevention projects, for example, work on a smaller scale and usually involve interactions between fewer people (Friedman, 1999; Friedman,

2000; Levine, 1999; Levine and Smolak, 1997; Rice, 1996). Prevention projects may involve introducing lesson plans, working with staff in a school or similar organization, or running peer support groups, but few prevention projects require the same amount of cross-sector work.

As described above, the HOM project requires involvement with at least three sectors of the community. The subcommittee found that working in this way involves time, organization, and individuals. Subcommittee members identified their challenges as the lack of time to implement the project, the confusion in the subcommittee about role definition and task distribution, communication issues between group members around the workload and rejected grant proposal, along with communication difficulties with ANAD and the moving company. For example, difficulties arose when the moving company did not relay some of the location specs to their driver, and the driver was unprepared and unwilling to deal with some of the manual demands the unloading site necessitated. As a result, the committee had to request assistance from a local company to assist in the move. The subcommittee had not anticipated these kind of unexpected or last minute challenges. They described them as stressful and thought they could be prevented in the future.

Research on cross-sector work supports the subcommittee's experience, stating that the most frequent problems reported in the field are lack of time and organization, and poor communication (Seebaran, 1995). To circumvent these issues, Skage (1996) stresses the importance of clearly communicating goals and

objectives and using common language. Organization is described as effective when workers have a common understanding of individual and joint responsibilities, and are kept apprised of new developments. Discussing problems and resolving conflicts quickly are also considered good ways to ease communication amongst co-workers and agencies (McKay, Soothill and Web, 1998).

Research also recognizes the time and energy commitment initially involved in working relationships and partnership development (Skage, 1996; McKay, Soothill and Web, 1998). Not surprisingly, many feel that collaborative work requires an unaffordable investment of time, energy, and commitment (Seebaran, 1995). However, this work is also viewed by some as having the potential to offset workloads in the long-term (Skage, 1996).

The organizational experiences of the subcommittee are reflected in the research on community work. It is also likely that the subcommittee's use of the project as a prevention piece further intensified these issues.

Learning

The findings also indicate that ANAD members have to be mindful of the newness of the community development approach in the disordered eating field and mentor the approach in practice. In much the same way as professionals who work in multidisciplinary teams need to be educated about teamwork

(Payne, 2000; Pritchard, 1995), different community sectors will need support while they learn about collaborative efforts.

To address some of the working group challenges, future communities could be encouraged to incorporate more process characteristics into their committee work. For example, Payne's (2000) review of the literature identifies important aspects of team process as a willingness to: a) share knowledge; b) learn from others; c) share and take on aspects of work; d) accept information from different sources; e) work on team relationships in a structured and planned way; f) allow members to guide the team when appropriate; g) identify the reasons for mistakes; and, h) learn from mistakes. Incorporating the process aspect of group work would encourage regular debriefing, help to eliminate additional stresses, and foster stronger working relationships.

Despite these organizational challenges, the community felt they had an opportunity to create a voice and build support around disordered eating at a local level. The focus group findings indicate that the subcommittee was able to engage community sectors to contribute to the exhibit in some way, despite inexperience with the organizational aspects of a community development approach. Engaging community sectors in this way enabled the community to initiate a dialogue around disordered eating at the local level for the first time. By encouraging a community development approach, ANAD members hope to model a means of bringing together diverse philosophies and backgrounds to work toward building community accountability. However, the focus group

findings indicate that past experience with community work did not necessarily demystify a community development approach.

For these reasons, along with the prevention and organizational issues mentioned above, ANAD could actively mentor its community development approach in practice. Mentoring would involve providing communities with more information about what a community development approach in the HOM project entails. This information could be set out in a manual or workshop, and could include tips on: a) how to get started (i.e. introducing the idea to the community and forming a subcommittee), b) how to find interested community members, c) group process skills, d) building partnerships, e) installation set up, and f) curriculum development.

Connections and Relationships

Data from the pilot project also indicated that there were different levels of community involvement, which I described in the "Findings section" as connections, relationships, and partnerships. As previously discussed, connections are a form of networking that involve engaging or reaching out to community sectors without necessarily building a relationship or actively engaging them in an organized way. Partnerships are deeper commitments that include collaborative work, an understanding of each other, and active

involvement of all partners in building a mutually beneficial relationship. Relationships fall in between.

This learning about working relations distinguishes a fundamental difference between networking and community development. In a general sense, the connections I have described above involve linking or networking with people on a relatively superficial level. In a technical sense, networking can be understood as a process of simplifying complex relations with points in a network representing individuals or groups, and the lines between points representing their connection. The number of links between individuals can vary greatly, but links are considered to be stronger when they are used frequently. The strength and quality of network links are also described as a network's density and weight. The presumption is that a dense network is the best with a network's quality also being assessed in different terms, such as efficiency (Payne, 2000). Connections or links, then, vary in strength and are a facet of networking that may be used as a resource in community work. For example, the subcommittee used its (networking) connections with the education and health sector to send out invitations to the exhibit.

In contrast, the concept of relationships stems from the subcommittee and its group interactions and working relationship during the HOM project. These relationships are similar to aspects of teamwork, which, is described as collaboration between people in regular working relationships concerned with the same group of people (Payne, 2000). Similarly, the three core activities of an

effective group are outlined as: 1) accomplishing goals, 2) maintaining good working relationships among members, and 3) developing and adapting to changing conditions to improve group effectiveness (Johnson and Johnson, 1994).

The similarities in the subcommittee interactions and teamwork descriptions help to illustrate how there are different levels of involvement between connections and relationships. The distinction between connections and relationships is further reinforced in the teamwork literature as Payne describes networking (connections) and teamwork as opposite points on a continuum (2000).

Relationships also vary in degree, which Payne may consider to be a more advanced stage of teamwork. In this study, however, a deeper relationship is described as a partnership. A partnership involves forming, nurturing, and maintaining a deeper relationship. In community development partnerships, organizations are being encouraged to get to know themselves and the organizations they are working with. The intent of the HOM project was to foster this kind of relationship building.

As mentioned in the findings section, the partnership aspect of the project was not developed in the pilot. However, the following section will reflect on descriptions of partnerships in the literature and the importance of emphasizing this aspect of the project in future tours.

Partnership Building

Partnership building is discussed in a small portion of the social work literature in terms of collaboration and coordination (Lopez, Torres and Norwood, 1998; Payne, 2000; Seebaran, 1995), in family literacy projects (Skage, 1996), and in management research and practice (Payne, 2000; Rockandel, 2000). Partnerships are defined as long-term commitments to collaborative work that involve co-ordination and planning to achieve a goal (Payne, 2000). The above bodies of literature also state that the key to successful partnerships involves knowledge of your organization and your potential partner. The first step in partnership building is to develop a thorough understanding of: 1) your values; 2) what you do as an organization; 3) your goals and objectives; 4) how you want to accomplish your goals and objectives; 5) how your organizational structure works; 6) your organization's resources; and, 7) how you want to communicate your mission, values, and vision. Similarly, you must be familiar with your potential partner's characteristics, understand their priorities, strengths and challenges, whether or not your organizations are compatible, and how your partnership will be beneficial (Rockandel, 2000; Seebaran, 1995, Skage, 1996).

Additionally, Lopez, Torres and Norwood (1998) discuss the process and successes of partnership building in a social work and education initiative. In this project, initial planning efforts focused on establishing a working relationship through formal sharing of respective project visions and expectations. Researchers used Hanley, Johnson-Crawley and Gehrke's 1996

conceptual framework and described the levels of collaborative competencies as *intrapersonal, interpersonal, and interprofessional. Intrapersonal competence* refers to the expectation of workers to adopt a routine of personal reflection and self-awareness, where awareness is developed about beliefs, values, and thoughts about collaborative practice. Second, *interpersonal competence* refers to ongoing individual and collective efforts to develop, maintain, and nurture collaborative relationships in the partnership building process. Researchers note the importance of an appreciation and respect for relationships and willingness to share of self in this process. For example, respect was described by social workers and educators as exploring personal and professional values in relationship interactions, including ideas and knowledge from all perspectives, and a discussion of their personal and professional experiences. Third, *interprofessional competence* encompassed group process skills, original moxie, and socio-cultural understanding. Social workers and educators also described the following characteristics as important: a) a shared vision, b) knowledge of critical issues, c) awareness of professional differences, and d) skills at collaboration and collective power.

Given the findings on collaboration, researchers also recongnize how difficult it is to incorporate these principles in practice. McKay, Soothill and Web (1998) state that it is hard enough working well intraprofessionally with one's own colleagues: communicating with those who have been trained in different traditions is an added challenge. In the health care field, most professionals are

trained to function both independently and autonomously, and as a result learning to work as part of a team is not always easy. Additionally, as mentioned above, collaboration and participation can be frustrating, time-consuming, and a burden to already overstretched staff. Therefore, researchers caution us to be mindful of these difficulties when assessing practice.

Limitations of My Study

My study considers important information about community connections and partnership building in the HOM project. However, my study is also limited in some respects. First, the qualitative aspects of the design and the small sample size limit the generalizability of the data to a larger population (Kvale, 1996).

Second, the evaluation did not explore the exhibition viewers' disordered eating awareness before and after experience of the exhibit in detail. Future project evaluations need to consider this aspect of the project.

Third, the subcommittee's prevention focus and lack of concentration on partnership building did not provide the opportunity for this evaluation to assess the full capabilities of the HOM project in terms of funding reallocation in Campbell River. Thus, the impact of community development on funding reallocation could also be studied further.

Finally, the self-report nature of the focus groups and survey responses also present limitations, as the contributions of research participants are reliant

on their motivation to accurately articulate their experiences, and their willingness to disclose information (Kreuger 1994; Kvale 1996). Additionally, the research may have been impacted by the narrow time frame for building trust with focus group members in the research relationship (Ristock and Pennell, 1996) and in the evaluative nature of the project.

Implications for Practice and Future Research

Despite the above limitations, the findings of my study have important implications for the profession of social work. These implications include relationships and partnerships in practice, training and education, and policy and funding issues.

Relationships and Partnerships in Practice

The study suggests that relationship and partnership building need to be encouraged and supported in practice. Whether they practice clinical or community work, social workers are constantly building relationships with clients and other professionals. Applying the partnership principle to cross-sector relationships will help community workers to strengthen their current projects and assert the social mobilization aspects of community work. Many community development projects are put on by one or two organizations. While these initiatives are valuable, community workers could start to address some of their financial concerns by using opportunities like the HOM project, and by

taking the time to build strong partnerships and to branch out into other sectors of the community.

As social workers, we must also take responsibility for promoting cross-sector relationships and for demystifying the partnership building process. If we value the principle of inclusiveness, we must model inclusiveness in our practice through interdisciplinary teamwork and cross sector working relationships, which encourage collective work. As community workers, we must also encourage future research in this area.

Training and Education

The study identifies the need to encourage the principles of inclusiveness and partnership building in university training programs. Pritchard (1995) notes that the traditional approach to primary health care involved putting different professionals together and expecting them to work with each other, without joint training. He argues that while team members may be very skilled at their own jobs, few have received any education or training in how to work together as an effective team. This was indicated in the difficulty some members of the subcommittee had discussing and dealing with process issues during the project.

Beatie (1998) and Payne (2000) also discuss boundaries and conventional divisions between professionals created in the health care services. Beatie ascribes these boundaries to a socialization process within educational

institutions which favour curriculum development that separates subjects to dissuade students from comparison. This principle can also be seen in some university social work departments, like the University of Alberta which may encourage a division in the department between clinical and community work by encouraging students to choose one area of specialization. While this separation, may also be intended to ensure community work is taken seriously and not lost in a "mainstream" curriculum, a more integrative approach could minimize this separation by making some community work courses mandatory. For example, students in the Master of Social Work Program at the University of British Columbia "community focused" are able to take a range of courses in counselling skills. Despite this more integrated curriculum approach, during my course work I could not enrol in any family therapy courses because they were offered at the same time as one of the main community courses.

To support the study of community work, then, university social work departments could make their courses a fundamental part of social work learning. Encouraging and including the study of both community and counselling courses would also support these principles.

Policy and Funding Issues

The findings of my study indicate that inclusiveness and partnership building need to be supported with policies that reflect and back these principles

in practice. The regionalization of health care services in British Columbia has led to an overall need for the collaboration of services with the aim of providing services, based on people's needs while co-ordinating the planning and delivery of local, regional and provincial health services. The government's endorsement of regionalization supports inclusiveness and partnership building to a certain extent. Regionalization is considered to be the most cost-effective way of using limited resources, and it is not uncommon for provincial and federal funding criteria to include a demonstration of strong, significant partnerships with other agencies (Skage, 1996).

In the disordered eating field, however, there are currently no structures to support the movement to regionalization. Therefore, workers share a concern that the promotion of partnerships is a way for the government to place responsibility on community volunteers. Additionally, there is a need to take care that collaborative efforts encourage change and do not divert attention from the pervasiveness of inequalities (Skage, 1996).

To create support for alliance building and inclusiveness, social workers can incorporate the principles outlined above into their practice. The first step is for social workers to become involved, and they can begin on an individual basis by educating themselves about disordered eating and available resources. Social workers can also encourage clients to take their concerns to the appropriate forum in their area. In Vancouver, consumer concerns are voiced at the Consumer Advisory Committee, which meets bi-monthly. Concerns can also be

raised by social workers when they attend practice, policy, and research meetings, such as the ones held by the B.C. Centre of Excellence for Women's Health. Similarly, collective work could involve alliance building within communities and with the B.C. Coalition to End Disordered Eating. Social workers can participate and encourage participation in community work like the HOM project, and encourage policy makers to use these principles to develop reflective and supportive policy.

Summary

Overall, the pilot project went well in Campbell River and the evaluation provided ANAD members with valuable insights that have already been beneficial in planning the upcoming northern tour. This year the HOM will travel to 100 Mile House in March, to Prince George in April, and to Smithers in May. Plans are well underway with great interest expressed from community members in the three locations. Other organizations have also expressed an interest in the project. The University of British Columbia's Women's Student Office, and the Victoria based British Columbia Eating Disorder Association have recently submitted letters of intent to host the project in the upcoming year.

Given the findings, the incorporation of more direct support from ANAD members around relationships and partnership building in the HOM project will greatly strengthen these future tours. Creating nurturing and sustainable partnerships will allow disordered eating workers to move beyond the

prevention aspects of the project and strengthen their ability to create awareness and secure resources. Taking the time to build strong relationships is the first step toward strengthening organizations, while facilitating community building, and societal change.

These findings speak to the need for ANAD members to be really clear about their philosophy, and for the need to mentor a community development approach in practice. Part of this mentoring process will involve noting the differences between prevention, treatment, and community development.

As mentioned above, community development in the HOM project means moving away from prevention and treatment frameworks, but is not meant to belittle work at an individual level. Service users require individual support, but individual work can only go so far in changing the oppressive societal structures that are what ANAD members believe to be a root cause of disordered eating.

Therefore, ANAD members are encouraging a community development approach to help facilitate larger societal change. This does not mean that ANAD members are trying to control how the change happens or what the change will look like. ANAD members hope the HOM project will assist communities to create an environment for change. In order to create large-scale changes, different sectors of the community need to be involved. Thus, the HOM project encourages communities to involve the health, art, education, and business sectors of the community. Involving the whole community in disordered eating work re-frames the issue as a community issue, and the

community as a whole becomes responsible and accountable for dealing with disordered eating issues.

Strong community involvement is currently being encouraged in the northern tour. Introductory slide shows and presentations were hosted by a sponsoring organization in 100 Mile House and Prince George in the fall as a means of eliciting community interest. A number of organizations have expressed an interest in the project and Smithers is also planning to present a slide show in January. Bringing the various community sectors together to work on the project will encourage the community to work together outside of the current system to create societal change.

> *In one sense, the biggest issue facing communities and service providers is not the specific issues such as substance abuse, violence against women, and so on. Rather, it is the way we have organized ourselves to address these issues. The biggest issue, therefore, can be perceived as communities, and institutions serving them, not working effectively together. What we need to do, with enthusiasm and vigour, is to PRACTISE WORKING TOGETHER. And to keep on practising. When we become effective at this, I believe that the specific community issues will be much easier to tackle (Seebaran, 1995: 3-4).*

Suggestions for Future Tours:

- Ensure the project remains true to ANAD's community development philosophy and intent. ANAD could ask interested communities to outline how their intentions fit with this perspective prior to receiving the project.

- Facilitate a community development approach. ANAD could provide communities with more substantial information on community organizing. More in depth information would help to demystify organizational issues such as work distribution, timing, and volunteer management. This information could be developed as part of the HOM project's resource

manual, and could be delivered in a workshop format at the beginning of the project.

- Facilitate partnership building in the HOM. Provide communities with a journal that sets out learning from previous tours. This resource manual could also include practical experiences with relationship building, including relationship successes and challenges in other communities.

- Ensure the bulk of the work does not rest on one or two individuals. Communities could be encouraged to develop a volunteer pool to complete subcommittee tasks.

- Further ensure task distribution. Communities should follow ANAD's requirements for a collaborative working model that involves three strong partnerships in different sectors of the community.

- Generate more community involvement and awareness. Communities should follow ANAD's requirement of holding at least two activities to accompany the exhibit.

- Make structural changes that create support and address funding needs. The partnership aspects of the project must be actively pursued, and would ideally include keen involvement from three sectors of the community.

- Support regional and provincial work. ANAD could facilitate and support discussions between communities interested in the project. For example, ANAD could suggest the organization of a regional tour and relationship building between the participating communities.

- Fully assess the project's impact on funding. The community must embrace the community development approach. To document the process, I would suggest a six-month and one year follow up evaluation.

Bibliography

Adamson, N., Briskin, L., and McPhail, M. (1988). *Feminist organizing for change: the contemporary women's movement in Canada.* Toronto: Oxford University Press.

Addictions Research Foundation. (1996). *The Hidden Majority: A guidebook on alcohol and other drugs for counsellors who work with women.* Toronto: Addictions Research Foundation.

Adult and Drug Services. (1996). *The Biopsychosocial theory.* Government of British Columbia: Ministry of Health and Ministry Responsible for Seniors. Victoria: Author.

Asbury, J. (1995). Overview of Focus Group Research. *Qualitative health research,* 5(4), pp. 414-420.

Association for Awareness and Networking around Disordered Eating (2001). *The House of Mirrors Facilitators Manual.* Vancouver: Association for Awareness and Networking around Disordered Eating. In press.

Association for Awareness and Networking around Disordered Eating. (2000). *Developing self-awareness around disordered eating: A Research Document.* Vancouver: Association for Awareness and Networking around Disordered Eating.

Association for Awareness and Networking around Disordered Eating. (1999a). *The Association for Awareness and Networking around Disordered Eating Brochure.* Vancouver: Association for Awareness and Networking around Disordered Eating.

Association for Awareness and Networking around Disordered Eating (1999b). *Creating Change in Your Community: the House of Mirrors Project: Draft Instruction Guide.* Vancouver: Association for Awareness and Networking around Disordered Eating.

Association for Awareness and Networking around Disordered Eating. (November 1998a). *The House of Mirrors Project - Building Community around Disordered Eating.* United Way 1998 Special Projects Application Form.

Association for Awareness and Networking around Disordered Eating. (1998b). *Organizing for Change Conference Manual.* Vancouver: Association for Awareness and Networking around Disordered Eating.

Anderson, D. (1998). *Literature Review: The Context for Qualitative Research with Disordered Eating.* Unpublished Paper.

Ball, B. (1991). Ways of seeing: Perspectives on survivors and substance abuse. In Mackinnon, M. (ed.) *Each small step: Breaking the chains of abuse and addiction.* Charlottetown, Prince Edward Island: Gynergy Books. pp.140-143.

Barber, J. G. (1994). Alcohol addiction: Private trouble or social issue? Social *Service Review,* 68 (4), pp. 520-535.

Barnsley, J., and Ellis, D. (1992). Research for change: participatory action research for community groups. Vancouver : Women's Research Centre

Beatie, A. (1998). War and peace among the health tribes. McKay, K. Soothill, L., and Web, C. (eds.). *Interprofessional relations in health care.* London: Edward Arnold. pp. 11-23.

Beecher, S. (1989). A Gender Critique of Family Therapy. In Marchant, H. and Wearing. B. (eds.) *Gender reclaimed: women in social work.* Sydney, N.S.W.: Hale and Iremonger. pp. 64-79.

Berg, F. (1999). Health Risks Associated with Weight Loss and Obesity Treatment Programs. The Society for the Psychological Study of Social Issues. *Journal of Social Justice Issues.*, 55 (2), pp. 277-297.

Bernard, R. (1994). Unstructured and Semistructured Interviewing. *Research Methods in Anthropology.* Thousand Oaks: SAGE. pp. 208-243.

British Columbia's Children's Hospital (1997). *Eating Disorder Program Description.* Vancouver: British Columbia's Children's Hospital.

British Columbia Coalition to End Disordered Eating. (1998). *Winter Meeting Minutes.* Vancouver: ANAD.

British Columbia Ministry of Education. (2000). *Teaching Students with Mental Health Disorders: Resources for Teachers.* Volume 1 - Eating Disorders. British Columbia: Ministry of Education Special Programs Branch.

British Columbia Ministry of Health and Ministry Responsible for Seniors. (1998). *Revitalizing and Rebalancing British Columbia's Mental Health System: The 1998 Mental Health Plan.* Vancouver: Government of British Columbia.

British Columbia Ministry of Health and Ministry Responsible for Seniors. (1999). *Mental Health Advocacy Survey Questionnaire.* Vancouver: Mental Health Advocacy Reference Committee.

British Columbia Ministry of Health and Ministry Responsible for Seniors. (2000a). *Mental Health Advocacy Framework Project: Background Information and Consultation Questions Third Draft.* Vancouver: B.C. Ministry of Health - Adult Mental Health Division.

British Columbia Ministry of Health and Ministry Responsible for Seniors. (2000b). *Mental Health Advocacy Framework Project Report.* Vancouver: B.C. Ministry of Health - Adult Mental Health Division.

Bordo, S. (1993). *Unbearable Weight: Feminism, Western Culture and the Body.* Berkeley: University of California Press.

Brown, C. (1993a). The Continuum: Anorexia, Bulimia, and Weight Preoccupation. In Brown, C. and Jasper, K. (eds.). *Consuming Passions: Feminist Approaches to Weight Preoccupation and Eating Disorders.* Toronto: Second Story Press. pp. 53-68.

Brown, C. (1993b). Feminist Contracting: Power and Empowerment in Therapy. In Brown, C. and Jasper, K. (eds.). *Consuming Passions: Feminist Approaches to Weight Preoccupation and Eating Disorders.* Toronto: Second Story Press. pp. 176-194.

Brown, C. and Jasper, K. (1993), Why Weight? Why Women? Why Now? In Brown, C. and Jasper, K. (eds.). *Consuming Passions: Feminist Approaches to Weight Preoccupation and Eating Disorders.* Toronto: Second Story Press. pp. 16-35.

Brown, C. and Zimberg, R. (1993). Getting Beyond Weight: Women's Health Clinic Weights Preoccupation Program. In Brown, C. and Jasper, K. (eds.). *Consuming Passions: Feminist Approaches to Weight Preoccupation and Eating Disorders.* Toronto: Second Story Press. pp. 400-408.

Burstow, B. (1992). *Radical Feminist Therapy: Working in the Context of Violence.* London: Sage Publications Inc.

Canadian Conference of the Arts. (October 1997). From the Committee in Increasing the Relevance and Integration of Arts in the community. *Arts in Transition Project: Report and Discussion Paper Toward a Culture of Shared Resources.*

Carey, M.A., and Smith, M. (1994). Capturing the group effect in focus groups: A special concern in analysis. *Qualitative health research,* 4(1), pp. 123-127.

Carey, M.A. (1995). Comment: Concerns in the analysis of focus group data. *Qualitative health research,* 5(4), pp. 487-495.

Carol, G., and Brown, L. (1992). *Meeting at the Crossroads: Women's Psychology and Girl's Development.* Cambridge: Harvard University Press.

Checkoway, Barry. (1997). Core Concepts for Community Change. *Community Practice: Models in Action.* Haworth Press, Inc.

Cheetham, J., Fuller, R., McIvor, G., and Pitch, A. (1992). *Evaluating social work effectiveness.* Buckingham; Philadelphia : Open University Press.

Coates, John. (1991). Putting knowledge for practice into perspective. *Canadian Social Work Review,* 8 (1), pp. 82-96.

Cogan, J. and Ernsberger, P. (1999). Dieting, Weight, and Health: Reconceptualizing Research and Policy. *Journal of Social Justice Issues.* The Society for the Psychological Study of Social Issues, 55 (2), pp. 187-205.

Coffey, A. and Atkinson, P. (1996). *Making Sense of Qualitative Data.* Thousand Oaks: Sage.

Creswell, J. W., (1998). *Qualitative Inquiry and Research Design: Choosing Among Five Traditions.* London: Sage Publications.

DeVault, M. L. (1990). Talking and listening from women's standpoint: Feminist strategies for interviewing and analysis. *Social Problems,* 37 (1), pp. 96-116.

Dominelli, L. (1990). *Women and Community Action.* Birmingham: Venture Press.

Eating Disorder Awareness and Prevention Inc. (1999). *Go Girls! Giving Our Girls Inspiration and Resources for Lasting Self-esteem: A Curriculum for High School Girls.* Seattle: Eating Disorders Awareness and Prevention Inc.

Erensberger, P. and Koletsky, R. (1999). Biomedical Rationale for a Wellness Approach to Obesity: An Alternative to a Focus on Weight Loss. *Journal of Social Justice Issues.* The Society for the Psychological Study of Social Issues, 55 (2), pp. 221-260.

Feminist Research, Education, Development and Action Centre. (1999). *Swallowing the Hurt: Family Violence, Anorexia, and Bulimia.* Vancouver: The Feminist Research, Education, Development and Action Centre.

findlay, b. (1991). *With all of who we are: a discussion of oppression and dominance.* Vancouver: Lazara Press.

Fook, J. (1993). *Radical casework: a theory of practice.* North Sydney: Allen and Unwin, 1993.

Freeman, D. (1992a). *Family therapy with couples: the family-of-origin approach.* Northvale, N.J., London: Jason Aronson.

Freeman, D. (1992b). *Multigenerational family therapy.* New York: Haworth Press.

Friedman, S. (2000). *Nurturing Girl Power: Integrating eating disorder prevention/intervention skills into your practice.* Vancouver: Salal Books.

Friedman, S. (1999) *Just for girls: facilitator's manual.* Vancouver: Salal Books.

Gil, D., (1998). *Confronting Injustice and Oppression: Concepts and Strategies for Social Workers.* New York: Columbia University Press.

Gingras, J. (1999). *The Intersection of Weight Loss Pharmacology and Disordered Eating: Who is Accountable?* Unpublished Paper.

Gould, Ketayun, H. (1987). Feminist principles and minority concerns: Contributions, problems, and solutions. *Affilia: Journal of Women and Social Work,* 2 (3), pp. 6-19.

Harding, S. (1997). Is there a Feminist Method? In Kemp, S., and Squire, J. (eds.) *Feminisms*. Oxford: Oxford University Press. pp. 160-170.

Hart, E., and Bond, M. (1995). *Action Research For Health and Social Care: A Guide to Practice*. Buckingham: Open University Press.

Hawkins, Gay, Allen and Uwin. (1993). The Challenge of Community. *Nimbin to Mardi Gras Constructing Community Arts*. Australia: St. Leonards.

Herman, J. (1997). *Trauma and Recovery: The aftermath of violence - from domestic abuse to political terror.*. New York: Basic Books.

Hoskins, M., and Dellebuur, K. (2000). *Consuming Identities: Young Women, Eating Disorders and the Media: A Research Agenda and Annotated Bibliography*. Vancouver: B.C. Centre of Excellence.

Ife, J. (1995a). Ecology and social justice: A vision for community development. In Ife, J. (ed.) *Community Development: Creating community alternatives - vision, analysis and practice*. Australia: Longman. pp. 79-99

Ife, J. (1995b). Community development: Social, economic and political. In Ife, J. (ed.) *Community Development: Creating community alternatives - vision, analysis and practice*. Australia: Longman. pp. 131-153.

Jasper, K. (1993). Out from Under Body-Image Disparagement. In Brown, C., and Jasper, K. (eds.). *Consuming Passions: Feminist Approaches to Weight Preoccupation and Eating Disorders*. Toronto: Second Story Press. pp. 195-217.

Johnson, David and Johnson, Frank. (1994). Effective Groups and Effective Group Skills. *Joining Together: Group Theory and Group Skills*, (5th edition). Boston: Allyn and Bacon. pp. 23-28.

Kasl, C. D. (1992). *Many roads, one journey: Moving beyond the 12 Steps.* New York: Harper Collins.

Katzman, M., and Lee, S. (1997). Beyond Body Image: The integration of feminist and transcultrural theories in the understanding of self starvation. *International Journal of Eating Disorders*, 22, pp. 385-394.

Kvale, S. (1996). *Interviews*. Thousand Oaks, CA: Sage.

Kitchener, P. (1999). *Food is not the Issue 1.* Building Community Accountability: Redefining Disordered Eating Conference. Vancouver, Canada. May 1998. Plenary Session. Video taped by the Association for Awareness and Networking around Disordered Eating.

Kirby, S. and McKenna, K. (1989). Experience, research and social change: Methods from the Margins. Toronto: Garamond Press.

Kreuger, R. A. (1994). *Focus groups: A practical guide for applied research (2nd edition).* Thousand Oaks, CA: Sage.

Lacy, S. (1995). Debated Territory: Toward a Critical Language for Public Art. In Lacy, Suzanne (Ed.). *Mapping The Terrain: New Genre Public Art.* Seattle Washington: Bay Press. pp. 171-185.

Larkin, J., Rice, C., and Russel, V. (1999). Sexual Harassment and the Prevention of Eating Disorders: Educating Young Women. In Levine, M., Piran, N., and Steiner-Adair, C. (eds.) *Preventing eating disorders: a handbook of interventions and special challenges.* Philadelphia, PA: Brunner/Mazel, 1999. pp. 194-207.

Larsen, Gary O. (1997). Culture and Community. *American Canvas: An Arts Legacy for Our Communities.* United States: National Endowment for the Arts. pp. 75-90.

Levine, M., Piran, N., and Steiner-Adair, C. (1999). *Preventing eating disorders: a handbook of interventions and special challenges.* Philadelphia, PA: Brunner/Mazel.

Levine, M., and Smolak, L. (1997). The mass media and disordered eating: Implications for primary prevention. In Vandereycken, W., and Noordenbos, G. (eds.) *The Prevention of Eating Disorders.* New York: New York University Press. pp. 23-56.

Levine, M. (1996). *The Prevalence of Eating Disorders: Some Tentative "Facts".* Seattle: Eating Disorder Awareness and Prevention.

Lopez, Torres and Norword. (1998). Building Partnerships: A Successful Collaborative Experience between Social Work and Education. *Social Work in Education,* 20 (3), pp. 165-175.

MacDonald, Gayle. (2001). Girls under the Knife. *The Globe and Mail,* January 13th, www.workopolis.com

MacNeil, T. (1997). Assessing the Gap between Community Development Practice and Regional Development Policy. In Wharf, Brian., and Clague, Michael. (eds.). *Community Organizing: Canadian Experiences.* Toronto: Oxford Press. pp. 149-163.

McInnis, B. (1993). Fat Oppression. In Brown, Catrina, and Jasper, Karen. (eds.). *Consuming Passions: Feminist Approaches to Weight Preoccupation and Eating Disorders.* Toronto: Second Story Press. pp. 69-79.

McKay, R. (2000a). *Notes from the Provincial Eating Disorder Steering and Advisory Committee.* Association for Awareness and Networking around Disordered Eating: Email Correspondence.

McKay, R. (2000b). *ANAD Steering Committee Minutes September 2000.* Vancouver: Association for Awareness and Networking around Disordered Eating.

McKay, R. (1998). *The Proposed Use and Implementation of the Needs Assessment Prepared for the Provincial Eating Disorder Advisory Committee.* Vancouver: Association for Awareness and Networking around Disordered Eating.

McKay, L., Soothill, K., and Web, C. (1998). *Interprofessional relations in health care.* London: Edward Arnold.

Marchant, H., and Wearing. B. (1986). *Gender reclaimed: women in social work.* Sydney, N.S.W.: Hale and Iremonger.

Martineau, Sheila. (2001). The Risky Business of Translating Resiliency Research into Advocacy Practice. *B.C. Institute against Family Violence Newsletter.* Vancouver: B.C. Institute against Family Violence, 7 (3), pp 18-21.

Maxwell, J. A. (1996). *Qualitative Research Design: An Interactive Approach.* London: Sage Publications.

Melody, P., Miller, A., Miller, K. (1989). *Facing Co-dependency: What It Is, Where It Comes From, How It Sabotages Our Lives.* San Francisco: Perennial Library.

Miller, W. (1999). Fitness and Fatness in Relation to Health: Implications for a Paradigm Shift. The Society for the Psychological Study of Social Issues. *Journal of Social Justice Issues,* 55 (2), pp. 207-219.

Milner, .J and O'Bryne, P. (1998). The Weather Map: Anti-oppressive Practice. In Milner, J. and O' Bryne, P. *Assessment in Social Work.* Macmillan Press Ltd. In Press.

Morgan, D. (1995). Pearls, Pith, and Provocation: Why Things (Sometimes) Go Wrong in Focus Groups. *Qualitative Health Research,* 5(4), pp. 516-523.

Moore, S. (1998). *Mapping Resistance on the Body: Intersections of Violence, Anorexia, and Bulimia in Girls.* Vancouver: Feminist Research, Education, Development and Action Centre.

Morrow, Marina, and Chappell, Monika. (1999). *Hearing Women's Voices: Mental Health Care for Women.* Vancouver: B.C. Centre of Excellence.

National Eating Disorder Information Centre. (1985). *An Introduction to Food and Weight Problems.* Toronto: National Eating Disorder Information Centre.

Niblock, A., and Anderson, D. (1998). *Needs Assessment of Eating Disorder Services in British Columbia.* Vancouver: B.C. Provincial Eating Disorders Steering Committee.

Office on Women's Health. (1999). *Body Wise Handbook: Eating Disorders Information for Middle School Personnel.* Washington: U.S. Department of Health and Human Services Program Support Centre.

Orbach, S. (1999). *Why is this a Disorder?* Building Community Accountability: Redefining Disordered Eating Conference. Vancouver, Canada. May 1999. Plenary Session Video tape. Association for Awareness and Networking around Disordered Eating.

Orbach, S. (1994). *What's Really Going on Here? Making Sense of Our Emotional Lives.* London: Virago.

Orbach, S. (1986). *Hunger Strike: the anorectic's struggle as a metaphor for our age.* London: Faber.

Padgett, D. (1998). The Researcher as Instrument. *Qualitative Methods in Social Work Research.* Thousand Oaks: SAGE. pp. 18-24.

Payne, M. (2000). *Teamwork in multiprofessional care.* Basingstoke: Macmillan.

Payne, M. (1991). Radical and Marxist Approaches. *Modern Social Work Theory: A Critical Introduction.* Chicago, IL: Lyceum Books.

Payne, M., and Campling, J. (1997). *Modern social work theory.* Houndmills, Basingstoke, Hampshire: Macmillan.

Piran, N. (1999). On the Move from Tertiary to Secondary and Primary Prevention: Working with an Elite Dance School. In Levine, M., Piran, N., and Steiner-Adair, C. (eds.) *Preventing eating disorders: a handbook of interventions and special challenges.* Philadelphia, PA: Brunner/Mazel, 1999. pp. 256-269.

Prevention Project Advisory Committee. (2000). *Preventing Disordered Eating Among Youth: A Proposed Framework for British Columbia.* Draft Consultation Paper. Vancouver: Ministry of Health and Ministry for Children and Families.

Poople, K. (1995). *Analysing community work: its theory and practice.* Bristol, Pa.: Open University Press, 1995.

Poulton, Terry. (1996). *No Fat Chicks: How Women are Brainwashed to Hate Their Bodies and Spend Their Money.* Toronto: Key Porter Books, 1996.

Pritchard, P. (1995). Learning to work effectively in teams. In Owens, P., Carrier, J., and Horder, J. (eds.). *Interprofessional issues in community and primary health care.* London : MacMillan. pp. 205-231.

Prokop, C. (1998). Canada Council ventures into community art. *Artichoke.* Vancouver. Summer. pp. 18-25.

Reinharz, Shulamit. (1992). *Feminist methods in social research.* New York: Oxford University Press.

Rice, C. (1996*). Dismantling Old Myths, Building New Models: Emerging Approaches to Promoting Healthy Body Image and Preventing Eating Disorders.* Toronto: Ontario Prevention Clearinghouse.

Riger, S. (1992). Epistemological Debates, Feminist Voices: Science, Social Values and the Study of Women. *American Psychologist.* pp. 730-740.

Riskock, J.L., and Pennell, J. (1996). Community Research as Empowerment: Feminist links, Postmodern Interruptions. Toronto: Oxford University Press.

Rockandel, K. (2000). *The Working Workshop: Developing Strategic Marketing Partnerships.* Vancouver: Rockandel Associates.

Rothblum, E. (1999). Contradictions and Confounds in Coverage of Obesity: Psychological Journals, Textbooks, and the Media. The Society for the Psychological Study of Social Issues. *Journal of Social Justice Issues*, 55 (2), pp. 355-369.

Rothman, J. (1995). Approaches to community intervention. In. Rothman, J., and Erlich, J., and Tropman, J. (Eds.) *Strategies of Community Intervention.* (5th edition). Itasca, Ill: Peackock. pp. 26-63.

Schoenfielder, L., Wieser, B., and Mayer, V. (1983). *Shadow on a Tightrope: Writings on Fat Oppression.* San Francisco: Aunt Lute Books

Seebaran, R. (1995). *Inter-agency and Community Collaboration: Working Together Effectively.* Summary of Child and Youth Committee Networking Conference. Comox Valley, Canada.

Siegler, A. (1993). Grieving the Lost Dreams of Thinness. In Brown, C., and Jasper, K. (eds.). *Consuming Passions: Feminist Approaches to Weight Preoccupation and Eating Disorders.* Toronto: Second Story Press. pp. 151-160.

Sesan, R. (1994). "Feminist inpatient treatment for eating disorders: An Oxymoron?" In Fallon, P., Katzman, M., and Wooley, S. (eds.) *Feminist Perspectives on Eating Disorders.* New York: Guilford Press. pp. 251-271.

Shaw, I., and Lishman, J. (1999). *Evaluation and social work practice.* Thousand Oaks, London: SAGE, 1999.

Shekter-Wolfson, L. F., Woodside, D. B., and Lackstrom, J. (1997). Social Work Treatment of Anorexia and Bulimia: Guidelines for Practice. *Research on Social Work Practice*, 7 (1), pp. 5-31.

Shisslak, C. M., and Crago, M. (1994). Toward a New Model for the Prevention of Eating Disorders. In Fallon, P., Katzman, M., and Wooley, S., (eds.) (1994). *Feminist Perspectives on Eating Disorders.* New York: Guilford Press. pp. 419-437.

Sied, Roberta Pollack. (1989). *Never too thin.* New York: Prentice Hall Press.

Skage, S. (1996). *Building Strong and Effective Community Partnerships: A Manual for Family Literacy Workers.* Alberta: The Family Literacy Action Group.

Steiner-Adair, C. (1994). The Politics of Prevention. In Fallon, P., Katzman, M., and Wooley, S. (eds.) (1994). *Feminist Perspectives on Eating Disorders.* New York: Guilford Press. pp. 381-394.

Steiner-Adair, C., and Vorenberg, A. (1999). Resisting Weightism: Media Literacy for Elementary - School Children. In Levine, M., Piran, N., and Steiner-Adair, C. (eds.) *Preventing eating disorders: a handbook of interventions and special challenges.* Philadelphia, PA: Brunner/Mazel, 1999. pp. 105-121.

Steward, D.W. and Shamdsani, P.N. (1990). *Focus groups: Theory and practice.* Newbury Park, CA: Sage Publications.

Strauss, A., Corbin, J. (1998). *Basics of Qualitative Research (2nd ed.).* Thousand Oaks. CA: Sage.

Swigonski, M. E. (1993). Feminist Standpoint Theory and the Questions of Social Work Research. *AFFILIA.* (2). pp. 171-183.

The Anorexia and Bulimia Nervosa Foundation of Victoria Inc. (1998). Online Eating Disorder Article. www.oxdir.comabnfv

The Canadian Paediatric Society. (1998). Eating disorders in adolescents: Principles of diagnosis and treatment. *Paediatrics and Child Health,* 3, pp. 189-192.

Thompson, B. (1994). *A Hunger So Wide and Deep: American women Speak Out on Eating Problems.* Minneapolis: University of Minnesota Press.

Truan, F., (1993). Addiction as a social construction: A Postempirical View. *Journal of Psychology,* 127 (5), pp. 489-499.

Twelvetrees, A. (1991). The community development process II: Working with community groups. In Twelvetrees, A. (ed.) *Community work.* Hampshire and London: McMillan. pp. 35-79.

VISTA (1998). *Information for New Residents.* Vancouver: St. Paul's Hospital Eating Disorder Program.

Wang, C., Burris, M. A., and Xiang, Y.P. (1996). Chinese Rural Women as Visual Anthropologists: A Participatory Approach to Reaching Policy Makers. *Social Science and Medicine*, 42 (10), pp. 1391-1400.

Warf, Brian, and McKenzie, Brad. (1998). *Connecting Policy to Practice in the Human Services.* Toronto: Oxford University Press.

White, Jennifer, and Jodoin, Nadine. (1998) *"Before-the-Fact" Interventions: A Manual of Best Practices in Youth Suicide Prevention.* Vancouver: Ministry for Children and Families and Faculty of Medicine, UBC.

Women's Student Office (1999). *The UBC Clothesline Project Handouts.* Vancouver: University of British Columbia Women's Student Office.

Women's Therapy Centre Institute. (1994). *A Feminist Psychoanalytic Treatment Model.* New York: Basic Books.

World AIDS Group (1999). *Annual General Meeting Report.* Vancouver: WAG.

Appendices

Appendix A: Diagnostic Criteria for Eating Disorders

Eating disorders are characterized as "Anorexia Nervosa", "Bulimia Nervosa" and "Eating Disorders Not Otherwise Specified" by the American Psychiatric Association's Diagnostic and Statistical Manual for Mental Disorders (DSM-IV). The diagnostic criteria for these eating disorders are listed below.

Diagnostic Criteria for Anorexia Nervosa

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
B. Intense fear of gaining weight or becoming fat even though underweight.
C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)

Specify type:

Restricting Type: during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

Binge-Eating/Purging Type: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

Diagnostic Criteria for Bulimia Nervosa

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   (1) eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
   (2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.
D. Self-evaluation is unduly influenced by body shape and weight.
E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Specify type:

Purging Type: during the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas

Nonpurging Type: during the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas

Diagnostic Criteria for Eating Disorder Not Otherwise Specified

The Eating Disorder Not Otherwise Specified category is for disorders of eating that do not meet the criteria for any specific Eating Disorder. Examples include

1. For females, all of the criteria for Anorexia Nervosa are met except that the individual has regular menses.
2. All of the criteria for Anorexia Nervosa are met except that, despite significant weight loss, the individual's current weight is in the normal range.
3. All of the criteria for Bulimia Nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week or for a duration of less than 3 months.
4. The regular use of inappropriate compensatory behavior by an individual of normal body weight after eating small amounts of food (e.g., self-induced vomiting after the consumption of two cookies).
5. Repeatedly chewing and spitting out, but not swallowing, large amounts of food.
6. Binge-eating disorder: recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviors characteristic of Bulimia Nervosa.

Appendix F: Letter of Support from ANAD

Association for Awareness and Networking around Disordered Eating
109 – 2040 West 12th Avenue, Vancouver, BC V6J 2G2
phone (604) 739-2070 fax (604) 730-2843 e-mail: anad@direct.ca

The University of British Columbia 19/04/01
Office of Research Service
Behavioural Research Ethics Board
Room 323 - 2194 Health Sciences Mall
Vancouver, BC V6T 1Z3

To Whom it May Concern,

This is a letter to acknowledge ANAD's involvement with research being conducted by Lara Marlaine Coutts who is currently enrolled in the Masters of Social Work program. at UBC. We have read the attached research proposal, and understand and agree with the research parameters as outlined.

ANAD agrees to support Lara in the following ways:

- provide access to the study population
- provide a feedback system for critical review at a committee level and at our steering committee
- use of our office space and equipment
- administrative support

ANAD will expect Lara to:

- conduct her research within the ethical guidelines outlined by UBC School of Social Work and Family Studies
- respect and value that, although the research is the property of UBC, she will be representing an ANAD endorsed activity and to act accordingly
- provide ANAD with a final copy of the research findings and present these findings to the societies membership

For further clarification please feel free to contact me at 739-2070.

On behalf of our steering committee,

Raine J. McKay, Executive Director

Appendix G: Focus Group Interview Guide

Focus Group Interview #1

1. How did you become interested in working on the House of Mirrors Community Development Pilot Project?

2. What was your relationship with other sectors of the community (i.e. health, business, art and education) prior to the House of Mirrors Community Development Pilot Project?

3. Could you describe how you work together as a group, and as a community?

4. I know that there were some problems with the move of the exhibit to Campbell River, could you talk about how you dealt with them?

Focus Group Interview #2

1. Looking back on your experience of working with other sectors (i.e. health, business, art and education) of the community on the House of Mirrors Community Development Pilot Project, could you describe any insights you have gained about community relationships in the last few months?

2. Could you describe how the House of Mirrors Community Development Pilot Project effected your relationship with other sectors of the community?

3. Is there anything you would recommend to other communities that are interested in the project?

Appendix H: House of Mirrors Advisory Committee Feedback Survey

A. Introduction

As a requirement of my Master's of Social Work degree, I (Lara Marlaine Coutts) am conducting a research study with the Association for Awareness and Networking around Disordered Eating ("ANAD"), which evaluates the House of Mirrors Community Development Project. As a part of this evaluation, we are very interested in collecting feedback from the House of Mirrors Advisory Committee and sub committee in order to help clarify the focus group feedback and further explore other aspects of the project.

Your participation will contribute to an overall evaluation of the project, which focuses on community relationships, the disordered eating/ eating disorder community, disordered eating/ eating disorder awareness, and funding resources in Campbell River. We ask that you take a few minutes to consider the following questions. In order to respect you confidentiality, the surveys are anonymous. The survey is also optional; however, any feedback you could provide to us would be most helpful.

By participating in the evaluation, you will be able to use the final report to secure future disordered eating/ eating disorders and collaborative community initiative funding requests. A copy of the final will be mailed to interested individuals.

After you have completed the survey, please place it in the envelope provided and seal it and return it to your BC Coalition to End Disordered Eating Representative. **Thank you!**

B. Community Relationships

The purpose of this section is to collect feedback with regard to the community relationships involved in bringing the House of Mirrors (HOM) exhibit to Campbell River. Take a moment and consider the different sectors of your community (i.e. art, business, education, health etc.).

1. Please check off the sector of the community you are presently working in:
   - ☐ Art
   - ☐ Business
   - ☐ Education
   - ☐ Health
   - ☐ Other_____

2. Prior to the House of Mirrors exhibition I had worked on a community project(s) with one or more sectors (art, business, education, health) of the community (Please Circle).

1. Yes 2. No

If yes, how many?

If no, why?

3. Prior to the House of Mirrors exhibition I had worked on a disordered eating/ eating disorder project(s) with one or more sectors (art, business, education, health) of the community (Please Circle).

1. Yes 2. No

If yes, how many?

If no, why?

4. AFTER: As a result of the House of Mirrors exhibition I have worked on a project (s) with one or more sectors (art, business, education, health) of the community (Please Circle):

1. Yes 2. No

If yes, how often?

If no, why?

5. As a result of the House of Mirrors exhibition I have worked on a disordered eating/ eating disorder project(s) with one or more sectors (art, business, education, health) of the community (Please Circle).

1. Yes 2. No

If yes, how often?

If no, why?

6. Do you think the House of Mirrors Community Development Project encouraged different sectors of the Campbell River Community to work together? (Please Circle)

1. Yes 2. No 3. Unsure

Why?

7. Was there enough support in the Campbell River Community to organize the House of Mirrors exhibition? (Please Circle)

1. Yes 2. No 3. Unsure

Why?

8. How did the Campbell River Advisory Committee and House of Mirrors sub-committee work together on the project?

9. Do you feel that the project required a reasonable amount of work from community members? (Please Circle)
1. Yes 2. No 3. Unsure

10. Did ANAD provide Campbell River with enough support during the project? (Please Circle)
1. Yes 2. No 3. Unsure

Yes, ANAD provided support by...

No, ANAD did not provide enough support in the following respects....

11. Did the HOM Community Development Project present challenges for the Campbell River community (Please Circle)?
1. Yes 2. No 3. Unsure

If yes, what kind of challenges?

12. Was the HOM Community Development Project rewarding for the Campbell River community?
1. Yes 2. No 3. Unsure

Why? or in what way?

C. Disordered eating/ Eating disorders Community

The purpose of this section is to collect feedback about Campbell River's relationships in the disordered eating/ eating disorders field. Given your involvement on the advisory committee, take a moment and consider your relationships in the disordered eating/ eating disorders community at a local, regional and provincial level.

1. Using a five-point scale where 1 is Not At All Useful and 5 is Very Useful, please indicate whether you think the House of Mirrors Community Development Project was a useful way to raise your committee/ organization's profile in the disordered eating/ eating disorders community by circling a corresponding number:

Not at All	Not Very Useful	Somewhat	Useful	Very Useful	Don't Know
1	2	3	4	5	DK

The House of Mirrors Community Development Project was a useful way to raise the committee/ organization's profile in the disordered eating/ eating disorders community:

a) at a local level	1	2	3	4	5	DK
a) at a regional level	1	2	3	4	5	DK
c) at a provincial level	1	2	3	4	5	DK

Please comment further:

2. What events or activities did Campbell River organize to accompany the House of Mirrors Exhibit (i.e. did you have an opening gala, did you organize a support group or school tour etc.)? (Please List)

1.
2.
3.
4.

3. Did different sectors of the community (i.e. art, education, health and business) work together on these events or activities? (Please Circle)

1. Yes 2. No 3. Unsure

If yes, what did the various sectors contribute?

If no, why?

If no, could this be facilitated in the future?

4. Were the events or activities well received in the Campbell River community? (Please Circle)
1. Yes 2. No 3. Unsure

5. Are any of the disordered eating/ eating disorder events still running? (Please Circle)
1. Yes 2. No 3. Unsure

If yes, please list:

If no, could any of the disordered eating/ eating disorder events be facilitated again in the future?

6. Would the Advisory Committee be interested in participating in disordered eating/eating projects in the future? (Please Circle)
1. Yes 2. No 3. Unsure

Why?

7. Would the Advisory Committee be interested in participating in similar community development projects in the future? (Please Circle)
1. Yes 2. No 3. Unsure

Why?

8. What advice would you give other communities interested in using the House of Mirrors Community Development Project?

D. Disordered Eating/ Eating Disorder Awareness

The purpose of this section is to collect feedback with regard to the educational aspects of the exhibit. Using a five-point scale where 1 is Not At All Knowledgeable and 5 is Very Knowledgeable, please indicate your level of knowledge about the following issues by circling a corresponding number:

Not at All	Not Very Knowledgeable	Somewhat	Knowledgeable-	Very Knowledgeable	Don't Know
1	2	3	4	5	DK

1. BEFORE the exhibition I was knowledgeable about:

a)	The unattainable physical ideals found in fashion magazines.	1	2	3	4	5	DK
b)	The impact of media images on girls and women.	1	2	3	4	5	DK
c)	The problem with diet/weight-loss programs.	1	2	3	4	5	DK
d)	c)Anorexia Nervosa.	1	2	3	4	5	DK
e)	Bulimia Nervosa.	1	2	3	4	5	DK
f)	Compulsive Eating.	1	2	3	4	5	DK
g)	Fat prejudice.	1	2	3	4	5	DK
h)	The prevalence of disordered eating/ eating disorders.	1	2	3	4	5	DK

2. AFTER the exhibition I was knowledgeable about:

a)	The unattainable physical ideals found in fashion magazines.	1	2	3	4	5	DK
b)	The impact of media images on girls and women.	1	2	3	4	5	DK
c)	The problem with diet/weight-loss programs.	1	2	3	4	5	DK
d)	Anorexia Nervosa.	1	2	3	4	5	DK
e)	Bulimia Nervosa.	1	2	3	4	5	DK
f)	Compulsive Eating.	1	2	3	4	5	DK
g)	Fat prejudice.	1	2	3	4	5	DK
h)	The prevalence of disordered eating/ eating disorders.	1	2	3	4	5	DK

3. What do you think is the main disordered eating/ eating disorder philosophy presented in the House of Mirrors exhibit?

4. What three things have you learned from the House of Mirrors exhibit?

1.

2.

3.

5. In your opinion did the House of Mirrors create awareness in Campbell River about disordered eating/eating disorders? (Please Circle)

1. Yes 2. No 3. Unsure

Please give an example:

E. Funding Resources

The purpose of this section is to collect feedback with regard to funding resources.

1. Using a five-point scale where 1 represents no funding and 5 represents a lot of funding, please indicate the amount of disordered eating/ eating disorder resources in Campbell River, by circling a corresponding number:

No Funding	Not Very Much	Some	An Adequate Amount	A Great Deal	Don't Know
1	2	3	4	5	DK

Before the HOM project, the community of Campbell River had:

a)	new or reallocated disordered eating/ eating disorder funding	1	2	3	4	5	DK
b)	disordered eating/ eating disorder treatment programs	1	2	3	4	5	DK
c)	space for a disordered eating/eating disorder support group	1	2	3	4	5	DK
d)	disordered eating/ eating disorder educational programs	1	2	3	4	5	DK

After the HOM project, the community of Campbell River had:

a)	new or reallocated disordered eating/ eating disorder funding	1	2	3	4	5	DK
b)	disordered eating/ eating disorder treatment programs	1	2	3	4	5	DK
c)	space for a disordered eating/eating disorder support group	1	2	3	4	5	DK
d)	disordered eating/ eating disorder educational programs	1	2	3	4	5	DK

2. In your opinion, was the House of Mirrors a useful way to attract new funding or encourage the reallocation of funding? (Please Circle)

1. Yes 2. No 3. Unsure

If yes, how

If not, could you explain why the exhibit was not a useful way to attract new funding

Additional Comments:

Thank You!