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Understanding Body Image Disturbance in the Promotion of Mental Health: A Discourse Analytic Study

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ABSTRACT

Health care interventions in the area of body image disturbance and eating disorders largely involve individual treatment approaches, while prevention and health promotion are relatively underexplored. A review of health promotion activities in the area of body image in Australia revealed three programmes, the most extensive and longest standing having been established in 1992. The aims of this programme are to reduce body image dissatisfaction and inappropriate eating behaviour, especially among women. Because health promotion is concerned with the social aspects of health, it was hypothesized by the authors that a social understanding of body image and eating disorders might be advanced in a health promotion setting and reflected in the approach to practice. In order to examine approaches to body image in health promotion, 10 health professionals responsible for the design and management of this programme participated in a series of semi-structured interviews between 1997 and 2000. Three discursive themes were evident in health workers' explanations of body image problems: (1) cognitive-behavioural themes; (2) gender themes; and (3) socio-cultural themes. While body image problems were constructed as psychological problems that are particularly experienced by women, their origins were largely conceived to be socio-cultural. The implications of these constructions are critically discussed in terms of the approach to health promotion used in this programme. Copyright © 2001 John Wiley & Sons, Ltd.

Key words: body image; cognitive-behavioural; discourse; gender; health promotion; psychology

INTRODUCTION

Body image dissatisfaction and dieting are widely reported among women and girls in westernized societies (c.f. Thompson, 1992; Wade *et al.*, 1996). Body image dissatisfaction is generally understood as linked to the promotion of the thin body ideal for women (c.f. Silverstein and Perdue, 1986; Thompson, 1992), however, cognitive-behavioural

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theory is often used to explain its mechanisms (Thompson, 1990). The concepts of 'body image disturbance' and 'body image distortion', which originate as diagnostic criteria for eating disorders, have also been used to describe body image dissatisfaction and overestimation of body size among both eating disordered and non-eating disordered women (c.f. Button *et al.*, 1977; Thompson, 1992; Thompson and Thompson, 1986; Cash and Deagle, 1997).

Health care interventions to address body image disturbance and eating disorders in Australia, the US and the UK primarily involve the provision of individual psychiatric and psychological treatment, and socio-cultural aspects of body image and eating disorders have not been a major focus of health care intervention. However, over the past decade calls for the prevention of eating disorders have increased (Hsu, 1996; Striegel-Moore and Steiner-Adair, 1998; Hepworth, 1999), bringing with them a greater emphasis on the social and political aspects of body image, and strategies to modify the conditions that give rise to eating disorders. While few programmes identify themselves with the theory and practice of health promotion, there are examples of programmes aimed at social rather than individual change. These include a comprehensive community intervention programme that works at three levels of prevention with an understanding that change is a collective process (see Latzer and Shatz, 1999), and a participative programme in a ballet school based on the health promotion principles of empowerment and collective action (see Piran, 1998).

In Australia, few health programmes have addressed body image and eating disorders. The only published literature reports on the evaluation of a time-limited school-based health education programme for adolescent girls addressing body dissatisfaction and disordered eating (Paxton, 1993). A review of body image-related health promotion activity in Australia in 1997 revealed three other programmes. Two of these were time-limited and implemented only on a relatively small scale. The most extensive programme undertaken in this area was established in 1992 with the aim of reducing body image dissatisfaction and inappropriate eating behaviour, particularly among women. Because health promotion traditionally defines itself as concerned with a social view of health, in line with international policies such as the Ottawa Charter for Health Promotion (WHO, 1986), we hypothesized that a social understanding of body image might be advanced in a health promotion setting. As there has been little critical examination of the application of health promotion in this area, we were particularly interested in the ways in which different conceptualizations of body image might relate to health promotion practices, and the extent to which these might be considered consistent with health promotion principles.

METHODS

In order to reveal the ways in which body image dissatisfaction is conceptualized in a health promotion programme, 10 health workers responsible for the design and management of the most extensive of the three programmes identified were invited to participate in an interview study between 1997 and 2000. These interviews form part of a larger on-going discourse analytic study examining relationships between constructions of 'body image' and 'eating disorders', and approaches to health care practice. Health workers from a wide range of disciplines, including social work, psychiatry, nursing, psychology, health promotion and general practice, have participated in interviews focusing on theoretical

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explanations of body image and eating disorders, and approaches to therapy and prevention.

The health promotion programme in which the 10 health workers are involved will be referred to only as the body image dissatisfaction (BID) programme, in order to protect the identities of the participants. Health workers responsible for managing the BID programme were identified as people who would provide the most information on approaches to body image used in health promotion through 'critical case sampling' (Grbich, 1999). Respondents included four psychologists, two dietitians, a health promotion worker, general practitioner, market researcher and fashion design lecturer. Seven of the respondents were female and three were male. Nine respondents were voluntary members of the programme's management committee who also worked in paid capacities elsewhere in private practice, health promotion and tertiary education. One respondent was employed as the health promotion officer with the programme.

The 10 health workers were invited to participate by telephone, with all agreeing to take part in the study. Nine interviews were conducted in participants' workplaces, and one interview was conducted in another city while a respondent was visiting. Seven interviews were conducted in 1997, and three further interviews were undertaken in 2000 when it was decided to widen the sample to include health workers from a wider range of disciplines to ensure maximum variability of responses (Kuzel, 1992).

Semi-structured interviews were undertaken in order to obtain extensive, rich and detailed information about use of the terms 'body image' and 'body image problems'. Interviews were loosely structured around a series of questions about how body image problems might be defined and the causes explained. There was an assumption of intersubjectivity and mutual creation of data between the interviewer (first author, NM) and participants (Olesen, 1994). For example, participants introduced a number of areas for discussion themselves, and this is indicated at relevant points in the analysis. Interviews ranged between 50 minutes and 2 hours, were audio-tape recorded and fully transcribed.

The approach to analysis used in this study is informed by the work of Michel Foucault and post-structural feminists such as Weedon (1987) and McNay (1992). This theoretical framework offers possibilities to examine the constructive use of language (cf. Potter and Wetherell, 1987), and the ways in which explanations of women are structured through historical, social, and political discourse. Discourse is defined by Parker (1992) as 'a system of statements which constructs an object' (p. 5). The approach to discourse analysis used in this study involved, first, the identification of 'themes' in the interview data. These are analogous to Potter and Wetherall's (1987) concept of 'interpretative repertoires', defined as 'recurrently used systems of terms used for characterising and evaluating actions, events and other phenomena' (Potter and Wetherell, 1987, p. 149). Following this, the interview data was examined using Parker's (1992) 10 criteria and associated steps for discourse analysis. In this way, discourses informing the object of 'body image problems' and the subject of 'women with body image problems' were identified. A critical approach was employed, attending to the ways discourse is shaped by power relations, and the constructive effects of discourse upon subjectivities and social relations (Fairclough, 1992; Parker, 1992). An approach to validity was used which draws on the work of Guba and Lincoln (1989), where the 'trustworthiness' of the data was analysed independently by the two authors and agreement was reached on the range of discursive themes evident in the transcripts.

This study is not concerned with illuminating the 'true' nature of body image problems, but with the ways in which particular constructions of 'body image problems' have effects

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for the promotion of women's health. Illustrative examples of the discursive themes from the 10 interviews are provided as interview extracts, words, or sentences from a more extensive collection of analysed material. Based on the interview material, we identify three discursive themes through which body image problems were constructed: (1) cognitive-behavioural themes; (2) gender themes; and (3) socio-cultural themes.

ANALYSIS/DISCUSSION

Cognitive-behavioural themes

This thematic category constructed body image problems in terms of cognitive-behavioural theory, drawing on the concepts of perception, cognition, emotion and behaviour. In response to questions about how body image problems might be defined, respondents (D, F, and G) identified these four key components:

> Respondent D: . . . the definition I like of body image disturbance, if you like, has three dimensions to it. There's the concept of size perception accuracy, so how a person actually views their size, how accurately they view their size . . . [.] . . . The second one is the cognitive, the person's own attitudes towards their body. You can probably include in that the person's, you know, feeling, the way a person thinks about their body and the way they feel . . . [.] . . . a third dimension of body image which I think is actually really critical, and is often missed, is the behavioural component. This is one way that you can actually pick up whether there are body image problems, and that's the degree to which a person avoids engaging in activities, or engages in activities because of a negative feeling about their body.

> Respondent F: One of the really simple definitions which sort of makes sense to me is just that obviously [body image] is how you perceive your body. It has three main components, one being the more subjective, how satisfied or dissatisfied I might feel. A behavioural component, so how does the way I feel, think about my body affect my behaviour. And I think that's a really important one, the core of what we're trying to tackle. And I guess just how accurately I might perceive my body shape and size . . . you know, overestimating, underestimating . . .

> Respondent G: Body image is a much more general term that . . . [.] . . . takes into account cognitive components, physical components, and emotive or affective components, but my particular interest, and I think it's mostly the focus of our work, is in what really relates to the affective component, the body image satisfaction component because it's that affective component that drives destructive behaviours.

Respondent D introduces the concept of 'body image disturbance' as involving 'size perception accuracy', 'cognitive' and 'behavioural' components. 'Feeling' has a key place in this account, however, it is the behavioural component that is emphasized as the observable aspect of body image disturbance and as 'often missed' Respondent F constructs body image in terms of 'how you perceive your body', 'the way I feel, think about my body', and a 'behavioural component'. For respondent G, body image involves 'cognitive components, physical components, and emotive or affective components', with the latter emphasized because they drive 'destructive behaviours'.

The notion that body image involves perception, cognition, emotion and behaviour draws on long-standing ideas from cognitive-behavioural psychology. Within this theoretical approach, individuals perceive and respond to external and internal stimuli, think about them, react emotionally, and this determines behaviour (Lazarus, 1991). Explanations of body image disturbance in the literature most often draw on cognitive-behavioural theory, dividing body image into these same four components (Thompson, 1990).

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A cognitive-behavioural definition of body image draws on humanist discourse, which maintains a separation between individual and social aspects of phenomena. This is often referred to as 'individual-society dualism', where society's norms and values are seen as internalized by individuals but the individual is understood to be, at the same time, separate from the socializing effects of the wider collective (Davies, 1991). Constructing body image and body image disturbance in this way assumes an individual to be a 'unitary subject', and also involves a Cartesian split between mind/body. Here, the mind is synonymous with the self and superior to the physical body (Lloyd, 1989). A dualistic concept of the individual is clearly employed by these respondents to describe body image, with cognitive-emotional components able to perceive and appraise the physical body.

The importance of emotion, or 'affect', is emphasized in respondents' (D, F and G) descriptions of body image problems. This is elaborated further below, where feelings are used to describe the dynamics of body image:

> Respondent G: Well, I think of body image as an umbrella term for all the other, in particular, our emotive responses, affective responses to our bodies. That would be how we feel about, how we relate to our own bodies. So that is about body satisfaction, love or hate, acceptance or enjoyment.

> Respondent A: One of the questions that I would ask at a first consultation ... [.] ... is how do they feel about their body or body image, and most people feel it's disgusting, yuk, that level of dissatisfaction, so ... on a continuum it's pretty much down the bottom of feeling negative.

> Respondent J: ... I do think some people would feel hate towards either their whole body or part of it. I think there would be a jealousy that they would want, you know, they would be jealous of other people who have the body they think that they would want or would like ...

Respondent G emphasizes the importance of emotions in defining body image as an 'umbrella term for, in particular, our emotive responses, affective responses'; while respondent A has 'a particular interest' in how individuals 'feel about their body'. While emotions are emphasized as an important aspect of body image problems, they are described as 'negative'. For example respondent A states that most people describe their body as 'disgusting' or say 'yuk', respondent J suggests people feel 'hate' and 'jealousy' and, earlier, respondent G describes the effects of emotion as 'destructive'.

The portrayal of emotions as negative and destructive in these accounts of body image problems also draws on humanist discourse. Here, rationality and agency are synonymous with being a normal human self (Davies, 1991), and the emotions are treated with suspicion because they are conceived of as bodily and therefore as impediments to rationality (Spelman, 1989). Describing body image problems in this way constructs the individual with this problem as lacking in the rational and agentic aspects of selfhood.

A number of respondents also included the notion of 'perceptual distortion' as part of cognitive-behavioural explanations. It is important to note that respondents were not directly asked about 'body image disturbance' or 'perceptual distortion', but introduced these concepts themselves as part of defining body image problems. The following extracts from respondents E and H, as well as earlier extracts from respondents D and F, illustrate this notion:

> Respondent E: ... to talk about body image problems, then I think there's [ ] a definition of some issue which is usually a distortion of any of those factors of how we perceive ourselves, so some, er, our perception is not the same as the reality.

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> Respondent H: ... I think it is different for everyone depending on where they visualize their problem is, which frequently isn't a problem to someone looking from the outside. [Interviewer: OK, there can be a difference between ...?] ... the perception of the person who thinks they have this problem and what really is a problem.

The 'accuracy' of perceptions was referred to earlier by respondent D as an important aspect of 'body image disturbance', while respondent F presented body image as '... just how accurately I might perceive my body shape and size ... you know, overestimating, underestimating ...'. Normal perception is constituted as the similarity between a person's estimate of the physical dimensions of the body and its actual dimensions. For respondent E, an incongruence between perception and actual body size is described as '... a distortion of any of those factors of how we perceive ourselves ... our perception is not the same as the reality'. Respondent H also identifies an incongruence between perception and reality in identifying a difference between 'the perception of the person who thinks they have this problem and what really is a problem'.

The individual's capacity for perceptual distortion is supported by the notion of mind-body separation, as well as by the view that there is a constant, stable reality from which the psyche detaches when it distorts perception. In addition, the size and physical dimension of the body dominates discussion in these extracts. An emphasis on the objective physicality of the body makes it possible to compare a person's subjective interpretation with the objective gaze of the health professional. Consequently, the identified incongruence becomes categorized as *perceptual inaccuracy, distortion,* or *disturbance*, and the health professional is positioned as the person with access to a stable reality, able to determine the extent of psychological dysfunction. The construct of body image distortion has a fundamental link with eating disorders, originating as a central feature of body image disturbance, which is one of five diagnostic criteria for anorexia nervosa outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, American Psychiatric Association, 1980). While this concept has been used to describe overestimation of body size in eating disorders, it has also been suggested that body image distortion has become a 'normal' feature of the female population (Powers and Erikson, 1986, cited in O'Dea, 1995). There have even been calls for the creation of a new diagnostic psychiatric category: 'Body Image Disorder' (Thompson, 1992). These ideas draw on medical discourse and construct body image disturbance and distortion as abnormal psychological states.

Gender themes

Gender was another discursive theme in respondents' accounts. While most respondents described body image problems as experienced by both women and men, they were presented as primarily a women's problem, and as having more serious effects for women. This idea was introduced by respondents themselves as part of their definitions of body image problems:

> Respondent E: ... I mean I'll put it also in the context of personal beliefs, personal values, personal history. Um as in mothers, sisters, girlfriends, all of those sorts of things, and myself, have all had issues related to body image ...

> Respondent D: ... only 3% of women have bulimia nervosa and estimates range between 10 to 15% of young women have actually tried self-induced vomiting to control their weight. Then you're looking at a body image problem that's much more severe than just what presents in extreme forms. But then if you go beyond that sub-clinical group, most women are uncomfortable about their shape in this community.

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> Respondent D: . . . with men [body image] is actually an increasing problem, potentially it could be, even though for men I guess body image isn't associated with fundamental self worth which is the difference. Men can be big and seem to carry on functioning in life without being so affected.

> Respondent C: Men are not so dissatisfied with their bodies, there's just no doubt about it. So they're really not the priority for us.

Three features structure the presentation of gender. First, while respondent E includes himself as affected by body image issues, his reference to 'mothers, sisters, girlfriends' reinforces the commonality of women's experiences of body image problems. Second, respondent D constructs body image disturbance as a problem for most women by presenting it as a feature of 'bulimia nervosa', as present in 'the sub-clinical group' and, lastly, as a problem for 'most women'. Third, body image problems, while 'increasing' among men, do not share the same aetiological characteristics as those of women because 'men can be big' and 'carry on functioning in life', and are not 'so affected' by size (respondent D). Respondent C's presentation of men as not being so 'dissatisfied' with their bodies excludes them as the primary group for body image problems. Both respondents C and D position males as having similar potential to develop body image problems, but it is women who develop the most severe problems.

Body image problems become situated within a discourse of femaleness in these accounts. We are not suggesting that men experience similar levels of distress in this area, however the emphasis on negative emotion in respondents' constructions of body image problems maintains and reproduces the idea that psycho-emotional problems are the province of women. It is significant that it is mainly women who are deemed to suffer from body image problems and their attendant 'disturbances', 'distortions', 'negative emotional states'and 'destructive behaviour'. This draws on femininity discourse with its historical associations between 'male', 'rationality', and 'order', and between 'female', 'bodily', 'irrationality' and 'emotion' in Western thought (Jaggar, 1989). Women have been consistently portrayed as inherently more emotional than men (Spelman, 1989). One respondent draws directly on these ideas in answer to a question about why body image problems are more common in women:

> Respondent H: I think women are more concerned with what other people think and take things like that to heart, and I really think that that's at the heart, the very nature of women.

This respondent describes women's 'nature' as inherently more concerned with others' opinions, and as more emotional than men's because women 'take things like that to heart'. However, most respondents in this study did not portray women as inherently more emotional, because they also identified the causes of body image problems as socio-cultural, involving differential pressures for women.

Socio-cultural themes

This thematic category constructed body image problems in socio-cultural terms, rather than those of individual psychology. Respondent C was the only health worker to offer an alternative account emphasizing cultural ideas when asked to define body image problems:

> Respondent C: . . . the body image part of it I think is about people not being comfortable with their own reality and also having a sense that their body is a fixed thing and not a fluid thing and so therefore they can't cope with changes to their body. They have a sense that . . ., [.] . . . well,

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> when you think about women getting pregnant and after they've had a child, the concept that's frequently used is getting your body back, as if you've as if it shouldn't look as though you've ever had a child, and that's really a modern and a sort of foolish idea, like you shouldn't have wrinkles because they show your age, well they've also showed you've lived. It's that sense of not acknowledging the reality of living and aging so, you know, about all these dislocations between reality and ideals.

For respondent C, body image problems result from individuals 'having a sense that their body is a fixed and not a fluid thing'. Individuals' inability to cope with changes to their bodies is linked to particular cultural ideas in; 'that's really a modern and a sort of foolish idea'. Rather than define body image problems in terms of individual perceptual distortion, this respondent identifies a discrepancy between individuals' perceptions of their bodies and cultural ideals as 'all these dislocations between reality and ideals'. In common with cognitive-behavioural explanations, this construction is also supported by the mind-body separation and the view that there is a constant, stable reality which individuals can access, however, unlike earlier constructions of perceptual distortion, individuals with body image problems are constructed as having access to this reality.

While most respondents drew on cognitive-behavioural theory to define body image problems, many offered socio-cultural explanations of the *causes* of body image problems in response to the questions: 'What do you think causes body image problems?' and 'Why do you think body image problems are more common in women?':

> Respondent A: Certainly in the environment that we live in today there's a, more risk factors for women than men to develop these things, and particularly the diet culture ...

> Respondent D: ... systematically women, through marketing, have actually been taught to loathe their bodies ...

> Respondent E: ... the promotion of the ideal is stronger for women ... for women there's a whole lot of other things, like there's diets and fashion and all those sorts of things, but they're all sub-contexts or sub-texts of the ideal for women is very strongly promoted.

These extracts identify the causes of body image problems as outside the individual, although each has a different emphasis. Respondent A identifies 'the environment' as a source of 'risk factors'. For respondent D, 'marketing' is identified as the source of body image problems, while respondent E focuses on 'promotion' of the body ideal for women being 'stronger'. Three other respondents also offered socio-cultural explanations of the causes of body image problems in women, identifying: 'a very strong promotion of slim body types' (respondent B); 'the media' (respondent H), and; 'the social pressure on women to look good' (respondent J).

The notion that the media, marketing and the diet culture cause body image problems draws on a socio-cultural discourse which constructs body image as a social, rather than an individual, problem. This explanation also relies on individual-society dualism, where society's norms and values are seen as internalized by individuals through socialization (Davies, 1991). Thus, in these accounts, women are constructed as developing body image problems through inappropriate socialization about the female body through the media and other cultural sources. Here, the potentially complex, dynamic realm of culture and its relationship to the individual is conceived of as one-directional, while the socio-cultural aspects of body image problems are conceptualized only in terms of the promotion of the thin female body ideal. Thus, women are constructed as the victims of cultural expectations.

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While the idea that socio-cultural factors play a role in causing body image problems is also present in the following extracts, these accounts emphasize individual self-esteem as the key causal factor:

> Respondent E: I think that body image dissatisfaction is an expression of a greater sense of self-esteem problems that manifests through body image dissatisfaction because we exist in a world where that's a really easy hook to hang your issues about yourself on.

> Respondent H: I think it's very much centred around self-esteem. I'm not sure what the causes of self-esteem are but I think self-esteem has to do with it. I think it contributed to it. [It] is certainly fashion and society and media and all those images forming things that we're bombarded with . . . [ ] . . . I think then those kind of images begin to act on poor self-esteem and help to form, I guess, poor body image . . .

> Respondent F: . . . I think it's very different for each individual and, you know, why is it for example that some people are protected from these influences and others seem really vulnerable to them? And it just seems to me that things like self-esteem seem to be the really key ones which do determine whether people are more or less vulnerable to some of those other influences.

For respondent E, body image dissatisfaction acts as 'a convenient hook' for 'self-esteem problems'. For respondent H, media images 'act on poor self-esteem', and for respondent F some individuals 'seem vulnerable' because of determining factors such as 'self-esteem'. Earlier, respondent D also used 'self-esteem' to explain differences between the extent and severity of body image problems in women and men.

The positioning of self-esteem as the root cause of body image problems in these accounts gives primacy to 'intrapsychic' processes as an explanation of body image problems. The internal factor of self-esteem also helps to maintain the separation between the individual and wider socio-cultural factors, ultimately determining whether body image problems develop. Thus, in the final instance, cause rests with the individual, however, socio-cultural discourse, through reference to 'fashion', 'society', 'media' and 'influences', is also drawn on in these accounts to explain how body image problems are triggered in vulnerable individuals.

In a variation on socio-cultural themes, two respondents draw on feminist ideas to explain the causes of body image problems:

> Respondent C: . . . it's very much based within the cultural expectations of women, compared to men. And also women aren't meant to be, women are meant to be more controlled. They're meant to be good . . . [Interviewer: So some sort of a moral component there?] . . . Oh yeah, yeah I think there's definitely a moral component to what's perceived as being ideal for women, is very much morally based.

Respondent C refers to the idea that women are 'meant to be good' as a moral imperative arising out of 'cultural expectations'. Feminist theorists have argued that eating disorders are linked to moral ideas about women, food and the body. For example, MacSween (1993) shows how portrayals of female sexuality as dangerous in Western Christianity are tied to the notion that women must control their desires.

Respondent D draws on a different aspect of feminist discourse to explain why body image problems are more common in women:

> Respondent D: . . . it's more I think that women have, I suppose traditionally, it's very complex, . . . traditionally the roles of men and women, and I suppose you go back a couple of hundred years, women were largely viewed as the property of men, didn't have an identity and rights in and of themselves, and so women were there to basically be available to and please and serve men. Although I don't know that that's consciously there in the culture, I'm sure that those sorts of things I think hang on for much longer . . .

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Respondent D, a male, refers to historical gender power relations where 'women were largely viewed as the property of men' without 'identity and rights'. These ideas are presented as enduring, perhaps 'unconsciously', in contemporary culture. This draws on a feminist discourse where women's oppression is understood as resulting from unequal gender power relations in patriarchal societies, with women positioned as subservient to the needs of men (c.f. Rawlings and Carter, 1977, cited in Ussher, 1991). In contrast to socio-cultural discourse, which narrowly defined the causes of body image problems in terms of the promotion of the thin female body ideal, feminist discourse locates the causes in wider gender power relations and patriarchal ideologies and structures.

IMPLICATIONS OF THE DISCURSIVE THEMES FOR HEALTH PROMOTION

The dominance of humanist and socio-cultural discourses in respondents' constructions of body image problems has a number of implications for the approach to health promotion used in practice. The BID programme involves four areas of intervention: strategies to raise individuals' awareness about body image and appropriate eating behaviour, including media campaigns and distribution of written material; professional education; research; and advocacy in terms of assisting the fashion, advertising and media industries to identify appropriate changes in their practices. This is reflective of a 'multidimensional' approach to health promotion (O'Connor and Parker, 1995, p. 87), of which Green and Kreuter's (1991) PRECEDE/PROCEED model is an example that is directly referred to in the BID programme's documentation (Green and Kreuter, 1991, cited in O'Connor and Parker, 1995). The model is based on the premise that health and health behaviour are caused by multiple factors, both individual and social/environmental, and that health promotion needs to address both these levels to be effective (O'Connor and Parker, 1995).

The dominance of cognitive-behavioural theory and humanist discourse in respondents' accounts is reflected in the incorporation of education strategies that seek to raise individuals' awareness about body image dissatisfaction and inappropriate eating. The inclusion of education strategies is based on humanist assumptions about the rational subject and their ability to make choices about body image dissatisfaction and eating behaviour, and appeals to a dualistic notion of the mind being able to monitor and control the body. This reflects health promotion's origins in liberal-humanism with its emphasis on notions of individual responsibility for health behaviour (c.f. Gardner, 1995). While respondents' drew on humanist, and to a lesser extent medical, discourses to construct body image dissatisfaction/disturbance as abnormal psycho-emotional states, the approach to intervention is based on the complementary humanist idea that individuals nevertheless have the *capacity* for rationality and agency.

Respondents' constructions of the causes of body image problems through socio-cultural discourse enables a simultaneous focus on changing social/environmental factors seen as causes of health behaviour, retaining a behaviour change goal as the end-point of intervention. While there was some emphasis in respondents' accounts on the cognitive construct of self-esteem as the key causative factor in body image problems, this is consistent with an approach that seeks to modify the social conditions seen as triggering these problems in vulnerable individuals. The inclusion of social/environmental strategies distinguishes this programme from health education programmes addressing body image and eating disorders which attend only to educating individuals (c.f. Shisslak *et al.*, 1990; Killen *et al.*, 1993; Paxton, 1993). In this sense, the BID programme includes

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a focus on the social aspects of body image and eating, and incorporates the health promotion principle of creating healthy environments outlined in the Ottawa Charter (WHO, 1986).

The Ottawa Charter also includes the principle of strengthening community action (WHO, 1986), emphasizing the idea of communities having power and control over programme initiatives and activities (O'Connor and Parker, 1995). The BID programme attempts to incorporate this principle through working with community groups to develop strategies at the local level, and through undertaking community consultations and focus groups. However, community participation is largely treated as a discrete area of intervention, while community involvement in the overall management and implementation of the programme is relatively limited. This reliance on professional, rather than community, knowledge and expertise in programme management corresponds with three features of respondents' constructions of body image dissatisfaction. Firstly, the discourses used by respondents positioned the speaker, as the health professional, as having knowledge about the 'true' nature and causes of body image problems, rather than women themselves. Secondly, the incorporation of health education strategies based on humanist notions of individual responsibility for health positions individuals as the recipients of intervention, rather than as active partners in social change. Thirdly, the individual-society dualism which structured respondents' accounts of body image is reflected in an approach to practice where interventions targeting individuals are treated as distinct from those addressing social change. This tends to partition the social realm from that of the individual, restricting opportunities for individuals to be active participants in change.

In contrast to this, Piran (1998) gives primacy to community participation and empowerment in a health promotion programme addressing eating disorders in a ballet school, emphasizing the mutual production of knowledge and the transformative effects for young women involved in challenging the forces contributing to the development of eating disorders. Here, health promotion is a more interactive process 'where institutions and communities become transformed as people who participate in changing them become transformed . . .' (Wallerstein and Bernstein, 1994, p. 142). The tying together of individual and social change as one dynamic process reflects the idea that 'the outer is reproduced in the inner' and that 'social structures become mental ones' (Gottlieb, 1984, p. 107, cited in MacSween, 1993, p. 81), rather than a dualistic understanding of the individual's relationship to society.

While body image problems were universally presented as primarily women's problems, only two respondents' drew on feminist discourse as an explanation and these ideas are not explicitly reflected in the approach of the programme. Firstly, feminist discourse locates the causes of body image problems and eating disorders in wider gender power relations and patriarchal ideas and structures, while the BID programme focuses more narrowly on the promotion of the thin female body ideal. Secondly, feminist approaches to health care intervention involve an emphasis on women's, rather than professional, knowledge and participation (c.f. Piran, 1998). The fact that feminist discourse was uncommon in health workers' accounts, and does not explicitly inform the approach to practice, can be partly explained by the historical and continuing marginalization of feminist approaches to health care in the Australian health care system more generally. Overtly feminist programmes and services experience ongoing difficulties securing government funding and support (c.f. Broom, 1991), and remain on the periphery of the health care system. The BID programme, instead, draws on more mainstream health promotion approaches that are embedded in wider systems of institutional organization

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and support, thereby reproducing dominant understandings of individuals and their relationship to wider social forces.

CONCLUSION

The discourses used by health workers to construct body image dissatisfaction and disturbance, and the women with these problems, have a number of important implications for the promotion of women's health. While there was some variation in respondents' accounts, the dominance of humanist and socio-cultural discourses is reflected in an approach to health promotion that tends to separate different levels of intervention from each other, restricting opportunities for community involvement and action. It is positive that health promotion programmes such as this one have broadened the range of health care interventions in the area of body image and eating disorders to include a focus on prevention as well as treatment. However, there is scope for the further development of practice approaches that more fully embrace the health promotion principles of the Ottawa Charter. In particular, a focus on strengthening community action and empowerment can have transformative effects for women involved in challenging the dominant discourses and practices which impact on their health.

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