

CALIFORNIA STATE UNIVERSITY NORTHRIDGE

EXPLORING AND ENHANCING BODY IMAGE AND SEXUAL FUNCTIONING: A
12 WEEK SUPPORT GROUP FOR WOMEN

A graduate thesis project in partial fulfillment of the requirements
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By
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DEDICATION

I would like to dedicate my thesis project to my best group of friends, Edahn Small, Erica Pollack, Michelle Gomez, and Rena Jacobs. Throughout the course of completing my thesis project, I questioned in the back of my mind to whom I wanted to dedicate my project. Throughout my journey in this program and completing my project, many people have helped and supported me. I am so blessed to be surrounded by people who encourage and want to help me succeed. Yet, it was Edahn, Erica, Michelle, and Rena who truly helped me make it through my last semester.

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ABSTRACT

EXPLORING AND ENHANCING BODY IMAGE AND SEXUAL FUNCTIONING: A 12 WEEK SUPPORT GROUP FOR WOMEN

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The purpose of this project thesis is to create a twelve week support group for women that focuses on enhancing both body image and sexual functioning. The curriculum covers the five stages of grief and takes women on a journey toward the final stage, body acceptance. The support group also teaches women the possible dangers of poor body image, while educating them on mindfulness and other methods that will lead toward loving one's body. The last few sessions incorporate information on how body image relates to sexual functioning, and allows women to explore their own sexuality. Since women will be in a group among other women, women are also anticipated to enhance interpersonal communication through camaraderie.

Chapter I: Introduction

Introduction

Today's society is bombarded in nearly every direction by the media, whether it is through television, magazines, movies, advertising, or social networking. Frequently, the media portrays unrealistic images of women that are not representative of the general population. Consequently, women tend to internalize these images, and may take on a negative perception of their own bodies when they do not match what they see in the media (Myers & Biocca, 1992; Roberts & Gettman, 2004).

In 1997, Fredrickson and Roberts created self-objectification theory, indicating that women have been acculturated, primarily through the media, to take on an observer's view of their bodies. Women are considered to be self-objectifying their bodies when they look at themselves as a bundle of parts, intended for the consumption of others, instead of viewing themselves as a human being. Fredrickson and Roberts suggested that self-objectifying one's body may cause shame, anxiety, depression, sexual dysfunction, and eating disorders.

With many women being displeased with their bodies and having a poor body image, researchers have examined how body image affects other areas of women's lives, especially sexual satisfaction and functioning (Ackard, Kearney-Cooke, & Peterson, 2000; Calogero & Thompson, 2009; Donaghue, 2009; Pujols, Metson, & Seal, 2010; Satinsky, Reece, Dennis, Sanders, & Bardzell, 2012; Schick, Calabrese, Rima, & Zucker, 2010; Steer & Tiggerman, 2008). Many of these researchers have found that poor body image is linked to less sexual satisfaction and functioning, such as ability to be aroused

and reach orgasm (Ackard et al.; Calogero & Thompson; Schick et al.; Steer & Tiggerman). In addition, researchers have found that cognitive distractions, often involving thoughts about how their bodies appear during physical intimacy, are correlated with poorer sexual functioning in women (Cuntim & Nobre, 2011; Purdon & Holdaway, 2006).

Treating body image issues with group process is an effective intervention (Devaraj & Lewis, 2010). Not only do process groups tend to normalize feelings, but they also create a sense of camaraderie among group members or universality, providing them with a sense of belonging (Yalom, 1995). In addition, group interventions are more affordable and take a shorter period of time than individual counseling (Corey & Corey, 2002). Improving body image and gaining body acceptance has also been achieved through grief work (Courtney, 2008). Lastly, research has also shown success for improving body image, sexual functioning, and sexual satisfaction through the use of women's support groups (Walen & Wolfe, 1983).

Statement of Problem

Many women suffer from poor body image, with even more being dissatisfied with specific aspects of their body, such as genitalia or breasts (Algars, Santtila, Jern, Johansson, Westerlund, & Sandnabba, 2011; Forbes & Frederick, 2008; Frederick, Peplau, & Lever, 2008). For this reason, the purpose of the current project is to increase women's positive image of their body and their body acceptance. Sex is an integral part of human existence and as such, should be enjoyed by each partner involved. In 1943, Abraham Maslow even theorized that sex is among human's most basic needs, in the

same category as food, water, and breathing (Thompson, Rudolph, & Henderson, 2004). For that reason, while developing a more positive body image, the goal of the current group is also to increase women's sexual satisfaction and sexual functioning.

Purpose of Project

The present support group will meet weekly for 2 hours for 12 consecutive weeks. The group will consist of all women and will be facilitated by a master's student in a marriage and family therapy graduate program, a marriage and family therapist intern, or a licensed marriage and family therapist. The purpose of the group is to increase both positive body image and sexual satisfaction and/or sexual functioning in women, as well as reduce non-erotic cognitive distractions during physical intimacy. Each week, the facilitator will present a general theme for the session. Discussion and process during sessions will be flexible and tailored to group members' needs. Sessions will include grief work, psychoeducation on the effects of media on body image and sexuality, healthy and safe sexual behaviors, and teaching mindfulness. Members will also explore how negative body image has affected their sexual identity and sexual experiences. The facilitator will use psychoeducation in group related to non-erotic thoughts and their implications on sexual satisfaction. Group members will explore non-erotic thoughts they may or may not have. Lastly, members will process their experience within the group.

Terminology

Body image: “a multifaceted construct referring to people's subjective perceptions of and attitudes about their own body, with an emphasis on physical appearance” (Cash &

Pruzinsky, 2002 as cited in La Rocque & Cioe, 2011, p.397). Having a negative or poor body image indicates dissatisfaction with one's body appearance. Having a positive body image indicates satisfaction with one's body appearance.

Body mass index (BMI): A frequently used measure to predict body size, calculated by using a person's height and weight. The higher the BMI, the plumper a person is.

Conversely, lower BMIs indicate thinner people (Weaver & Byers, 2006).

Cognitive distractions and cognitive distortions: Refers to any type of non-erotic thoughts during sexual intimacy (e.g. *I'm not turned on* or *I look fat in this position*) (Dove & Widerman, 2000).

Female sexual functioning: the ability to have sexual desire, sexual arousal, lubrication, orgasm, sexual satisfaction, and lack sexual pain (Satinsky, Reece, Dennis, Sanders, & Bardzell, 2012).

Genital self-image: subjective perceptions and attitudes a person has about his or her own genitalia, usually emphasizing physical appearance (Schick et al.). Having a negative or poor genital self-image indicates dissatisfaction with one's genitals. Having a positive genital self-image indicates satisfaction with one's genitals.

Sexual esteem or sexual self esteem: “the individual's sense of self as a sexual being, ranging from sexually appealing to unappealing and sexually competent to incompetent. Sexual self-esteem may be viewed as the value one places on oneself as a sexual being” (Mayers, Heller, & Heller, 2003, p.270).

Sexual satisfaction: the degree to which people feel satisfied with their sexual experiences (Dove & Wiederman).

Summary

The following literature review will begin by examining the effects of media on women's body image and sexuality. Next, there will be an explanation of how body image issues differ among men and women, as well as how body image issues impact sexual functioning among both genders. A more detailed review of women's body image issues, including how perceptions of their breasts and genitalia affect their self image, and their relation to sexual satisfaction and functioning will follow. Differences among cultures and studies conducted in other countries will also be examined. There will also be literature regarding the role of cognitive distractions in sexual functioning. Lastly, a review of literature regarding potential treatment options and interventions to improve body image and sexual satisfaction and functioning in women will be explored.

Chapter II: Literature Review

Introduction

Research has indicated that mainstream media images and messages are highly correlated with women having poor images of themselves (Myers & Biocca, 2002).

Women have begun to objectify their own bodies, just as the media has done (Fredrickson & Roberts, 1997), resulting in the majority of women being dissatisfied with at least some aspect of their physical self (Algars, Santtila, Jern, Johansson, Westerlund, & Sandnabba, 2011; Forbes & Frederick, 2008; Frederick, Peplau, & Lever, 2008).

Researchers have looked at the differences between men and women with regards to body image, finding that women tend to be more negatively affected by body shame (Sanchez & Kiefer, 2007). In addition, researchers have found a high correlation between negative body image and sexual functioning, with many women reporting difficulty becoming sexually aroused or reaching orgasm (Ackard, Kearney-Cooke, & Peterson, 2000; Satinsky, Reece, Dennis, Sanders, & Bardzell, 2012). Some of the problems women experience with sexual functioning have also been linked to cognitive distractions regarding body image. Through group intervention treatment and cognitive-behavioral techniques, body image, self esteem, and overall satisfaction have increased.

Media, Body Image, and Sexual Health

Over the past two decades, an abundance of research has looked at both the causes and effects of negative body image (Calogero & Thompson, 2009; Myers & Biocca, 1992; Roberts & Gettman, 2004; Steer & Tiggerman, 2008). It is an accepted conclusion that the unrealistic portrayals of men and women in the media has led to negative body

image (Calogero & Thompson). In a study of 76 female students from a southern university in the United States ranging in age from 18 to 24, Myers and Biocca examined the effects of television advertising and programming on women. Participants were assigned to one of five groups (one control group and four experimental groups). The four experimental groups each watched one of four videos approximately 26 minutes in length, that were edited to contain both high image and neutral image television commercials and programming. Programming segments came from three different categories, including prime-time drama/comedy, talent competitions, and music videos. Within the experimental groups, participants watched and rated the videos on how much they liked what they were seeing. The experimental participants also completed a mood test before and after watching the video. Additionally, they were asked to estimate their body size with a body image detection device, estimating the width of their chest, waist and hips. Participants then had their objective body size measured by researchers. Results indicated that the most common body image distortion in experimental groups was an overestimation of body size. Myers and Biocca also found that women's perceptions of their waist and hips were affected by the images they saw in commercials and programming.

Another study found dramatic effects to take place when priming participants with a state of self-objectification (Roberts & Gettman, 2004). Self-objectification theory was created by Fredrickson and Roberts in 1997. The theory lends that women have been acculturated to take on an observer's view of their bodies and to look at themselves merely as a collection of parts. Roberts and Gettman had a total of 160 students from an

undergraduate college, ranging in age from 17-30 that took part in their study. The sample was comprised of 70 men and 90 women. Participants were randomly assigned to one of three different word scrambles. Two word scrambles were priming factors for either self-objectification or body-competence. The third was neutral. Words such as *sexiness*, *weight*, and *proportional* were in the self-objectification scramble, whereas the body-competence scramble contained words such as *health*, *coordinated*, and *strength*. Participants also completed questionnaires regarding shame and disgust, appeal of sex, and appearance anxiety (Roberts & Gettman). Findings displayed that women can enter into a state of self-objectification simply by being exposed to words regarding physical appearance, rather than physical health. Even more disheartening is the results indicating that women in a state of self-objectification led to heightened levels of anxiety concerning one's appearance (Roberts & Gettman).

Participants in the study by Myers and Biocca (1992) previously mentioned watched *less than* 30 minutes of television programming and advertising containing body images and had significantly greater overestimations of their body size than participants who watched programming containing neutral images. According to a survey conducted by the Nielsen Company, the average American watches *over* 35 hours of television each week (Calhoun, 2011). Roberts and Gettman (2004) found women in an anxiety evoking state of self-objectification by merely performing a word scramble containing self-objectifying words. Examining these statistics, it becomes alarming to imagine the effects of prolonged media usage on American's body image, and what consequences this usage poses to physical, psychological, and emotional well-being in children,

adolescents, and adults.

Not only does media have a negative affect on women's body image (Myers & Biocca, 1992; Roberts & Gettman, 2004), but it may also have implications for women's sexual health (Batchelor, Kitzinger, & Burtney, 2004). Batchelor and colleagues conducted a study to explore the types of messages the media sends to young people and how these messages might have implications on sexual health and sexual health promotion. Researchers analyzed media gathered from a variety of sources, including nine magazines targeted toward adolescents and young adults, ten daily and eight Sunday newspapers, and several television programs. Items involving sexual content were collected, with Batchelor and colleagues defining sexual content as any depiction of sexual behaviors, discussion of sex or sexuality, sexually suggestive behavior/images/language, sexual health, or sexuality-related issues. Actions, such as kissing or posing in a sexually suggestive manner were also considered sexual content. Through content analysis, researchers explored how gender roles were depicted and portrayed, as well as whether or not sexual messages were presented with humor, as serious, positive or negative. Researchers found clear gender differences regarding how young men and women talked, felt about, and acted toward sex. They found that the media tends to portray women as being able to talk about their decision to have sex and feelings regarding sex, whereas men tended to brag to their friends about engaging in sex. In addition, men were seen as the pursuers and women as the pursued (Batchelor et al.). Magazines directed toward females tended to focus on romance and emotions, whereas magazines directed toward males included greater visual 'sexual suggestiveness'.

Researchers suggested that these media portrayals send a message to the public that men are 'only after one thing' and it is a woman's obligation to create boundaries. With these unequal messages being sent to men and women, it becomes important for people to understand that these messages are not fact, nor necessarily reality.

Gender Differences in Body Concerns and Sexual Functioning

Several studies have indicated that more women have body image distortions (Feingold & Mazzella, 1998; Haavio-Mannila & Purhonen, 2001; La Rocque & Cioe, 2011; Meana & Nunnink, 2006) and are affected more by body shame (Sanchez & Kiefer, 2007) than men. Algars, Santtila, Jern, Johansson, Westerlund, and Sandnabba (2011) used participants from data collected by the Genetics of Sex and Aggression population-based sample, consisting of 9,532 Finnish twins and their siblings (6,201 women and 3,331 men). Participants were required to be at least 18 years of age with targeted age between 18 and 33. Examining sexual body image, researchers found that 68.1% of men were satisfied with their penis size, while only 54.9% of women were satisfied with the appearance of their vagina, supporting previous research that men are generally more satisfied than women with their physical appearance (Algars et al.). Haavio-Mannila and Purhonen (2001) found similar gender differences in their study that retrieved representative data on sexuality from Finland in 1992 and 1999 as well as St. Petersburg, Russia in 1996. There were a total of 5,827 participants, ranging in age from 18 to 81 years old. Data was also collected from detailed interviews in St. Petersburg with 44 women ranging from age 20 to 63. Haavio-Mannila and Purhonen discovered that the direct correlation between body mass index (BMI) and self-rated sexual

attractiveness was stronger in women than in men, both in Finland and St. Petersburg. Body mass index is one of the most frequently used measures of body size and is easily calculated with a participant's height and weight (Satinsky, Reece, Dennis, Sanders, & Bardzell, 2012).

Examining how body image affects sexual avoidance, La Rocque and Cioe (2011) hypothesized that there would be statistically significant correlations between body image evaluations, body image investment, and body image affect among men and women. Body image evaluations were considered to be one's level of satisfaction with the discrepancy between their actual self and idealized self. Body image investment referred to how much a person invests into maintaining and improving their physical appearance. Body image affect was the emotional experience a person had from body image evaluations, such as during physical intimacy. La Rocque and Cioe also hypothesized that there would be greater levels of negative body image in women than in men, and poorer body image would be associated with greater sexual avoidance.

La Rocque and Cioe's (2011) sample consisted of 264 female and 98 male undergraduate students, ranging in age from 18 to 23 years. An overwhelming majority (86.5%) of subjects were White. Regarding relationship status, 32% were single, 16.6% casually dating, 45.3% exclusively dating, 5.8% common-law, and 0.3% married, indicating that the majority were in some type of partnered relationship. Participants were required to have a history of some type of sexual experience, including vaginal sex, oral sex, anal sex, and mutual masturbation (La Rocque & Cioe). Using independent sample *t* tests, researchers found that women scored significantly lower than men on the

appearance satisfaction subscale, appearance orientation subscale, and body exposure during sexual activities questionnaire. This indicates that women were more dissatisfied with their bodies and tended to have more self-conscious concerns during sexual activity than men. Additionally, women were more likely to try and conceal parts of their bodies from their partner during physical intimacy. Across both genders, findings suggested that the more negatively a person evaluated their body, the more importance they tended to place on body image appearance. Not only were women more dissatisfied with their bodies than men, but they were also more invested (La Rocque & Cioe).

In a sample of 457 college participants (220 men and 237 women), Meana and Nunnink (2006) sought to examine the gender differences in self-reported content of cognitive distortions during physical intimacy. Over three-quarters of the participants were between the ages of 18 and 20 years, and 55.5% were in a romantic relationship ranging in length from 1-80 months. Ethnic backgrounds comprised of 56.5% Caucasian, 14% Asian American, 11% African American, 9% Hispanic American, and 6% as other unidentified. Cognitive distortions and distractions refer to any non-erotic or non-sexual thoughts, such as worries about sexually transmitted diseases or pregnancy. Meana and Nunnink supposed that women would have more cognitive distractions than men. They also hypothesized that women would have greater appearance-based thoughts, while men would have more performance-based concerns.

Meana and Nunnink (2006) used Dove and Wiederman's (2000) Cognitive Distraction Scale to assess the frequency and type of cognitive distortions men and women experience during physical intimacy. The scale is comprised of 20 items, 10

appearance-based statements and 10 performance-based statements. Participants were asked to rate the degree to which they experienced these thoughts on a 6 point Likert scale ranging from *always* to *never*. An example of an appearance based statement is: “While nude in front of my partner, I can't help but think about how unattractive my body is.” An example of a performance based statement is: “During sexual activity, I think too much about whether my partner is happy with the way I am touching his body” (Dove & Wiederman).

Meana and Nunnink's results indicated that women had more cognitive distractions than men (2006). Additionally, women had significantly more appearance-based concerns during sex than men. Meana and Nunnink did not find, however, that men had more performance-based thoughts than women. Yet, negative body image was the strongest predictor for appearance-based thoughts for *both* men and women. After psychological distress, negative body image was also the next strongest predictor for performance-based distractions in women. Meana and Nunnink posited that women are more susceptible to internal and external distractions than men. Considering women's greater susceptibility, it becomes important to intervene and increase women's body image.

Similarly, Sanchez and Kiefer (2007) predicted women would report greater body concerns and sexual functioning problems than men. Sexual functioning problems included difficulty becoming sexually aroused and an inability to reach orgasm. Sanchez and Kiefer also hypothesized that body shame would be correlated to less sexual arousability and pleasure and greater difficulties reaching orgasm. Lastly, Sanchez and

Kiefer supposed that reduced sexual arousability and ability to orgasm would predict lower overall sexual pleasure. This study contained a sample of 320 participants, 122 men and 198 women, ranging in age from 17 to 71 years of age. Supporting past research, Sanchez and Kiefer found that women reported greater body image concerns, specifically body shame and self-consciousness, as well as more difficulty becoming sexually aroused and reaching orgasm. Sanchez and Kiefer also discovered that body shame, when one's perceived image of his or herself does not meet cultural norms or expectations, predicted greater sexual self-consciousness during physical intimacy.

It is evident that both men and women are affected by poor body image, as evidenced by La Rocque and Cioe's (2011) findings that men and women who had poorer body image found greater importance in body image appearances. Yet, it is clear that women tend to be more dissatisfied and have greater body image concerns overall (Meana & Nunnink, 2006; Sanchez & Kiefer, 2007). If a woman is experiencing self-consciousness about her body to the point in which she feels she needs to conceal certain parts from her partner, it seems obvious that she is not enjoying herself as much as she would like. In addition, a woman feeling concerns about her body during is clearly unable to stay fully present in the moment while she is being intimate with her partner. Women who have these concerns and struggle with these distracting thoughts could benefit from the current support group.

Body Image and Sexual Satisfaction and Functioning

Researchers have examined how women's perceptions of their physical appearance (body image) is correlated with their sexual satisfaction and sexual

functioning. In a study conducted by Satinsky, Reece, Dennis, Sanders, and Bardzell (2012), researchers examined the relationship between body appreciation and sexual function in women of various body mass indexes (BMIs). Body appreciation was defined as respecting and accepting one's body, despite its shape or size. They also described body appreciation as rejecting unrealistic body standards. Satinsky and colleagues hypothesized that BMI would predict sexual function, body appreciation would predict sexual function, and BMI would mediate the relationship between body appreciation and sexual function. The study consisted of 247 North American females, ranging in age from 18 to 58 years. Fifty-three percent identified as heterosexual, 27.1% as bisexual, 7.7% as queer, and 3.2% as lesbian (Satinsky et al.) Researchers used two different scales as a means of collecting data, including the Body Appreciation Scale and Female Sexual Function Index. Using multiple regression analyses and controlling for age and partner status, results indicated that body appreciation positively predicted sexual functioning, specifically arousal, satisfaction, and orgasm. Body appreciation was not, however, associated with desire or lubrication. Additionally, BMI was not a mediator of body appreciation and sexual function (Satinsky et al.). While Satinsky and colleagues succeeded in finding a wider variety of women from different sexual orientations than other studies, the study was limited in the fact that most women were White and well educated.

Examining body image from a positive framework, Donaghue (2009) wished to examine the relationship between women's sexual self-schemas (the generalizations a person makes about their self as a sexual being based on previous and current sexual

experiences), body satisfaction, and overall sense of subjective well-being. Donaghue hypothesized that there were positive correlations between body satisfaction, sexual self-schemas, and subjective well-being. Ninety-one female participants completed a series of scales regarding satisfaction with life and sexual self-schemas. Participants were recruited from an Australian university and ranged in age from 18 to 68 years. Findings indicated that, as predicted, the greater a woman's subjective sense of satisfaction with her life, the greater her satisfaction with her body. Additionally, body satisfaction was significantly correlated with life satisfaction, positive affect, and negative affect. Donaghue also found that the passionate/romantic aspect of sexual self-schemas was associated to life satisfaction and positive affect, while the embarrassed/conservative aspect was related to negative affect.

In a cross-sectional, correlational designed study, researchers aimed to examine the relationship between sexual satisfaction and body image (Pujols, Metson, & Seal, 2010). Women over the age of 18 were recruited across the United States through online advertisements. The sample consisted of 154 women ranging in age from 18 to 49 years, with 60.4% having an undergraduate degree and 39.6% having an advanced degree. Regarding ethnic background, an overwhelming 79% identified as White/Caucasian, 4% African American, 7% Asian, 6% Hispanic/Latina, 2% other, and 2% did not report. Researchers found through a series of surveys and measures that the greater esteem a woman had about her body parts and functions, the higher her sexual satisfaction with her partner (Pujols et al.). Furthermore, when women feel better about the way their body looks and how it performs, they tend to enjoy sex more frequently. Results also indicated

that more appearance-based thoughts during physical intimacy were related to lower sexual function and satisfaction (Pujols et al.).

Similarly, in a study consisting of 3,627 female participants, ranging in age from 14 to 74, researchers aimed to examine the relationship between body image and sexual behavior (Ackard, Kearney-Cooke, & Peterson, 2000). The majority of subjects identified as heterosexual (94.7%) and Caucasian (81.1%). Participants responded to a survey in Shape magazine, “Does Your Body Image Affect Your Love Life?” asking questions regarding body image, overall appearance perceptions, sexual experiences and practices. Results indicated that women who were more satisfied with their body image tended to take part in more sexual behaviors and feel more comfortable during various sexual activities. Specifically, body image played a major role in predicting frequency of initiating sex, reaching orgasm, comfortableness with new sexual activities, and pleasuring one's partner (Ackard et al.).

It is helpful that research has looked at, not only the possible consequences of *poor* body image, but also the possible outcomes of having a positive body image. With Donaghue (2009) finding a positive correlation between body image and life satisfaction and Ackard, Kearney-Cooke, and Peterson (2000) discovering that women feel more comfort in exploring their sexuality and experience more orgasms when they have a greater body image, it seems that a support group aiming to increase positive body image could have a plethora of positive outcomes for group members.

Body Image Outside North America

In examining the abundance of literature from the past decade, it becomes evident

that a majority of the research concerning body image and sexual functioning has been done within the United States and Canada. These studies have generally led to similar conclusions, being that women with poorer body appearance perceptions tend to have less sexual functioning (Ackard, Keraney-Cooke, & Peterson, 2000; Pujols, Metson, & Seal, 2010; Satinsky, Reece, Dennis, Sanders, & Bardzell, 2012). Less research has focused on countries outside North America, and even fewer have looked at non-Westernized countries to assess if there is a difference in how body image affects sexual functioning.

In a study conducted by Carvalho and Nobre (2010), body image beliefs and self-body image thoughts did not predict sexual desire within a sample of 237 Portuguese women, ranging in age from 18 to 73 years. Researchers did find, however, that failure and disengagement thoughts, such as “I’m not turned on” were significant predictors of sexual desire. This study is limited in that Carvalho and Nobre used a convenient sample that consisted of mostly married (49.4%) and well educated (53.6% with a graduate degree) females. Thus, the findings are not very generalizable to the larger population of women. Yet, it is important to notice that cognitive distractions regarding failure stopped women from becoming sexually aroused.

In a study looking at Australians, participants consisted of 211 men and 226 women, ranging in age from 18 to 86 years old (Davison & McCabe, 2005). Researchers aimed to examine the role of body image throughout the lifespan in males and females. Participants completed the Body Image Satisfaction and Body Image Importance subscales of the Body Image and Body Change Questionnaire. These subscales asked

questions such as, “How important to you is the shape of your body, compared to other things in your life?” Participants also rated their perceived physical attractiveness. The degree to which a person concealed their body from others and the tried to improve their body were also assessed. Lastly, participants completed the Social Physique Anxiety Scale and Physical Appearance Comparison Scale. Davison and McCabe found that women reported lower levels of body image satisfaction and higher levels of social physique anxiety than did men. Women also concealed their bodies more frequently and were more likely to compare their appearance than men. After controlling for BMI, results indicated that both men and women in their 30's and 40's reported lower body satisfaction and more frequent attempts to conceal their bodies. Yet, participants in late adulthood had fewer concern about others evaluating their bodies and less frequent appearance comparisons than younger participants (Davison & McCabe).

In another Australian study, a sample of 116 South Australian college females, ranging in age from 18 to 54 years, completed a series of surveys and questionnaires regarding sexual functioning, relationship status and satisfaction, self-consciousness during sexual activity and body image (including self-objectification, self-surveillance, and body shame) (Steer & Tiggerman, 2008). Sexual functioning was measured in terms of having experienced the following within four weeks prior to the study: desire/arousal, orgasm, and sexual satisfaction. Results indicated that self-objectification and self-surveillance were not related to sexual functioning. This indicates that women who tend to monitor their bodies on how it looks, rather than how they feel physically, are still able to become aroused, reach orgasm, and be sexually satisfied. Steer and Tiggerman did

find, however, that self-objectification and self-surveillance were positively correlated with self consciousness during physical intimacy. These findings suggest that women who monitor their bodies and look at their bodies as a collection tend to be more concerned with the appearance of their bodies during sexual activity. Supporting Fredrickson and Roberts (1997) self objectification theory, Steer and Tiggerman found that women with body shame and appearance anxiety were more likely to feel self conscious during sexual activity than women without body shame and appearance anxiety. Results also indicated that self consciousness during physical intimacy was negatively correlated with sexual functioning. Women who tend to feel more self conscious about their bodies are less likely to become aroused, reach orgasm, and be sexually satisfied (Steer & Tiggerman).

A study conducted with 112 British women, however, *did* show a negative correlation between body shame and body surveillance with sexual self-esteem and sexual satisfaction (Calogero & Thompson, 2009). Participants in this study ranged in age from 18 to 39 and had been sexually active at least twice in the 12 weeks prior to the study. Researchers excluded women in long term relationships (more than 10 weeks). Participants completed a series of questionnaires examining media internalization, body surveillance, body shame, sexual self-esteem, and sexual satisfaction. Media internalization was referred to as the extent to which women have internalized media appearances. For example, a woman with high media internalization may believe that she should look like the models and movie stars seen in magazines and on television. Through regression analysis, Calogero and Thompson found that higher internalization of

media appearance portrayals led to greater body monitoring and body shame. They also found that body monitoring directly led to less sexual satisfaction. These findings support Myers and Biocca's (1992) research indicating that the media negatively affects women's body image perceptions. Calogero and Thompson moved one step further and found that women who survey their bodies tend to also be less sexually satisfied.

As previously mentioned in the review of literature on gender differences, Haavio-Mannila and Purhonen (2001) examined how thinness correlated to one's self-rated sexual attractiveness in a sample of 5,827 women ranging in age from 18 to 81. Not only did Haavio-Mannila and Purhonen look at differences between men and women, but also between two different cultures: Finland (considered a more Westernized nation) and St. Petersburg, Russia (considered, at the time during data collection, to still live under communist ideology). Researchers hypothesized that (1) slimmer people would consider themselves more sexually attractive than stouter people, (2) women would demonstrate a stronger association between thinness and sexual attractiveness, and (3) body size has more influence on sexual attractiveness in Finland than in St. Petersburg, Russia (Haavio-Mannila & Purhonen).

Haavio-Mannila and Puhonen (2001) used both qualitative and quantitative methods in their study. Results demonstrated that thinner people tended to rate themselves as more sexually attractive than did plumper people (Haavio-Mannila & Purhonen). Men from St. Petersburg, however, were an exception to this finding in that their body size was not linked to their perceived sexual attractiveness. Findings also displayed that women hold stronger relationships between body mass index and sexual

attractiveness than men. These results, indicating that women tend to be more affected by body image than men, were later supported by Sanchez and Kiefer (2007). Since there was no direct link between body mass index and self-rated sexual attractiveness in St. Petersburg men, Haavio-Mannila and Purhonen concluded that Western ideals of thinness were not as strong in St. Petersburg as they were in Finland. Upon reading excerpts from interviews with both Finnish and Russian women, both cultures indicated that they would not mind losing weight. Yet, Finnish women seemed more preoccupied with such ideas and elaborated more on their dissatisfaction, indicating that Western ideals indeed have taken a stronger hold in Finland (Haavio-Mannila & Purhonen).

This discrepancy in findings throughout literature outside North America could be attributed to the varying ways in which researchers have defined body image. Some studies have used BMI to attempt to predict sexual functioning (Satinsky, Reece, Dennis, Sanders, & Bardzell, 2012; Weaver & Byers, 2006). Other researchers, however, have used women's subjective, or perceived, body image, which tends to fall in line with Fredrickson and Roberts' self-objectification theory (1997). Weavers and Byers conducted a cross-sectional, correlational study with a sample of 214 heterosexual female Canadian students with a mean age of 20.64 years old. Results were contrary to what was originally hypothesized, that women with higher BMI would also have poorer sexual functioning, specifically sexual anxiety, sexual arousability, sexual assertiveness, sexual esteem, sexual problems, and sexual satisfaction. Weavers and Byers found no correlation between BMI and exercise level with any of the sexual functioning variables. They did find, however, that women with higher BMIs tended to be more dissatisfied

with their bodies than women with lower BMIs. In turn, women who were more dissatisfied tended to avoid specific situations or activities as a result of their BMI (Weaver & Byers).

As mentioned previously, however, Satinsky, Reece, Dennis, Sanders, and Bardzell (2012) did not find that BMI in and of itself predicted sexual functioning. One of the largest limitations to studies that include body mass index as their measure of determining body size is that BMI is not always an accurate representation of a person's body size (Kaneshiro et al., 2008). It does not, for example, account for athletes, who may weigh quite a bit more due to muscle mass. Nor does it account for elder adults who may have significantly less muscle, and possibly more fat than a young or middle aged adult. This lends to the conclusion that it is a woman's *subjective* perception of her physical appearance, rather than her actual body size or shape, that better predicts sexual functioning (Weavers & Byers).

Overall, it appears that the majority of body image issues are more prevalent in women from Westernized countries, as evidenced by findings from Davison and McCabe (2005) and Steer and Tiggerman's (2008) Australian studies. Non-western countries, such as Russia, have not found as strong of correlations between body image and sexual satisfaction (Haavio-Mannila & Purhonen, 2001). Due to these findings, it is important for the current support group to target women acculturated with Western ideals.

Body Image and Sexual Functioning Across Cultures

Little to no research has looked at body image in relation to sexual functioning within specific minority groups. Many studies have included minorities, but the samples

are generally an overwhelming percentage of White participants (Ackard, Kearney-Cooke, & Peterson, 2000; Pujolos, Metson, & Seal, 2010; Satinsky, Reece, Dennis, Sanders, & Bardzell, 2012). Some literature exists, however, looking at either body image (Wardle, Haase, & Steptoe, 2006) *or* sexual functioning (Tang, Lai, Phil, & Chung, 1997) within minority groups. Wardle, Haase, and Steptoe examined data collected from the International Health and Behaviour Survey in 22 different countries between 1999 and 2001. The aim of the study was to examine weight loss behaviors and weight perceptions among university students. Wardle, Haase, and Steptoe placed countries into one of five different groupings, including North-Western Europe and USA, former socialist states of Central and Eastern Europe, Mediterranean countries, countries of the Pacific-Asian rim, and South American countries. There were a total of 18,512 participants (8,115 men and 10,397 women), ranging in age from 17 to 30. Participants reported their height and weight and indicated their perceived weight (e.g. slightly overweight, very underweight), as well as whether or not they were attempting to lose weight. Wardle and colleagues found that women were more likely than men to perceive themselves as overweight. An average of 43.7% of women across 22 countries believed they were overweight, with a range of 23% (Germany) to 63% (Japan). Women were also much more likely to be trying to lose weight than men. An average of 51.2% of women across 22 countries were attempting to lose weight, with a range of 29% (Portugal) and 77% (Korea) (Wardle et al.). With nearly half of the women across 22 different countries believing they are overweight, it becomes apparent that body image could potentially be a global issue.

In a different study, Tang, Lai, Phil, and Chung (1997) examined sexual functioning in Chinese college students. Participants included 160 men and 145 women, with a mean age of 20.5 years old. Findings indicated that men tended to have more sexual information and held more liberal sexual attitudes. Additionally, males had higher levels of sexual drive, fantasy, and satisfaction. Eighty-seven percent of men reported having sexual fantasies weekly, while 59% of females reported having fantasies monthly. More men reported masturbating (43.8%) than women (21.4%). Only 11% of students reported having experience with sexual intercourse. Even fewer indicated experience in oral-genital stimulation (4.2% of women and 8.2% of men) and anal sex (0% of women and 1.2% of men) (Tang et al.).

In reviewing the literature, the sexual functioning statistics of Chinese college students tend to be much lower than that of Americans. That is, men and women in college in the United States seem to be more sexually active than Chinese male and female college students. Tang, Lai, Phil, and Chung (1997) attribute this to the fact that Chinese culture tends to stress academic achievement with enormous competition among universities. Thus, many men and women focus on their studies, and spend less time in sexual activities. Tang and colleagues also posited that Chinese students tend to live at home during their college years, allowing for less opportunity to have privacy with one's partner.

Another study consisting of 729 women from the University of California, Los Angeles, examined the ethnic differences in overall body dissatisfaction and breast size dissatisfaction (Forbes & Frederick, 2008). Participants included 32.5% of women who

classified themselves as Asian, 26.9% as European/White/Caucasian, 15.0% as Hispanic/Latino, and 8.0% as Black/African American. The remaining women (17.7%) were not reported due to having too few participants in other ethnic groups. Women were asked to indicate their actual and desired breast sizes as well as their height and weight in order to calculate BMI. A breast size dissatisfaction scale and appearance evaluation scale was also completed by the participants. Confirming one of their hypotheses, women with smaller breasts reported greater breast dissatisfaction than women with larger breasts. Having smaller breasts, however, was not associated with overall body dissatisfaction. Researchers also found that European American and Asian women with greater breast dissatisfaction also had lower overall body dissatisfaction (Forbes & Frederick).

Regardless of ethnicity in Forbes and Frederick's (2008) research, the majority of women (70% Asian, 50% European/White/Caucasian, 66% Hispanic/Latino, 54% Black/African American) desired larger breasts. Looking only at breast dissatisfaction, an even greater percentage of women reported not being satisfied, 69% Asian, 83% European/White/Caucasian, 73% Hispanic/Latino, and 74% Black/African American. Asians were found to desire larger breasts than any other ethnic group (Forbes & Frederick). It is important to note, however, that this study did not use actual measurements to identify breast or body size. Women self reported their cup size as A, B, C, or D and indicated if they were either small, medium, or large within that cup size. Despite whether or not these participants misreported their breast size, the issue is still extremely significant, seeing that an overwhelming majority of women were dissatisfied

with their breast size.

Supporting research looking primarily at White participants, (Haavio-Mannila & Purhonen, 2001; La Rocque & Cioe, 2011; Meana & Nunnink, 2006) Wardle, Haase, and Steptoe (2006) found that women were more likely to have body image issues, with more women than men believing they were overweight and trying to lose weight across South American, Asian, and former Socialist cultures. In addition, the majority of Hispanic, Asian, and African American women have found to be dissatisfied with their breasts (Forbes & Frederick, 2008). Consequently, it is essential for the current support group to include women from various ethnic backgrounds and cultures, as this is an issue affecting women across the globe.

Effects of Breast and Genital Appearance Perceptions on Sexual Functioning

Following objectification theory, some researchers have looked for a correlation between specific body parts, specifically female genitals, and sexual functioning and satisfaction (Berman, Berman, Miles, Pollets, & Powell, 2003; Schick, Calabrese, Rima, & Zucker, 2010). With women looking at themselves as a collection of parts, it would be justified to examine how certain body parts are related to sexual functioning. Berman et al.'s study included 31 female patients who were visiting a sexual health center, with a mean age of 38 years. Eighty-four percent were in a partnered relationship (61% married and 23% in a relationship), while 16% identified as single. Participants were asked to complete a set of scales and surveys that required them to rate the degree to which they resonated with statements about their genitals. Examples of statements rated were, “I feel ashamed/embarrassed about the size of my genitals” and “I feel my genitals

work/function as they should.” Results indicated that positive genital self-image was correlated with sexual desire. No significant correlation was found, however, between genital self-image and lubrication, orgasm, satisfaction, or absence of pain (Berman et al.). The lack of correlation could be due to the fact that female genitalia parts were not separated into its individual parts, instead it was lumped into one category. Considering objectification theory, researchers may need to specifically identify different female parts in future research.

Schick, Calabrese, Rima, and Zucker (2010) aimed to examine the relationship between genital appearance dissatisfaction and reported genital image self consciousness during sexual activity. Additionally, they believed these cognitive preoccupations would affect women's sexual self-esteem and motivation to avoid risky behavior. Schick and colleague's sample consisted of 217 female undergraduate students, ranging in age from 18 to 28 years. Most of the women were White (80%) and reported a family annual income greater than or equal to \$100,000 (73%). Sixty-three percent of women reported having experienced vaginal intercourse. Contrary to past research, Schick and colleagues broke down the category of “female genitalia” into its individual parts: labia majora, labia minora, clitoris, vaginal canal, and pubic hair. Findings showed that vulva appearance dissatisfaction and genital image self-consciousness were associated with sexual esteem and sexual satisfaction. They were not, however, correlated with motivation to avoid risky sexual behavior (Schick et al.).

In 2008, Frederick, Peplau, and Lever examined women's satisfaction with their breast size and shape across the lifespan. Researchers hypothesized that younger women

would be more concerned with the size of their breasts, while older women would be more concerned about the droopiness of their breasts. In addition, they aimed to answer whether or not if women who were dissatisfied with their breasts would rate themselves as less attractive and be more uncomfortable displaying themselves in public situations, such as wearing a swimsuit. Lastly, Frederick et al. wanted to see if women who were dissatisfied with their breasts were more unwilling to show their naked bodies to their sexual partner.

Frederick, Peplau, and Lever (2008) recruited 26,703 female participants, ranging in age from 18-65. Of these tens of thousands of women, an alarming 70% reported being dissatisfied with some aspect of their breasts, 33% wanting less droopy breasts, 28% desiring larger breasts, and 9% wanting smaller breasts. Confirming their hypothesis, younger women most desired larger breasts, while older women most desired perkier breasts. Upon taking body mass index (BMI) into account, 53% of underweight women and 33% of healthy weight women wanted larger breasts. Forty-four percent of overweight women and 53% of obese women considered their breasts too droopy. While most women reported that they undress in front of their sexual partners, women who were dissatisfied with their breasts were more likely to try concealing their breasts during physical intimacy (Frederick et al.). Considering that women have no control over the size or shape of their breasts without surgical intervention, it becomes quite alarming that the vast majority of women are dissatisfied with their breasts. It may be useful for women experiencing such dissatisfaction to take part in a support group aimed towards body acceptance (Devaraj & Lewis, 2010).

As mentioned previously when examining literature on gender differences, Algars, Santtila, Jern, Johansson, Westerlund, & Sandnabba (2011) aimed to examine sexual body image with Finnish twins and their siblings. Focusing now on the 6,201 female participants, findings displayed that nearly half (45.1%) of women were dissatisfied with the appearance of their vagina. Over half of the participants did not think they had attractive breasts, with 40.7% wanting larger breasts, and 13% desiring smaller breasts. Results also indicated that genital satisfaction was positively correlated with frequencies of sexual fantasies, kissing and petting, oral sex, anal sex, and vaginal intercourse. Furthermore, the more positively a woman felt about her genital appearance, the more frequently she engaged in various sexual activities. Lastly, having a positive general body image was correlated with women feeling that they had an attractive vagina and breasts (Algars et al.).

Cognitive Distractions

Researchers have also begun to examine how cognitive distortions are associated with sexual functioning (Dove & Wiederman, 2000; Nobre & Pinto-Gouveia, 2008) and satisfaction (Purdon & Holdaway, 2006). These cognitive distortions include, but are not limited to, low body image thoughts. An example of this would be a woman worrying about how her body appears to her partner while engaged in sexual activity. In a sample of 207 Portuguese women, 47 with sexual dysfunction, 160 with normal functioning, researchers found that women with orgasmic disorder presented significantly higher scores on believing that body image plays a central role in sexual activities (Nobre & Pinto-Gouveia). Findings also indicated that women with orgasmic disorder tended to

think about poor body image more often than the control group (Nobre & Pinto-Gouveia). This study is severely limited, however, as only ten of the 47 participants with sexual dysfunction had orgasmic disorder. A larger sample would allow for more representativeness to the greater population of women with orgasmic disorder. In addition, it is important to look at how thoughts of body image during sexual activity affect women without sexual dysfunction.

Purdon and Holdaway (2006) studied the range of thoughts men and women have during sexual intimacy, and how these thoughts relate to their sexual attitudes, satisfaction, and functioning. Participants were recruited from an undergraduate psychology class, and consisted of 50 females and 47 males under the age of 25 (mean age of 20) who had engaged in sexual activity at least once during the three months prior to the study. Subjects completed an open-ended questionnaire created by the researchers of the study. The questionnaire required subjects to write down, verbatim, all distracting thoughts they had during their most recent sexual experience with a partner. Research members were able to code the 345 different thoughts they received and place them in one of nine categories: intrusion, body concerns, sexually transmitted infections/pregnancy, emotional/relationship, morality/guilt/regret, dislike of the sexual activity, distracting thoughts (i.e. school or work), thoughts of others, and performance. Participants rated each thought on how frequently it occurs during sexual situations on a 7-point Likert scales, ranging from *rarely* to *always* or *no anxiety* to *extreme anxiety*. Participants also completed a series of questionnaires regarding sexual functioning, sexual satisfaction, and sexual opinion (Purdon & Holdaway).

Results indicated that men and women both engaged in an array of non-erotic thoughts during sexual activity, with men reporting more performance based thoughts and women reporting more body image-related thoughts (Purdon & Holdaway, 2006). Women tended to have more non-erotic thoughts than men, as well as more anxiety related to their thoughts. Thirteen out of 41 women (31.7%) reported that body image was their first or second distracting thought, and 11 (26.8%) reported performance as their first or second thought. Additionally, women who reported more distracting thoughts and higher anxiety evoked by these thoughts tended to have poorer sexual functioning and less sexual satisfaction (Purdon & Holdaway). These findings that women tend to have greater body image-related thoughts than men supports Meana and Nunnink's (2006) research. Sanchez and Kiefer (2007) later found that women are more affected by body shame than men, which seems to mirror Purdon and Holdaway's findings that women evoke more anxiety from their non-erotic thoughts than men.

In a study of 120 females recruited from an undergraduate psychology course, participants ranged in age from 18 to 21 years and predominantly identified as Caucasian (93%) (Dove & Wiederman, 2000). Researchers wished to examine women's cognitive distractions during physical intimacy, and how these distractions are related to sexual esteem, sexual satisfaction, orgasm consistency, and pretending orgasm. Participants were asked to complete a series of questionnaires regarding general self-focus and affect, body dissatisfaction, sexual attitudes, sexual drive and desire, cognitive distraction, sexual esteem, orgasm consistency, and pretending orgasm. Prior to examining their results, Dove and Wiederman had placed cognitive distraction items into two categories,

appearance-based and performance-based. After discovering that the appearance-based distractions contributed to only 6.8% of the variance, researchers combined the two factors, allowing for cognitive distractions to account for 71.6% of the variance. Researchers supposed that the distractions did not fall into two factors due to what society has taught women to view as “sexy.” Since societal norms have defined adequate sexual partners as appearing “sexy,” women may be prone to classify their distractions as performance-based if they are under the belief that having an attractive body is intertwined with performing well as a sexual partner (Dove & Wiederman).

Cuntim and Nobre (2011) conducted a study examining the difference in automatic negative thoughts among women with and without difficult reaching orgasm. Participants included 191 sexually active women, ranging in age from 18 to 59 years. Most of the women were married (49.7%). Findings suggested that the greater a woman had non-erotic thoughts during sexual activity, the lower the level of orgasm (Cuntim & Nobre). Additionally, they discovered that women with orgasm difficulties had significantly more thoughts of sexual abuse, failure and disengagement, passivity and control, lack of affection, and lack of erotic thoughts during physical intimacy than did those with no orgasm difficulty. Body image related thoughts did not, however, differ significantly between the group with orgasm difficulty and the group without (Cuntim & Nobre). Researchers did not provide tables or figures displaying their data or statistical analyses. Perhaps, however, there was not a significant difference between groups in frequency of body image related thoughts because women without orgasm difficulty have just as many thoughts about their appearance as women with orgasm difficulty.

Since many women tend to have non-erotic thoughts during physical intimacy (Cuntim & Nobre, 2011; Dove & Wiederman, 2000; Nobre & Pinto-Gouveia, 2008; Purdon & Holdaway, 2006), with many of these thoughts pertaining to body appearance, the current support group aims to improve positive body image before exploring sexual satisfaction and sexual functioning. It is hypothesized that by improving body image first, women's sexual satisfaction may naturally raise as well. The facilitator and group members can then examine body image on a deeper level, along with any other non-erotic thoughts or concerns women experience.

Treating Negative Body Image

With an overwhelming amount of research showing that greater negative body image is related to higher frequency of various sexual problems, ranging from sexual avoidance to inability to reach orgasm (Algars, Santtila, Jern, Johansson Westerlund, & Sandnabba, 2011; La Rocque and Cioe, 2011; Pujols, Metson, & Seal, 2010; Satinsky, Reece, Dennis, Sanders, and Bardzell, 2012) as well as literature pointing toward body image as the main predictor in appearance-based cognitive distractions during physical intimacy (Meana & Nunnink, 2006), it appears evident that treatment needs to start at the root of the issue, body image, and work toward enhancing women's satisfaction with their bodies.

In a study of 47 females from Australia, ranging in age from 16-52, researchers aimed to increase subjects' satisfaction with their general appearance, along with individual body parts through a cognitive behavioral group intervention program (Devaraj & Lewis, 2010). Pre- and post-intervention questionnaires concerning

demographics, attitude toward and perceptions of their body image, impact of their body image upon their psychosocial functioning, and satisfaction with life were completed by participants. The group intervention program met weekly for 1.5 hours and was facilitated by masters level students in a clinical psychology program (Devaraj & Lewis).

During the first session, researchers offered psychoeducation to participants on body image and the effects of negative body image (Devaraj & Lewis, 2010). In the following session, participants were explained the development of body image, as well as cognitive behavioral explanations for the relationship between thoughts, feelings, and events. The third week entailed educating the women on common appearance assumptions and body image related cognitive distortions, thus normalizing feelings they may possess. Participants also practiced body affirmation exercises, focusing on changing internal dialogue from a negative framework to a positive one. In the fourth session, facilitators psychoeducated on eating disorders, a possible result of negative body image, and healthy weight management techniques. Session five was characterized by learning about stress management and relaxation techniques, mindfulness, and negative emotion regulation. The final session worked on self-esteem improvement techniques, goal setting, and relapse prevention. Finally, participants completed the post-intervention questionnaire (Devaraj & Lewis).

Results indicated a statistically significant lower mean physique anxiety score and mean body surveillance after the group participation intervention (Devaraj & Lewis, 2010). Additionally, women tended to perceive body image as having a more positive impact on life after group treatment. Body shame was also reduced upon completing the

intervention group. Self esteem and satisfaction with their bodies showed statistically significant raises between pre- and post-intervention. Satisfaction with overall health and fitness and life satisfaction showed slight increases, but were not statistically significant (Devaraj & Lewis). This small increase in overall health and life satisfaction could be accounted for by the fact that life satisfaction and overall health and fitness satisfaction were already fairly high in the pre-intervention questionnaire. Lastly, mean satisfaction with weight and lower, mid-, and upper torsos were significantly higher upon completion of the group intervention treatment (Devaraj & Lewis). The same researchers conducted the same group intervention with different participants to support their initial findings (Lewis & Devaraj, 2010). In the following study, however, they included a control group that simply took the pre- and post-intervention questionnaires, but did not attend any type of group program over the six week period. This was done in order to confirm that it was indeed the program that was related to change in participants, and not some external factor. Researchers found that participants in the group intervention had statistically significantly higher self esteem, body satisfaction, body surveillance, overall body image, and quality of life, as well as a significant decrease in body shame. Participants from the control group did not show any significant change in satisfaction with overall body appearance, weight, and lower, mid-, and upper torso regions. There was also no change in the control group's perception that body image has a positive impact on their life, nor self esteem (Lewis & Devaraj).

With both Devaraj and Lewis (2010) and Lewis and Devaraj (2010) finding positive outcomes, including higher self esteem, greater body satisfaction, and a more

positive body image, it would be beneficial for the current support group to incorporate similar aspects into its weekly sessions. In addition, both previously mentioned groups were effective in reducing body shame among group members. Consequently, the current project will adopt similar cognitive behavioral techniques and approaches.

Therapeutic Interventions

Cognitive Behavioral Groups

In a study aiming to increase self esteem through cognitive behavioral techniques, Waite, McManus, and Shafran (2012) hypothesized that cognitive behavioral therapy (CBT) would show greater improvements in self esteem, anxiety, depression, overall functioning, and reductions in psychiatric diagnoses compared to a waitlist (control) group. Waite and colleagues also supposed that any improvements made in the immediate treatment group would still be present after an 11 week follow-up. There were a total of 22 participants, ten women and one man in the immediate treatment group (mean age of 30.64) and eight women and three men in the waitlist group (mean age of 36.55). Fifteen participants were referred by clinicians, while the other seven were self-referred through advertisements (Waite et al.). In order to be included in the study, participants had to experience clinically significant low self-esteem as evidenced by specific scores on the Robson Self-concept Questionnaire and Clinical Outcomes in Routine Evaluation – Outcome Measure. Participants in the immediate treatment group received ten individual one-hour sessions by an accredited CBT therapist who was supervised by another experienced CBT therapist. Sessions included goal setting, teaching skills to re-evaluate anxious and negative self-talk, improving self-acceptance,

and developing healthier beliefs regarding planning for the future (Waite et al.).

Results indicated that participants in the immediate treatment group showed significantly higher scores on the Robson Self-concept Questionnaire, measuring self-esteem, as well as greater overall functioning, and less depression (Waite, McManus, and Shafran, 2012). Seventy percent of the members of the immediate treatment had clinically significant self-esteem improvement, and 90% had reliable change. In addition, members of the immediate treatment group had significantly fewer psychiatric diagnoses at post-treatment. No participants in the waitlist group showed significant or reliable change in self-esteem, nor any improvement in symptoms from pre- to post-test. Once participants in the waitlist group received CBT, there were no significant differences between groups (Waite et al.). This provides greater support for Waite and colleagues to suppose that it was the cognitive behavioral techniques that improved self esteem, and not a confounding variable. Upon 11 week follow-up assessment, 66.7% of participants had clinically significant improvement, and 72.2% had reliable improvement (Waite et al). Considering the current support group is exclusive to women, and Waite and colleagues participants were primarily women, their findings are important to consider in creation of the group curriculum.

Mindfulness-Based Groups

Brotto, Basson, and Luria (2008) created a mindfulness-based psychoeducational support group for women struggling with sexual arousal and desire complaints. Twenty-six women participated in the study, ranging in age from 24 to 55 years. All of the women had received a higher level of education than high school and 96.2% identified as

heterosexual. Regarding ethnicity, 58% identified as Euro-Canadian, 23% as East Asian, and the remaining 19% were either Hispanic or African Canadian. Women were recruited from the BC Centre for Sexual medicine in British Columbia, Canada (Brotto et al.). Women with sexual desire/interest disorder, combined, genital or subjective sexual arousal disorder were informed of the study. Screening of participants simply required that the participant be fluent in English, willing to participate in the group, and diagnosed with the before mentioned disorders. Prior to beginning group treatment, participants completed a series of questionnaires pertaining to sexual response, sexually related distress, sexual interest and desire, sexual arousal, relationship adjustment, depression, and participant's perceptions of genital sexual arousal. Upon completing the measures, all participants took a sexual arousal assessment. This assessment was completed by measuring sexual arousal response from an inserted vaginal photoplethysmograph as participants watched neutral and erotic film segments.

Brotto, Basson, and Luria (2008) did not provide much information regarding the curriculum for sessions, other than that it was altered from a previous study to be better tailored for a group atmosphere. They also indicated that it included cognitive behavioral therapy, education, sexual therapy, relationship therapy, and mindfulness. Participants attended three 90 minute sessions that met every 2 weeks. During sessions, group members were given handouts and assigned homework pertaining to that week's session. After group treatment, 24 of the 26 participants were able to complete the post-sexual arousal assessment. Results indicated that there was an increase in sexual arousal from pre- to post-test, but it was not statistically significant. Post group questionnaires also

showed significant increases in sexual desire and significant decreases in sexual distress. Participants reported that the mindfulness exercises and discussions were most helpful throughout group therapy. One of the major limitations to this study, however, was the lack of a control group. If a control group had been used, Brotto and colleagues would have been able to better attribute their successes to the therapeutic treatments. Due to the self reported effectiveness of mindfulness, however, the current support group will incorporate this into its curriculum.

Grief Work and Body Acceptance

Upon working with body size acceptance in women for over twenty years, Courtney (2008), a licensed marriage and family therapist, has applied a grief process technique when working to help her clients increase their positive perception of their bodies. After accepting the fact that women cannot change the size of their bodies, Courtney argued that women either self-blame or accept their body as it really is. In order to guide clients toward body acceptance, and ultimately self acceptance, Courtney attempts to increase their self awareness through grief process. She claims that women experience a sense of loss after letting go of the idea that they can control the size of their bodies. Courtney describes this grief process in terms of Kubler-Ross's (1969) five stages of grief: denial, anger, bargaining, depression, and acceptance, while incorporating her own interventions with each stage.

In the denial stage, women may accept and acknowledge that weight loss is a never-ending struggle, yet they take on the “No, not me” attitude and continue to start new diets and trying to lose weight. They believe that, through perseverance and strict

discipline, they will be able to sustainably lose weight and appear like the small minority of women who fall in line with society's standards (Courtney, 2008). Clients may use humor to temporarily diminish their anxiety about their weight or dissociate from their body. Furthermore, they may be counting calories at every moment, but not actually know whether or not they are hungry or what their body needs. Courtney uses deep breathing and body scanning as interventions during this stage, in addition to unconditional positive regard. For clients in which there is a strong therapeutic alliance, gently questioning their unrealistic assumptions about body size and control can be effective (Courtney).

The second stage of grief, anger, is characterized by the thought, "Why me?!" Women in this stage tend to feel angered, frustrated, jealous, and irritated (Courtney, 2008). If a client does not have size acceptance awareness yet, she may turn her anger inward and internalize the fact that she cannot change the size of her body. This anger often leads to self-loathing, in which a client may binge eat or compulsively diet to self-soothe (Courtney). These behaviors can be extremely dangerous, and may lead to an eating disorder, such as Anorexia Nervosa or Bulimia, if not treated properly. If women do have size acceptance awareness, their anger is often turned toward the media for its unrealistic portrayals of femininity and beauty, as well as friends and family members that may have expressed distaste for their body size. These women, however, may still turn toward destructive eating behaviors. Thus, it is important for the therapist to assess eating patterns. As a form of intervention, Courtney recommended asking clients to write a list of things they believe they would enjoy if they were thinner, and then encourage

clients to start doing trying these activities now.

In the next stage, bargaining, women who do not accept their body size tend to blame themselves for not trying hard enough or being disciplined enough to lose weight. They bargain for one last opportunity to, once and for all, lose the weight they have been struggling with (Courtney, 2008). Women may stay in this stage for years, continuously cycling between failing and bargaining. Those who do practice size acceptance awareness display their place in the bargaining stage in a more subtle way. While trying to accept themselves for the way they are, they still receive conflicting messages from mainstream culture. Consequently, some women may make resolutions to become more healthy by eating better and exercising more. These efforts, however, seem to also have undertones of hoping to lose weight in the process of becoming a “healthy” person. Courtney suggested that women write a letter to their body, or even specific parts of their body, and process the emotions that come up through her letter-writing.

The depression stage can involve two different types of depression: reactive depression, in which the client feels guilty or shameful, and preparatory depression, realizing the fact that we live in a society where the media displays “beauty” as a very cookie-cutter concept that few women fall into (Courtney, 2008). It is vital for therapists to provide empathy to clients in this stage, as they grieve the loss of their dreams of fitting into mainstream standards. After the client has processed this grief, Courtney has found it useful to educate the client on what options they *do* have, in order to create a sense of empowerment.

A woman is in the final stage, acceptance, when she no longer avoids or delays

activities due to her body size. Instead, she is able to enjoy activities that once seemed unreachable. She is more attuned to her body and does not need external cues to dictate her eating patterns and behavior. She takes care of and nurtures herself. A woman who is in the acceptance phase has an overall love for her body (Courtney, 2008).

Many of the techniques Courtney (2008) utilizes within each stage come from a cognitive-behavioral background, as seen by the emphasis of replacing unrealistic expectations with more reasonable goals as well as exchanging maladaptive behaviors for more positive and helpful ones. Considering the effectiveness of the previously described studies using and coming from a cognitive-behavioral therapeutic framework, as well as the general nature of poor body image arising from negative self talk, the current support group will also use a cognitive-behavioral framework.

Benefits of Group Treatment

Creating a support group for women has many positive consequences. Group counseling tends to be more cost effective and allows for a large group of people to be helped in a relatively short period of time. In addition, clients build relationships with the other group members and often form camaraderie (Corey & Corey, 2002). Being in a group creates a sense of community for group members, and allows for much more interpersonal communication. Clients tend to hold irrational thoughts that they are the only person experiencing their presenting problem. When group members begin to share their experiences, participants are able to see that they are not alone (Corey & Corey). Yalom (1995) has found that the interpersonal relationships between members in group therapy greatly reduces anxiety and self-blame. Groups tend to be a microcosm for what

is occurring in the macrocosm of each member's life. In other words, members tend to interact with group members the way they do with other people in their lives. When facilitated by an effective leader, these patterns can be identified, allowing for a powerful and possibly life-changing experience for group members (Corey & Corey).

In a study examining the effects of interpersonal learning on anxiety in women with binge eating disorder, Gallagher, Tasca, Ritchie, Balfour, Maxwell, and Bissada (2013) hypothesized that interpersonal learning would be correlated with positive changes in self esteem, depressive symptoms, and binge eating. To be included in the study, group members had to be considered clinically overweight and met the DSM-IV-TR criteria for Binge Eating Disorder. Group members were either self-referred by advertisements, or referred by health care professionals. Eighty-four women completed group treatment, with a mean age of 44.25, and 86% identifying as White. The groups met weekly for 16, ninety minute sessions, with 8-10 women in each group (Gallagher et al.). Group treatment was carried through three phases. The first phase included exploring the link between interpersonal patterns and self-concept. The therapist focused on cultivating group cohesion, and helping members gain a better ability to observe themselves accurately. During the second phase, group process was focused on interrupting and challenging maladaptive interpersonal patterns. The therapist pointed out group process and supported individual emotional processing. The purpose of the second phase is to improve interpersonal patterns, in hopes of reducing binge eating. The third and final phase explored termination and thoughts and feelings surrounding that (Gallagher et al.)

Gallagher, Tasca, Ritchie, Balfour, Maxwell, and Bissada (2013) found that women with Binge Eating Disorder developed a more positive sense of self as group treatment progressed. This was evaluated by group members rating their own level of cohesion to the group, as well as rating how all other members cohered to the group. Researchers would compare each individual's self-rated cohesion to the average rating provided by group members. As the individual's rating became closer to the group average, it was supposed that their sense of self became more positive and realistic, and that they placed a higher value on their impact to the group (Gallagher et al.). Women who showed a convergence of cohesion ratings also displayed significantly higher levels of self esteem at post-treatment. Gallagher and colleagues posited that this was due to interpersonal learning and receiving feedback from group members. As women saw and heard how others perceived them, they were able to adjust their own perceptions of themselves.

In a study consisting of 46 women, ranging in age from 18 to 53 years, Bhatnagar, Wisniewski, Solomon, and Heinberg (2012) explored the effectiveness of cognitive behavioral therapy (CBT) in a group setting for women with eating disorders. Fifty percent of participants were diagnosed with anorexia nervosa, 13% with bulimia nervosa, and 37% with eating disorder, not otherwise specified. Participants were primarily White (95.7%) and had either a graduate or college degree (63%). In regards to marital status, 63% were married, 26.1% were single, 6.5% were living with their romantic partner, and 4.3% were divorced. Participants were randomly assigned to either an immediate treatment group or a delayed treatment group. After losing some participants to attrition,

both the immediate and delayed treatment groups had 19 women each. All participants completed a baseline and post-treatment assessment (Bhatnagar et al.).

Groups in Bhatnagar, Wisniewski, Solomon, and Heinberg's (2012) study met for weekly one hour sessions over 8 weeks. Throughout sessions, the facilitator focused on several CBT techniques, such as mirror confrontation, desensitization to body image triggers, cognitive restructuring, and relapse prevention techniques. Other interventions included psychoeducating on body image and eating disorders, deep breathing, and muscle relaxation techniques. Upon the immediate treatment group completing therapy, results indicated a favorable change in overall appearance, satisfaction with individual body parts, less discrepancy between perceptions of their current body and their ideal body, as well as fewer body image avoidance behaviors. Group members with immediate treatment also experienced less depression. The delayed treatment group showed no significant changes in any of these areas. After the delayed group completed treatment (and 8 weeks after the immediate group completed treatment), results indicated similar lower levels of body image disturbances. There was a decrease in depressive symptoms, but it was not statistically significant (Bhatnagar et al.).

All women who completed treatment in this study reported that the group treatment they received effectively addressed challenges they encounter regarding body image, with 71.1% feeling that it did so to “a great deal” (Bhatnagar, Wisniewski, Solomon, & Heinberg, 2012). All but one participant reported that they learned useful strategies in dealing with negative body image, with 71.1% of those women saying it helped “a great deal.” All women felt that the discussion was helpful during sessions and

85.9% thought it was to “a great deal” (Bhatnagar et al.)

Due to supporting evidence from Gallagher, Tasca, Ritchie, Balfour, Maxwell, and Bissada's (2013) study that interpersonal communication is effective in increasing self esteem; the current support group facilitator will encourage feedback between group members to enhance interpersonal learning. In addition, cognitive behavioral techniques have shown to be useful in both individual (Waite, McManus, & Shafran, 2012) and group therapy (Brotto, Basson, & Luria, 2008; Gallagher, Tasca, Ritchie, Balfour, Maxwell, & Bissada, 2012; Bhatnagar, Wisniewski, Solomon, & Heinberg, 2012). Thus, the current support group will implement cognitive restructuring and challenging group members' irrational image perceptions as seen in previous studies. As a result of the association between poor body image and eating disorders, as seen in Gallagher et al. and Bhatnagar and colleague's studies, the current support group will also provide education on eating disorders and their role as a risk factor in poor body image.

In discussing sexual functioning and sexual satisfaction, it can be even more helpful to have a group rather than individual counseling. As women can see and hear other women describing their sexuality and sexual experiences, they become more comfortable sharing their own journeys. Walen and Wolfe (1983) found that women especially feel more at ease doing homework regarding masturbation knowing that other women in the group are doing the same thing. They also discovered that women in sexual enhancement groups tend to take on new, more positive, belief systems and are supported by group members for asserting their own wants and desires. Furthermore, women become much more comfortable discussing their genitals and sexuality

throughout the group process, allowing them later on to be more comfortable discussing these issues with their partners (Walen & Wolfe).

Walen and Wolfe (1983) have found that groups are most effective when they contain between six and nine women. Considering the success they have found in their studies, the current support group is suggested to contain a similar number of women. A female facilitator is necessary because research has shown that women tend to speak differently among women than they do when in mixed company (Meador, Solomon, & Bowne, 1972 as cited in Walen & Wolfe). In order for women to have a better sense of belonging, Walen and Wolfe recommend that there be more than one woman from each age group. Groups tend to range from 6-15 weeks. Considering the fact that the current support group is covering both body image and sexual satisfaction issues, it will run for 12 weeks. Corey and Corey (2002) recommend that well-functioning adult groups meet weekly for two hour sessions. They argued that this allows for intensive work without getting burned out toward the end of session. Lastly, groups held in comfortable rooms with few distractions both inside and outside the room tend to create a more cohesive group (Corey & Corey).

Summary

Through decades of research, it is evident that body image has become an increasingly important issue to address, even more so among women. Through the media and society's unrealistic portrayals of what is “beautiful” and “sexy,” women have taken on an observer's perspective of their bodies. This spectator view has led to many women reporting having a negative view of their overall bodies, as well as individual parts.

Research has also indicated that women's negative body image is highly correlated with problems in sexual functioning and sexual satisfaction. In addition, cognitive distractions concerning body image also have found to be related to worse sexual functioning.

Cognitive behavioral techniques, group process, and treating body image as a grief process have shown to be effective in increasing self esteem and body image, which in turn, will help increase sexual functioning. With the majority of women feeling dissatisfied with some aspect of their bodies, it is imperative that measures be taken to increase body acceptance and image.

Chapter III: Project Audience and Implementation Factors

Introduction

Through psychoeducation and therapeutic process, the goal of the current support group for women is to increase body image and sexual satisfaction and functioning, as well as to reduce cognitive distractions during sexual activity. Throughout the 12 weeks, group members will explore their thoughts and feelings related to their bodies and how they developed these thoughts. The facilitator will provide interventions and techniques to replace irrational, maladaptive thoughts with more positive ones. Group members will explore the five stages of grief in an effort to achieve body acceptance. Sexual satisfaction and functioning will be addressed by group members by examining how their body image affects their sexual identity and sexual health. As group members become more comfortable in discussing sex and sexual behaviors, the women in the group will also become more comfortable in talking about their sexual needs and desires with their partners. Throughout the group process, the facilitator will also encourage interpersonal communication between members, such as providing feedback to one another. Not only will this increase group cohesion, but it will also provide group members with a sense of how they impact the group.

Development of Project

In creating this group, I have examined an abundance of literature regarding body image and sexual functioning, specifically how they relate to one another. Reviewing this literature has provided me with a foundation for topics to be addressed in the group as well as interventions and a theoretical model to follow. I have also researched the

utility of support groups and how they benefit clients. The review of research on groups with the goal of enhancing either body image or sexual satisfaction and functioning has enabled me to develop my own group curriculum that integrates the work on both concepts.

Intended Audience

The current group is open to women of all ages, although it is preferred that there are at least two women from each age group. Women struggling with body image and poor sexual satisfaction and/or sexual functioning and sexual satisfaction will be recruited for this group. The current group will recruit women from referrals by a therapist in order to ensure that women have some prior experience in the therapeutic process. During the screening process, the screener will make sure the woman is open to being a member of a group, in order to create greater group cohesion. In addition, women will need to be excluded if they feel extremely uncomfortable discussing sexual behaviors and feelings about their body with others, as they may be better served in individual counseling prior to participating in a group such as this. Lastly, women should be informed that they may notice emotional changes in themselves as they continue with group process, as they explore thoughts and feelings they may have never addressed.

Personal Qualification

Due to the therapeutic nature of this group, it is required that the facilitator is either a marriage and family therapist trainee, marriage and family therapist intern, or licensed marriage and family therapist. It is also required that the facilitator be female in order to allow group members to speak more freely and feel more comfortable.

Environment and Equipment

The current support group should be held in a room that is both comfortable and open. Members should not be able to be heard outside of the room, nor should outside noise be heard inside the room. The room will need enough chairs for all group members and the facilitator. During certain weeks throughout the course of the group, the facilitator will provide homework and/or worksheets regarding body image, self-esteem, cognitive distractions, and sexual identity. These will be included in the group curriculum in the appendix.

Formative Evaluation

In order to gain feedback and obtain suggestions about this support group, I consulted with professors in the marriage and family therapy program at California State University Northridge, as well as colleagues at The Center for Individual and Family Counseling.

Project Outline

- **Week One:** Introductions; educate and set group norm; goal setting; psychoeducation on negative body image causes and risk factors (media, society, messages from parents, friends, family, strangers); explore group member's first experiences with negative body image and how it has played a role in their lives
- **Week Two:** Educate on grief process and explain body image in terms of grief work. Explore stage 1: denial. How have group members denied the idea that they can control the size of their body? Does denial have any positive consequences for any members? For those who have moved through denial, how did they do it? Practice a mindfulness exercise.
- **Week Three:** Explore stage 2: anger. Who (or what) are group members angry with? Practice empty chair with the person (or concept) they are angry with. Where do members feel the anger in their bodies? Have members make

a list of things they think they would enjoy if they were thinner. *Homework:* Encourage members to do one activity before next session.

- **Week Four:** Get feedback from members who tried one of their listed activities from week three. Educate on eating disorders, specifically Anorexia Nervosa and Bulimia. Explain warning signs and provide resources, such as local OA meetings.
- **Week Five:** Explore stage 3: bargaining. Normalize feelings of being stuck in this stage. Educate members that they may stay in one stage longer than another, or go back and forth between stages. *Homework:* Encourage members to write a letter to their body (or specific parts of their body) and bring to next session.
- **Week Six:** What came up for members as they wrote their letters? Invite all members to read their letter to the group. Process feelings on reading the letter in front of others. Invite members to find closure with their letter (such as burning or tearing it). If no members wish to share their letter, process the fear and anxiety behind not wanting to share.
- **Week Seven:** Explore stage 4: depression. What have members experienced within this stage and at what points in their lives? What has been helpful in these situations and what hasn't? What messages would members like the media to portray instead? Challenging members' thoughts about their body image. What messages do you want to send to your children and/or future generations about body image?
- **Week Eight:** Learning to love your body; risks of negative self talk; reframing negative thoughts into positive thoughts; self-esteem building exercise
- **Week Nine:** Explore stage 5: acceptance. How does it feel (or what would it feel like) to fully love your body? How to maintain body image gains. Reflect on past 8 weeks. What has been helpful? What has not? Start transitioning into sexual self esteem. Homework assignment on nakedness.
- **Week Ten:** Explore members' experiences with body image in relation to their sex life. What is it like to be naked in front of your partner (or last partner)? How has body image affected your sexual functioning? Has this changed since starting the group? Explore women's ability (or inability) to reach orgasm.
- **Week Eleven:** Educate on non-erotic thoughts and their relationship to sexual

functioning. Explore group members experience with cognitive distractions. Process thoughts and feelings that come up when talking about sexual functioning. Go over mindfulness again. Provide resources for those who may be concerned with sexual dysfunction.

- **Week Twelve:** Process members' experience over the past twelve weeks. What did members find most useful? Least useful? Ask each member to provide feedback on each member in the group.

Chapter IV: Conclusion

Summary of Project

The current project is a twelve week support group for females, with the intention of increasing body image, while also addressing how body image and cognitive distractions have affected their sexual functioning. Through interpersonal communication among group members, as well as education provided by the facilitator, it is hoped that women will experience a heightened sense of awareness and acceptance of their bodies, thus also improving their sexual satisfaction and ability to communicate with partners.

This project is divided into five sections, which include four chapters and the curriculum for a process group. The first chapter provides a brief introduction to the problem: that the media's unrealistic portrayal of women has led to most women disliking at least one part of their bodies, and many having a negative self-image. It also explains self-objectification theory, which states that women tend to look at themselves as a collection of parts intended for the use of others. The second chapter gives an extensive review of the literature surrounding body image. It begins by examining the media's effects on body image and sexual health, followed by gender differences in body image concerns. Next there is a review of how body image affects sexual satisfaction and functioning, as well as how this relationship is seen in other cultures and in other countries. The following section explores how women's breast and genital appearance perceptions affect sexual functioning, along with an explanation of cognitive distractions and their relationship to sexual functioning. The final portion of the literature review

discusses various therapeutic treatment options for treating negative body image and poor sexual functioning. Chapter three restates the need for the project, followed by an explanation for how the project was developed. It also includes the intended audience, qualifications necessary for the facilitator, and the expected environment and equipment necessary to carry out the group. The reader will also find a brief outline of the project in this chapter. The fourth chapter gives a brief summary of the project, along with limitations and potential areas of future research. Lastly, the project includes the curriculum for a twelve week support group for women desiring to increase body image and sexual satisfaction and functioning. The curriculum is written in a way that the facilitator would be guided through each week with information on the topics to be presented, along with examples of questions to ask the group. The facilitator is also provided with necessary homework assignment instructions and any extra materials required for group activities.

Recommendations for Implementation

This project was greatly enhanced by the recommendations and support provided by my chair, Dr. Dana Stone. Upon meeting with her several times and exchanging numerous drafts back and forth, I have included several of her suggestions regarding possible interventions, as well as additional research in the literature review. I also consulted with other professors, peers, colleagues, and supervisors to seek their opinion on how to implement this group in my own practice someday.

It is recommended that the facilitator use the curriculum provided as more of a guideline, rather than something to be strictly followed. Each group is different, and the

facilitator may find that more time is needed on one topic than another. Questions provided in the curriculum are simply ideas of what a facilitator may find useful to ask group members in order to open up dialogue or process various activities and homework assignments. The facilitator is encouraged to change these questions to fit her personal style and preference.

Recommendations for Future Research

As I was researching this topic and creating the group curriculum, I noticed a need for more time spent exploring women's sexual satisfaction and functioning. We live in a society where women are taught not to speak about sexual behaviors. As a result, many women are uncomfortable talking about their experiences or asking questions. In the future, perhaps this group could be divided into a two part series. First, women would enter into an 8 to 12 week support group, only focusing on improving body image. Upon completing the first group, women could then enter into the second phase, which would focus on increasing sexual satisfaction and sexual functioning for another 8 to 12 weeks.

Conclusion

The negative effects, specifically poor body image, believed to be greatly caused by the media's unrealistic portrayals of women have been brought to attention over the past decade. I became interested in this topic due to my own experiences with poor body image, as well as experiences shared with me by friends and colleagues. As I began to research this topic more extensively in a research course, I discovered that this was an even bigger issue than I had imagined. My passion for the topic increased greatly, and I would love the opportunity to implement this support group in the near future.

This support group is intended to reach out to women and help them gain self-confidence and self-acceptance, which will translate into positive body image. In discussing their struggles with other women, there is hope that the women will understand that they are not alone in their experiences. By discussing sexuality and sexual functioning in a safe group environment, women are likely to become more comfortable talking about sex and their sexual needs with their partner(s). Our society has created a taboo in discussing sexual behaviors, and this group intends to break those taboos. I believe a sense of closeness and camaraderie will develop among women in the support group, which will also enhance their interpersonal communication skills. I feel very passionate about this topic, and hope that this support group will touch the lives of many women and create beautiful, positive changes in their perceptions of themselves.

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APPENDIX A

Exploring and Enhancing
Body Image and Sexual Functioning:
A 12 Week Support Group
For Women



Created by: Holly Purcell

A Note from the Author:

This is intended to be a process group where women will learn more about their relationships with their bodies and the impact of body image on sexual functioning. In addition, women will learn more about how they are perceived by other people through interpersonal communication with group members.

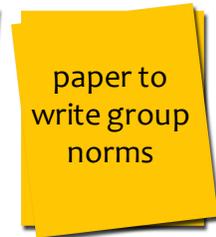
Some topics may take longer or shorter than planned. It is up to the facilitator's discretion to spend more or less time on topics when she feels fit. Questions listed in the following curriculum are merely suggestions for how to commence discussion. The facilitator should feel free to change, add, or remove questions as she feels necessary.

The most important aspect of being the facilitator is to build a relationship with group members and create safety so that each woman feels heard and understood.

Week One:

Icebreakers and Goal Setting

Bring to
session...



GOALS:

- Introduce group members
- Explain the purpose of the group
- Decide on group norms
- Set goals
- Discuss risk factors for developing a poor body image
- Explore group members first experiences in which they were aware of body image

SETUP: Place chairs in a circle so that group members are facing each other.



This may be the first group experience for many people in the group. Therefore, many group members may be very nervous to start this process. Create as safe and warm an environment as possible. Thank group members for coming and express your excitement for the group.

What Does That Look Like?

ICEBREAKER

- Have group members break off into pairs, and address the following:
 - Name? Age? Relationship status? Where from?
 - What are your goals for this group?
 - What do you need to feel safe in this group?
- Have pairs introduce each other to the rest of the group.

GOALS & GROUP NORMS

- Revisit group members goals and point out any themes.
 - How can we hold you accountable for your goals?
- Explore and write down all group norms the members agree upon. Post this somewhere in the room where it is visible to all group members. Continue to bring to all sessions.
 - Make sure to include: confidentiality, respect others turns to speak (no interruptions), arrive on time and commit to attending each week.

POINTS TO EDUCATE

- Research has shown that the majority of women are dissatisfied with at least some aspect of their body.. **You are not alone!**
- Studies have shown that the media's unrealistic portrayals of women are linked to developing poor body image.

QUESTIONS TO ASK

- “Do any of you feel that the media (television, advertisements, movies, magazines, etc) have affected the way you view your body?”
 - “Who/What else influenced the way you perceive your body?”
 - (If members struggle with this question, suggest: messages from peers and/or family.)
- “When was the first time you remember being aware of the way your body looked?”
 - How old were you? How did it feel?
 - Link group members experiences if applicable.

CLOSING

- “What was today's session like for you?”

Week Two: Stages of Grief Stage I: Denial

Bring to
session...



GOALS:

- Educate on grief process
- Explain how grief work can be tied into gaining body acceptance
- Explore the first stage of grief – *denial*
- Practice a mindfulness exercise

SETUP: Place chairs in a circle so that group members are facing each other.



Remind group members on confidentiality and ensure that members are compliant. Since this is only the second week, start noticing which group members are more talkative, and which members may need prompting.

Some group members may currently be in denial about their ability to change their body size, while others may be in a different stage.

What Does That Look Like?

WELCOME BACK

- Revisit limits of confidentiality.
 - “Is everyone okay with the idea that what happens in group, stays in group?”

POINTS TO EDUCATE

- Grief Work
 - Kübler-Ross originally developed the five stages of grief for those suffering from a terminal illness.

DENIAL → ANGER → BARGAINING → DEPRESSION → ACCEPTANCE

QUESTIONS TO ASK

- “How does grieving relate to body image?”
 - Relate this to grieving the loss of the body size they wish they had, and slowly working toward accepting the size and shape they actually are.
- What does denial look like in body image acceptance?
 - (If members struggle with this, suggest: new diets or extreme measures to lose weight)
 - Link common experiences between group members.
- “Are there any positive aspects to being in denial?”

MINDFULNESS EXERCISE

- Explain that mindfulness can be used to reduce anxiety, or simply as a daily ritual.
- Notify members that they aren't required to take part in the exercise, and may stop at any point if they so wish.
- See attached Mindfulness Script

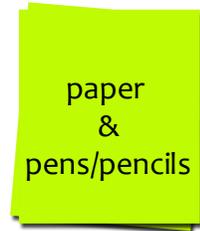


Week Three:

Stages of Grief

Stage 2: Anger

Bring to
session...



GOALS:

- Explore the second stage of grief – *anger*
- Have group members identify where they feel anger inside themselves
- Create a list of activities or behaviors group members would engage in if they were thinner
- Explain homework assignment

SETUP: Set up chairs in a circle so that group members are facing each other.



Keep in mind cultural differences in how anger is expressed. Perhaps allow group members to explain to you how they have experienced anger in the past.

Encourage and support group participation.

What Does That Look Like?

QUESTIONS TO ASK

- “With whom or with what are you angry?”
 - Perhaps the media? Society? A parent or sibling?
- “Where can you feel anger in your body?”

INTERVENTIONS

- Empty Chair
 - Ask for a volunteer. Have the volunteer sit in their chair in the center of the circle across from an empty chair. Say to the group member, “I want you to pretend that you are staring at the person (or thing) you are angry with. Imagine it cannot reply back, but only listen. What do you want to say to it?”
 - Process the exercise
 - “What was that like for you?”
 - “What feelings came up as you spoke to your anger?”
 - Ask the rest of the group, “What was that like to see her talk to her anger?”
- Make a List
 - Have group members create a list of activities or behaviors they would engage in if they were thinner (or their ideal size).
 - Process the exercise
 - “Did any feelings come up for you in creating this list?”

HOMEWORK ASSIGNMENT

- Encourage group members to attempt at least one behavior or activity from their list before the next session. Recommend that they either journal about their experiences.



Week Four:

Eating Disorders and Healthy Resources

Bring to
session...



GOALS:

- Check in with group members on their experiences with homework from last week
- Provide psychoeducation on eating disorders and healthy eating
- Provide information on local Over Eaters Anonymous meetings by visiting www.overeatersanonymous.org
- Explore group members past or present experiences with disordered eating

SETUP: Set up chairs in a circle so that group members are facing each other.



Some group members may be embarrassed to admit that they have performed behaviors related to eating disorders, such as purging or taking laxatives. Be sure to provide unconditional positive regard for group members so that they feel safe enough to share their experiences.

What Does That Look Like?

CHECK IN

- Would anyone like to share their experience with the homework assignment from last week?
 - What was that like for you?
 - What feelings came up?
 - Could you feel them somewhere in your body? Where? How intense?
- Identify patterns in group members' experiences

POINTS TO EDUCATE

- Poor body image has been linked to the development of eating disorders.
- Anorexia Nervosa
 - Features: refusal to maintain normal body weight, fear of being fat or gaining weight, absence of a menstrual cycle
 - Subtypes
 - Restricting type: dieting, fasting, or excessive exercise
 - Binge-eating/Purging type: eating excessively and/or self-induced vomiting, or misusing laxatives/diuretics/enemas
- Bulimia Nervosa
 - Features: eating great amounts of food in a short period of time, self-induced vomiting, misusing laxatives, fasting, excessive exercise, evaluating one's self based on body shape and weight
 - Subtypes
 - Purging type: self-induced vomiting, misusing laxatives, diuretics, and enemas
 - Nonpurging type: Does not misuse laxatives or induce vomiting, but may fast or excessively exercise

QUESTIONS TO ASK

- Has your body image played a role in your eating behaviors or dieting?

PROVIDE RESOURCES

- Provide group members with a list of local Overeaters Anonymous meetings.
- Find any other support groups or centers in the area that deal with Anorexia Nervosa, Bulimia Nervosa, or disordered eating.

Week Five:

Stages of Grief

Stage 3: Bargaining

Bring to session...



GOALS:

- Explore the third stage of grief – *bargaining*
- Educate group members that some stages may last longer than others and that they may move back and forth between stages
- Explain homework assignment

SETUP: Set up chairs in a circle so that group members are facing each other.



Be aware of the difference between true acceptance and bargaining. Some women may seem that they have accepted their body, as evidenced by exercising regularly and eating healthy because they respect the body they have. However, some women may have made these changes because of an underlying belief that they wish to lose weight and change their appearance.

What Does That Look Like?

POINTS TO EDUCATE

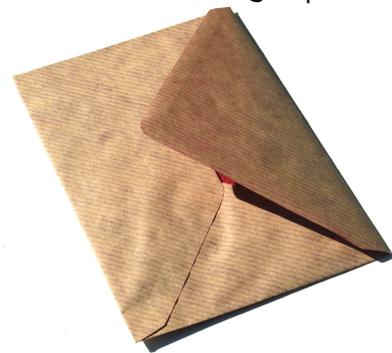
- In the bargaining stage, women tend to blame themselves for not being more disciplined with themselves.
 - "If I were more strict, I'd be able to lose the weight."
- Women may want to give one last effort to, once and for all, lose weight.
- Some stages may take longer than others for different people. Everyone has their own timeline.
- Some women may go back and forth between stages. It is not necessarily a continuous progression.

QUESTIONS TO ASK

- Do any of you feel like you are in the bargaining stage?
 - What does that feel like?
 - What "last ditch efforts" have you made to change your body? What was the result?
- How long have you been in this stage?
 - Point out that many women can stay in this stage for years.
 - Link commonalities between group members.
- How would it feel to be out of this stage?
- How would you know you were out of this stage?

HOMEWORK ASSIGNMENT

- Encourage group members to write a letter to their body or specific parts of their body. Ask them to be conscious of the body sensations and feelings that come up as they write their letter. Remind group members to bring their letters next week and to think about possibly sharing their letter with the rest of the group.



Week Six: Sharing Letters

Bring to
session...



GOALS:

- Explore feelings that came up for group members as they wrote their letters
- Invite all members to read letters aloud to group
- Process thoughts and feelings from sharing their letters

SETUP: Set up chairs in a circle so that group members are facing each other.



Reading their letters aloud may be extremely emotional for some group members. Create a warm and welcoming environment for group members so that they feel safe. Make sure to thank group members for sharing, and allow for enough time to process the experience.

If group members show or express embarrassment from reading their letters or becoming emotional, suggest that the member asks the group for feedback.

What Does That Look Like?

QUESTIONS TO ASK

- Would anyone like to share their experience in writing the letter?
 - What feelings came up?
 - Where could you feel it in your body? What was the intensity?
 - Did you learn anything about yourself that you didn't realize before?

READ LETTERS: "WOULD ANYONE BE WILLING TO SHARE THEIR LETTER WITH THE GROUP?"

- Allow for silence if group members are not immediately willing.
- After a group member has shared...
 - Allow group members to provide feedback for the member.
 - If the group is struggling to respond on their own, possible questions to ask:
 - What was that like for you to share with everyone?
 - What was that like for [the group] to hear her read this?
 - Would you like feedback from a certain member? From all members?
- Point out themes and similarities you see in group members letters.

CLOSURE

- Thank all members for writing and/or reading their letters aloud.
- Ask group members what they would like to do with their letters.
 - Shred
 - Burn
 - Keep for themselves
 - Give to someone
 - Throw away



Week Seven:

Stages of Grief

Stage 4: Depression

Bring to session...



GOALS:

- Explore the fourth stage of grief – *depression*
- Explain the difference between reactive and preparatory depression
- Explore what interventions group members have tried while depressed both successful and unsuccessful
- Discuss what types of body image messages they would like future generations to receive

SETUP: Set up chairs in a circle so that group members are facing each other.



We are seven weeks in now, and group members should be feeling more and more comfortable with each other. Prompt members that are quieter than others so that everyone feels they are a part of the group.

What Does That Look Like?

POINTS TO EDUCATE

- Reactive depression
 - feeling guilty or shameful about your body size.
- Preparatory depression
 - accepting the idea that we live in a society where we are bombarded with unrealistic body image advertisements that we are expected to live up to.

QUESTIONS TO ASK

- How have you experienced depression?
 - Where do you feel it? How intense is it?
- What strategies have you used to get yourself out of a depression?
 - Encourage both successful and unsuccessful interventions members have tried.
 - Suggest: eating healthy, optimism, regularly exercising, talking to your support system, individual therapy, psychiatric evaluation.
- Welcome group members to share their views of their bodies.
 - Challenge and reframe group members thoughts about their bodies.
 - For example: A group member says, "My legs are too fat." Ask the group member to look at herself as a whole person instead of her individual parts.
- What messages do you want future generations (or your children) to receive about body image?
 - How are you going to be a part of that change?



Week Eight: Loving Your Body

Bring to
session...



GOALS:

- Explore what “loving your body” means to group members
- Teach members how to reframe and use positive, adaptive statements instead of negative ones
- Complete self esteem activity

SETUP: Set up chairs in a circle so that group members are facing each other.



Speaking positively to one's self may be quite difficult for some group members. They may become discouraged or report feeling helpless and hopeless. Remind group members that they have been playing the same tapes in their heads for many years and that it will take time to retrain their brains to start thinking in a different way. This process may be discouraging and emotionally exhausting at times, but it is possible to overcome.

What Does That Look Like?

QUESTIONS TO ASK

- If you woke up loving your body tomorrow, what would that look like?
 - Avoid from members describing physical changes in their body. Focus on intrinsic attributes and values.
- Do you feel that you have made progress in learning to love your body since we started this group?
 - Encourage group members to ask each other for feedback on progress.
 - How does that feel to have someone see a change in you?

POINTS TO EDUCATE

- Talking to yourself with negative words may lead to low self esteem, depression, and anxiety.
- It takes time to change these negative tapes playing in your head. As you begin to speak positively to yourself, you may not believe the words at first. As you repeat them, however, you will begin to change the way you think.

QUESTIONS TO ASK

- How has negative self talk served you?
 - How does it make you feel?
- How can we start changing negative thoughts into positive ones?
 - Help group members reframe their negative thoughts if they are struggling with this concept. Have them focus on something they *do* like about themselves or looking at the statement through a different point of view.

SELF ESTEEM ACTIVITY

- Have each group member say three things they like about themselves out loud to the group. This should be a combination of both physical features and intrinsic values.
- Process the exercise.
 - What was it like to say something nice about yourself?
 - Since many group members probably aren't used to this, they may feel embarrassed or guilty for speaking kindly about themselves. Be sure to reflect back these feelings.
 - How did it feel to say these things in front of others?

Week Nine:

Stages of Grief

Stage 5: Acceptance

Bring to
session...



GOALS:

- Explore the fifth stage of grief – *acceptance*
- Reflect on the past eight sessions and check in with group members on what is helpful or not helpful for them
- Introduce sexual self esteem
- Explain homework assignment

SETUP: Set up chairs in a circle so that group members are facing each other.



Group members may have criticisms of the group. Do not take these comments personally. Many group members aren't used to exploring these issues and may find themselves uncomfortable at times. They may be projecting onto you how they act in the real world. These are great opportunities for growth in both group members and group facilitators.

What Does That Look Like?

POINTS TO EDUCATE

- Acceptance involves having an overall love for your body.
 - A woman who is in the acceptance stage no longer stops herself from engaging in activities due to her body size or shape.
 - Accepting one's body means nurturing it as well.

QUESTIONS TO ASK

- What has your journey toward acceptance looked like?
 - Were there any "aha moments" for you in this process? What did those feel like?
- How do you plan to maintain your positive body image?
 - What obstacles do you foresee?
 - How will you manage them? Who is part of your support system?
- What have the past eight weeks been like for you?
 - What has worked for you? What hasn't?
 - Point out themes group members share in their responses.
 - What do you look forward to in the next few sessions?

POINTS TO EDUCATE

- Sexual self esteem is the degree to which one views himself or herself as a sexual individual.
- Research has shown that women with poor body image tend to have problems with sexual functioning, such as inability to reach orgasm, difficulty becoming aroused, non-erotic thoughts during sex, and pain during sex.

HOMEWORK ASSIGNMENT

- Before you can become comfortable being naked with a partner, you have to be comfortable with yourself.
 - Make some time to be alone in a comfortable setting (probably your home). Spend a few minutes looking at yourself in the mirror naked.
 - Perform an activity naked that you would normally perform with clothes on (e.g. washing the dishes, watching a television show, making the bed).
 - Be aware of what feelings come up as you look in the mirror and perform an activity. Most importantly, have fun with it. This is an experience just between you and your body.

Week Ten:

Nakedness & Sexual Functioning

Bring to
session...



GOALS:

- Invite group members to share their experiences with the homework assignment from last week
- Explore group members thoughts and feelings about being naked in front of a partner
- Examine how body image has affected group members' sexual functioning

SETUP: Set up chairs in a circle so that group members are facing each other.



Many people are not used to discussing sex openly with others. Some women may be very uncomfortable at first discussing sexual activities or talking about their body parts. Make sure that *you* feel comfortable and confident talking about breasts, penises, vaginas, intercourse, etc. As they see how easily you discuss it, they too will become more comfortable.

What Does That Look Like?

PROCESS HOMEWORK ASSIGNMENT

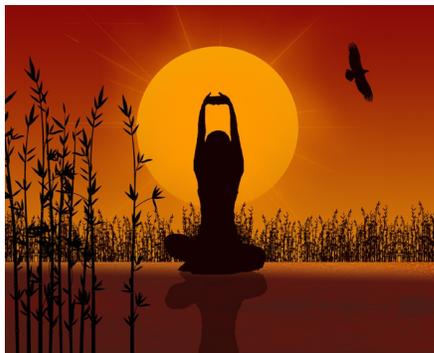
- “Would anyone like to share their experience with the homework assignment?”
- How did it feel in the beginning? How did it feel by the end of the activity?
- Could you see yourself doing this again?

QUESTIONS TO ASK

- In the past, what was it like for you to be naked in front of a partner?
 - Has that changed? If so, how?
 - What did you feel then, and what do you feel now?
- How has your body image affected your sexual functioning?
 - What has been the most challenging?
 - How long can you remember this being an issue?
 - Point out themes between group members responses and reflect back to the group.
- Has your sexual functioning changed since beginning this group? If so, how?
 - Are there changes you would like to see?

REACHING ORGASM

- It is common for women with negative body image to have difficulty achieving orgasm.
- Encourage group members to share ideas or experiences that helped them climax, especially those who have also struggled with having an orgasm. (e.g. vibrators, dildos, positions, techniques)
- If some group members have never reached orgasm, encourage them to spend time masturbating and learning what they enjoy so that they are better able to describe this to a partner in the future.



Week Eleven: Cognitive Distractions

Bring to
session...



GOALS:

- Educate on cognitive distractions and their impact on sexual functioning
- Explore what kinds of non-erotic thoughts group members have encountered
- Reemphasize the importance of mindfulness
- Provide resources for those who believe they may have a clinical problem with sexual dysfunction
- Explain homework assignment

SETUP: Set up chairs in a circle so that group members are facing each other.



Women may still feel discomfort in discussing or describing sexual behaviors. Normalize feelings of embarrassment or shyness. Remind them that it will get easier as they continue talking about it.

What Does That Look Like?

POINTS TO EDUCATE

- Cognitive distractions are non-erotic thoughts that occur during sexual intimacy.
 - Women generally report having primarily appearance based thoughts.
 - *My partner must think I look so unattractive right now.*
 - *I can't stand the way my body looks in this position.*
 - Many women also experience performance based thoughts.
 - *I'm not turned on.*
 - *I'm taking too long to reach orgasm.*
 - Other thoughts may include thinking about STDs, pregnancy, etc.

QUESTIONS TO ASK

- What kinds of cognitive distractions have you experienced?
- How have these distractions affected your sexual functioning?
 - What feelings come up when you have these thoughts?
- What is it like for you to be discussing sexual behaviors?
 - If group members voice that they are embarrassed or nervous, make sure to normalize their feelings and remind them that there is no judgment made in group sessions. Remind them that it will continue to get easier as they keep talking about it.

REVISIT MINDFULNESS

- Remind group members the importance of feeling present in the here and now.
- "How might mindfulness be helpful during sexual activities?"
- Explore ways of becoming mindful during sexual activities, such as focusing on certain sensations (feelings, smells, tastes).

PROVIDE RESOURCES

- Provide group members with a list of local sexual health centers and certified sex therapists if they voice concern of having a clinical sexual dysfunction.

HOMEWORK ASSIGNMENT

- Inform group members that the next session will be their last. Be prepared to provide feedback for each group member. Feedback may include how each person has affected you, how you experience them, and/or progress you've seen in them.

Week Twelve:

Feedback and Termination

Bring to
session...



GOALS:

- Process group members experience over the past twelve weeks.
- Allow each group member, including the facilitator, to provide feedback for each woman.
- Thank group members for being a part of the group and ensure that group members have your contact information in case they are ever in need of support or resources in the future.

SETUP: Set up chairs in a circle so that group members are facing each other.



You have probably made strong connections with the women in this group by this point. Don't be afraid to share your experience as the facilitator with them and how they have impacted you.

What Does That Look Like?

PROCESS THE PAST 12 SESSIONS

- What have these last few months been like for you?
- What changes have you experienced in yourself?
- How has your image of yourself changed?
- Which was the most difficult week? How did it affect you?
- Point out themes in group members responses and reflect them back to the group.

PROVIDE FEEDBACK

- Have each group member, including yourself, provide feedback to each individual woman.
- "What is it like for you to know that she feels that way about you?"

TERMINATION

- Thank group members for their openness in the group.
- Consider sharing your experience as facilitator and the group's influence on you.
- Give group members your business card, and inform them that they are always more than welcome to contact you if they feel that they need support or resources.
- Answer any questions group members may have at this time.



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APPENDIX B

Mindfulness Exercise

Adapted from: Jon Kabat-Zinn

I would like you to close your eyes, and get comfortable in your chair. Place your hands on your legs or allow them to lay folded in your lap. For now, just focus on your breathing. Breathing in.. feeling the air fill up your lungs...and out, feeling all of your breath leave your body. Relax your mind. Take another deep breath in...and out. If your mind wanders, it's okay, just guide it back to your breathing. No judgment. Deep breath in, and out.

Now, I would like you to focus on your feet. Feel your feet pressing against the ground, the feeling of your shoes surrounding your feet. Maybe wiggle your toes a bit. Still taking slow, deep breaths. I would like you to imagine all your stress leaving your body through your feet. You don't need to hold on to it anymore.

Next, I would like you to focus on your legs. Think about your pants touching your skin. Feel all the stress in your body leaving through your legs. You don't need to hold on to it anymore.

Keep taking deep breaths, in...and out. Now I would like you to focus on your bottom. Feel it pressing against your seat. Feel the muscles in your bottom relaxing. Imagine all the stress in your body fleeting away. You don't need to hold on to it anymore.

Now focus on your back. Feel as it presses against the back of your chair. It works so hard throughout the day, but right now, just let it relax. Picture all your stress leaving your back. You don't need to hold on to it any longer.

Keep breathing. You're doing wonderful. If your mind lingers away, just bring it back here. It's okay. There's no judgment. I would like you now to think about your shoulders. Allow them to rise up...and down. Feel the muscles in your shoulders completely relaxing. Imagine all the stress in your shoulders drifting away. You don't need to hold on to it anymore.

Now I would like you to focus on your face. Feel your lips against each other. Be aware of your eyelids keeping themselves shut. Allow the muscles in your face to relax, and

imagine all the stress in your body leaving. You don't need to hold on to it anymore.

We are now near the end of our journey. But before we finish, I would like you to keep taking deep breaths. Imagine any leftover tension in your body floating away. Now breathe in...and out. When you feel comfortable, you may open your eyes.