Inside and Out: How Western Patriarchal Cultural Contexts Shape Women's Relationships with Their Bodies

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12.1 Introduction

A woman's relationship with her body is experienced from the inside as it is felt, known, and lived personally through her first-person perspective. At the same time, a woman's relationship with her body is shaped by broader sociocultural influences around her, which are evident in the context of personal relationships, organizations, and media. All of these influences express cultural values about women's bodies. These broader influences can simultaneously feel both invisible and ubiquitous, and they play a significant role in a woman's experience of her physicality: whether she feels she can move freely through the world, enjoy her sexuality, feed herself, go places and know she is safe, dance and play with abandon, and see herself as a holistic agentic being rather than as a sexualized object. How she experiences and expresses her physicality also tells a story about her relationship to her social context, and her phenomenological experiences of being a woman.

Disordered eating appears to be a symptom of these ubiquitous yet sometimes invisible patriarchal cultural values about women's bodies. Girls and women receive 90–95% of eating disorder diagnoses [1] and risk of developing an eating disorder increases with time spent in Westernized cultures [2], which perpetuate a thin ideal female body type, an ideal which is largely unattainable. Narratives of femininity in patriarchal cultures foster the objectification of women and girls and are linked to

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internalized objectification, body shame, low self-esteem, lack of internal awareness, and disordered eating [3].

Below, we present a case history of a woman we will call 'Annie' to illustrate the influences of a Western patriarchal cultural context on her relationship with her body, specifically her development of Anorexia Nervosa, and her experience with medical and psychological treatment within the same Western patriarchal context.

12.2 The Story of Annie

Annie[1] *first came into my (HM) therapy office when she was 28. She was seeking weekly psychotherapy after having recently been dismissed from an eating disorder treatment facility for being non-compliant with the treatment provider's interventions. Her physician had labelled her Anorexia Nervosa as 'treatment resistant', she was considered to be chronically ill, was unable to sustain employment, and was referred to the treatment facility for more intensive medical monitoring and group and individual therapy. When she communicated to the treatment providers that she did not want to participate in one of the group therapy activities involving mechanical eating, she was given a 'warning' about her involvement in the program. When she shared with her psychiatrist that she did not want to continue on the medication he had prescribed to her, as it was making her feel too sleepy to participate in individual therapy, she was told she was 'non-compliant' and was being ejected from the program.*

During the initial assessment phase of therapy, Annie indicated that her disordered eating behaviour began when she was a child. When she was young, she was sexually abused by an older male in her extended family. She remembered that after the abuse occurred she felt dirty and wanted to punish herself by not eating, thinking of herself as not worthy of being fed. On one occasion she attempted to tell her parents about the abuse but her concerns were invalidated and dismissed, and she remembered being scolded for making up a lie about this family member. The eating disorder behaviour increased in frequency and intensity in her late teens when she began having regular nightmares about the abuse from her childhood. She shared that she was both restricting her caloric intake as a way of punishing herself, and over-exercising to the point of fatigue, hoping that that would make it easier for her to fall asleep and stay asleep at night.

Although she initially sought psychotherapy with me to continue treatment for the eating disorder, she first wanted to address her experience at the treatment facility. How she was managed at the treatment facility left her feeling like she did as a child when she told her parents about the abuse: punished and shamed for speaking up about what did not work for her. After this experience in the treatment facility, it was particularly important to support Annie to have a different experience of treatment in which she would be given a voice about deciding what happened in therapy, and when. Although the therapist is traditionally viewed as the expert, guiding

[1] Annie is a pseudonym. Story used with the individual's consent.

treatment based on the therapist's assessment of the clinical issues, for the purpose of our work together Annie was seen as the expert of her lived experience and needed to be actively involved in her own healing. This meant that she was given options about what the possible courses of treatment could look like, and was considered a collaborator in treatment planning. Whenever Annie asserted herself in session, or advocated for something (i.e. asking for a particular kind of therapy in one session, asking for a specific concern to be addressed, or saying 'no' to the therapists' requests to engage with particular topics or styles of therapy until more time had passed) this behaviour was celebrated and meta processed as an essential part of the therapeutic process.

Annie stated that it was the experience of being celebrated for having and using her voice that allowed her to feel emotionally safe enough to begin working on the eating disorder behaviour and the trauma that lay beneath it. This allowed her to begin to explore how she had learned to punish her body (through eating disorder behaviour and occasional self-harm) because she had learned from her cultural context and interpersonal experiences that her body was bad, and that this was the reason she was hurt by others. Through this she came to understand how her body was not the problem, but that the Western patriarchal narrative about, and treatment of, the female body was the problem.

As Annie began to think critically about the social context within which her experience of her body was shaped—such as the sexualized violence against girls and women, the sexual objectification of women's bodies, and the silencing of girls' and women's ability to advocate for their own bodies—she began to develop a new relationship with her body: one of trust, kindness, compassion, and nurturance. She began to practice intuitive eating (listening to her satiety cues instead of following a rigid meal plan) and exercise gently to care for herself and build strength, instead of punish or control her body. Although Annie had previously been labelled as treatment resistant, when her resistance was not pathologized but was encouraged as a healthy response to problematic sociocultural context, she began to heal and her eating disorder symptoms slowly began to subside, and were replaced with healthy behaviours. After 18 months of therapy (initially every week, then ever 2 weeks), Annie did not meet diagnostic criteria for Anorexia Nervosa, her weight was stable, and she was able to resume regular employment.

12.3 The Values in Annie's Story

In encountering Annie's story, it is apparent that conflicting values are present in her experience. Through early experiences of sexual abuse, Annie internalized the value that her body was 'bad' and engaged in disordered eating and excessive exercise as a form of self-punishment. When Annie reached out for support from her parents, she was silenced and even punished for speaking up, further perpetuating her harmful attitudes and behaviours towards her own body. At the same time, one can detect an inextinguishable sense of agency in Annie's story, a form of resistance to the external pressures to be silenced, shamed, and punished. From this sense of agency

arises evidence of another value emerging from within her as the desire to find and express her voice in and through her body. Exemplifying this, Annie actively resisted pressures to conform to the status quo when participating in the treatment programme for eating disorders.

The idea of 'resistance' from a treatment facility is framed pathologically. From a feminist perspective, however, Annie's resistance can be understood as a way of rising up to the silencing and oppressive forces of her treatment team. Paradoxically, although the treatment existed to address eating disorder behaviours, the dynamics of power and control over Annie as a patient resembled her experience of learning that her body is for others, is to be controlled, and is bad. In engaging a different form of outpatient therapy following her dismissal from the eating disorders programme, Annie was able to embrace the value of discovering her own voice and agency and the value of connecting to her body.

Several values are apparent in the treatment facility and in the attitude of the treating psychiatrists. These values are also conflicting with each other. On the one hand, we can presume that there is a value for patients of this facility to recover from eating disorders and be healthy. On the other hand, this value is expressed in a way that is shaped by power hierarchies in the broader sociocultural context, resulting in a 'top-down' treatment structure in which the so-called experts maintain power, and the patients are expected to blindly comply with treatment expectations. This value of compliance within an externally imposed power structure dangerously misses the need for women suffering with eating disorders to develop voice and agency in their bodies.

Another value apparent in the treatment facility is the value placed on cognitive-based interventions. This reflects a dualistic view, pervasive in the broader sociocultural context, of mind being separate from body and mind existing to control the body. Consistent with this dualistic view in which the body is seen as object to be controlled, the treatment facility exhibits a value on medication used with the aim of suppressing the embodied agency of the patient. Due to the hierarchical power structure of the treatment facility, the patient's resistance to compliance results in further pathologization of the patient.

12.4 The Cultural Influences

Although women who have struggles in and with their bodies, particularly in cases of severe eating disorders, such as Annie's, are typically pathologized as 'sick', it is apparent that their symptoms reflect values of the sociocultural context. Western patriarchal values about the female body measure its worth by appearance and maintain appearance standards which are largely unattainable. The pervasive dualistic view of women's bodies and minds as separate diminishes opportunities for women to develop interoceptive awareness of somatic cues and affect. Instead of supporting women to listen to and develop an attuned awareness of their physiology, an exclusive focus in treatment on changing cognition about one's body or eating has reinforced a disembodied and fragmented perspective of the self [4]. Ultimately, the cultural influences perpetuate a devaluation and the resulting

silencing of women. Within this context, sexual objectification of women and sexualized violence towards women is widespread.

12.5 Implications for Therapy

In my (HM's) work with Annie as her therapist, I aimed to exhibit contrasting values with those evident in the treatment facility from which she was expelled. Rather than adopting a hierarchical 'top-down' approach to treatment based on positioning my expertise *over* Annie as the patient, I embraced the feminist values of mutuality and collaboration in which the patient is an active participant in her own treatment and in which her own voice is valued. Within this context, Annie's resistance to the treatment facility and her own opinions about therapy are neither punished nor merely tolerated; they are celebrated and encouraged.

In this approach, guided as it is by feminist values, the therapist embodies a value of the patient's voice, offering a field of development for the patient's voice and agency. This was crucial for Annie. By adopting a collaborative stance in which power is shared and resistance is sought to be understood rather than shamed, the therapist exemplifies humanistic and compassion-focused work in which the patient's perfectionistic inner critic is given an opportunity to step aside while her inner 'knowing' and self-acceptance are allowed to develop. Finally, in contrast to the dualistic separation of mind over body, the therapist demonstrates a value of body-based work centred around the patient developing trust in and through the body rather than attempting to help the patient control her body.

Unlike more androcentric approaches to psychotherapy, such as the interventions and theoretical frameworks used in the evidence-based treatment unhelpful to Annie, feminist approaches to psychotherapy are particularly useful when considering issues of body, agency, and voice, as it relates to women's experiences of distress and suffering [5]. Feminist approaches to psychotherapy see women's resistance to oppressive and silencing systems as a strength, not a problematic behaviour to be challenged or reformed. Additionally, therapists who work within a feminist perspective consider the sociocultural narratives of gender, the idealization of the disappearance of the female body, and the systemic silencing of women, as contributing to women's distress, in which a normal or healthy response to unhealthy cultural contexts is to struggle [6]. This reframes these experiences of women, like Annie, from a pathology that needs to be corrected, to a kind of cultural truth telling, in which the symptoms act as a canary in the coal mine of the social context.

12.6 Conclusions

The programme that dismissed Annie from treatment was following an evidence-based model. However, her story is a reminder of the importance of clinicians, treatment programmes, and theorists, being able to see the individual (and what has been identified as an individual psychopathology) within a social context which has

constructed women's bodies in a particular manner. Instead of women's body-based challenges, and their attempt to discover their own agency in treatment being seen as a form of illness, this must be celebrated in the light of cultural contexts that have overwhelmingly silenced women and their bodily knowings.

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12.7 Guide to Further Sources

A more extensive exploration of eating disorders and their treatment through feminist, existential, and body-based approaches is provided in a book edited by the authors of this chapter: H. McBride & J. Kwee (Eds.), Embodiment and Eating Disorders: Theory, Research, Prevention, and Treatment. New York, NY: Routledge.

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