

**UNIVERSITY OF THE WESTERN CAPE**  
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**Title:** Body dissatisfaction in Anorexia Nervosa: Clinical psychologists' approach to assessment and intervention or treatment planning.

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## Declaration

I declare that the mini-thesis entitled, “Body dissatisfaction in anorexia nervosa: Clinical psychologists’ approach to assessment and intervention or treatment planning” is my own work. It has not been submitted for any degree or examination at any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Omega Yolandi Bronkhorst

Signed.....



Date.....

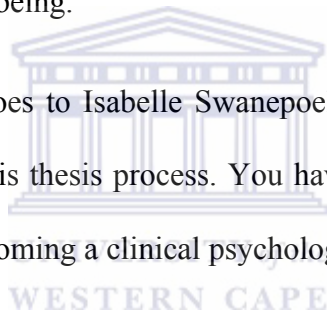
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**Abstract:** Anorexia nervosa is a debilitating disorder with dangerous potential health consequences. Body dissatisfaction is an important aetiological aspect of the development and maintenance of Anorexia Nervosa (AN). The purpose of this research study was to ascertain how clinical psychologists assess body dissatisfaction and how they formulate treatment for AN considering body dissatisfaction. In this qualitative study, semi-structured interviews were conducted with 9 registered clinical psychologists who specifically work in the area of eating disorders. The information provided by the participants was analysed using thematic analysis. Participants were recruited using snowball sampling. Sampling, data collection and analysis occurred concurrently until saturation was reached after 9 interviews have been conducted. Permission to conduct the study was obtained from the Senate Research Ethics Committee (Social and Human Sciences) of the university of the Western Cape. Participation was voluntary and could be withdrawn at any time without fear of negative consequence or loss of perceived benefit. Ethics principles were strictly adhered to in the management of data and dissemination of findings. Potential participants received an information sheet detailing what participation entailed, as well as the rights and responsibilities of the student researcher and research participants respectively. An indication was also provided of the recourse participants had in the event of dissatisfaction with or concerns about the study. The research contributed to the knowledge base of how body dissatisfaction is conceptualised and operationalised in treatment planning for patients presenting with AN. Findings revealed that the role of theory is essential as it facilitates an explanatory system, which creates an understanding of body dissatisfaction in AN. Another finding was that the participants had their own subjective operationalisation of body dissatisfaction but feels that it is important to formally operationalise body dissatisfaction in anorexia nervosa. In terms of treatment, the participants believed that a multimodal approach is the most beneficial when treating body dissatisfaction in anorexia nervosa.

## **1. Introduction**

### **1.1. Background**

Anorexia Nervosa (AN) and Bulimia Nervosa (BN) are debilitating clinical disorders with dangerous potential health consequences including decreased bone density, damage to the oesophagus and teeth, and even death (Nevid, Rathus, & Greene, 2011). These disorders are characterized by behaviours such as over-concern with shape and weight; restricting and limiting food intake; bingeing and eating large amounts of food in one sitting; and purging food after eating through self-induced vomiting; laxative misuse; and diuretic misuse. According to Smink, van Hoeken and Hoek (2012) AN is an eating disorder where patients keep an abnormally low body weight; have a distorted body image and a severe fear of gaining weight. In women, amenorrhea may also occur. BN is an eating disorder where patients go through continuous binge eating which is followed by self-induced purging (Sadock, Sadock & Ruiz, 2015). In both diagnostic groups patients demonstrate an obsession with body weight and shape that is referred to as body dissatisfaction.

AN can have severe and irreversible consequences on the physical health of those who experience it, some of which at times can be life threatening and fatal (Katzman, 2005). Mortality rates for eating disorders are higher compared to other disorders such as depression, schizophrenia and alcoholism (Hoffman et al., 2012) with anorexia nervosa often described as consistently having the highest mortality rate than any other psychiatric disorder over time (Herzog, Nussbaum, & Marmor, 1996; Palmer, 2003; Walsh, 2013). The American Psychiatric Association (APA, 2013) reports a long-term mortality rate of 10% with suicide, starvation and electrolyte imbalance as the most common causes of death. Smink et al. (2012) in a review of research studies on mortality suggest that standardised rates range between 9.6% and 10.5%. With these alarming rates it is therefore crucial that effective treatment is provided for patients with AN, and this can only be achieved when one understands the patient's treatment needs.

According to Bell (2003) four common themes in AN patients were identified when reviewing existing studies on patients' perspectives on the treatment of AN: (1) The importance of control; (2) the importance of supportive relationships; (3) the importance of addressing psychological issues; and (4) the importance of experiences outside the treatment setting.

1. Control is an important factor for many patients with AN (Hepworth, 1999; Malson, 1998). Psychological theories of AN suggest a need for control in the person's life as a key precipitating and maintaining factor of the pathology (Fairburn, Cooper, & Shafran, 2003). Malson (1998) did an interview study and found that for participants the thin body symbolised self-control because by controlling weight and food the person with AN feels in control of their life. Many of the women interviewed described how their anorexia made them feel more in control. Malson (1998) suggested a dualist discourse of AN, where for the anorexic patient, the body and mind are separated; the body wants the food but the mind prohibits it and therefore exercises control over the body not to have it. With this struggle between body and mind, we can see that the concept of control is fundamentally linked to body dissatisfaction (Bell, 2003).

2. Supportive and understanding relationships both in treatment (with healthcare professionals) and outside the therapeutic setting (with family and friends) were reported as an important factor in helping with recovery in a number of qualitative studies (Bell, 2003). Protinsky and Marek (1997) reported that anorexic patients needed to expand their relationships with family and friends in order to help recovery as doing so helped them to reduce their maladaptive eating behaviours. These participants also found it helpful to be able to talk openly about their thoughts and feelings without being judged. Cockell, Zaitsoff and Geller (2004) similarly reported improved health and functioning for participants who used social interaction and talked openly with others as a coping mechanism in place of their previously used eating disordered behaviours.



3. The importance of addressing psychological issues: Many of the studies reviewed by Bell (2003) reported that participants felt there was too much emphasis on weight gain in their treatment, which in itself was a difficult undertaking. Participants felt that medical interventions were unhelpful since it only placed focus on the physical body whereas psychotherapy emphasized the psychology behind it. Both le Grange and Gelman (1998) and Cockell et al. (2004) reported that participants found behavioural strategies helpful; however, some aspects such as food monitoring were not favoured. Many of the participants also felt that the causes of the disorder were not effectively attended to and some felt that the treatment focused too heavily on issues around eating and not on the psychological difficulties underlying these dysfunctional behaviours. This aspect of treatment focusing too heavily on weight and not on psychological difficulties was also underscored by Colton and Pistrang (2004), de la Rie, Noordenbos, Donker, & van Furth (2006), and Rich (2006). Therefore it is important to understand and address the link between the mind and body for the AN patient.

4. The importance of experiences outside the treatment settings: Bell (2003) reviewed a number of studies and reported that factors that assisted in recovery often came from outside the treatment setting, a finding that has been reiterated in numerous studies (e.g. Matoff & Matoff, 2001; Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2003; Cockell et al., 2004; D'Abundo & Chally, 2004; Weaver, Wuest, & Ciliska, 2005; Nilsson & Hagglof, 2006). According to the researchers the significance of factors outside the treatment environment suggests that treatment should preferably occur through an outpatient setting. Meads, Gold and Burls (2001) encourages outpatient care over inpatient care as it permits the AN patient to continue functioning in their everyday environment. Furthermore, it is recommended that outpatient treatment is likely to be more suitable to the patient than inpatient treatment as it allows patients to work on causes affecting the disorder in their social setting, and allows them to have some accountability over their treatment (Meads et al.,

2001). On the other hand more recent literature (Sadock et al., 2015) proposes two somewhat different approaches to AN and BN. Hospitalisation in AN would depend primarily on the patient's medical condition and how serious their health has been compromised. The inpatient treatment would usually include individual and family therapy, where the family/outside world is brought into the inpatient treatment. Most patients are not willing to be hospitalised and involuntary admission becomes necessary to prevent the risk of death, in some cases. On rare occasions the patients proved the doctors' recommendations wrong, that outpatient treatment alone can be successful. In BN, hospitalisations will depend on the severity of the case and type of the disorder. In obese patients the psychotherapy can be managed on an outpatient basis, however when eating binges are out of control, outpatient treatment has shown to be unsuccessful and the patient need to be treated as an inpatient (Sadock et al., 2015). After exploring the themes in the progress and recovery of anorexic patients, it became evident that it was important to look more closely at body dissatisfaction.

Body dissatisfaction manifests itself in the onset and the maintenance of eating disorders such as AN and BN. According to Smolak (2004) body dissatisfaction is a multidimensional construct, which entails the conscious experience of 'embodiment' and its psychological links. The construct comprises negative appraisals of and beliefs about one's physical appearance (Cash, 2004). Body dissatisfaction has also been defined as the difference between the actual and ideal body weight and shape (Polivy & Herman, 2002). However, this definition is incorrect considering that some who are close to the ideal may still not be satisfied with their bodies and vice versa (Cash & Pruzinsky, 2002; Polivy & Herman, 2002 ). Polivy and Herman (2002) argued that suitable methods to measure body dissatisfaction involve strategies to which people report specifically about body parts that are causing dissatisfaction. Stice and Shaw (2002) on the other hand defined body dissatisfaction as referring to "negative subjective evaluations of one's physical body, such as figure, weight, or specific body parts e.g. stomach and hips".

Extensive research studies have investigated body dissatisfaction in relation to body change attitudes and behaviours (e.g., Ferreira, Pinto-Gouveia & Duarte, 2013; Fitzsimmons-Craft et al., 2012). Body dissatisfaction has also been recognised as a significant factor in the development of disordered eating at sub-clinical and clinical/ pathological levels (Ferguson, Winegard, & Winegard, 2011). Changes in body satisfaction may depend on the type of eating disorder diagnosis. For example, bulimic patients showed improvements in body satisfaction during inpatient psychosomatic treatment, whereas body dissatisfaction remained constant in anorexic patients (Benninghoven et al., 2006). In summary it seems safe to deduce that body dissatisfaction is implicated in both AN and BN, but it is more robust and resistant in AN. Therefore, the present study focused on body dissatisfaction in AN. Below is a further exploration of body dissatisfaction in AN.

Social influences as communicated by family, peers and the media has been documented as a source of body dissatisfaction over two decades (e.g. Polivy & Herman, 2002; Stice, 1994; Ferguson et al., 2011). Shroff and Thompson (2006) replicated the tripartite influence model of body image and eating disturbance, initially suggested by Thompson, Coovert and Stormer (1999), and empirically tested by Keery, van den Berg and Thompson (2004). The tripartite influence model represents a theoretical method to explain body dissatisfaction, and suggests that peers, parents and media are three vital precursors in the development of AN. The model also suggests two interceding processes that affect body dissatisfaction. These include the internalisation of societal standards of appearance and appearance comparison. Lastly the model assumes too, that body dissatisfaction has a direct effect on restrictive eating and bulimic behaviours. This assumption indicates that body dissatisfaction is a causal risk factor for pathological eating (Keery et al., 2004; Smolak, Murnen, & Thompson, 2005). Body dissatisfaction has even been identified as a risk factor and a diagnostic criterion in AN (Criterion C) and BN (Criterion D) according to the Diagnostic and Statistical Manual of Mental Disorders Version Five (DSM-5) (American

Psychiatric Association, 2013).

## **1.2. Problem Statement**

There is consensus on body dissatisfaction as a risk factor and a diagnostic criterion in AN and BN however, there is a lack of clarity about the theoretical and operational definitions of body dissatisfaction. Within the DSM-5, the body dissatisfaction criterion is described, but not operationalised as with some of the other criteria in AN (American Psychiatric Association, 2013). Therefore clinicians working with AN are left to rely on their clinical judgment when it comes to the assessment and management of body dissatisfaction, as a feature of the syndrome. The resultant variation in the emphasis given to body dissatisfaction in assessment practices and intervention planning, poses a risk to relapse and health. Thus it is important to understand or explore the ways in which clinical psychologists understand the role of body dissatisfaction, and incorporate it into their clinical service delivery e.g. assessment and treatment planning for anorexic patients. As mentioned before, the present study focused on body dissatisfaction in AN to attain a clearer picture of how clinicians deal with this specified diagnostic group.

## **1.3 Rationale for the study**

The rationale for the study stems from the fact that AN is a complicated clinical disorder with life threatening qualities (Smink et al., 2012). Sullivan (2002) stated that AN has the highest mortality rate of any psychiatric illness, it is estimated that 10% of individuals with anorexia nervosa will die within 10 years of the onset of the disorder. Higher mortality rates of 18% have been reported in Swedish and English studies over 20- and 30-year periods (Sadock et al., 2015).

AN has both physical and psychological diagnostic criteria, complications and manifestations. The diagnostic criteria around the physical criteria are clearly operationalised,

whereas the psychological criteria are presented in a more descriptive manner without being operationalised as in the case of Criterion C (body dissatisfaction). According to Benninghoven et al. (2006) body dissatisfaction remains as a clinical difficulty in AN since it doubles up as a diagnostic criterion and a robust risk factor. This has an implication for the diagnosis of and treatment planning for AN. Therefore, gaining insight into the conceptualisation and operationalisation of body dissatisfaction will aid in improving assessment practices, improving the link between assessment and treatment, informing psycho-education and finally improving clinical decision-making.

Apart from the obvious focus, within South Africa we have the National Development Plan 2030 (The National Planning Commission, 2011) and the National mental health policy framework and strategic plan (National Department of Health, 2013), which both emphasise the importance of highly skilled professionals in healthcare, which includes mental health. The key points addressed in the National Development Plan 2030 are the following: promoting healthy behaviours and lifestyles, to reduce illness (medical or psychological), and to have appropriately trained mental healthcare workers (National Planning Commission, 2011). The Comprehensive service plan focuses on distributing trained professionals within hospital and community settings (National Department of Health, 2013). This study will contribute to this particular goal by systematically examining the processes and trends in how psychologists conceptualise and operationalise body dissatisfaction. Thus the study is also motivated by larger policy and advocacy mandates.

## **2. Literature review**

### **2.1. Eating disorders**

Body dissatisfaction forms an integral part in the diagnosis of eating disorders (Keizer et al., 2011). Eating disorders are characterised by disturbed eating behaviours and maladaptive ways of controlling body weight (Ferguson et al., 2011). The term ‘eating

disorder' encompasses a range of conditions that have overlapping psychiatric and medical symptoms. These conditions are best thought of as psychological disorders with high levels of psychiatric and medical co-morbidity that may involve acute and chronic complications that can be life threatening and/or lifelong (Buckett, 2002). The term 'eating disorder' is commonly used to refer to one or more of a range of disorders with widely ranging degrees of severity and duration. Eating disorder diagnoses include AN, BN, Binge eating disorder and a composite category of 'Eating disorders not otherwise specified', as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013). For the purpose of this study, the focus will be placed on AN.

## **2.2. Nosology of Anorexia Nervosa (AN)**

The AN syndrome includes "the refusal by individuals to maintain a minimal normal body weight, for example, that the individual weighs less than 85 % of the weight that is considered normal for that person's age and height" (APA, 2013). According to the DSM-5 (APA, 2013) clinical features involve the misperception of body weight and shape; and a substantial fear of weight gain; excessive food restriction; inappropriate eating habits or rituals; obsession with having a thin figure; as well as a distorted body self-perception. Two subtypes of AN are identified namely the restricting type and the binge type (Sadock et al., 2015).

The restricting type is characterised by weight loss through dieting, fasting or excessive exercise. Binge eating and purging represent another subtype that is characterised by regular (weekly) incidents of binge eating and purging. The binge eating and purging type differs from BN in that diagnosed individuals present with extreme underweight according to the diagnostic criteria often resulting in amenorrhea (Polivy & Herman, 2002). Some individuals who are diagnosed with AN at baseline may eventually gain weight, but continue to binge and purge, consequently developing BN, causing a change in the eating disorder diagnosis

(Fairburn, Cooper, & Shafran, 2003). See Appendix A for the comprehensive list of DSM-5 criteria for AN according to the American Psychiatric Association (2013).

The new DSM-5 criteria have several minor but important changes in diagnostic criteria in comparison to the DSM-IV-TR. For example, Criterion A focuses on behaviours, like restricting calorie intake, and no longer includes the word “refusal” in terms of weight maintenance since that implies intention on the part of the patient and can be difficult to assess. The DSM-IV-TR Criterion D requiring amenorrhea, or the absence of at least three menstrual cycles, was removed (APA, 2013).

According to Nevid et al. (2011) the aetiology of AN is generally considered to be multifactorial; no single etiological factor in isolation can account for the development of the disorder in an individual, nor can it be seen to account for the variation among individuals. The development of an eating disorder will depend on a variety of variables, including individual vulnerability; the presence of biological or other predisposing factors; exposure to particular aggravating risk factors and the operation of protective factors (resilience). Following the establishment of the disorder a further combination of risk and protective factors may act to maintain the condition or determine whether an individual recovers (Nevid et al., 2011).

The multifactorial aetiology of AN inevitably means that accompanying comorbid disorders are important to note (Sadock et al., 2015). According to Zipfel, Giel, Bulik, Hay and Schmidt (2015) three quarters of individuals diagnosed with AN, reported a lifetime mood disorder where major depressive disorder was the most common (65%). These authors also reported that between 25% and 75% of individuals diagnosed with AN has been diagnosed with at least one anxiety disorder, which typically precedes AN and starts in childhood. Lastly obsessive-compulsive disorders occur in 15-29% of individuals diagnosed with AN, and up to 79% experiencing some form of obsessions or compulsions during their lifetime (Zipfel et al., 2015). An argument then becomes quite relevant and can be further

investigated, specifically referring to the fact that AN becomes the comorbid diagnosis, and the comorbid disorders for example, depression and anxiety can be viewed as premorbid conditions that constitutes a vulnerability in the AN patients.

### **2.3. Incidence of Anorexia Nervosa (AN)**

According to Nevid et al. (2011) the majority of AN cases occur amongst young women. Although eating disorders may develop in middle or even late adulthood, the onset is typically during adolescence or early adulthood when the pressure to be thin is the strongest. As these social pressures increase, so too does the rate of eating disorders. An estimated two million college women in the United States are believed to have a diagnosable eating disorder (Nevid et al., 2011). They indicate that AN affects about 0.9% of women in our society (9 in 1000). Hawkins, Richards, MacGranley and Stein (2004) epidemiological studies show that AN is not randomly distributed among the population, as young women comprise the most vulnerable group. The incidence of eating disorders is continually increasing, with 95% of AN patients being female and with both body dissatisfaction and restrictive eating practices more commonly found among females (Walsh, 2013).

Incidents of AN amongst men are estimated at about 0.3 % (3/1000) (Nevid et al., 2011). Cohane and Pope (2001) stated that dissatisfaction with body image differs between men and women as women reportedly have higher body dissatisfaction and often choose the thinner 'ideal' for themselves. In terms of sexual orientation, Siever (1994) did a study on homosexual men and heterosexual women who suffer from body dissatisfaction and their susceptibility to eating disorders due to their ideas about attracting and pleasing men. Siever (1994) concluded that gay men and heterosexual women were more concerned with their own physical attractiveness and were prone to body dissatisfaction and eating disorders.

According to Szabo and Allwood (2004) from the University of Witwatersrand, it seems that there is an increase in the number of black eating disordered patients being



hospitalised for an eating disorder. When looking at South Africa after 1994, racial integration and blending of western ideals with traditional values became a developmental playground for mental illness, and specifically eating disorders among the female adolescent population (Morris & Szabo, 2013). In their research they focused on the privately funded schools, which were viewed as dominated by the ideals of the western society, however their scholars also included black females (constituting a minority group in an alien cultural setting). Their total sample consisted of 1353 female respondents with an 86% response rate. Szabo and Allwood (2004) concluded that black and white adolescent females scored almost identical to be at risk for an eating disorder, including disturbing eating attitudes and behaviours.

Much later Morris and Szabo (2013) did a qualitative study on the meaning of thinness and dysfunctional eating in black South African females. Their aim was to explore the meaning of thinness and dysfunctional eating, in the fast westernising socio-cultural context of black high school females in local KwaZulu-Natal, post-apartheid. Eating disorders are defined by the westernised culture and criteria, which is much different in the more traditional cultures. For example, thinness is idealised in the western culture and in the traditional culture plumpness is a metaphor for beauty and purging is seen as a ritual for cleaning, in specifically the Zulu culture. Thus the result of this study found that although the meaning of thinness and dysfunctional eating behaviour could be seen as a cultural specific phenomenon, it seems that the black school girls in South Africa may be at risk of developing a variety of dysfunctional eating behaviour which may not be held by the western diagnostic criteria. Yet these behaviours require clinical attentions and prevention programmes (Morris & Szabo, 2013).

The incidence of AN in South Africa is still being researched (Morris & Szabo, 2013). Further examination of the trends reflecting the fact that eating disorders now occur at equal rates between black and white university student populations in South Africa has been

recommended (Morris & Szabo, 2013). In some cases, the results show that body dissatisfaction has been higher amongst black students when compared to white undergraduates (Swartz, 2002).

The incidence rates in regards to AN shows that it prevails on a large scale and perhaps it is safe to conclude that the rates are on the increase (Walsh, 2013). Body dissatisfaction forms an integral part of these incidence rates. Individuals experiencing AN generally hold a disturbed perception of their body size and shape and will attempt to control their weight and appearance through excessive dieting, exercising, and/or purging. It is also noticeable that more recent research in regards to this is needed, especially in South Africa.

#### **2.4. Predisposing factors of Anorexia Nervosa (AN)**

According to Walsh, Bulik and Fairburn (2005) potential risk factors predisposing an individual to AN include age and gender, which indicates that AN usually develops during adolescence and being female is probably the most reliable risk factor for anorexia nervosa (Walsh et al., 2005). Other predisposing factors include, biological factors (endogenous opioids, thyroid function and hypothalamic-pituitary axis dysfunction) (e.g. Zipfel et al., 2015); social factors (society's emphasis on thinness, parental relationship, vocational and avocational interests such as ballet (e.g. Boone, Soenens, & Braet, 2011) and lastly the psychological factors (relationship with mother, self-esteem and body dissatisfaction, to name a few (e.g. Koskina & Giovazolias, 2010; Brockmeyer et al., 2012; Sadock et al., 2015).

Early childhood eating problems such as picky eating, anorexic symptoms in childhood, digestive and early eating-related problems, eating conflicts, struggles concerning meals are thought to be risk factors for AN. Walsh et al. (2005) further identifies perinatal events, more specifically perinatal adverse events such as prematurity, small size for gestational age, and cephalohematoma as increased risks of developing AN. Personality traits

according to Walsh et al. (2005) represents the personalities of individuals with AN, which are characterised by perfectionism, anxiety, low self-esteem, and obsessive driven behaviour. Another risk factor is early puberty, where they state that there is a greater risk for developing an eating disorder in girls who experience early puberty due to puberty being a time for biological changes in body weight, shape, and size with increased deposition of body fat (Walsh et al., 2005).

Sack, Boroske-Leiner and Lahmann (2010) indicated physical and sexual abuse as another risk factor for AN. This is corroborated by research that suggests that individuals who have been sexually abused have about the same or only slightly higher incidence of AN as those who have not been abused (Sack et al., 2010). Family history or family psychopathology is another risk factor indicated by Walsh et al. (2005). It is indicated that there are elevated rates of psychiatric disorders (anxiety disorders and affective disorders) in first-degree relatives of patients with AN. Competing in competitive sports also has certain risks involved in regards to AN. Participation in certain sports or activities that place a greater emphasis on body weight and appearance (e.g., ballet and gymnastics) put individuals at risk for AN (Sadock et al., 2015).

Finally, there are weight concerns, dieting and negative body image/ or body dissatisfaction, which are important and prevalent risk factors in AN (Walsh et al., 2005), and the focus of this study. According to Ferguson et al. (2011) individuals engage in dieting, exercise, and many other ways to try to conform to what is considered 'beauty' and/or the 'perfect body' ostensibly due to body dissatisfaction. In some instances, this can spiral out of control; creating chaos in the affected persons' social, occupational and physical lives when eating disorders develop. These eating disorders are seen as illnesses where there is a drastic change in eating behaviour due to an intense body image distortion, as well as a fixation with actual body weight (Ferguson et al., 2011). People who are over concerned with their body shape come from all walks of life; children as young as six have been found to be

hospitalised for being overly concerned with their body image (Nicholls, Hudson & Mahomed, 2011).

Ogden (2003) conceptualises body dissatisfaction in terms of three viewpoints. According to the first viewpoint; body dissatisfaction is theorised as distorted body size estimation and a perception that the body is larger than it really is. Based on the second viewpoint; body dissatisfaction arises when an individual internalises a culturally determined body ideal and realises that there is a discrepancy between their own bodies in comparison to the ideal. According to the third viewpoint; negative responses to the body refer to one's negative feelings and cognitions regarding the body (Ogden, 2003). These three viewpoints of body dissatisfaction guided this research in the aim to gain a clearer understanding of body dissatisfaction within AN psychopathology.

Firstly, according to Guardia et al. (2012), individuals diagnosed with AN usually report that they feel fatter and larger than they actually are. This body overestimation seems to be linked not only to the individual's body image but also to an abnormal representation of their body in action. This skewed view in body image is a major clinical symptom and criterion of AN. It is also a major prognostic factor, which increases body dissatisfaction and the development of an obsessive drive to lose weight and thus maintaining restrictive eating behaviours (Guardia et al., 2012).

Secondly, eating disorders have become more prevalent in Western society due to increasing pressure on women to achieve the thin ideal (Ferguson et al., 2011). These pressures include media exposure, peers, family and genetics that contribute to the internalisation of thin ideals. According to Boone et al. (2011) the preoccupation with the thin ideal and internalisation of this thin ideal has resulted in many women feeling dissatisfied with their actual body shape and weight and has been found to predict body dissatisfaction and eating pathology. They further argue that as women internalise the thin ideal, they experience increased body dissatisfaction, unrealistic body dimension goals and

disordered eating behaviours to achieve this goal (Boone et al., 2011). Therefore the internalisation of the thin ideal represents an important determinant of body dissatisfaction.

Thirdly, a culture of thinness has developed in which the thin ideal is to be even thinner than before, but the average weight of young women has increased (Ferguson et al., 2011). They further indicate that an unrealistic standard of thinness is portrayed in the media where the ideal female is typically 15% below the average weight of most women. The media transmits cultural ideals about body types that influence people's perceptions of their bodies and encourage body dissatisfaction (Ferguson et al., 2011). Exposure to this subculture of slenderness and perfectionist achievement has therefore increased the risk for unhealthy weight loss techniques and the development of AN (Esnaola, Rodriguez, & Goñi, 2010). It seems evident that this thin ideal is created by socio-cultural factors like the media and peers and trickles down into a plausible, common denominator cause in some eating disorders, namely body dissatisfaction. According to Brockmeyer et al. (2012) body image is an important part of self-identity and self-esteem. Our body image is categorised by the physical and cognitive representation of the body which includes values about how we should look along many dimensions (age, size, height, colour, and attractiveness) and emotional feelings connected to acceptance or rejection of our values. Brockmeyer et al. (2012) further stated that self-esteem is significantly linked with self-perceptions related to body weight and shape. They also argued that the focus on body weight and shape may be an approach employed by individuals diagnosed with AN to regulate their self-worth, self-identity and their self esteem. It is proposed that weight loss in AN may provide the individuals with feelings of pride, power and superiority, and reactions such as these may reinforce or maintain the disorder (Brockmeyer et al., 2012). Therefore one can see that body dissatisfaction is a concern in regards to individuals diagnosed with AN, and that it is a dangerous and potentially debilitating phenomenon within AN. For this reason, this research study aims to attain a clearer understanding of body dissatisfaction through the viewpoint and experience of clinical

psychologists within the South African context.

## **2.5. Treatment modalities of Anorexia Nervosa (AN)**

After looking at the aetiological role of AN and body dissatisfaction as a criterion and risk factor and the manner in which it forms part of the onset and maintenance of AN it is important to note that body dissatisfaction has not been operationalised for assessment or treatment in AN. The clinicians are left to rely on clinical judgement and discretionary thinking about the relative importance of body dissatisfaction, how to assess for it as an ongoing indicator of risk for relapse and disorder level symptom development, as well as the physical and mental health of the individuals. There is no dispute across various empirical studies that body dissatisfaction is an important aetiological aspect of developing AN. According to Steinhausen (2002) patients diagnosed with AN mostly enter treatment at the bitter end of their disorder, where the physiological and overall psychological healing takes priority. The effects of body dissatisfaction create disorderly patterns in self-esteem, as well as patients' internal schemas (Steinhausen, 2002). The current treatments available for anorexia and bulimia exist at primary, secondary and tertiary levels of care. Pritts and Susman (2003) stated that the primary level of care for AN mainly entails a general physician assembling a team of experts. For example, nutritionists, dermatologists, dentists and finally psychologists may be included. The focus at this level is on changing eating behaviours and weight stabilisation and other physiological complications. Secondary level of care focuses on nutrition and weight stabilisation and co-morbid psychopathology. Tertiary level of care primarily focuses on stabilising the weight of anorexic patients and the purging behaviour in bulimic patients (Pritts & Susman, 2003). Currently, decisions about the right treatment setting in which to manage a person with an eating disorder currently depend on the nature of the disorder, the level of risk, physical and psychological complications and patient preference.

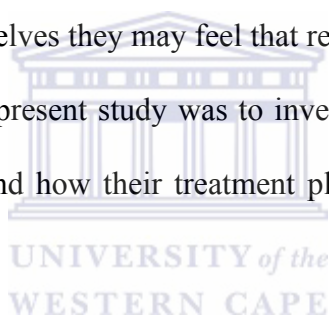
Patients with AN will generally be treated in secondary care, the choice of in, out, or day patient provision depending on the above considerations (Pritts and Susman, 2003). Most will have a trial of outpatient (primary) intervention first. A stepped-care model is created in which patients move up from secondary to tertiary care (hospitalisation). There is also considerable debate over the requirement for some or all of individuals with AN to be treated within the specialist eating disorder services. Various psychotherapies are used in the treatment of AN. According to Steinhausen (2002) these treatment regimes include family therapy, group therapy, cognitive behavioural therapy (CBT), dialectical behaviour therapy (DBT), with the initial nutritional and weight stabilisation and psychopharmacological interventions. There is a gap in the literature in terms of how treatment targets body dissatisfaction in AN specifically. The research only shows the overall treatment of AN including the physical criterion and how to stabilise the weight. The research shows no treatment specifically to address Criterion C (body dissatisfaction) in AN.

Participants in a number of studies have acknowledged feeling misunderstood by others around them, which includes family, friends, and healthcare professionals, who only see their AN as problematic, or who may only focus on the physical effects of the eating disorder (Eivors, Button, Warner, & Turner, 2003; Gremillion, 2003; Malson, Finn, Treasure, Clarke & Anderson, 2004; Rich, 2006; Walsh, 2013). Other participants in an ethnographic study by Rich (2006) disapproved of their eating disorder being medicalised in such a way that only the physical concerns of food, weight and the thin body were focused upon and how their psychological, emotional and social difficulties were never addressed. This left them feeling isolated and alone and they therefore pursued support and comfort from other people who suffers from AN, who they feel may understand them. Participants in the study felt both a connection and a disconnection to other sufferers through sharing tips and experiences but also competing with one another. For participants in Rich's (2006) study, the lack of understanding and stigmatisation from others reinforced their AN behaviours and

subsequently influenced their AN identity.

Malson et al. (2004) conducted a discourse analytic study and identified how participants felt about healthcare professionals concentrating only on the eating disorder and not on the individual experiencing it. Participants described instances where professionals dismissed what they were saying as being the disorder talking. This impersonal approach to treatment was not perceived well by the participants who consequently felt powerless. However, this construction of being only the disorder was also at times ascribed by the participants to themselves. According to Malson et al. (2004) these views are problematic if a patient feels that healthcare professionals only see them as the eating disorder, which results in them feeling depersonalised and this may lead to resistance in treatment, whilst if they ascribe this construction to themselves they may feel that recovery is not possible.

Therefore the aim of the present study was to investigate how clinical psychologists assess for body dissatisfaction and how their treatment plans target body dissatisfaction in AN.



## **2.6. Anorexia Nervosa (AN) and co-morbid pathology**

Eating disorders will quite often involve one or more co-morbid psychiatric disorders. According to Nevid et al. (2011) frequent co-morbidities include affective disorders (such as depression, bipolar disorder), anxiety disorders (especially social phobia and obsessive-compulsive disorder), substance abuse disorders (such as alcohol problems), and personality disorders (especially borderline personality disorder). Mortality rates for eating disorders are high (Walsh, 2013). Zipfel et al. (2015) reported that the suicide rate for women with an eating disorder was 58 times greater than it was for women without an eating disorder. In addition to a significantly elevated suicide risk, the medical complications of eating disorders, including the complications of starvation, contribute to eating disorders being associated with a relatively high risk of mortality.



According to the current research literature available, it seems clear that there are a few gaps in the body of literature and this fact contributed to the rationale of this study to attempt to address these current gaps. To conclude this review, a brief summary of the gaps will provide a clear indication of the gaps in the literature:

More research is needed to address the psychological difficulties underlying the individual's eating behaviour. In the past, the individuals themselves felt the biological aspect of AN was over-focused on. Thus addressing the link between body and mind in the expression of AN as a whole and not the individual parts.

An additional gap that was identified in the literature was the need for a clear empirical description of what body dissatisfaction is, in terms of the theoretical and operational definitions, to address the conceptualisation and treatment plan for the individual suffering with body dissatisfaction, expressed through the body in AN. Consequently the clinicians has been left with only using their own clinical judgement to asses and manage the AN individuals. It seem evident that a clear psychological criteria was not yet operationalised, and therefor body dissatisfaction remains a clinical difficulty in AN, since it doubles up as a diagnostic criteria and a robust risk factor.

There is also a gap in literature exploring the incidence, prevalence and manifestations of body dissatisfaction in AN representative of the South African population. Considering the diverse cultural population in South Africa, future research addressing these gaps will contribute greatly to the diagnosis, assessment and treatment of AN in South Africa.

Finally the gap in the current literature does not provide the clinician of how to treat body dissatisfaction to specifically address AN. There is no current research available on how to address the criteria C (body dissatisfaction) in AN. Therefor the present study aimed to explore how clinical psychologists operationalise, assess and treat body dissatisfaction in AN.

### **3. Methodology**

#### **3.1. Aims of the study**

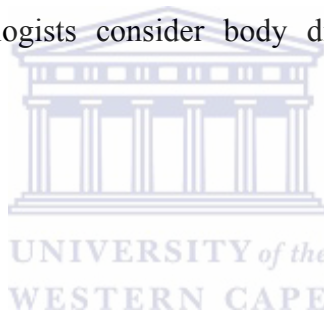
The aim of this study was to explore how clinical psychologists operationalised body dissatisfaction (criterion C) in assessing and planning treatment procedures for anorexic patients.

#### **3.2. Research Questions**

3.2.1. How do clinicians understand body dissatisfaction in the context of Anorexia Nervosa?

3.2.2. How do clinical psychologists operationalise body dissatisfaction in their assessment of Anorexia Nervosa?

3.2.3. How do clinical psychologists consider body dissatisfaction in the planning of treatments for Anorexia Nervosa?



#### **3.3. Theoretical Framework**

The present study incorporated social constructionist framework. Social constructionism occurred during the 1960's. This was at a time when a positivist approach became increasingly overshadowed by the idea that reality is an expression of deeper underlying processes, more related to ideology, interests or power (Alvesson & Sköldbberg, 2009). Gergen (1985) in Lock and Strong (2010) defines social constructionist inquiry as being “principally concerned with explicating the processes by which people come to describe, explain, or otherwise account for the world (including themselves) in which they live”. The self is defined by the means which it repeatedly comes into existence; a multitude of social processes and concepts that links into the development of this supposed self (Gergen, in Lock & Strong, 2010).

The study assumes a certain standpoint towards the nature of reality and how one may know or experience it. Reality is continually shaped by social context including artefacts like

language, and thus reality cannot be known definitively or directly (Lock & Strong, 2010). According to Lock and Strong (2010) the process of knowledge creation is facilitated through language and meaning assignation. Reality, and thus knowledge, is always historical and cultural, it always has a context to which it is relative. Reality is socially constructed and not a given, thus the paradigm places strong emphasis on how reality is constructed (Alvesson & Sköldbberg, 2009) rather than extracting the underlying hidden actual reality. Therefore, social constructionism does not consider certain realities as inherent, but that it is rather socially produced and reproduced (Burr (1995), in Braun & Clarke, 2006). This knowledge creates and describes the world (Lock & Strong, 2010).

According to social constructionism knowledge is not stable and is continually constructed through social processes. This knowledge generates certain images of the world which then operates as reality or as if they are 'true'. It not only describes reality, but also comes to prescribe reality. These constructions form an integral part of human activity and are not isolated perceived truths (Lock & Strong, 2010). Thus the researcher has to adopt an epistemological stance that explores the ways of experiencing reality as a function of the subject positions of the researcher and participants. The present study examined body dissatisfaction in AN as a construction that psychologists use. The notion of psychopathology and clinical syndromes will be considered and contextualised in the context of clinical practice and the consensually agreed-upon canon of psychological theory and practice conventions. Within the context of psychopathology and therapeutic intervention, certain realities are held as truthful or accepted knowledge, and thus it is important to engage psychologists as therapeutic service providers in an attempt to collaboratively explore the ways in which meaning is assigned to this construct. Thus these forms of understanding are intricately linked to how clinical psychologists not only understand body dissatisfaction in AN, but also how they respond to it in terms of intervention.

In social constructionism, language is the central means through which the self

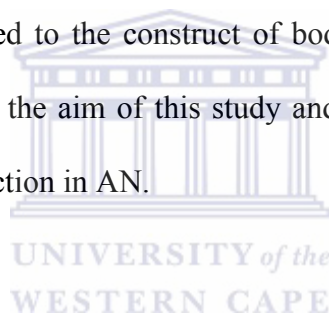
experiences reality and through which reality is constructed and by which knowledge is gained (Lock & Strong, 2010). It also reflects rhetorical assumptions about the processes of meaning assignment and the discourses that researchers might use to examine and also co-create the knowledge or findings produced in the study. Similarly, social constructionism also puts forward a set of values that are to be espoused by the researcher including, but not limited to recognition of the participant as a partner and the researcher as a co-constructor rather than objective other (Lock & Strong, 2010). These values are summarised in the axiological assumptions of the paradigm and are reflected in the present study in a recognition of the mutually reciprocal way in which the findings are co-constructed by all involved including ethics committees, departmental committees, training approaches etc.

The clarification of the paradigmatic assumptions inherent to the study is important as it informs the subsequent methodological decisions made (Carter & Little, 2007). It also necessitates a reflexive process in which the researcher examines how she came to know about the research question, or accumulated knowledge through the present study. These aspects will be further clarified and reported on under specific subheadings of the methodology.

For the purpose of this study, social constructionism was used at the most basic level as an explanatory framework within which to examine the nature of the world, our knowledge of the world and the processes whereby we construct such knowledge. When body dissatisfaction in AN is viewed from a social constructionist paradigm, the researcher will ask how body dissatisfaction is conceptualised and approached, is socially negotiated within the constraints imposed by the physical world, the body and the professional identity and scope of practice of psychologists (Carr, 2006).

It may be important to indicate that there are several interpretations of reality at play here at one level in regards to body dissatisfaction in AN. The clinical medical model, frames the AN syndrome and symptomatology as having reached disorder level, which has

debilitating health consequences. Knowing and understanding the syndrome and symptomology is extremely important for assessment and treatment in AN. Therefore, clinical psychologists are provided a scope of practice and registration within a category with the Health Professions Council of South Africa (HPCSA) that constructs them as knowledgeable about mental health (HPCSA, 2011). They thus have the capacity to assess and formulate treatment for the AN patient inclusive of body dissatisfaction. The patient and psychologist further engage in a process with other role-players e.g. family and health professionals as well as society and cultural ideals to engage in a reciprocally influencing process in which information is shared and co-constructed until there is a consensually agreed upon reality such as what constitutes illness. Given this philosophical frame, it is important to examine how meaning is assigned to the construct of body dissatisfaction by a designated group of professionals. This was the aim of this study and the results did succeed in an in-depth meaning of body dissatisfaction in AN.



### **3.4. Research Design**

The present study was explorative by nature. Polonsky and Waller (2005) noted that exploratory studies are most useful in phenomena where there are limited information available and where the researcher wishes to have the flexibility to explore future areas of research.

According to Cooper and Schindler (2006) explorative research does not predefine dependent and independent variables, but focuses on the full complexity of human sense making as the situation emerges. These authors also stated that exploratory research is typically qualitative; whereby the intention is mostly to build an understanding of a phenomenon rather than to prove a theory (Cooper & Schindler, 2006). This type of research created the potential to provide this study with rich and useful data and it involved a high level of involvement and interpretation. Therefore, this study adopted an explorative

approach which aimed to explain the subjective reasoning and meanings that lie behind the clinical reasoning employed by psychologists in their approach to assessment and the treatment of anorexia nervosa with specific reference and focus on body dissatisfaction.

Exploratory studies typically employ an open, flexible and inductive approach to research as it attempts to look for new insights into the phenomenon (Orina et al., 2015). It uses meaning (versus measurement) oriented methodologies, such as interviewing, that rely on a subjective relationship between the researcher and subjects (Polonsky & Waller, 2005). Thus explorative studies prefer qualitative methodologies (Orina et al., 2015).

### **3.5. Qualitative Methodology**

Qualitative methodology is appropriate for this study, as key components include “subjective perceptions and understandings arising from experience; objective actions or behaviours; and context” (Ulin, Robinson, & Tolley, 2005). The participants in this study are specialists in the field of eating disorders and therefore their perceptions and understanding of body dissatisfaction AN was subjectively valuable. The Qualitative method is known to explore the social, cultural, political and physical environments of the people they are studying, thus this approach was appropriate for this study (Ulin et al., 2005). Qualitative methods are appropriate to understanding some aspect of social life, and its methods which (in general) generate words, rather than numbers, as data for analysis. Qualitative methods generally aim to understand the experiences and attitudes (Creswell, 2007). In this case the clinical psychologists’ experience and attitude in terms of body dissatisfaction. These methods aimed to answer questions about the ‘what’, ‘how’ or ‘why’ of the phenomenon of body dissatisfaction rather than ‘how many’ or ‘how much’, which are answered by quantitative methods.

The use of qualitative methods was “an attempt to capture the sense that lies within, and the structures explored relating to what we say about what we do” (Bannister, Burman,

Parker, Taylor & Tindall, 2001, p. 3). It may entail an exploration, elaboration and systemisation of important facets of a phenomenon at hand (Bannister et al., 2001) relying on text data rather than numerical data (Carter & Little, 2007). This was vital to the question at hand: “What are clinical psychologists’ approach to assessment and intervention or treatment planning in AN?” The meaning of the phenomenon at hand namely the perceptions/constructions of body dissatisfaction in AN was from the viewpoint of the participants (clinical psychologists) and was emergent rather than tightly preconfigured (Creswell, 2007).

According to Cavana, Delahaye and Sekeran (2001), the qualitative method is interested in the perspective and the beliefs of the participants being interviewed and it places emphasis on their words and actions, with an aim to identify patterns or themes through observations, documentation and analysis. The qualitative method is also valuable for gaining quality data from relatively few participants, by allowing the researcher to develop the research question or hypothesis throughout the research process.

The aim of the present study was to understand the subjective process by which the clinical psychologist assesses for and treats body dissatisfaction as part of the syndrome of AN in an exploratory manner framed within a social constructionist theoretical framework. Thus the present study used employed qualitative methods of data collection and analysis to execute the study as it was deemed consistent with social constructionism and appropriate for exploratory research.

### **3.6. Participants & sample.**

The participants were clinical psychologists registered with the Health Professions Council of South Africa (HPCSA). The researcher's aim was to identify clinical psychologists whom specialise in the field of eating disorders. Participants were recruited using snowball sampling. According to Heckathorn (2011) snowball sampling is sampling by means of a gradual accumulation of relevant cases through contacts and references. The

researcher identified these participants based on a set of criteria for inclusion. The inclusion criteria: registered clinical psychologists as well as the active engagement in treatment of eating disorders. This sampling technique proved to be relevant to the study, as it required expertise in the clinical understanding of psychopathology.

The researcher first identified one of the well-known eating disorder clinics in Cape Town, and used this as a starting point to make contact with clinical psychologists who provided services in this clinic. After the initial contact with a clinical psychologist at this clinic, the researcher was given names and contact details of other clinical psychologists known for working with patients presenting with eating disorders. Sampling, data collection and analysis occurred concurrently until saturation was reached after 9 interviews have been conducted. There is no agreed upon ideal number of participants for qualitative studies as researchers tend to agree that the numbers depends largely on factors such as the nature of the research, the theoretical framework and the available resources (Okoli & Pawlowski, 2004; Tuckett, 2004). For epistemologies such as Social Constructionism where a particular depth and richness of data is required, it is suggested that the sample size be between six and twelve (Baker & Edwards, 2012). Thus the size of the sample in the present study was consistent with the recommendations in literature.

### **3.7. Method of data collection**

The data was collected through the use of a semi-structured individual in-depth interview. The decision to interview implies a value on personal language as data. Interviewing may be appropriate where depth of meaning is important and the research is primarily focused in gaining insight and understanding, therefore the interviewer can pursue in-depth information around the topic. Silverman (2011) explain that interviews resemble everyday conversations, although they are focused (to a greater or lesser extent) on the researcher's needs for data. They also differ from everyday conversation, because there is a



concern to conduct them in the most rigorous way possible in order to ensure reliability and validity (i.e. ‘trustworthiness’). Conducting an interview is a more natural form of interacting with participants than making them fill out a questionnaire, complete a test, or perform a task, and therefore it fitted in well with the explorative approach to this research.

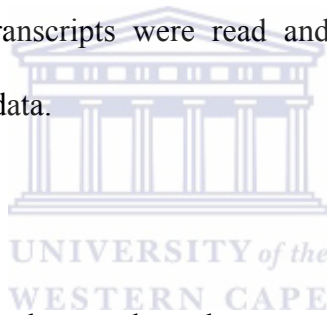
Semi-structured interviewing is an overarching term used to describe a range of different forms of interviewing most commonly associated with qualitative methods. According to Silverman (2011) the defining characteristic of semi-structured interviews is that they have a flexible and fluid structure, unlike structured interviews, which contain a structured sequence of questions to be asked in the same way of all interviewees. The structure and schedule of a semi-structured interview was developed and organised around an interview guide (Appendix C), which the researcher used to guide the interview. By using a semi-structured interview, the researcher was able to ask more questions to get clarifications on certain questions. The semi-structured interview contains topics, themes, or areas to be covered during the course of the interview, rather than a sequenced script of standardised questions. These topic and themes of the semi-structured interview evolved from the aim and research question of this study. The aim of the structure of the semi-structured interview is usually to ensure flexibility in how and in what sequence questions are asked, and in whether and how particular areas might be followed up and developed with different interviewees. This is so that the participant can shape the researcher's own understandings, as well as the researcher's interests on body dissatisfaction as the main focus point (Silverman (2011)).

The initial interview schedule was assessed by the supervisor who is a trained clinician, as well as the ethics committees. These two processes enabled revisions or refinements that assisted in aligning the proposed questions and domains with the objectives of the study. The first initial contact interview was used as a pilot to see if any further changes in the interview structure were needed. The structure and flexibility of the semi-structured interview proved to be sufficient and allowed the researcher to gain an in-depth

understanding of body dissatisfaction in AN and addressing the research questions sufficiently.

### **3.8. Procedures**

All individual interviews were taped using a Dictaphone and hand written notes were taken. After each interview initial impressions were recorded and then discussed in the supervisory space to continue assessing the efficacy of the interview schedule, as well as the instrumental process of conducting the interview. The data transcription process started shortly after interviews were conducted. The researcher of this study transcribed the data by listening to the recordings and typing the transcriptions on a word document. This was a time consuming process, since the transcripts were read and re-read, which allowed for the researcher to be immersed in the data.



### **3.9. Data Analysis**

Thematic analysis was used to analyse the transcripts. Denzin and Lincoln (2005) reported that thematic analysis is the most common form of analysis in qualitative research. It emphasises pinpointing, examining, and recording patterns (or "themes") within data (Creswell, Hanson, Clark Plano, & Morales, 2007). The themes become the categories for analysis. The researcher must be immersed in the data through reading and rereading the transcripts (Ryan, Coughlan & Cronin, 2007). Thorough immersion in the data will assist the researcher to determine when saturation has occurred and no or little new information is being retrieved (Creswell, 2007). Coding and identification of themes throughout the research process ensures thorough understanding and exploration of the data (Silverman, 2011). Thematic Analysis is a qualitative method that is well suited with the social constructionist epistemology (Denscombe, 2014) and thus will produce relevant knowledge within this study. Despite being a flexible and user friendly research tool to new researchers, it yields,

organises and describes data giving a rich and detailed account and allowing patterns to emerge (Larkin, 2009). It further offers a method not only identifying, but also analysing these patterns of meaning (Milosevic, Brborovic, Mustjbegovic, & Montgomery, 2013). The qualitative data of this study was analysed and finalised according to phases of thematic analysis as outlined by Braun and Clarke (2006). To follow is a brief description of the six phases followed by the researcher in this study, according to the thematic analysis phases proposed by Braun and Clarke (2006).

Phase 1: In this phase the researcher familiarised herself with the data. To this end the researcher first transcribed the 9 semi-structured interview audio recordings. After this step the researcher read through the transcripts/data and then re-read it again. From here ideas and possible codes and themes were noted down. The transcription and the familiarising of the data was time consuming, but provided the researcher with valuable information pertaining to participants' view and understanding of body dissatisfaction in AN and the overall sense of the data.

Phase 2: In this phase the researcher generated the initial codes that provided interesting features about the data. This coding was done in a systematic fashion across the entire data set. Data that was relevant to the different codes were added. Subsequently these codes guided the process of the analysis by informing the emerging themes and subthemes of the study. A total of 35 codes were identified.

Phase 3: In this phase the researcher searched for the themes within the codes indicated by the data. The researcher collated the codes into themes, where all the data relevant to each potential theme was gathered and organised according to content relating to the themes. Eight potential themes were identified in this phase.

Phase 4: In this phase the researcher reviewed the themes that emerged from the data. The researcher checked that the themes operated in relation to the coded extracts in phase 1 and the entire data set in phase 2, and through this the researcher generated a thematic map of

the analysis.

Phase 5: In this phase the researcher defined and named the themes. The analysis was continued in order to refine the specifics of each theme, which included the emerging subthemes. At this phase the researcher also decided to organise the themes into three categories, namely conceptualisations of body dissatisfaction, operationalisation of body dissatisfaction and treatment of body dissatisfaction. The relevant identified themes were placed in these categories in order to facilitate an in-depth understanding of body dissatisfaction in AN, as well as relating it back to the research question of the study. The overall narrative of the analysis unfolded during this phase, whereby it generated clear definitions and named each theme and subtheme under the specified categories.

Phase 6: This is the final phase of the analysis, which involves producing the final report. The researcher started to construct the findings and the discussion of this study. This presented the final opportunity for the analysis. Findings were related back to the analysis, to the research question and literature reviewed, providing a comprehensive report of the analysis. The writing up of this report was the thesis in manuscript format.

### **3.10. Reflexivity, Credibility and Trustworthiness**

Rigour was achieved by involving another researcher in the analysis. The additional researcher is a qualified researcher with a masters in Research Psychology. The researcher of this study, with the additional researcher and supervisor had an initial meeting to discuss the conceptualisation and aim of the study. After this regular meetings were held to discuss the process. This allowed for greater depth in interpretation, accountability, and inter-rater comparison. There were some disagreement in terms of themes, and it was resolved and refined by discussions between the researchers and the supervisor of this study. The resultant analysis was verified for rigour, trustworthiness and consistency by the supervisor. This process constituted an external audit in keeping with the recommendation of Silverman

(2004). This accountability process also assisted in facilitating reflexivity during analysis.

Reflexivity occurred throughout the research process. I realised at the start of the research process that I myself is very much part of the population that is affected by body dissatisfaction. I am a 35 year old single woman, studying to become a clinical psychologist, and also with a qualification in exercise science. Being a qualified personal fitness trainer gave me various exposures to the idea of body dissatisfaction and the maladaptive ways it presents. I myself went through a period of excessive exercising and calorie counting to strive for the ideal body. My personal and professional experience with body dissatisfaction initiated the conceptualisation of this study.

Body dissatisfaction in eating disorders has always interested and intrigued me, therefore I was already familiar with the research on the subject before interviews commenced. I reflected on myself as the researcher and the impact I had on the research process, particularly during the interviews that served as data collection. As a trainee clinical psychologist, the experienced participants in this study broadened my knowledge base in terms of the topic, as well as the cannon of psychology. The participants were aware of my interest in body dissatisfaction (and history as a personal fitness trainer) and this allowed for information and knowledge to be shared freely. The participant's awareness of my interest in body dissatisfaction and a previous personal fitness trainer background deepened rapport.

The participants in each interview were forthcoming, open and empathic to the research process, since they had to do the same on their journey of becoming a clinical psychologist. The first interview provided me with additional information that could be applied to the interviews that followed after. Therefore I gained deeper insight and it resulted a richness of the data collected during the last few interviews, although the last few participants interviewed generally conveyed similar data to the initial participants.

As mentioned before, I am a qualified personal fitness trainer and have dealt with body dissatisfaction on more than one occasion, and I have trained and rehabilitated clients

diagnosed with bulimia nervosa, anorexia nervosa and obesity. For example with clients diagnosed with BN and AN, the fitness training is focused on toning and not energy expenditure like pilates-based training and resistance training. Obesity on the other hand, one deals with mainly energy expenditure in the form of cardiovascular training. As a physical fitness trainer, you attend to the physical needs of your client, as well as their emotional needs in terms of motivation, support and relevant 'psychoeducation'. The mind- body connection has always been part of my existential belief system, and the natural progression to psychology was inevitable.

### **3.11. Ethics**

Project registration and ethics clearance was obtained from the Senate Research committee of UWC (Appendix B). The participants were provided with an information sheet (Appendix D). This information included the aim of the study: to gain insight into clinical psychologists conceptualisation and operationalisation of body dissatisfaction in AN, to inform improvement in assessment practices, improving the link between assessment and treatment, informing psychoeducation and finally improving clinical decision-making. The participants were also informed that they will be asked to share their perceptions about body dissatisfaction, how they assess for it as well as how they design treatment modalities for body dissatisfaction in anorexic patients. Further information entailed that the interview will take place in the form of a semi-structured interview and that the duration of this interview would be 90 minutes. In order to assist the researcher in accurately capturing their thoughts and feelings, the interview was audiotaped.

They were informed that all participation was voluntary and participants could withdraw at any time without loss of perceived benefits or negative consequence. Confidentiality and anonymity was achieved by assigning codes to participants and removing identifying information. Due to the small psychology community this was done before the

supervisor saw the transcripts. Finally the participants were asked to provide written consent indicating that they understood the aims of the study and what participation would entail. They consented to participating and being audio-recorded, as well as the dissemination protocol (Appendix E). Transcribed data was kept in a safe location (in terms of computer access).

#### **4. Results and discussion**

The study aimed to explore how clinical psychologists conceptualise and operationalise body dissatisfaction in assessing and planning treatments for anorexic patients. The participants are all qualified (Master's Degree in Clinical Psychology) and registered clinical psychologists with the Health Professions Council of South Africa (HPCSA). There were five male participants and four female participants with various levels of clinical experience. Two participants had five or more years experience; two participants had ten or more years experience; four participants had 20 or more years experience and lastly there was one participant with 30 or more year's experience.

A thematic analysis of interview transcripts revealed the following three categories; conceptualisations of body dissatisfaction, operationalisation of body dissatisfaction, and lastly treatment of body dissatisfaction. The categories and related themes and subthemes are presented below and illustrated in more detail using illustrative quotes.

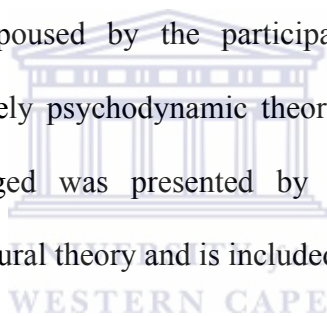
##### **Category 1: Conceptualisations of body dissatisfaction**

This thematic category was entitled, "conceptualisations of body dissatisfaction". The category essentially included thematic content related to clinical psychologists' understanding of body dissatisfaction as a criterion. Three themes are included in this category namely 1) Theoretical formulation; 2) Aetiological formulation and 3) Complex

influences. Each theme is presented below along with any subsidiary themes (sub-themes) that may have been identified (see table A to H). Illustrative quotes are also provided.

Category 1, Theme1: Theoretical Formulations

The first theme included in this category was theoretical formulation. The participants reported that theory was used as a means for conceptualising body dissatisfaction. Theoretical constructs and formulations provided a meaningful way for participants to make sense of the body dissatisfaction criterion. Participants drew on theory from the cannon of psychological knowledge as consensual ways of interpreting and understanding various phenomena including body dissatisfaction. Three subthemes emerged that were related to theoretical orientations or suppositions espoused by the participants. Two traditional theoretical conceptualisations emerged namely psychodynamic theory and cognitive theory (schema), the third subtheme that emerged was presented by participants as a core way of understanding which is socio-cultural theory and is included as the third.



Subtheme 1.1.1: Psychodynamic theory

Participants identified psychodynamic principles and theory. Table A provides a summary of the subthemes with illustrative quotes.

Table A: Category 1, Theme 1: Theoretical formulation, Subtheme: Psychodynamic theory

| Subtheme                    | Illustrative quotes  |
|-----------------------------|--|
| 1.1.1. Psychodynamic theory | <p><i>AP: "A displacement of maternal ambivalence and hate, directed at the self, as a mechanism of control and expression of negative affects".</i></p> <p><i>AP: "Residues of frustration and hate at maternal objects, internalised into the self, as the mainstay conduit for destructive affects that cannot find an alternative route into conscious expression".</i></p> <p><i>JB: "Emotional discomfort that they have they will project onto their body ... because there is a sense that if you are unhappy with your body, you can do something to change it, whereas maybe there is a feeling of powerlessness in the rest of your life".</i></p> <p><i>JS: "I like to look at things in terms of valences, ambivalence, the ambivalence that arises the inner tension, I see this but I want it to be that. It's either to this or to that. That tension that intra-psychic ambivalence is body dissatisfaction..."</i></p> |



|  |   |
|--|---|
|  | <p><i>Yes its dissociation".</i></p> <p><i>LF: "It's a person who sees their body as very ugly and usually because it is too fat and there is almost a psychotic aspect to it".</i></p> |
|--|---|

Participants indicated that intra-psychoic processes, as contained in broad psychodynamic theory, were useful to gain an understanding of body dissatisfaction. These intra-psychoic processes consisted of internal conflicts and internalisation, the use of defense mechanisms, the strength of the ego, which all implies the same construct of an individual's functioning when it comes to psychodynamic theory. Some participants referred to conflict-based explanations with defensive enactments while others used more object relation explanations as their point of theoretical reference in understanding the body dissatisfaction criterion of AN. The reason these intra-psychoic processes are similar under the psychodynamic framework is due to the dynamic process of the individual in relation to the self, others and their environment, as well as psychic determinism and the individual's early experiences that impact later functioning.

The intra-psychoic process of internal conflict or tension is illustrated by viewing the participant's conceptualisation of body dissatisfaction; participants AP, JB and JS stated that it can be best understood as "mainly a maternal ambivalence and hatred", producing an "internal tension within the body of the person" and being "expressed unconsciously through hatred of their own bodies and body dissatisfaction". The emotional discomfort caused by the maternal ambivalence may also be experienced as a feeling of powerlessness extended into the rest of their lives and can only be expressed/expelled and not contained inside the intra-psychoic structures of the individual.

Another intra-psychoic process, namely the use of defense mechanisms were indicated by participants AP, JB and JS as a manner in which to formulate theoretically and understand body dissatisfaction. According to the participants, it also seems likely that they make use of certain defense mechanisms to control and express these negative affects and to minimise

their anxiety. Defense mechanisms can be conceptualised as a manner in which an individual can attempt to minimise anxiety and/or protecting themselves against internal and external forces. These defenses also serve to sustain a consistent, positively valued sense of self. The theoretical tenets underlying the use of defenses suggest a conflict-based formulation consistent with psychodynamic theory.

The participants reported defences that were identified in seminal texts as being associated with poor psychic health or personality functioning and diminished resources for coping (e.g. Sadock et al., 2015). For example dissociation (participant JS) and psychosis (participant LF) are more drastic mechanisms indicative of more fragile psychic states (McWilliams, 2011). Dissociation (neurotic defense) is "a temporary but drastic modification of character or sense of personal identity to avoid emotional distress; it induces vague states and hysterical conversion reactions" (McWilliams, 2011). On a psychotic level, this takes the form of frank delusions about external reality, usual persecutory, includes both perception of one's own feelings and those of other with subsequent acting on the perception (psychotic paranoid delusions) (McWilliams, 2011). Thus the nature of the defense mechanisms used in the theoretical formulation of anorexic patients suggest fragile ego states with moderate to severe symptoms.

Similarly, Denial (participant AP), Projection (participant JB) and displacement (participant AP) are associated with less functional or adaptive outcomes in clinical and non-clinical samples (e.g. Sadock et al., 2015). Displacement as a defense mechanism entails "a purposeful, unconscious shifting of impulses or affective investment from one object to another in the interest of solving a conflict. Although the object is changed, the instinctual nature of the impulse and its aim remain unchanged". Displacement is considered to be a neurotic defense (McWilliams, 2011).

Projection is "perceiving and reacting to unacceptable inner impulses and their derivatives as though they were outside the self. On a non-psychotic level, projection

involves attributing one's own unacknowledged feelings others; it includes severe prejudice, rejection of intimacy through suspiciousness, hypervigilance to external danger, and injustice collecting" (Sadock et al., 2015). Projection is considered a narcissistic and immature defense (McWilliams, 2011).

The participants' identification of these defences suggest that they view body dissatisfaction in anorexic patients as a more severe symptom which manifests as a result of compromised ability to cope with internal or external stressors. This is consistent with the psychodynamic formulations of psychic health and dysfunction (e.g. Sadock et al., 2015). According to McWilliams (2011) the reliance on a specific defense or set of defenses is the consequence of complex interactions among the following factors. These are the individual's constitutional temperament; the nature of the stresses that the individual experienced in early childhood; the defenses modelled or taught by parents and/or significant others; and the experienced consequences of using these specific defense mechanisms (McWilliams, 2011). Thus the level of psychic health is implied in the choice of defense mechanism employed and the manner in which the individual uses these defenses.

To conclude this subtheme, these participants suggested that the intra-psychic processed and psychic determinism that underlies psychodynamic thinking provided an acceptable and shared explanation in the clinical psychology practice community. The participants believed that early experiences in an individual's life have a significant impact on their current functioning and manner in which they relate to the self, others and the environment. This finding reflects the core of psychodynamic theory (Leighsenring & Leibing, 2007). Thus the finding is that this particular formulation was shared and accepted as a legitimate meaning assignation or explanatory system within the community of clinical psychologists who subscribe to psychodynamic theory.

Subtheme 1.1.2: Cognitive theory

The second subtheme that emerged was focused on cognitive theory. Table B below provides illustrative quotes for the subtheme.

Table B: Category 1, Theme 1: Theoretical formulation, Subtheme: Cognitive theory

| Subtheme                | Illustrative quotes   |
|-------------------------|---|
| 1.1.2. Cognitive theory | <p><i>GA: "So where it is primarily your anorexic that is dissatisfied in terms of body image, which really becomes the metaphors, through which the sense of dissatisfaction and self-concept is projected onto the body..."</i></p> <p><i>GA: ... "addressing what are the core belief systems ... it's what we call in schema therapy a 'coping mode', so the distortion becomes a preoccupation, and through over compensation by starving I am in some way I am going to find a sense of control, power and so forth and in order to have that drive towards power and control, I got to maintain a sense that my body is not small enough or not refined enough. So holding on to the dissatisfaction is the mechanism that ensures that one can continue the drive to find that sense of control and that in itself is an illusion".</i></p> <p><i>PP: "Their desire to maintain that life threatening unhealthy weight is mostly motivated by cognitive distortion and body dissatisfaction and they would be extremely dissatisfied if they were to put on weight, which needs to be addressed".</i></p> |

Some participants reported drawing on theoretical frameworks and constructs that are more cognitive in orientation to make sense of body dissatisfaction in AN. The cognitive schema specialist, participant GA, identified body dissatisfaction as a manifestation of self-concept and also used core beliefs as their reference point. According to Westbrook, Kennerly and Kirk (2011), the core principle that governs cognitive theory refers to an individual's emotional responses and behaviours that are strongly directed by their cognitions. Cognition in this theory refers to thoughts, beliefs and interpretations about themselves/situations, and how these cognitions give meaning to the events in their world.

Participant GA, primarily conceptualised anorexia nervosa in terms of the core belief systems. According to this system, the dissatisfaction with their body image becomes a metaphor through which they can project their sense of dissatisfaction and self-concept onto their bodies. Participant GA conceptualised the person's "coping mode" as follows: their distortion of their body image becomes a preoccupation, and has to be maintained to ensure a continuous drive towards a sense of control. This distortion of the body image serves as (over) compensation by starving the body to find a sense of control and power. To get to the

sense of power and control, the illusion of the body as not small enough or not refined enough needs to be maintained, to ensure the status quo of continuous drive towards a sense of control and power in their own life. Thus it emerges how the tenets underpinning cognitive theory provide a conceptual framework that enabled the participants to formulate body dissatisfaction as a symptom and criterion of anorexia nervosa.

To conclude in this subtheme the participants reported that cognitive processes and thought patterns contained in cognitive theory, as useful explanatory systems to gain insight into body dissatisfaction in the anorexic patient. Conceptualisations were drawn on the primary assumption that beliefs predate behaviour and that behaviour can only be understood in the context of antecedent thoughts including dysfunctional cognitive processes such as misattributions, overvalued ideas, delusional systems, as well as functional cognitive processes e.g. reality testing, distortions etc (e.g. Beck, 2011 & Westbrook et al., 2011). Thus this particular theoretical formulation was embraced as a legitimate explanatory system that is acknowledged and shared by other practitioners and the canon of psychology. What emerges very clearly is that similar to the psychodynamic formulation, participants clearly identified with certain belief systems within psychology that helped shaped their professional identities and their formulatory approach when working with patients who present with an eating disorder.

#### Subtheme 1.1.3: Sociocultural theory

This subtheme emerged based on contributions from participants that focused on how social, cultural and familial influences contributed to the “thin ideal”. Table C below provides quotes that illustrated the theme.

Table C: Category 1, Theme 1: Theoretical formulation, Subtheme: Sociocultural theory

| Subtheme                    | Illustrative quotes  |
|-----------------------------|--|
| 1.1.3. Sociocultural theory | <p><i>CT: "The lack of satisfaction with one's physical appearance, where one seeks to moderately improve their physical presentation within reasonable limits".</i></p> <p><i>LS: "Usually a desire to appear perfect, to be admired by others and to be taken seriously. Average is not OK".</i></p> <p><i>LF: "It's a person who sees their body as very ugly and usually because it is too fat and there is almost a psychotic aspect to it".</i></p> <p><i>PP: "When somebody feels uncomfortable in their own skin, for example when looking in the mirror or when they feel anything less than accepting of who they are physically but obviously it can take different forms and on a whole continuum of, so it might be like, I don't like my calves or I hate my whole body".</i></p> <p><i>NS: "Body dissatisfaction is not feeling ok with certain aspects of your body but more than just not feeling ok. It goes further, it almost gets to a hate point, where I need to change this part, if I don't change this part, and I cannot continue to be happy".</i></p> |

The idea behind the thin ideal is that there is a body ideal that is dictated by or is an artifact of sociocultural processes such as the media, fashion, sport, family and peers. For example, participant LS reflected that body dissatisfaction reflects “a desire to appear perfect... Average is not OK.” Essentially the participants reflected that individuals diagnosed with AN have more than just a lack of satisfaction with their physical appearance, they are actively seeking ways to improve their physical presentation outside of reasonable limits. For them being average is not good enough and they will strive to be admired by others and taken seriously, through the thin/ideal body image. Thus body dissatisfaction was understood to be integrally linked to the thin ideal.

The thin ideal was derived from the participants’ theoretical conceptualisations or formulations of body dissatisfaction. Although the thin ideal is not a theory in itself, it emerges as a construct from sociocultural theory and it was an extremely important concept in the theoretical understanding and formulation of AN for the participants. The thin ideal is a concept that drives the symptomology in AN through internal and external influences. Thus participants reflected that the sociocultural theory with concepts like the thin ideal, provided an acceptable way to theoretically formulate body dissatisfaction in anorexic patients.

The findings are consistent with seminal texts on disordered eating in which the thin ideal has been implicated as an important concept in the onset of anorexia nervosa. For example, Walsh (2013) asserted that eating pathology has been conceptualised as a western culture-bound phenomenon, where the thin ideal is idealised and most often unattainable. In western societies this thin ideal is seen as the acceptable norm in reference to social and cultural ideals (Szabo & Allwood, 2004). Traditionally, in contrast, in non-western societies like South Africa, especially in black (rural) communities the thin ideal is not important, since they place value on plumpness, which suggests attractiveness, prosperity, fertility and health (Morris & Szabo, 2013). Morris and Szabo (2013) identified that young black students are also now starting to deal with eating pathology as a result of body dissatisfaction due to acculturation and the adoption of more modern ways in South Africa.

The findings also indicated that self-evaluation, peer evaluation and human interaction take on the tenor of the thin ideal. The participants strongly acknowledged sociocultural agendas and influences in their formulation of body dissatisfaction. These findings resonated with Ahern, Bennett, Kelly and Hetherington (2011) who reported increasing evidence supporting the relationship between the thin ideal and body dissatisfaction in eating pathology. This relationship reportedly causes an individual diagnosed with AN to have a profound disturbance in body image, distorted self perception, starvation and an obsessive fear of gaining weight. Similarly, Ferreira et al. (2013) underscored the emphasis and value placed on the thin ideal, connecting this thin ideal to desirable personality characteristics, power and happiness. This creates a fear of judgement and inadequacy when one does not adhere to this thin ideal, which in turn can be transformed into eating pathology (Fergusson et al., 2011). Sadock et al. (2015) identified that within Anorexia, the thin ideal becomes internalised and maintained the disorder. Society's conceptualisation of the ideal body may influence an individual's body image assessment and

affect all spheres of their life. The danger that this poses is that this beauty/thin ideal is so ultra-thin that it is both unattainable and unhealthy (Esnaola et al., 2010).

What became evident in this subtheme is that social and cultural influences in the environment contribute to the establishment of body image ideals including the thin ideal that in turn fuels body dissatisfaction in individuals with AN. The resultant body dissatisfaction has both psychological and physiological sequelae. In this way, socio-cultural theory inclusive of the thin ideal becomes a meaningful theoretical formulation of body dissatisfaction in anorexic patients.

Theoretical formulation as a theme underscored that theory represented an agreed-upon way in which clinical psychologists could construct the developmental trajectory of the syndrome or disorder. The results identified the psychodynamic, cognitive and sociocultural theoretical approaches as consensually agreed upon ways of meaning assignment through formulations within the discipline of psychology and the practice community of clinical psychologists in the treatment of anorexic patients. In this way the theme indicates that theoretical formulations form an integral part in the understanding and treatment of individuals diagnosed with AN. Practically, within this profession it is often experienced that clinical psychologists will utilise several theoretical frameworks, which contributes to a more holistic understanding of the development and maintenance of the individual's disorder (Sturmey, 2009).

In conclusion a core finding in this study is that the role of theory is to flesh out an explanatory system, and creating an understanding of body dissatisfaction in AN. From the findings it emerges that the participants use theory and theoretical formulations to conceptualise body dissatisfaction in AN. Within the cannon of psychology, a theoretical formulation is one of the first skills a psychologist is taught at a postgraduate level before entering the enduring and challenging profession of psychology. Therefore it would make sense that they use this as an explanatory system. The theoretical formulation is intended to



give a more in-depth and holistic picture of the individual. McWilliams (1999) argued that theoretical formulations enable the clinician to understand the individuals in the field of clinical psychology and psychological formulation. She further argued that through these theoretical formulations, the clinician can understand an individual's unique, personal subjectivity, history and symptom maintenance. The theoretical formulation is extremely important to guide the treatment plan for the individual and to communicate to other practitioners (McWilliams, 1999 & Sturmey, 2009).

### Category 1, Theme 2: Aetiological formulation

The second theme that emerged related to content about an explanatory system that reflected a causal approach. The participants identified various factors that contributed to the development, triggered the onset or impacted the course of body dissatisfaction in patients diagnosed with AN. This theme was entitled, aetiological formulation based on the participants' identification of factors that approximated aetiological factors and presented in seminal diagnostic texts such as the DSM-V (APA, 2013). This theme comprised of three subthemes that were thematically organised to capture the site or location of the aetiological factors identified rather than their function. The subthemes were labelled, internal influences/ conflicts, external influences and the interaction between internal and external influences.

#### Subtheme 1.2.1: Internal influences and conflicts

Participants indicated that internal influences and conflicts form an important part of AN and it constitutes a part of the presenting problem, predisposing, precipitating and perpetuating factors when looking at the aetiological factors. Table D provides a summary of the subthemes with illustrative quotes.

Table D: Category 1, Theme 2: Aetiological formulation, Subtheme: Internal influences and conflicts

| Subtheme                                 | Illustrative quotes  |
|--|--|
| 1.2.1. Internal influences and conflicts | <p><i>AP: "It's a symptom of a deeper conflict, ambivalence to maternal and paternal conflicts and alliances".</i></p> <p><i>LS: "a fear that they...will lose control and become very over weight. ... to compensate for "all or nothing thinking" which is typical in all addictive thinking ... I am ugly so need to compensate with a perfect body, I need to be fragile to remain dependent on others, I have to always be in control, I need to appear perfect to others – any flaws cannot be tolerated, conflict over sexuality".</i></p> <p><i>JB: "I think an inherent dissatisfaction with one self, their life and an attempt to intervene somehow with something tangible, so I think it is an escape from feelings, an escape from their emotional world".</i></p> <p><i>JS: ... "you have a visual aspect to it, a thinking aspect and you have a feeling aspect to it and you have a behaving aspect to it. How I see my body, how I think about it and how I feel about it and this make me behave in certain ways. It is that sense of not being satisfied with what I see when I look into the mirror".</i></p> <p><i>AP: "Conflict against the self and a desire for control".</i></p> |

The participants believed that these internal influences and conflicts create a pathway for body dissatisfaction to have a considerable impact on the emotional and physical health of individuals diagnosed with AN. The participants acknowledged low self-esteem in these individuals, which forms part of the internal conflicts and the internalisation of the thin ideal. Low self-esteem for example has a powerful influence on body dissatisfaction, whereby in turn the internalisation of the thin ideal, emotions and conflicts perpetuates and exacerbates AN.

Most of the participants conceptualised body dissatisfaction of their patients as a need to control their inner conflicts through their (im)perfect bodies. The body dissatisfaction then became a symptom of the deeper internal conflict and ambivalence with AN as a way to deal or regulate these conflicts or influences. Low self-esteem, internal conflict and ambivalence were identified as internal influences factors that predispose, precipitate and perpetuate the body dissatisfaction within AN. For the participants this translates into individuals with AN having problems with identifying and regulating their negative affects, which results into the need to control the body to deal with this ambivalence and internalised anxiety.

The findings replicated the core theme in the literature that internal or dynamic aspects are implicated in body dissatisfaction and disordered eating in general. Literature spanning more than two decades have replicated the finding that difficulties with emotion regulation play an integral part in the aetiology of AN. For example, in the early 1970s, Bruch (1973) stated that the onset of AN can be viewed as a maladaptive defense against feelings of ineffectiveness, inadequacy, low self-esteem and most importantly a struggle for control. In the 1980's, studies suggested that the anorexic patient's preoccupation with thinness can be viewed as a reparative defense resulting in an experience of inner conflict leading to helplessness and a sense of worthlessness that cannot be dispelled with available resources. Therefore a patient with AN becomes obsessed with their newly discovered form of reassurance through control over their bodies. This results in food and physiological processes become abnormally used to regulate emotions (Bruch, 1980; Goldberg, Halmi, Casper, Davis, & Roper, 1980; Casper, 1982; Fosson, Knibbs, Byrant-Waugh, & Lask, 1987). In the 1990's, studies supported an association between a distinct personality profile and the clinical expression of AN, more specifically tendencies towards emotional and behavioural inhibition and rigidity and the ability to restrict food successfully. The control over the body becomes the focus and a valued goal by the patient, which would keep emotional distress and negative emotions out of awareness (Casper, Hedeker & McClough, 1992; Eckert, Halmi, Marchi, Grove, & Crosby, 1995; Fichter & Quadflieg, 1996). 21st Century conceptualisations of AN increasingly emphasises the role of emotional difficulties in its onset and maintenance, resulting in this aspect being incorporated into the treatment and therapeutic models. Various research in this century have encapsulated that dieting and AN behaviours serves as a maladaptive strategy to compensate for deficits in emotion regulation in AN. It has been reported by various studies that the avoidance of unpleasant emotions are a core feature of AN. Therefore, according to the research, food restriction in AN is seen as a n attempt to avoid negative affective states mainly through an obsessive focus on weight, body

shape and food consumption (Fairburn et al., 2003; Brockmeyer et al., 2011; Schmidt et al., 2012; Zipfel et al., 2013; Wildes, Marcus, Cheng, McCabe, & Gaskill, 2014).

Several of the participants identified that anorexic patients often present with a need to stay dependent on the other/parents to survive. The body then becomes a vehicle to meet this particular need. The findings further suggest that anorexic patients compensate for their neediness by demonstrating control over attaining or maintaining a perfect body, always staying in control, always appearing perfect to others and never having flaws. Then only can they be experienced as fragile enough to stay dependent on others/parents. Participants attributed this to “all or nothing thinking.” Thus the faulty cognitions and compensatory behaviours that typify body dissatisfaction, are in response to an internal or dynamic need for dependency (e.g. participant LS).

Participant AP attributed AN to “a deeper conflict and ambivalence to maternal and paternal conflicts.” This conflict is considered an internal influence because it represents internalised conflicts that create difficulty with emotion regulation. This finding reflects sentiments expressed in the literature where poor attachment to parents or caregivers have been cited as a predisposing factor in the development of AN. For example, Galperin, Gleiser and Schwartz (2009) underscored that past research has already established a link between child attachment and the development of AN. Therefore they further argue that AN can be traced to estrangements between the parent-child attachment and the emotions associated with this relationship is internalised. They found that children who grow up with an insecure attachment style are at a greater risk, and that these children are not provided with a means of security and the development of AN serves as a way of coping with the unpredictability, ambivalence and stressors (Galperin et al., 2009).

What became evident in this subtheme is that there are factors influencing the development of body dissatisfaction as a symptom of AN that are intrapsychic or located within the patient. Some of those factors include psychological constructs like self-esteem,

temperament etc. Other factors operate internally or dynamically as representations of internalised relational or contextual experiences such as attachment. Participants indicated that through their practice of and training in clinical psychology, as well as their clinical management of anorexic patients, such internal influences and conflicts have consistently been identified in the aetiology of anorexia and contributed to a better understanding of body dissatisfaction in AN.

### Subtheme 1.2.2: External influences

This subtheme was titled, external influences based on participants' responses that highlighted factors in the anorexic patients' life, friendship circle and socio-cultural context.

Table E provides a summary of the subtheme with illustrative quotes.

Table E: Category 1, Theme 2: Aetiological formulation, Subtheme: External influences

| Subtheme                   | Illustrative quotes   |
|----------------------------|---|
| 1.2.2. External influences | <p><i>CT: "There may be numerous, accumulated instances heightening body dissatisfaction, such as teasing about appearance, body dissatisfaction already present in the family, romantic encounters, continuous comparison toward and by peers, media influences".</i></p> <p><i>PP: "a complex process of conditioning from the.... type of competitiveness that goes on at girls' schools... social forces that have made thin equal beautiful... the media also of course plays a huge role... so our society is extremely body preoccupied, appearance preoccupied".</i></p> <p><i>LF: ... "looking at magazines... they hear compliments one girl gets that is very thin, 'oh you look beautiful, you look terrific".... from a parent whose very conscience of body image, it can be the father, who does exercises and focuses on healthy body... There is something in the family that they feel out of control in, so they put the control in the only place they know which is their own body".</i></p> <p><i>JS: "One aspect of it is what the external world presents as, what we are supposed to look like and kids or people are bombarded by these external factors through social media, movies, models and the list goes on".</i></p> <p><i>LF: "I think it starts with unhappiness, feeling of helplessness at home or at times it starts at school where the kids get bullied, and is made to feel bad or made to feel ugly and then of course it moves over to the body dissatisfaction".</i></p> |

The participants identified specific sociocultural aspects that predispose, precipitate and perpetuate body dissatisfaction in AN and in so doing form part of the aetiology of the syndrome as a whole. Three core external influences were identified by participants that they

believed clearly can be seen in the development of body dissatisfaction namely: 1) Parental influences; 2) Peer influences and 3) Media influences.

i) Parental influences: Participants identified that when body dissatisfaction is already present in the family, the parental attitude towards body images and ideals constitute an external influence that negatively shapes the child's own body ideals. For example, participant LF described from clinical case work that the father's perception of the ideal body in terms of exercise and focus in what is a healthy body might place external pressure on the child and inculcate unhealthy beliefs. This finding resonated with literature that relates to parental modelling of unhealthy attitudes towards body shape like excessive exercising and dieting. Studies within the literature suggested that parents who make judgments about their own and their children's physical appearance, especially their weight, inflicts norms about body image and weight. These norms leads to a negative connotation of being overweight and creates an internalisation of the thin ideal. These parental influences poses as a significant influence on the development of body dissatisfaction (e.g. Ata, Ludden, & Lally, 2007; Kremer, Giles, & Helme, 2008; Rodgers, Paxton, & Chabrol, 2009).

Participant LF identified that feedback provided by the parental system might reinforce poor body ideals, attitudes and dissatisfaction. For example, Parents giving compliments when the patient has reached an ideal thin body. These findings echo sentiments expressed in the literature that reported if weight loss efforts are successful and reinforced by the responses of others in their immediate social environment for example parents and peers, the result is an intensified motivation to continue losing weight. The role of reinforcement through positive feedback on the thin ideal makes the patient believe that their ability to lose weight makes them more attractive, builds self-control, enhances feelings of expertise, and improves their ability to push their body further (e.g. Bardone-Cone & Cass, 2007; Ahern, Bennett & Hetherington, 2008; Harrison, Tchanturia & Treasure, 2010; Walsh, 2013).

The findings also indicated that volatile and unhealthy family/ parental relationships or home environment constitutes an external influence that can impact adversely on the patient's well-being. Participants perceived anorexic patients to treat their body as a physical representation of the familial context. The out of control feeling experience in the family is resonated in their discontent about their bodies. Thus they try to compensate for this by exerting excessive control over their body. The broader subtheme of parental influence resonated with Johnson (1991) who concluded that anorexic patients have complicated connections or relationships with AN's with their primary caregivers from childhood that is maintained throughout the onset and development of AN. The literature suggests that AN is multi-faceted, from the family environment, the patient's internal world and personality, to its commercial appropriation by the media. The family environment factors most mentioned in the literature are: the presence of an eating disorder or depression in the family history, adverse parenting involving insecure attachments, low contact, high expectations and parental discord. Other significant factors mentioned by the literature within the familial context that influences the AN sequelae are sexual abuse, family dieting, critical comments about eating, shape or weight. It is suggested the patient's symptoms lie within the root of the family's transactional patterns or ways of interacting with one another (Fairburn & Harrison, 2003; Krcmar et al., 2008; Legrand, 2010; Goldenberg & Goldenberg, 2013).

ii) Participants identified that peers can also play a very influential role in developing or maintaining body dissatisfaction. For example, peer influences include teasing and bullying; making comparisons between the girl's in schools and their different body appearances; and the competitiveness, especially in the all-girls schools and lastly complimenting the ideal thin body. This was perceived to have a detrimental effect in maintaining the preoccupation of what is being seen as the ideal body. Participants indicated that in this way peers construct an agreed-upon reality in which particular body images and attitudes are accepted as the norm or criterion reference. This finding resonated with Krcmar et al. (2008) who stated that weight

comparisons were principal correlates of body dissatisfaction and found that individual's whose peers considered thinness to be an important factor were more likely to internalise the thin ideal. These authors also found that peer competitiveness could reinforce body dissatisfaction and result in maladaptive food restricting or dieting (e.g. Krones, Stice, Batres, & Orjada, 2005; Krcmar et al., 2008; Bailey & Ricciardelli, 2010; Fitzsimmons-Craft et al., 2012).

Participants also identified that romantic partners can have a very negative impression on developing or maintaining body dissatisfaction. The participants identified that partners with an insecure sense of self, struggle to form or maintain healthy connection with significant others. For example, participant CT stated that "There may be numerous, accumulated instances heightening body dissatisfaction, such as teasing about appearance, body dissatisfaction already present in the family, romantic encounters, continuous comparison toward and by peers, media influences". This unhealthy way of relating is an external influence that contributes to the body dissatisfaction (e.g. Ferguson et al., 2011; Bulik, Baucom, & Kirby, 2012; Fischer, Baucom, Kirby, & Bulik, 2015).

iii) Media influences. The participants identified that the media has a very influential role to play in the development of body dissatisfaction. Models are presented in an idealised manner in television, movies etc. and the young or even older minds get consumed with what they are supposed to look like to have it all. Being thin is the ideal and is idealised by the young minds and get reinforced by the others' (family, peers, self) preoccupation of them looking the same, no matter of health concerns. Participant PP explains that external influences is "a complex process of conditioning from the... type of competitiveness that goes on at girls' schools... social forces that have made thin equal beautiful... the media also of course plays a huge role... so our society is extremely body preoccupied, appearance preoccupied". Participant JS agrees by stating that: "One aspect of it is what the external



world presents as, what we are supposed to look like and kids or people are bombarded by these external factors through social media, movies, models and the list goes on".

These findings reflected in this subtheme concurs with well-established sentiments expressed in the literature on disordered eating. For example, Ferguson et al. (2011) concluded that the media and the exposure to it, is considered to be a factor that contributes to the internalisation of the thin ideal and the maintenance of body dissatisfaction. Fernandez and Pritchard (2012) took this further by saying that the real difficulty arises when individuals are vulnerable to media images and then they internalise these thin ideals. Awareness and internalisation of sociocultural standards of appearance meaningfully predicts an individual's drive to thinness.

Within this subtheme the participants illustrated this developmental path to the onset of body dissatisfaction in AN through sociocultural indicators namely parental influences, peer relationships and the role of the media. It is clear that most individuals would have some experience of these external influences but the predisposing factors would become important in the development of body dissatisfaction in patients diagnosed with AN. Lastly, the participants indicated that external influences can function as aetiological factors and thus are important in the development of body dissatisfaction.

### Subtheme 1.2.3: Interactions between internal and external influences

Participants also reported that there was an interplay between internal and external influences. Table F below provides quotes to illustrate the sub-theme.

Table F: Category 1, Theme 2: Aetiological formulation, Subtheme: Interactions between internal and external influences

| Subtheme  | Illustrative quotes   |
|---|---|
| 1.2.3. Interactions between internal and external | <p><i>GA: "The influence of media, the influence of families, the notion of the drive for perfection, what we call in schema therapy the 'demanding parent', that pushes to actually get to a place of idealised self-perception, it is going to find through the body a tangible expression of where one can make real change.... the sufferer will quite easily find the body to be a platform upon which change can be made".</i></p> <p><i>PP: "It's such a multi-layered thing, and also it is linking the person or the child's temperament self-esteem and self-identity... And obviously like some of them are into 'Pro Ana' websites and stuff like that and I suppose that is a factor that also influences them to become anorexic, it enhances the body dissatisfaction and the desire to be completely emaciated".</i></p> <p><i>NS: "...the cause in terms of the family, the family has a lot of triggers and creates what unfolds... I look at it as originating within the family context. I don't believe it's a sort of intrinsic thing to "I" it's the relationships. It is for me a metaphor for what is going on in the family more than an individual problem".</i></p> <p><i>JS: "Obviously there are other intra-psychic factors and dynamic factors that I think often cause body dissatisfaction within a family or a family group. I mean what do you do when mom and dad are triathletes and every week they train and every weekend they do competitions, and here you are this plump little boy or girl? You are not going to be happy with what your body looks like. It might even be communicated by mom and dad, intentionally or not. And that creates a tension, and self-image is a part of it".</i></p> |

The participants indicated that the complexity of body dissatisfaction suggests that there is a more dynamic overlapping layered process that differs within each individual.

Participant GA described an interplay between the “demanding parent”, representing the media, family and social influences (external sources) and the drive to perfection (individual influence) in the following way: “the demanding parent” pushes the patient to a place of idealised self-perception, and the only way to express this tangibly is through the body. It is then through the body that they can make a real change and consequently the body can become the platform upon which change can be made and visually seen.” This interplay between internal and external influences was consistent with the formulation within schema therapy theory as identified by the participant. This was also consistent with seminal texts on schema therapy or cognitive therapy (e.g. Galperin et al., 2009; Campos et al., 2012; Treasure & Schmidt, 2013).

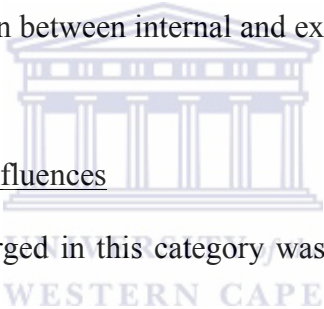
The participants also described body dissatisfaction as a multi-layered mechanism, linked to the temperament of the child, as well as the self-esteem and self-identity of the patient. Furthermore, Participant PP states that: "some of them are into 'Pro Ana' websites and stuff like that and I suppose that is a factor that also influences them to become anorexic, it enhances the body dissatisfaction and the desire to be completely emaciated". The literature has noted problematic websites like 'ProAna' and 'ProMia', which serves as a platform to exchange tips on maintaining the eating pathology and to reach 'better' results (e.g. Dias, 2003; Borzekowski, Wilson, & Peebles, 2010; Juarascio & Timko, 2010).

Lastly, it seems that the participants were in general agreement that body dissatisfaction develops in an interactional manner within the intrapsychic, familial and or social context. It becomes a metaphor for not only what is happening to the individual, but what is going on within the family system and the experience lived in the social world. The intentional or unintentional communication by the parents/peers/media can contribute or influence this body dissatisfaction tension and have a negative effect on the developing self-image. The interaction between internal and external influences depict the complexity of body dissatisfaction in AN and it advocates for the importance of applying an aetiological formulation in partnership with the theoretical formulation.

In conclusion another core finding in this study is that the role of the aetiological formulation in conjunction with the theoretical formulation is to flesh out a causal explanatory system, in creating an understanding of body dissatisfaction in AN. From the findings it emerged that the aetiological formulation again consists of the body of knowledge in psychology, which all clinical psychologists are trained in and it is identified as an important skill in the understanding of individuals pathology. The aetiological factors identified as part of the aetiological formulation is an internationally agreed upon explanatory system. This agreed-upon system comprises of predisposing, precipitating, perpetuating and protective factors, which again becomes an essential part of the cannon in psychology.

Interestingly when the participants spoke about these aetiological factors, they spoke about them in terms of internal influences and conflicts, and external influences.

For clinical psychologists there is a tacit understanding that the internal and external influences and conflicts act as potential predisposing, precipitating and perpetuating factors. Clinical psychologists, at postgraduate level, are trained to assess the function of these factors. However in this study, the participants rather assessed it in terms of the location of the factors, presented as internal and external. This forms part of the psychological thinking in the canon of psychology. Lastly, the participants used theory to inform and understand body dissatisfaction in AN, as well as to communicate with fellow mental health professionals. The participants used causal explanations to understand body dissatisfaction by indicating the important distinction between internal and external influences and conflicts.



### Category 1, Theme 3: Complex Influences

The third theme that emerged in this category was, complex influences. This theme involved influences that in and of themselves were complex and nuanced. Two subthemes comprised this theme namely: 1) trauma and 2) co-morbidity. Trauma as a sub-theme included traumatic experiences that impacted the nosology and aetiology of body dissatisfaction in anorexic patients. Co-morbid diagnoses in individuals/patients with AN contribute to the manifestation and development of body dissatisfaction and other symptoms in the syndrome.

#### Subtheme 1.3.1: Trauma

In this subtheme, participants identified that traumatic experiences play a major role in the development and maintenance of body dissatisfaction within AN. Table G provides illustrative quotes for the subtheme.

Table G: Category 1, Theme 3: Complex influences, Subtheme: Trauma

| Subtheme     | Illustrative quotes  |
|--------------|--|
| 1.3.1.Trauma | <p><i>PP: "Sexual abuse is a factor as well, because obviously that plays a huge role. Especially where there is a history of trauma or specifically sexual trauma. If there is trauma or sexual abuse I might work with them more than just on an individual level. In my private practice, my treatment strategy would be around the approach Internal Family Systems Model, which looks at sub personalities that's a part of the personal relationships within a family".</i></p> <p><i>CT: "sometimes PTSD is also diagnosed when there was a trauma such as sexual, physical and/or psychological abuse, and so on. Understanding what underpins the patient's body dissatisfaction in anorexia is a key aspect of therapy, in order to reduce its archaic influence over time".</i></p> <p><i>GA: "So the formulation would be more around core issues like sexual violation, fears around maturation, family dysfunctionality, trans-generational trauma, those would be more the broad themes. With sexual abuse, someone can go into an anorexic state to literally become physically small, cut off from their sexuality, both physically in terms of their anatomy or at a chronological level in terms of oestrogen being depleted, they are supposedly protecting their exposure of sexuality through emaciation".</i></p> |

Traumatic experiences were thought to have full aetiological impact in that it could predispose, precipitate, and maintain symptoms at disorder level. For example, participant GA stated that trans-generational trauma would be important when formulating body dissatisfaction in AN. And in terms of treatment, participant PP suggests using an internal family systems model to deal with the trauma and the sexual abuse.

The findings underscored the important role that a history of trauma, especially sexual trauma (e.g. participant PP), played in the development of body dissatisfaction as a symptom of AN. The participants considered traumatic experiences to constitute violations of the boundaries of the body that in turn impacts evaluations of the body and the need for control over the body. Participants reflected that sexual trauma was particularly noted in anorexic patients. For example, participant GA stated that with sexual abuse, someone can go into an anorexic state to literally become physically small, cut off from their sexuality, both physically in terms of their anatomy or at a chronological level in terms of oestrogen being depleted, they are supposedly protecting their exposure of sexuality through emaciation. This finding resonated with the literature where violations of body self-boundaries were reported to result in body dissatisfaction and experiences of reduced body confidence and comfort

(e.g. Sack et al., 2010; Reyes-Rodriguez et al., 2011). Similarly, Kearney-Cooke and Striegel-Moore (2010) reported that sexual violation of the individual's bodily integrity and safety engenders a feeling of having no control over his or her own physical space. The feeling of not having control is intensified by disruptions in the continuity of the self, the discontinuity of memory (e.g. resulting from dissociative responses), the loss of self-control, vulnerability related to environmentally triggered states of consciousness (e.g. flashbacks, panic attacks and regressive states) (Kearney-Cooke & Striegel-Moore, 2010). Thus the literature confirmed that a healthy and coherent body image can be severely impaired by sexual abuse or trauma. Sexual abuse is a complex phenomenon with a host of facets and the ensuing vulnerability and associated issues around loss of control become an important factor in the aetiology of AN. Literature resonated with these findings and identified that the most common traumatic event reported was sexual related traumas during childhood and adulthood (e.g. Kearney-Cooke & Striegel-Moore, 2010; Sack et al., 2010; Reyes-Rodriguez et al., 2011; Tagay, Schlottbohm, Reyes-Rodriguez, Repic, & Senf, 2014).

Participants also reflected that traumatic experiences can constitute trauma-related syndromes and reach disorder level e.g. Post traumatic Stress disorder (PTSD). For example, participant CT reflected that due to a trauma or sexual abuse, PTSD can also be diagnosed with AN. The PTSD diagnosis assist in the understanding of what underpins the patients' body dissatisfaction in AN. Thus a trauma-related diagnosis (such as PTSD) constitutes a premorbid condition, which becomes a predisposing factor or it might be superimposed on AN which presents as diagnostic complexity and comorbidity. For the purposes of this theme, the focus was on isolating the impact that traumatic experiences had on the development of body dissatisfaction. Co-morbidity will be dealt with separately. Literature supported the premorbid hypothesis. For example, Reyes-Rodriguez et al. (2012) reported that the majority of anorexic patients who presented with PTSD reported that the first traumatic event occurred before the onset of AN.

### Subtheme 1.3.2: Co-morbidity

In this subtheme participants identified co-morbidity as a complicating factor in AN.

Table H below provides quotes to illustrate the sub-theme.

Table H: Category 1, Theme 3: Complex influences, Subtheme: Co-morbidity

| Subtheme            | Illustrative quotes   |
|---------------------|---|
| 1.3.2. Co-morbidity | <p><i>PP: "There are so many co-morbidities with eating disorders, an individual with no other histories or comorbid disorders will be less likely to find anorexia".</i></p> <p><i>CT: "sometimes PTSD is also diagnosed when there was a trauma such as sexual, physical and/or psychological abuse, and so on".</i></p> <p><i>JS: "It has been reported through various research that AN is a complex disorder with co-morbid disorders, such as mood and anxiety disorders. This is important because depressed mood and anxiety may have an influence the manner in which individual's judge or evaluate themselves and objects. This may result in depression and anxiety influencing the body image evaluation and body dissatisfaction in AN".</i></p> <p><i>NS: "My experience thus far is that anorexia nervosa very often has comorbid diagnoses. If not diagnoses, then traits of the following conditions: depression, borderline personality disorder, anxiety (perfectionism), substance abuse (laxatives), adjustment disorder (initially stop eating/restrict food intake due to stressor i.e. death of loved one, family discord)".</i></p> |

All of the participants referred to co-morbidity as a given for anorexic patients. The participants highlighted the understanding that eating disorders in general and anorexia in particular, inevitably will be accompanied by comorbid disorders. They went as far as reporting that the diagnosis of anorexia (eating disorders) is unlikely if there are no other clinical histories of note or comorbid disorders (participant PP). The following quote from participant JS was the most illustrative:

“It has been reported through various research that AN is a complex disorder with co-morbid disorders, such as mood and anxiety disorders. This is important because depressed mood and anxiety may have an influence the manner in which individual's judge or evaluate themselves and objects. This may result in depression and anxiety influencing the body image evaluation and body dissatisfaction in AN” (Participant JS).

Literature resonated with the findings in this subtheme. For example, Zipfel et al. (2015) reported that three quarters of individuals diagnosed with AN has reported a lifetime

mood disorder, where major depressive disorder is most common. They also reported that between 25% and 75% of individuals diagnosed with AN has been diagnosed with at least one anxiety disorder, which typically precedes AN and starts in childhood. Lastly obsessive-compulsive disorders occur in 15-29% of individuals diagnosed with AN, and up to 79% experiencing some form of obsessions or compulsions during their lifetime (e.g. Walsh, 2013; Tagay et al., 2014; Brand-Gothelf, Leor, Apter, & Fennig, 2014; Zipfel et al., 2015). It is evident by the participant's responses that trauma/s and co-morbid diagnoses constitute complex influences on the development of body dissatisfaction in AN.

In conclusion of this category, the conceptualisation of body dissatisfaction in AN entails a wide range of knowledge based understanding by the participants, which includes theoretical formulations, aetiological formulations and other complex influences that forms part of the canon of psychology to which these participants subscribe to. This category also highlighted the learnt skills a clinical psychologist would use in the understanding of pathology and in reference to this study, the understanding of body dissatisfaction in AN. Finally, the importance of theory and the ability for these participants to formulate body dissatisfaction, becomes an integral part in informing the treatment regimen for the individual diagnosed with AN.

### **Category 2: Operationalisation of body dissatisfaction**

This thematic category was entitled, "operationalisation of body dissatisfaction". The category essentially included content related to clinical psychologists' understanding of indicators that they used to operationalise the body dissatisfaction criterion in AN. A reflection on the significance of operationalising body dissatisfaction yielded important insights in establishing connections to AN, the formulation and treatment plan, and the challenges it entailed. Three themes were included in this category namely, 1) Emotional indicators of body dissatisfaction; 2) Behavioural indicators of body dissatisfaction and 3)



Clinical utility of operationalising body dissatisfaction. Each theme is presented below along with any subsidiary themes (sub-themes) that may have been identified. Illustrative quotes are also provided in accompanying tables.

Category 2, Theme 1: Emotional indicators of body dissatisfaction

The first theme included in this category was emotional indicators of body dissatisfaction. The participants reported that emotional indicators of body dissatisfaction in AN is what drives and maintains the emotional aspect of the disorder. This is due to the internalisation of the thin ideal, the body dissatisfaction and emotional and relational aspects of the individual's world. This internalisation is also what makes AN a complex disorder and results in high relapse rates among individuals diagnosed with AN. Therefore the complexity of body dissatisfaction in AN needs to be accounted for and assessed in an in-depth manner, considering all the emotional indicators associated with body dissatisfaction within AN. The emotional indicators of body dissatisfaction by the participants included perfectionism, obsession and preoccupation, body image comparisons, and compromised reality testing in body imaging and body ideals and a delusional quality of body perception.

Subtheme 2.1.1: Perfectionism

In the first subtheme, participants identified perfectionism as an emotional indicator of body dissatisfaction in AN. Table I below reflects the quotes to illustrate the subthemes.

Table I: Category 2, Theme 1: Emotional indicators of body dissatisfaction, Subtheme: Perfectionism

| Subthemes            | Illustrative quotes  |
|----------------------|--|
| 2.1.1. Perfectionism | <p><i>CT: "Notions of reasonable weight loss, accepting limitations of their bodies, and moderate modifications of their appearance, disappear into a realm of excessiveness and illusory goals".</i></p> <p><i>LS: "if I am not perfect, I am a failure, I am not good enough, I am more special than others, , I am ugly so need to compensate with a perfect body, I need to be fragile to remain dependent on others, I have to always be in control, I need to appear perfect to others – any flaws cannot be tolerated".</i></p> <p><i>GA: "the notion of the drive for perfection, what we call in schema therapy the 'demanding parent', that pushes to actually get to a place of idealised self-</i></p> |

|   |
|---|
| <i>perception, it is going to find through the body a tangible expression of where one can make real change".</i> |
|---|

Participants defined perfectionism as a predisposition to set, strive for and to achieve extreme and unattainable standards of the ideal body. Participants offered possible operational definitions of perfectionism that included:

- overly critical self-evaluations of the experience of their bodies.
- loss of a sense of reality in the following areas:
  - weight loss
  - the limitations of their bodies
  - modification to their appearance
  - goal setting relative to bodily features
- excessiveness in pursuit of / maintaining thin ideals.

Participants reflected that the anorexic patient has difficulty establishing what constitutes realistic expectations in these areas. Perfectionism becomes a construct that drives the thin ideal and the internalised social pressure to be thin. Perfectionism becomes an expression of internal or intrapsychic processes and therefore is considered an emotional indicator of body dissatisfaction. This finding concurs with Boone et al. (2011) who reported that perfectionism has widely been implicated in the aetiology of AN as a predisposing and perpetuating factor and as a manifestation of the body dissatisfaction criterion (e.g. Boone et al., 2011; Brand-Gothelf et al., 2014; Wade et al., 2015).

Perfectionism has also been specified in the list of criteria for AN in the DSM-V. Thus the participants drew on their training in diagnosis in operationalising the emotional indicators of body dissatisfaction. This again supports the importance the participants placed on the agreed-upon fund of knowledge that psychologists share.

## Subtheme 2.1.2: Obsession and preoccupation

The second subtheme related to the obsession and preoccupation with body ideals.

Table J below contains quotes that illustrate the subtheme.

Table J: Category 2, Theme 1: Emotional indicators of body dissatisfaction, Subtheme: Obsession and preoccupation

| Subtheme                           | Illustrative quotes   |
|------------------------------------|---|
| 2.1.2. Obsession and preoccupation | <p><i>CT: "Also, in anorexia particularly, there is an element of not being or looking 'good enough' – that the extreme of perfection is the only option – in behaviour, thought, and/or appearance".</i></p> <p><i>JS: "Calorie and mirror checking. It is fascinating often how visual it is for them ... and their world falls apart because of one specific perceived flaw in their body, like a fold at a certain place on their body that they believe should not be there".</i></p> <p><i>GA: "... very strong preoccupation among the Anorexics".</i></p> |

Participants identified the obsession with body ideals and the subsequent control over the body as an emotional indicator of body dissatisfaction in AN. For example, participant JS reflected that the perceived flaws in their bodies could reach obsessional or delusional levels such as mirror checking. This in turn results in behavioural attempts to exert control e.g. via calorie counting. The participants indicated that the obsession with the thin body ideal and perceived imperfections were of an intrapsychic nature and therefore constituted an emotional indicator. The behavioural attempts at control are an outflow of the intense emotional experience. For example, participant JS reflected that anorexic patients will “fall apart if there is a fold at a certain place on their bodies, which they believe should not be there”. The participants were of the opinion that anorexic patients display body dissatisfaction through strong preoccupations with their bodies, idealised perfection (e.g. symmetry and exactness) and obsessional thought and behaviours.

The content of this theme has been well documented in the literature and seminal texts on diagnostic indicators. For example, Legrand (2010) reported that individuals diagnosed with AN, have frequent obsessions related to symmetry and exactness. Crane, Roberts and Treasure (2007) similarly reported that these obsessions and preoccupations are

perceived to be largely egosyntonic, which refers to the emotions, behaviours and values that are acceptable to the needs of the individual and is consistent with the individual's ideal self-image, but unrealistic. Zandian, Ioakimidis, Bergh and Södersten (2007) also reported that anorexic individuals display a stereotypic rigidity in their obsessional thoughts. Similarly, Hoffman et al. (2012) reported that the ensuing control over the body for anorexics is characterised by meticulousness indicative of the underlying obsession. The literature does not however, explicitly identify obsession and preoccupation as emotional indicators, but rather as general criteria.

### Subtheme 2.1.3: Body image comparisons

The third subtheme related to body image comparisons made by anorexic patients relative to other people and images. Table K contains illustrative quotes for this subtheme.

Table K: Category 2, Theme 1: Emotional indicators of body dissatisfaction, Subtheme: Body image comparisons

| Subtheme                      | Illustrative quotes   |
|-------------------------------|---|
| 2.1.3. Body image comparisons | <p><i>GA: "despite seeing the physicality of the other patients, it doesn't take away their personal sense of dissatisfaction".</i></p> <p><i>JB: ... "compare themselves to other people; mirror gazing and body checking".</i></p> <p><i>LF: ... "very anxious to take in food, as it will make them gain weight... feel very uncomfortable with other girls that are very thin because they feel that those girls are thinner than they are. And they will talk about hating their thighs or their hinds or their breasts or whatever they are unhappy with. Tummy's, tummy is a really big one... have them denying that they have a problem".</i></p> <p><i>NS: "And also consistently comparing yourself to others. Also seeking reassurance from other people, like "am I fat, do I look bigger to you etc".</i></p> |

The participants indicated that the internalised thin ideal becomes the basis for body image comparisons relative to other people and images. These body image comparisons are reciprocally linked to critical self-evaluations and other-evaluations. Participants also reported that these comparisons are made constantly. Participant LF reflected that "they [anorexic patients] keep on comparing themselves with other girls, complaining about various body parts, especially the "tummy" being a very big issue. They feel very

uncomfortable with other girls that seem thinner than them (and this leads to increased body dissatisfaction), with continuous mirror gazing and body checking”. The participants further described that even in the treatment setting, despite seeing the physical appearance of other patients, this does not take away the personal sense of dissatisfaction these patients have about their own imperfect bodies. It is important to note that the body comparisons can also take on an obsessional quality, as evidenced by their consistent seeking of reassurance from others. Thus the participants felt that the body image comparisons reflected an intense emotional experience constituting an emotional indicator of body dissatisfaction in anorexic patients.

The content of this sub-theme is reflected in the literature on anorexia where it has been reported that body dissatisfaction is exacerbated by the comparison of bodies (Fitzsimmons-Craft et al., 2012 ). The literature focuses on the reciprocal influence between body dissatisfaction and body comparisons, but has not explicitly identified body comparisons an emotional indicator of body dissatisfaction (e.g. Krones et al., 2005; Krcmar et al., 2008; Bailey & Ricciardelli, 2010; Fitzsimmons-Craft et al., 2012). Here too the participants drew heavily on clinical knowledge and experience of the diagnostic category. Their reflections increasingly moved to a more general discussion of the diagnostic indicators for the syndrome and they appear to extend the syndrome indicators to the operationalisation of the body dissatisfaction criterion.

#### Subtheme 2.1.4: Compromised reality testing and delusional qualities

The fourth subtheme related to distortions in perceptions that constituted compromised reality testing or delusional qualities. Table L below presents quotes that illustrate the essence of the theme.

Table L: Category 2, Theme 1: Emotional indicators of body dissatisfaction, Subtheme: Compromised reality testing and delusional qualities in body imaging, ideals and perception

| Subtheme   | Illustrative quotes  |
|--|--|
| 2.1.4. Compromised reality testing and delusional qualities in body imaging, ideals and perception | <p><i>JS: "We see it in anorexia, what they see is not physically real. So it's almost psychotic like in interpretations of what goes on around them and it is always pulled back to their body".</i></p> <p><i>JS: "it is a fixed entrenched dissatisfaction or ambivalence".</i></p> <p><i>LF: "So it is almost like a psychotic thing where they completely out of touch with reality about their bodies and of course they are comparing themselves to models. It is a psychotic thought process".</i></p> |

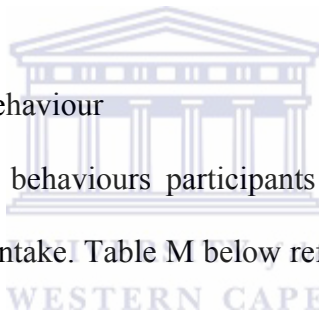
The participants identified disordered thinking and impaired reality testing as emotional indicators of body dissatisfaction in individuals diagnosed with AN. Participants identified that obsessive concerns about appearance and body image with the abnormality of the starvation of the body constituted psychotic features. For some of the participants these obsessions and preoccupations has taken on a psychotic dimension, of interpreting everything around them as happening inside their own bodies and it gets distorted from there. This is characterised by the intense and irrational beliefs concerning weight and shape, which also includes the intense fear of gaining weight. They further indicate that the fixed entrenched dissatisfaction with and ambivalence about their bodies can be seen as reaching delusional proportions. Therefore it expresses a disturbance in self-concept and body dissatisfaction of delusional proportions.

The findings of this theme have been well-documented since the early 70s. For example Bruch (1973) was one of the first to characterise the symptomology in AN as a “delusional denial of thinness”. Similarly Brewerton (2012) reported that the stereotypical rigidity in these individuals’ obsessional thoughts compromises their reality testing, that even in some individuals it can reach delusional proportions (e.g. Steinglass, Eisen, Mayer & Walsh, 2007; Guardia et al., 2012).

In conclusion, this theme essentially suggests that there are emotional indicators of body dissatisfaction in AN. Participants reportedly use these emotional indicators to operationalise the body dissatisfaction criterion.

Category 2, Theme 2: Behavioural indicators of body dissatisfaction

The second theme included in this category was behavioural indicators of body dissatisfaction in AN. The participants identified behavioural indicators as external or physical metabolizations and reactions to help facilitate an internal conflict. The participants divided the behavioural indicators into two subthemes that described the typical behavioural responses namely, compensatory behaviour and ritualistic behaviour.



Subtheme 2.2.1: Compensatory behaviour

This subtheme related to behaviours participants engaged with to compensate for perceived weight gain or calorie intake. Table M below reflects selected quotes that illustrate the respective subthemes.

Table M: Category 2, Theme 2: Behavioural indicators of body dissatisfaction, Subtheme: Compensatory behaviours

| Subtheme                       | Illustrative quotes   |
|--------------------------------|---|
| 2.2.1. Compensatory behaviours | <p><i>LF: "The obvious of course is the restricting or the avoiding of eating, using laxatives or exercising a lot".</i></p> <p><i>PP: "Pacing up and down when they have reached a stage where they not allowed to exercise".</i></p> <p><i>JB: "Restricting food, vomiting and exercise is a part of their life where they have a sense of control or perceived control".</i></p> <p><i>GA: "It is not something that lies at the core belief level, its is more your over compensatory behaviour, or that's where there is distortion or projection of what is actually otherwise the real source of dissatisfaction where certain behaviour like exercise or purging or laxatives is like the means by which to dismantle core beliefs of emotionally feeling fat or too big or ugly or revolting".</i></p> |

The participants reported that they observed two types of compensatory behaviours that were usually indicative of attempts to manage food intake. For example, participant LF

reported that patients behaviourally restrict or avoid food intake to compensate for perceived or actual calorie intake. Thus compensation through food or intake restriction becomes a behavioural indicator of body dissatisfaction.

The participants also reported patients behaviourally compensate by using consuming laxatives and engaging in extreme exercise. For example participant PP reported that patients would “pace up and down to reduce the effect of food intake.” Participant JB stated that "the restriction of food, vomiting and exercise is a part of their life where they have a sense of control or perceived control". Participant GA describes a different conceptualisation on this which is: " It is not something that lies at the core belief level, it is more your over compensatory behaviour, or that’s where there is distortion or projection of what is actually otherwise the real source of dissatisfaction where certain behaviour like exercise or purging or laxatives is like the means by which to dismantle core beliefs of emotionally feeling fat or too big or ugly or revolting". Thus compensation through exercise and substance use becomes a behavioural indicator of body dissatisfaction.

The findings reported above were consistent with the typology used in the DSM-5 specifiers of AN namely restricting type and binge-eating or purging type (APA, 2013). Zipfel et al. (2015) state that patient's with AN is classified and diagnosed by looking at these specifiers according to the DSM-5. The restricting behaviours documented in literature resonated with the compensatory behaviours reported in the study such as restriction and avoidance of food, and/or excessive exercising (e.g. Hoffman et al., 2012; Walsh, 2013; Sadock et al., 2015; Zipfel et al., 2015). The purging behaviour documented in literature resonated with compensatory behaviours reported in the study such as self-induced vomiting, and the misuse of laxatives (e.g. Hoffman et al., 2012; Walsh, 2013; Sadock et al., 2015; Zipfel et al., 2015).

The concordance between the findings and the literature can be attributed to the training of the participants in diagnostics or psychopathology. This training and their clinical



experience with the syndrome contributed to a high degree of consensus on the behavioural indicators of body dissatisfaction. Thus the participants draw heavily on their professional identity and fund of knowledge from their discipline to operationalise the body dissatisfaction criterion. The interesting thing to note is that the diagnostic texts do not operationalise body dissatisfaction, but use restricting and purging types as signifiers. The participants interestingly used the same notion to operationalise the body dissatisfaction criterion.

### Subtheme 2.2.2: Ritualistic behaviour

Table N: Category 2, Theme 2: Behavioural indicators of body dissatisfaction, Subtheme: Ritualistic behaviour

| <b>Subthemes</b>             | <b>Illustrative quotes</b>  |
|------------------------------|---|
| 2.2.2. Ritualistic behaviour | <p><i>LS: "... mirror checking, weigh themselves, body check, how "fat days and thin days" influence confidence and behaviour, rules and rituals, type of clothing, hair and make-up. Attitude to food and exercise and free time. Most anorexics are very punishing of themselves and believe they don't deserve any indulgence".</i></p> <p><i>PP: "checking in the mirror, mirror checking, body checking, constant weighing themselves and the kind of clothes they wear to either show off or hide their body".</i></p> <p><i>NS: "Mirror checking, standing on a scale the whole time, restricting ways of eating, drinking hot water, calorie checking, distortion of what is being seen in the mirror as well and that I think plays a big role as well".</i></p> |

The findings indicated that participant's operationalised body dissatisfaction behaviourally as including ritualistic behaviour. Thus they saw ritualistic behaviour as a behavioural indicator of the body dissatisfaction criterion in anorexia nervosa. The following behaviours has been identified by the participants as rituals that anorexic patients engage in: mirror, body and calorie checking; distortions of who and what they see in the mirror; ritualistic weighing themselves; body checking; how "fat and thin days" influences their confidence and behaviour; type of clothing, hair and make-up; attitude towards food, exercise and free time; denial of rewards and indulgence. It is evident that these ritualistic behaviours are constructed by the participants as indicators of the body dissatisfaction criterion in AN.

To finalise this theme, it once again became significant that the behavioural indicators are a response to internal conflict that the individual experiences.

The findings resonated with seminal texts that describe ritualistic behaviours as a standard feature of the anorexia syndrome. These texts reported that the rituals AN patients adhere to are mostly egosyntonic, where thoughts of food and weight repeatedly enter the mind of the patient, which results in the patient participating in ritualistic behaviour regarding food, eating, calories, weight and shape (e.g. Halmi et al., 2003; Walsh, 2013; Sadock et al., 2015).

Category 2, Theme 3: Clinical utility of operationalising body dissatisfaction

Participants identified that operationalising body dissatisfaction had great clinical utility. They identified three core areas in which they noted the usefulness of providing an operationalisation of the body dissatisfaction criterion in AN. These three core areas are formulation, assessment and intervention. Tables O to Q below summarises the quotes that are illustrative of these three subthemes.

Subtheme 2.3.1: Formulation

This subtheme related to how formulation becomes possible with operationalisation of body dissatisfaction. Table O below provides illustrative quotes for the subtheme.

Table O: Category 2, Theme 3: Clinical utility of operationalising body dissatisfaction, Subtheme: Formulation

| Subtheme           | Illustrative quotes   |
|--------------------|---|
| 2.3.1. Formulation | <p><i>AP: "It symbolises the deeper dynamic issues and enables a point of entry".</i></p> <p><i>CT: "It is then vital to understand the patient's view of themselves, in order to better understand the patient, and how they engage with (and survive) the world".</i></p> <p><i>GA: "I would use it as a platform from where I could springboard myself to where the real anguish lies".</i></p> <p><i>PP: "Because some of the anorexics that I have seen are quite satisfied with their bodies as they are but they are terrified of putting on weight, so in their emaciated state they are satisfied. So their desire to maintain that life threatening unhealthy weight is mostly motivated as much as the body distortion</i></p> |

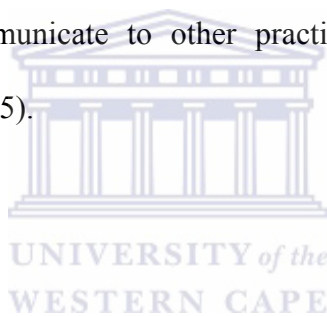
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|  | <p><i>and body dissatisfaction but they would be extremely dissatisfied if they were to put on weight. It is very important to the specifics of anorexia".</i></p> <p><i>PP: "It might be, I mean I assess it by I work a lot with sub personalities, the 'ED's', the eating disorder voice and the self-talk that goes with it".</i></p> <p><i>LF: "I think operationalising it is important. It would then be able to direct us to where the person is at with their body dissatisfaction".</i></p> <p><i>NS: "I think it plays a crucial role because for me, looking now systemically ... it is the cause or the underlying reason for anorexia, I think it is the way the symptoms express".</i></p> <p><i>JS: ... "using my body as this wall onto which I can project my conflicts and struggles ... the body was almost selected psychologically to be used to work through the conflict, so now the body is there being used as such... Body dissatisfaction is on the deeper level, it becomes important..."</i></p> |
|--|--|

The participants are of various opinions why the operationalisation of body dissatisfaction becomes of importance in clinical effectiveness. According to them it becomes very important to the psychologist so that they can gain a point of entry into the deeper dynamic issues of the patient (participant AP), and go directly to where the patient is at with their body dissatisfaction (participant LF), using themselves as a springboard to go to the patient's issues (participant GA). This will allow the psychologist to assess the sub-personalities, referring to the voice of the eating disorder and the self-talk that is probably maintaining some of the distortions (participant PP).

The participants further believed that when body dissatisfaction is operationalised, the psychologist can understand the patient's point of view of themselves and how they engage within their world (participant CT). For example, participant PP explains: "them being satisfied with their bodies as they are, but they are terrified of putting on weight, so in their emaciated state they are satisfied. So their desire to maintain that life threatening unhealthy weight is mostly motivated as much as the body distortion and body dissatisfaction but they would be extremely dissatisfied if they were to put on weight". It then becomes very important to recognise how the patient projects conflicts and struggles into the body, and

psychologically only work through the body to attempt to resolve the inner conflicts (participant JS).

Therefore the participants expressed the importance of operationalising body dissatisfaction in terms of emotional and behavioural indicators, whereby it will assist in the formulation of the patient. The findings resonated with the literature and seminal texts stating that formulation gives a more in-depth and holistic picture of the individual. The formulations enable the clinician to understand the patient in the field of clinical psychology and psychological formulations states that through these formulations, the clinician can understand an individual's unique, personal subjectivity, history and symptom maintenance. They further explain that the formulation is extremely important to guide the treatment plan for the individual and to communicate to other practitioners (e.g. McWilliams, 1999; Sturmey, 2009; Sadock et al., 2015).



### 2.3.2. Assessment

The second subtheme related to the use of operationalisation in assessment. Table P below summarises illustrative quotes.

Table P: Category 2, Theme 3: Clinical utility of operationalising body dissatisfaction: Subtheme: Assessment

| Subtheme          | Illustrative quotes   |
|-------------------|---|
| 2.3.2. Assessment | <p><i>JB: ... "with anorexic clients who don't have a low BMI that they might be missed in terms of severity or they might be under diagnosed in a clinicians office because the BMI is not of great concern but in terms of their own personal distress with the eating disorder".</i></p> <p><i>JS: "once the diagnosis has been made .... then you can look at this persons 'body dissatisfaction index' if you want to call it that, is extremely high versus the next person, then it becomes very important, in my view it goes towards the severity".</i></p> <p><i>LS: "I assess by asking them questions eg: mirror checking, weigh themselves, body check, , how "fat days and thin days" influence confidence and behaviour, rules and rituals, etc.".</i></p> |

It was suggested by participant JS to look at the patient's "body dissatisfaction index"; to refine the treatment and become aware of how it is possibly different to other groups of

people, when compared. This also can be said for only diagnosing eating disorders when using the BMI of the patient, then possibly missing the body dissatisfaction and the severity of the eating disorder as stated by participant JB. The body mass index (BMI) is used in the DSM-5 to assess the level of severity of the patient, and this allows the clinician to assess increased clinical (physiological) symptoms, the degree of functional disability and the need for supervision (American Psychiatric Association, 2013). The participants suggests that the operationalisation of body dissatisfaction ("body dissatisfaction index") will be important in assisting in the assessment and treatment of AN.

### 2.3.3. Intervention

This subtheme related to the use of an operationalisation of body dissatisfaction in intervention. Table Q reflects illustrative quotes for this subtheme.

Table Q: Category 2, Theme 3: Clinical utility of operationalising body dissatisfaction, Subtheme: Intervention

| Subtheme            | Illustrative quotes  |
|---------------------|--|
| 2.3.3. Intervention | <p><i>LS: "... to help them challenge their beliefs systems, rules and rituals. To help them dress in clothes that improves body image, rather than trigger ED urges".</i></p> <p><i>JS ... " it will further refine treatment in terms of informing us on how to work with that group of people, perhaps differently from the other group of people".</i></p> <p><i>NS: "It will be very useful to operationalise body dissatisfaction. I think to have criteria we can look at will help tremendously with planning the therapy and looking at progress. It can definitely add value".</i></p> |

Participant LS believes that operationalising body dissatisfaction can also be very important in clinical use, when the patient's belief systems, rules and rituals can be challenged. Participant JS and participant NS reports that it will assist in refining treatment. Zipfel et al. (2015) corroborates that treatment needs to focus on the therapeutic alliance that will assist in challenging pro-anorectic behaviour and egosyntonic beliefs.

Systematically, the importance of operationalisation and clinical utility was described, as anorexia being the underlying reason of symptom expression of body dissatisfaction. It became evident that the participants are in agreement with body dissatisfaction being

operationalised, since it will assist them as psychologists to understand the severity of the body dissatisfaction and the impact that may have on AN.

Despite the consensus on body dissatisfaction as a risk factor and a diagnostic criterion in AN there is a lack of clarity about the operational definitions of body dissatisfaction. Within the DSM-5 the body dissatisfaction criterion is described and not operationalised (American Psychiatric Association, 2013). The participants all agreed that to operationalise body dissatisfaction would be beneficial to the understanding (formulation), assessment and treatment of AN. They identified various emotional and behavioural indicators that could possibly be operationalised in order to gain a clear understanding of the effect of body dissatisfaction in the individual's lived experience of AN.

In conclusion of this category, the participants identified that it is important to operationalise the body dissatisfaction criterion in AN. Participants identified internal conflicts/ influences and external influences, as well as an interaction between these two. The participants further identified that body dissatisfaction could be operationalised in terms of emotional and behavioural indicators. The participants also concluded that the operationalisation of the body dissatisfaction criterion has clinical utility in that it would assist in assessing, formulating and planning treatments for body dissatisfaction and anorexia.

### **Category 3: Treatment of body dissatisfaction**

This thematic category was entitled, "treatment of body dissatisfaction". The category essentially included theoretical and contextual content related to clinical psychologists' understanding of possible treatments and other intervention implementations. Various treatment modalities and interventions emerged from the participants in this study. Two themes were included in this category namely 1) treatment modalities and 2) interventions in treatment. Each theme is presented below along with any subsidiary themes (sub-themes) that may have been identified.

### Category 3, Theme 1: Treatment modalities

The first theme included in this category was treatment modalities identified by the participants in this study. Each individual diagnosed with AN is in need of a unique and specialised treatment regimen and this is utilised by using specific treatment modalities or to use a multi-therapeutic approach to treatment. The participants as clinical psychologists would assess the individual's predisposing, precipitating, perpetuating and protective factors, which would entail internal and external influences and conflicts. After attaining this information they would tailor an individualised treatment regimen that would be most beneficial for the individual and finally to reduce the level of body dissatisfaction and the complexities it entails.

#### Subtheme 3.1.1: Specific treatment modalities

Category one explored the conceptualisation of body dissatisfaction in AN, which highlighted the importance of theory and the theoretical frameworks identified by the participants, namely psychodynamic, cognitive and sociocultural theory. These theoretical frameworks also translate into specific therapies used. This subtheme reported on the specific treatment modalities identified by participants.

Table R: Category 3, Theme 1: Treatment modalities, Subtheme: Specific treatment modalities

| Subtheme                             | Illustrative quotes   |
|--------------------------------------|---|
| 3.1.1. Specific treatment modalities | <p><i>JB: "Uses multi-therapeutic approach... psychodynamic as well as we use a bit of transactional analysis. CBT is also used from time to time. DBT is a big part of our programme, so we draw on many different models...our programme is quite holistic".</i></p> <p><i>LF: " I use psychoanalytic theories, attachment theories and cognitive".</i></p> <p><i>NS: "I have done mirror therapy ... I always do family therapy with patients with body image and dissatisfaction, since I believe it starts with the family. I rope them in straight away. I am systemic and holistic, so I tend to look at the whole person including spirituality and how the person's holistic system functions".</i></p> <p><i>GA: "I am a schema therapist, so when I look at body dissatisfaction I look at what the symbolic meaning is behind that at an emotional level. When looking at body dissatisfaction, where one is directly addressing the sense of dissatisfaction of body shape, body image, weight and so forth. I take it more to a psychodynamic level".</i></p> |

|  |  |
|--|--|
|  | <p><i>PP: "At the clinic I work with the patients individually as well as in the DBT groups... my treatment strategy would be around the approach Internal Family Systems Model".</i></p> <p><i>JS: "I work dynamically... and with guided imagery..."</i></p> |
|--|--|

A range of treatment modalities were identified by the participants, which would address the multi-faceted and complex domains of body dissatisfaction in AN. These approaches would typically include: Psychodynamic (including psychoanalysis and attachment theory); Transactional analysis; Schema therapy; Cognitive therapy; Cognitive behavioural therapy (CBT); Dialectical behavioural therapy (DBT); and Family systems therapy (including the Internal family system model). Malson et al. (2004) corroborates this by stating that treatment modalities have been shaped by the manner in which body dissatisfaction is understood. Furthermore, they identified pharmacological, CBT, DBT, family therapies, individual and group psychotherapies, feminist approaches and multi-dimensional approaches as treatment modalities for patients with AN (Malson et al., 2004). These treatment modalities resonate with the current literature, empirically supporting these treatment modalities (e.g. Stice, Shaw, Becker & Rohde, 2008; Nordbø et al., 2012; Treasure & Schmidt, 2013; Gutiérrez & Carrera, 2014; Zipfel et al., 2015).

From the findings in this theme, three interesting aspects to treatment of body dissatisfaction in AN emerged. Firstly, the participants at times identified at the level of the modality and secondly, at other times they identified at the level of intervention. For example participant NS work in the modality of family systems therapy (level of modality), but she uses mirror therapy (level of intervention) to address body dissatisfaction in AN. Similarly, participant JS specialises in a psychodynamic approach to therapy (level of modality) and uses guided imagery (level of intervention) to treat the internal conflicts due to body dissatisfaction in AN. Therefore it is suggested that the participants use these modalities as a whole or as a part of a modality. For example, participant GA, a specialist schema therapist



states "when I look at body dissatisfaction I look at what the symbolic meaning is behind that at an emotional level. When looking at body dissatisfaction, where one is directly addressing the sense of dissatisfaction of body shape, body image, weight and so forth. I take it more to a psychodynamic level". This suggests that some of the participants adhere to a specific modality, which is informed by their clinical training and theoretical preference. Whereas other participants works predominantly in one modality and then they would add aspects of other modalities to address the individualised needs of the patient.

Thirdly, the recovery from AN entails a complex matrix of emotional, physical and social factors. Therefore, some of the participants (participants NS, LF & JB) indicated that the holistic functioning of the patient with body dissatisfaction should always be considered in working with them therapeutically. The participants feel strongly about the interrelatedness of the whole person, so the emotional and psychological world of the patient can't be addressed with all the other realms of the person influencing and affecting the person and therapy. The body image component is not the core itself, the person is. Specifically, participant NS indicated that the mirror therapy holds the key in presenting not just the patient but also the family system as a bigger whole and should include working with the patient holistically and have multi-therapeutic interventions. The participant suggests that the family is the start of it all. Spiritual dimensions of the patient's world should also not be excluded. Similarly, participant JB advocates for a multi-therapeutic approach, which includes psychodynamic, transactional analysis, CBT and DBT. The participant further state that they draw on many different modalities since their programme is holistic. Again one can suggest that due to the complex nature of body dissatisfaction in AN, the clinical psychologist need to assess the individual holistically, which may require drawing from various theoretical frameworks to inform a multi-therapeutic approach in treatment.

It is interesting that the participants identify how they draw their therapeutic practices from the discipline of psychology, which supports the social constructionist point of view or framework.

### Subtheme 3.1.2: In-patient and out-patient treatments

This theme related to the setting or level of treatment identified by participants namely inpatient and outpatient setting. Table S below summarises illustrative quotes for this theme.

Table S: Category 3, Theme 1: Treatment modalities, Subtheme: In-patient and out-patient treatment modalities

| Subtheme                                     | Illustrative quotes   |
|--|---|
| 3.1.2. In-patient and out-patient treatments | <p><i>IN-PATIENT TREATMENT MODALITIES.</i></p> <p><i>LS: "An 8 week body Image group – Aim: to develop a relationship with your body similar to a mother's relationship with her child...activities involve: challenging beliefs, writing a feeling letter "to my body", mirror work, going through their wardrobes, exposure shopping to buy "recovery clothes", challenging rules and rituals, etc. "</i></p> <p><i>GA: "Within the inpatient program we have the rotation of the silhouettes types of body related group exercises, one is addressing the distortion directly, in other words, where actually is this dissonance in terms of personal perception of body and reality, one can work with a dissonance theory, the notion of how distorted are you. The body image component of our program plays a vital role".</i></p> <p><i>JB: "we have one of our counsellors running the body image programmes. So she does a lot of work with body image and intervening with body dissatisfaction... One of the other processes are, mirror work, so looking in the mirror and instead of listening to one's 'ED' voice".</i></p> <p><i>PP: "My role here at the clinic is one cog in a wheel, I see the patients once or twice a week and the rest of the team see them more, I am not working with them as their primary therapist. I also work with them in a group, if there is trauma or anxiety I might work with them more".</i></p> <p><i>OUT-PATIENT TREATMENT MODALITIES.</i></p> <p><i>GA: " I am busy with my research on Schema Therapy and eating disorders. So within Schema therapy one is looking at where there is vulnerability in the child, and whether that vulnerability is caused by internalised voices and that are critical or that are punitive or are overly demanding...".</i></p> <p><i>PP: "In my private practice, my treatment strategy would be around the approach Internal Family Systems Model, which looks at sub personalities that's a part of the personal relationships within a family... So my strategy involves working with that part of the person that is being extremist in their criticism of the body".</i></p> <p><i>NS: "I am systemic and holistic".</i></p> <p><i>JS: "I work with intrapsychic factors and dynamic factors that I think often cause body dissatisfaction within a family or a family group. I work a lot with</i></p> |

|  |   |
|--|---|
|  | <p><i>guided imagery, I work with a patient to visit parts of the body and coupling emotions to it".</i></p> <p><i>CT: "As a psychodynamic psychotherapist I generally explore the patient's understanding of themselves, which tends to include poor body image and body dissatisfaction. We tend to explore when this started, whether it has been around food, exercise and/or something else, whether there was sexual, physical and/or psychological abuse, and so on. Understanding what underpins the patient's body dissatisfaction in anorexia is a key aspect of therapy, in order to reduce its archaic influence over time".</i></p> <p><i>AP: "I work with the deeper emotional contents and dynamics within the patient and his/her family dynamic to address body dissatisfaction. Targeting this in treatment symbolises the deeper dynamic issues and enables a point of entry".</i></p> |
|--|---|

The clinical psychologist needs to assess the needs and functioning of the individual diagnosed with AN. Factors such as personality traits and severity of the AN could influence the decision on in-patient or out-patient treatment modalities. The participants in this study were from both in in-patient and out-patient settings. The in-patient settings were two private eating disorder clinics and the out-patient setting were the private practices of the participants. Participants JB and LS only worked in the in-patient setting, whereas participants LF, GA and PP were the head psychologists at these in-patient settings but they also provide out-patient services through their private practice. Lastly participant NS, JS, CT and AP only provide out-patient (private practice) services.

There is a difference in the treatment modalities used in in-patient and out-patient settings. It became evident that it is identified as two distinct levels of care, which is assessed according to the patient's physiological symptoms, level of functioning and the level of pathology. There seems to be patterned ways in which the participants provide service for patients diagnosed with AN. The findings suggest that there is a culture being dictated by the level of care and the knowledge shared within the cannon of psychology. In-patient settings involve hospitalisation, which ultimately falls under medical care. The custody the in-patient setting has over the patient becomes important since they make most of the decisions for the patient in treatment. This is done via a multi-disciplinary team. D'Abundo and Chally (2004) corroborates this by stating that the in-patient treatment of AN should involve a multi-

disciplinary team/approach, which will include primary care providers, nutritionists, and mental health professionals in order to promote recovery. Whereas in the out-patient setting there is a definitive construct between the clinical psychologist and the patient, which is different to that of the professional construct of in-patient settings. According to Nilsson and Hägglöf (2006) this definitive construct between therapist and patient is extremely important, since individual psychotherapy and the quality of the therapeutic relationship are seen as most important for recovery.

For example in the in-patient setting, the participants mostly work as a multi-disciplinary team and provide multi-therapeutic modalities such as individual and group psychotherapies; body image groups; silhouette exercises; mirror work and groups focussing on challenging beliefs, rules and rituals (CBT & DBT). Participant LS specifically identified working with group therapy, which entails an eight week body image group where the aims will be: to develop a relationship with your own body, similar to a mother's relationship with her child. The activities would typically involve the following: challenging the individual's beliefs, rules and rituals; writing a letter to your body about feelings and not looks; mirror work, going through your own wardrobe and exposure shopping to buy "corrective clothes" for your body. Within the in-patient setting it is important for the clinical psychologist to assess whether the patient would benefit from group treatment modalities, by assessing their temperament, personality traits and severity of their body dissatisfaction. This is supported by Fitzsimmons-Craft et al. (2012) who argue that group treatment modalities can result in patients participating in body comparisons, for some patient's a group setting would enhance body dissatisfaction. For other patient's a group setting may elicit support and help relieve social withdrawal. The in-patient setting will assess the prognosis of the patient as well, in order to assist in future treatment, which will be out-patient based. Due to the high relapse rate of patient's with AN, the literature suggests that long-term therapy has the best outcome (e.g. APA, 2006; Zipfel et al., 2013; Gutiérrez & Carrera, 2014).

In the out-patient setting, the participants work primarily from a certain treatment modality (e.g. Psychodynamic, Schema and Family systems), which is informed by their theoretical framework. Out-patient treatment is extremely important to reduce the patient from relapsing into AN symptomology (e.g. APA, 2006; Zipfel et al., 2013; Gutiérrez & Carrera, 2014). In the in-patient setting a multi-disciplinary team will facilitate a multi-therapeutic approach, whereas in the out-patient setting the therapeutic process/relationship between the clinical psychologist and the patient is of utmost importance. In out-patient treatment the participants identified focussing on specific aspects of the patient's body dissatisfaction pathology. For example, participants JS, CT and AP works psychodynamically and would focus on the internalisation of the thin ideal, the intrapsychic conflicts associated with it as well as dynamics exacerbating the body dissatisfaction. Participants NS and PP works in the family systems framework and would focus on sub personalities that's a part of the personal relationships within a family, as well as family therapy and looking at the whole person including spirituality and how the patient's holistic system functions. Lastly, participant GA who is a schema specialist focuses on looking at where there is vulnerability in the child, and whether that vulnerability is caused by internalised voices that are critical or that are punitive or are overly demanding. The out-patient treatment setting is more focused on the patient's internal and external factors that influence and maintains body dissatisfaction in AN (e.g. Brockmeyer et al., 2011; Campos et al., 2012; Espeset et al., 2012; Zipfel et al., 2013; Gutiérrez & Carrera, 2014).

The participants indicated that all the dimensions of the patient, her/his system and body dissatisfaction should be formulated and articulated in addressing body dissatisfaction in treatment modalities and therapy. Participants indicated that in order to choose a therapeutic modality, they need to assess the individual in terms of their theoretical formulations, aetiological factors, and the severity of the AN symptomology, which would inform in-patient or out-patient treatment.

### Category 3, Theme 2: Interventions in treatment

The second theme in this category pertained to specific interventions targeted at body dissatisfaction in the treatment of AN. Participants identified that there are specific clinical interventions that are used to address body dissatisfaction in the treatment of anorexic patients. These interventions constitute discrete clinical initiatives and subsequently have been presented here as sub-themes. Six subthemes or interventions have been identified from participants' responses. Table T to Y below summarises the interventions with illustrative quotes from the participants.

#### Subtheme 3.2.1: Increasing insight

This subtheme related to the importance of increasing insight. Table T below present illustrative quotes for this subtheme.

Table T: Category 3, Theme 2: Interventions in treatment, Subtheme: Increasing insight

| <b>Subtheme</b>           | <b>Illustrative quotes</b>   |
|---------------------------|--|
| 3.2.1: Increasing insight | <p><i>AP: "When only targeting conflicts apparently about the body, outcomes are poor. The deeper dynamics and affects need addressing, or the manifestation will continue. It is important as part of a deeper therapeutic strategy".</i></p> <p><i>CT: "Understanding what underpins the patient's body dissatisfaction in anorexia is a key aspect of therapy, in order to reduce its archaic influence over time".</i></p> <p><i>GA: "The internalisation of what is body dissatisfaction is something that I will right from the outset will pursue to the level to which they can engage and write, when I am feeling fat, I know that what I am actually feeling is an overwhelming-ness. We looking at body dissatisfaction, where one is directly addressing the sense of dissatisfaction of body shape, body image, weight and so forth. I take it more to a psychodynamic level".</i></p> |

The participants indicated that increasing insight is an integral strategy in the treatment of body dissatisfaction. Intervention aimed at increasing insight was identified by participants as a deeper therapeutic strategy addressing what underpins the body dissatisfaction. For example, Participant AP reported that insight "is an important part of a deeper therapeutic strategy" and argued that body dissatisfaction will continue to present if not addressed. The identification of insight as an important strategy flows logically from the

earlier identification of intrapsychic or internal processes underlying the body dissatisfaction in theoretical formulation (e.g. theme 1 of category 1), aetiological formulation (e.g. theme 2 of category 1), and emotional indicators (e.g. theme 1 of category 2).

The findings are consistent with the literature on treatment for anorexia. For example, Zipfel et al. (2013) stated that developing insight is the only way the archaic influence of AN can be treated. Nordbø et al. (2012) also argued that the deeper dynamics and affects needs to be addressed, in AN since only targeting the inner conflicts about the body has proven to result in poor outcomes and continuous manifestation of the symptoms. Similarly, Zipfel et al. (2015) identified that there is a significant interaction between internal and external aspects that necessitates the specific target of increasing insight in order to reduce symptoms such as body dissatisfaction. These authors also argue that this intervention will be beneficial and increase the prognosis for anorexia nervosa. The findings also reflect the understanding that effecting change is contingent on making symptomatology ego-dystonic, which can only be achieved by increasing insight. Thus increasing insight is a well-accepted intervention for the treatment of anorexia and body dissatisfaction (e.g. Nilsson & Hägglöf, 2006; Campos et al., 2012; Zipfel et al., 2013; Gutiérrez & Carrera, 2014).

The results reflect conventional clinical wisdom as evidenced by the identification of this intervention in seminal texts and current literature. Thus this particular findings is a product of the training and practice models of clinical psychologists

### Subtheme 3.2.2: Emotion regulation and expression

This subtheme related to the importance of emotional regulation. Table U below present illustrative quotes for this subtheme.

Table U: Category 3, Theme 2: Interventions in treatment, Subtheme: Emotion regulation and expression

| Subtheme                                 | Illustrative quotes  |
|--|--|
| 3.2.2. Emotion regulation and expression | <i>PP: "Ya I think that it is very important and I also think self-esteem and self-concept and the capacity to self-regulate are also important factors. But it is very important to the specifics of anorexia...The role of the self is to harmonise,</i> |

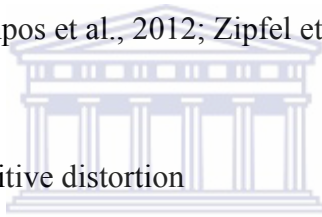
|  |   |
|--|---|
|  | <p><i>to regulate, and they struggle with that, but it is important".</i></p> <p><i>NS: "We looking at sort of deprivation of emotions, emotional starving, they can't manage their emotions".</i></p> <p><i>LF: "There are emotions in the family that they feel out of control in, so they put the control in the only place they know which is their own body".</i></p> <p><i>JS: "This body dissatisfaction lies under everything, it came first, so the initial perceptual, thinking, feeling about the body image, me becoming dissatisfied, getting negative thoughts about behaving, it is the entrenched part, it is the part in therapy that you want to be working with, otherwise the person will just relapse".</i></p> <p><i>JB: "But a deeper understanding I would think that any emotional discomfort/dysregulation that they have they will project onto their body, so it is easier to sit with a feeling of how fat my thighs feel, rather to sit with any other feelings of insecurity or dissatisfaction about ones life or ones relationships and that kind of thing, because there is a sense that if you are unhappy with your body, you can do something to change it, whereas maybe there is a feeling of powerlessness in the rest of your life".</i></p> |
|--|---|

According to the participants, to address emotional regulation and expression of internalised body dissatisfaction during treatment interventions was identified as a core strategy. Participants identified that patients must be assisted to identify emotions accurately and to express it effectively. For example, participant JB suggests "that any emotional discomfort/dysregulation that they have they will project onto their body, so it is easier to sit with a feeling of how fat my thighs feel, rather to sit with any other feelings of insecurity or dissatisfaction about one's life or one's relationships and that kind of thing, because there is a sense that if you are unhappy with your body, you can do something to change it, whereas maybe there is a feeling of powerlessness in the rest of your life". Similarly, participant JS believes that "the body dissatisfaction lies under everything, so the initial perceptual, thinking, feeling about the body image, getting negative thoughts about behaving, it is the entrenched part, and it is the part in therapy that you want to be working with, otherwise the person will just relapse". The findings here appear to be a logical outflow from the formulations offered by participants in aetiological formulation (theme 2 in category 1, specifically subtheme: Internal influences/conflicts). Participants identified that emotion



dysregulation, avoidance and difficulty with emotional regulation seems to be one of the core internal features body dissatisfaction elicits in AN.

The findings resonated with the literature on AN. For example, seminal texts identify that anorexic patients engage in emotional dysfunctional eating patterns and weight loss in an attempt to regulate distressing emotional states. Thus poorly developed emotion regulation skills, avoidance of negative emotions and emotional suffering are hallmarks of the syndrome (e.g. Wildes, Ringham & Marcus, 2010; Brockmeyer et al., 2011; Espeset et al., 2012; Oldershaw et al., 2015). Literature recommends that improved emotion regulation can improve the prognosis of most syndromes in general and eating disorders in particular. Again the findings is an intuitive finding reflective of the canon of psychopathology and therapeutic intervention (e.g. Campos et al., 2012; Zipfel et al., 2013; Oldershaw et al., 2015).



### Subtheme 3.2.3: Addressing cognitive distortion

This subtheme related to how cognitive distortions are to be addressed in intervention.

Table V below summarises quotes that illustrate the subtheme.

Table V: Category 3, Theme 2: Interventions in treatment, Subtheme: Addressing cognitive distortion

| Subtheme                               | Illustrative quotes   |
|--|---|
| 3.2.3. Addressing cognitive distortion | <p><i>GA: ... "doing silhouettes types of body related group exercises, one is addressing the distortion directly, in other words, where actually is this dissonance in terms of personal perception of body and reality, one can work with a dissonance theory, the notion of how distorted are you. I look at the distortion at an emotional level or where it is already a notion of other areas of distortion, that once those are addressed, I see patients sense of body dissatisfaction and preoccupation with the body start changing remarkably".</i></p> <p><i>PP: "Their desire to maintain that life threatening unhealthy weight is mostly motivated by cognitive distortion and body dissatisfaction and they would be extremely dissatisfied if they were to put on weight, which needs to be addressed".</i></p> <p><i>NS: "distortion of what is being seen in the mirror as well and that I think plays a big role as well".</i></p> <p><i>JB: "One of the other processes are, mirror work, so looking in the mirror and instead of listening to one's 'ED' voice, you will say, I see that person, you encourage that person to think from a recovery perspective because the distortions is always going to be there, even when someone is in recovery the distortion can still be there, so working on strengthening your recovery voice, so saying things like, when I look at myself, I can see I have broad shoulders, and my hips are in proportion to my shoulders, I have got blue eyes and blonde hair</i></p> |

Participants reported that it was important to address cognitive distortions in the treatment of body dissatisfaction in anorexia nervosa. The participants felt that targeting the body distortions directly with doing silhouettes types of body related group exercises were found to be an effective method in addressing cognitive distortions. This finding similarly reflects the link between formulation and intervention. Some of the participants utilised a cognitive formulation in which they suggest that there is an inconsistency or dissonance between an individual's health beliefs and behaviours, which then result in psychological distress. Addressing the distortions provide an opportunity to challenge their beliefs and to reduce this inconsistency.

The finding is consistent with the literature particularly the formulations offered in dissonance theory (Stice et al., 2008). Dissonance theory advocates targeting the internalisation of the thin ideal by addressing the cognitive distortions in a collaborative process between the psychologist and the patient that will help to reduce body dissatisfaction and dysfunctional eating behaviours. The findings also reflects the sentiment in literature that cognitive distortion are key symptoms in the syndrome and therefor should be targeted in intervention regardless of the theoretical orientation or modality (e.g. American Psychiatric association, 2006; Grave, 2010; Beck, 2011; Westbrook et al., 2011; Treasure & Schmidt, 2013; Zipfel, 2013).

#### Subtheme 3.2.4: Psycho-education/ Information

This subtheme addressed the use of Psycho-education in change and recovery. Illustrative quotes are reflected below in Table W.

Table W: Category 3, Theme 2: Interventions in treatment, Subtheme: Psycho-education/ Information

| Subtheme                             | Illustrative quotes  |
|--------------------------------------|--|
| 3.2.4: Psycho-education/ Information | <p><i>GA: "When I formulate for a patient I look at all the predisposing and precipitating factors, I doubt that I will never put body dissatisfaction as a primary focus but that is not to say that my formulation or conceptualisation will not include body dissatisfaction as part of the precipitating components".</i></p> <p><i>NS: "I always do family therapy with patients with body image and dissatisfaction, since I believe it starts with the family. I rope them in straight away and give the relevant information to the patient and family".</i></p> |

Participants identified Psycho-education as an important constituent of change and recovery. For example, Participant GA reported that he uses knowledge about aetiological factors to educate and provide information to the patient (and family) about AN including the complexity of the syndrome and possible treatments, as well as prognosis for recovery. Participant NS, who specialises in family therapy believes that it is important to provide psychoeducation to both the patient and the family at the start of the therapeutic process.

This finding is consistent with the literature where psychoeducation is rooted within the therapeutic process of many schools of psychotherapy (e.g. American Psychiatric Association, 2006; Stice et al., 2008; Smart et al., 2011). Psychoeducation is recommended as an important component in cognitive and behavioural interventions where socialising the patient into treatment and knowledge of the disorder is underscored (e.g. Treasure & Schmidt, 2013; Zipfel et al., 2013; Gutiérrez & Carrera, 2014).

#### Subtheme 3.2.5: Increasing reality testing and accurate perception

This sub-theme focused on the inclusion of increased reality testing and accurate perception in the treatment of body dissatisfaction in AN. For example, participant JS stated “relapse becomes a big possibility ...[if] reality testing could not be increased and accurate perceptions not established”. Table X below provides selected quotes to illustrate the essence of this sub-theme.

Table X: Category 3, Theme 2: Interventions in treatment, Subtheme: Increasing reality testing and accurate perception

| Subtheme  | Illustrative quotes  |
|---|--|
| 3.2.5: Increasing reality testing and accurate perception | <p><i>JS: "We see it in anorexia, what they see is not physically real. So it's almost psychotic like in interpretations of what goes on around them and it is always pulled back to their body. The initial perceptual, thinking, feeling about the body image ... it is the entrenched part, it is the part in therapy that you want to be working with, otherwise the person will just relapse".</i></p> <p><i>LF: "So it is almost like a psychotic thing where they completely out of touch with reality about their bodies and of course they are comparing themselves to models. It is a psychotic thought process that needs to be addressed".</i></p> <p><i>GA: "one is addressing the distortion directly, in other words, where actually is this dissonance in terms of personal perception of body and reality".</i></p> |

The participants reflected that reality testing and accurate perception must be worked with in therapy. The finding appears to be a reflective of the literature where reality testing and accurate perception are identified as treatment goals, because symptoms like body dissatisfaction have a delusional quality (e.g. Bruch, 1973; Steinglass et al., 2007; Brewerton, 2012; Guardia et al., 2012).



Subtheme 3.2.6: Graded/ controlled/ slow process approach

This theme entailed using control to adopt a graded approach to the treatment.

Illustrative quotes for this sub-theme are presented in Table Y below.

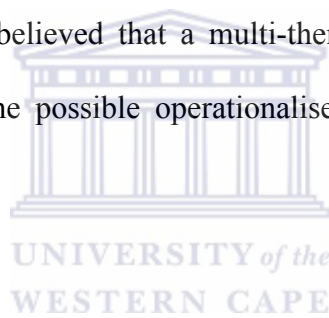
Table Y: Category 3, Theme 2: Interventions in treatment, Subtheme: Graded/ controlled/ slow process approach

| Subtheme   | Illustrative quotes   |
|--|---|
| 3.2.6. Graded/ controlled/ slow process approach | <p><i>JS: "You need to work with the conflict as it was laid down at first and then over the time you have layer upon layer, and it is long-term therapy that removes those layers safely, one at a time. The patients I dealt with have always been long-term therapies and often over a period of 6 to 7 years".</i></p> <p><i>JS: ... "it is about control at the end, it is about what I can control for the patient".</i></p> <p><i>NS: "I include the family as part of the treatment, and it is a long process and can't be rushed. There are no quick fixes".</i></p> <p><i>JB: "It is never just the body image or body dissatisfaction alone. It is a process that takes time".</i></p> |

Participants felt that the pathology (AN) was complex and that intervention must include an intentional attempt on the part of the therapist to provide a contained process in which issues could be dealt with in a piece meal manner. For example participant JS said that the treatment must be “long-term” and that it starts “ the conflict as it was laid down at first and then therapy removes those layers safely, one at a time.” From this quote it becomes evident that a controlled approach is imperative and that the gradual process provides containment for the patient. Similarly, participant JB reports that "it is never just about the body image or body dissatisfaction alone, it is a process that takes time".

The findings here reflect how severe the participants perceived the syndrome and the fragility of the anorexic patient. Thus their responses here indicate an agreed-upon or commonly accepted clinical belief in the fraternity that is reflective of the training and practice model. The findings also reflect the acknowledgment of the importance of control for the anorexic patient and that a less graded approach to treatment would constitute a threat as it would require the patient to relinquish control, which is integral to the nosology of the disorder. The control over the body becomes the focus and a valued goal by the patient, which would keep emotional distress and negative emotions out of awareness (Casper et al., 1992; Eckert et al., 1995; Fichter & Quadflieg, 1996). Given that AN is a multi-faceted disorder that can run a chronic course, it is essential to conduct long-term treatment in order to minimise the patient relapsing (Carter et al., 2011). Psychotherapy is the treatment of choice for patients with AN, and they report that long-term therapy is often more successful than short-term optimised treatment. They further argue that these long-term therapies lead to relevant weight gains and a decrease in general and disorder-specific psychopathology (Zipfel et al., 2013). The American Psychiatric Association (2006) concurs by stating that due to AN's enduring nature, psychotherapeutic treatment is commonly required for at least one year and may take many years.

The important findings in category three, in treatment of body dissatisfaction, the participants were in consensus that the psychologist needs to address both internal and external influences and conflicts as well as the internalisation of the thin ideal in treatment of body dissatisfaction. They further stated that they assess the individual holistically and the severity of the symptom presentation in order to inform treatment, whether it is in-patient or out-patient treatment. Accordingly they suggested specific interventions such as increasing insight, emotional regulation, addressing cognitive distortions and psychoeducation, which they feel should be a graded approach and is essential in the treatment of body dissatisfaction in AN. In conclusion, adhering to different theoretical frameworks, some of the participants identified the treatment modalities at the level of the modality and the level of the intervention. Other participants believed that a multi-therapeutic approach to treatment is preferred and that theory and the possible operationalised factors of body dissatisfaction informed the treatment regimen.



## **5. Conclusion**

The findings of this study provide insight into the clinical understanding, conceptualisation, operationalisation and treatment of body dissatisfaction in AN. The findings were generally consistent with that reported in the literature and serves to validate the existing body of knowledge.

The clinical psychologists interviewed came from different professional backgrounds and theoretical frameworks. The participants were all qualified with Masters degrees in Clinical Psychology and registered clinical psychologists with the Health Professions Council of South Africa (HPCSA), with various levels of clinical experience. The participants in this study were from both in in-patient and out-patient treatment settings. The in-patient settings were two private eating disorder clinics and the private practices of the participants constituted out-patient treatment settings.

The overall findings emerged in terms of the three categories namely: conceptualisations of body dissatisfaction, operationalisation of body dissatisfaction, and lastly treatment of body dissatisfaction. The conceptualisation of body dissatisfaction in AN entailed a wide range of knowledge based understanding by the participants, which included theoretical formulations (psychodynamic, cognitive & sociocultural), aetiological formulations (internal and external influences and conflicts & the interaction between internal and external) and other complex influences (trauma/s & comorbid diagnoses) that formed part of the canon of psychology to which these participants prescribe to. This category also highlighted the learned skills a clinical psychologist would use in the understanding of pathology and in reference to this study, the understanding of body dissatisfaction in AN. A core finding in this study was that the role of theory is to flesh out an explanatory system, and creating an understanding of body dissatisfaction in AN. Participants used theoretical formulations in conjunction with aetiological formulations focussing on causal factors for the conceptualisation and understanding of body dissatisfaction in AN. The importance of theory and the ability for these participants to formulate body dissatisfaction, became an integral part in informing the treatment regimen for the patient diagnosed with AN. This was consistent with sentiments expressed by Sturmey (2009), Esnaola et al. (2010), Beck (2011), McWilliams (2011) and Walsh (2013)

With the operationalisation of body dissatisfaction in AN, the participants identified as part of the findings that there is a significant importance in the interaction between internal and external influences, conflicts and indicators (emotional and behavioural) of body dissatisfaction in AN. The participants further identified that the operationalisation of body dissatisfaction could occur by exploring an individual's presentation in emotional and behavioural indicators, which would present differently in individuals diagnosed with AN (e.g. Boone et al., 2011; Brand-Gothelf et al., 2014; Wade et al., 2015). Participants did not report on assessment practices in an explicit way although their ability to provide detailed

information about operationalisation in the form of indicators might suggest that observation and systematic enquiry through history taking would constitute an implicit assessment practice. The explicit operationalisation of body dissatisfaction indicators would assist in assessing at what level and specifically at which part of the body dissatisfaction is higher and distorted. It is evident that the participants would like to see body dissatisfaction formally operationalised so it could assist them in their clinical understanding, assessments and treatment of AN.

The participants were in consensus that treatment of body dissatisfaction needs to address both internal and external influences and conflicts, as well as the internalisation of the thin ideal in treatment of body dissatisfaction. The participants identified a range of treatment modalities, which was informed by their theoretical approach. They identified these treatment modalities at the level of the modality and at other times at the level of intervention. Some participants primarily worked from a certain modality, while others worked in a multi-therapeutic approach. The choice of treatment modality was depended on two distinct levels of care, which the participants identified as in-patient and out-patient treatment. They further stated that they assess the individual in terms of physiological symptoms, personality traits and the severity of the AN symptom presentation in order to inform treatment (e.g. inpatient vs. out-patient). In-patient treatment was identified as a multi-therapeutic approach whereas out-patient treatment focussed on the individual and the therapeutic relationship. The participants suggested specific interventions such as increasing insight, emotional regulation, addressing cognitive distortions and psychoeducation, which they feel should be a graded approach and is essential in the treatment of body dissatisfaction in AN (e.g. Nilsson & Hägglöf, 2006; Campos et al., 2012; Zipfel et al., 2013; Gutiérrez & Carrera, 2014).



## 6. Limitations of the study

The first limitation of the study was that the social constructionist framework was used in a limited capacity. There are different ways to use the social constructionist framework, and the limited or baseline use of this framework in the study, did not lend itself to more of an in-depth social constructionist analysis. The decision for a limited or baseline approach to the framework was a methodological decision that was consistent with the scope of the study and the requirements for a mini-thesis.

The second limitation of the study was that the sample of participants consisted of clinical psychologists that work in two different private contexts (e.g. private practice & private eating disorder clinic). Therefore saturation was not considered by group, but rather saturation was considered for the sample as a whole. When looking at the participants certain profiles emerged, namely, there are participants in private practice only; participants in private in-patient care and participants in private in-patient care and private practice. The decision was made to track saturation as a whole and not per group. The decision to analyse the data in this manner was because the sample was never designed to be a stratified sample. The study was purely looking for clinical psychologists who works with or specialises in eating disorders.

The third and related limitation of the study was that snowball sampling was prioritised, so that eligible participants who had expertise in eating disorders could participate in the study. The snowball sampling was prioritised above stratification. Therefore as it started to emerge from the findings that there is a differentiation in the participant groups, the question of switching from snowball sampling to stratified sampling emerged. The final decision was to continue with snowball sampling. The advantage of the snowball sampling was that it provided participants with recognised expertise, which is important in the social constructionist framework, but it did limit the sampling in a stratified

manner. Thus an exploration of patterned responses to body dissatisfaction could not be explored on the basis of level of care or treatment context

The fourth limitation of the study was that the person who helped with the thematic analysis was not a clinical psychologist, and therefore the initial stages, specifically step four and five of the thematic analysis was limited in terms of depth. This resulted in myself and my supervisor who are clinically trained to work more in depth at certain stages. The advantage of working with this person who is trained in research is that the study could draw from his expertise in the field of analysis.

## **7. Significance of the study**

This study contributed at the level of content, practice and methodology. It also validated the use of theory as clinical psychologists in practice. At the level of content the study identified that the description of body dissatisfaction in the DSM-5 is not sufficient and that it is limited in the understanding of body dissatisfaction. The participants expressed the importance of a more formal operationalisation of body dissatisfaction, which would then be able to more effectively assist in the assessment, practice and treatment of it in AN. Another significant contribution at the level of content was that the study really underscored the understanding of AN from the cannon of psychology. There is a core understanding of what body dissatisfaction in AN means in terms of psychopathology and psychotherapy. The knowledge base of how body dissatisfaction is conceptualised and operationalised in treatment planning for patients presenting with AN, validated the fund of knowledge and the body of knowledge in the cannon of psychology.

At the level of practice the study offered the participants the opportunity to engage reflexively with their own practice and theory. Through this the study provided an opportunity to identify gaps in the development of their own work.

At the level of methodology the study identified the challenges of sampling in qualitative methods. It identified limitations in how we approach, think and write about sampling techniques and particularly how that relates to the theoretical framework and aim of the study. Studies often report on using a social constructionist framework as if it is homogeneously and uniformly applied. This study attempted to acknowledge that there are different levels of which social constructionism can be used as a theoretical framework.

In terms of theory the study crystallised that clinical psychologists use theory and constructs interchangeably. This was most evident in the manner they identified modalities, individual treatment and interventions. That created fluidity, which detracted from the scientific rigour of how clinical psychologists practice and work.



## **8. Recommendations for future studies**

This current study formed the groundwork for developing measurements that can operationalise body dissatisfaction to be used in assessment and treatment of eating disorders.

The findings highlighted that a more in-depth study using the social constructionist framework would be advantageous to the research on body dissatisfaction in AN, focussing on the South African population.

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## **Appendix A: Diagnostic criteria for AN as per DSM-V (APA, 2013)**

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.

B. Intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Specify whether: Restricting type: During the last 3 months, the individual has not engaged in re-current episodes of binge eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.

Binge-eating/purging type: During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Specify if: In partial remission: After full criteria for anorexia nervosa were previously met, Criterion A (low body weight) has not been met for a sustained period, but either Criterion B (intense fear of gaining weight or becoming fat or behaviour that interferes with weight gain) or Criterion C (disturbances in self-perception of weight and shape) is still met. In full remission: After full criteria for anorexia nervosa were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity: The minimum level of severity is based, for adults, on current body mass index (BMI) (see below) or, for children and adolescents, on BMI percentile. The ranges below are derived from World Health Organisation categories for thinness in adults;



for children and adolescents, corresponding BMI percentiles should be used. The level of severity may be increased to reflect clinical symptoms, the degree of functional disability, and the need for supervision.

Mild:  $\text{BMI} > 17 \text{ kg/m}^2$ , Moderate:  $\text{BMI} 16-16.99 \text{ kg/m}^2$ , Severe:  $\text{BMI} 15-15.99 \text{ kg/m}^2$  or

Extreme:  $\text{BMI} < 15 \text{ kg/m}^2$



## Appendix B: Ethics clearance



### OFFICE OF THE DEAN DEPARTMENT OF RESEARCH DEVELOPMENT

13 June 2014

#### To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by:  
Ms O Bronkhorst (Psychology)

Research Project: Body dissatisfaction in Anorexia Nervosa:  
Clinical psychologists' approach to assessment  
and intervention or treatment planning.

Registration no: 14/4/32

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

*Ms Patricia Josias  
Research Ethics Committee Officer  
University of the Western Cape*

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A place of quality,  
a place to grow, from hope  
to action through knowledge

## Appendix C: Interview guide



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Interview Guide.

1. How do clinicians understand body dissatisfaction in the context of Anorexia Nervosa?

1.1. What is your understanding of body dissatisfaction?

1.2. What do you think causes body dissatisfaction?

1.3. How important do you think body dissatisfaction is in regards to anorexia nervosa pathology?

2. How do clinical psychologists operationalize body dissatisfaction in their assessment of Anorexia Nervosa?

2.1. How does body dissatisfaction present in anorexia nervosa?

2.2. Do you feel that it is important to operationalize body dissatisfaction and why?

3. How do clinical psychologists consider body dissatisfaction in the planning of treatments for Anorexia Nervosa?

3.1. Have you ever formulated a treatment targeting body dissatisfaction? If so, what was the outcome?

3.2. Do you feel that it is important to target body dissatisfaction with treatment for anorexia nervosa and why?

## Appendix D: Information sheet



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### INFORMATION SHEET

Project Title: Body dissatisfaction in anorexia nervosa: Clinical psychologists' approach to assessment and intervention or treatment planning.

What is this study about?

This is a research project being conducted by Ms, Omega Bronkhorst at the University of the Western Cape. We are inviting you to participate in this research project because you are a clinical psychologist with expertise in anorexia and bulimia nervosa. The purpose of this research project is to explore your perceptions about the assessment of body dissatisfaction and the manner in which you tailor treatment for it.

What will I be asked to do if I agree to participate?

You will be asked to share with me your perceptions about body dissatisfaction, how you assess for it as well as how you design treatment modalities for body dissatisfaction in anorexic and bulimic patients. Our discussion will take place in the form of a semi-structured interview. The duration of this interview will be 90 minutes. In order to assist us in accurately capturing your thoughts and feelings, we will audiotape the focus group.

Would my participation in this study be kept confidential?

This research project involves making an audiotape of your participation in the individual interview. This information will be accessed by myself and my supervisor. We will do our best to keep your personal information confidential. To help protect your confidentiality, your name will not be mentioned in my research project and the tape recording will be

destroyed at the end of this study. This information will be kept locked in a secure safe at all times. If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

What are the risks of this research?

There are no known risks associated with participating in this research project

What are the benefits of this research?

The benefits to you include

- An opportunity to reflect on the assessment of body dissatisfaction.
- An opportunity to reflect on the issue of treatment for body dissatisfaction.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

Is any assistance available if I am negatively affected by participating in this study?

Appropriate referrals will be made if unforeseen negative impacts arise.

What if I have questions?

This research is being conducted by Ms, Omega Bronkhorst at the Department of Psychology at the University of the Western Cape. If you have any questions about the research study itself, you can contact

Ms, Omega Bronkhorst

Dept of Psychology, UWC

082 566 2202

omegabronkhorst@gmail.com

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Supervisor: Dr. Mario Smith

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This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

## Appendix E: Letter of consent

### LETTER OF CONSENT

I, the undersigned, fully understand the research aims, my rights and my role as participant in the study, as well as issues related to confidentiality, as outlined in the information leaflet.

I hereby express my willingness to participate in this study. I am aware of my right to withdraw at any time.

I also grant permission to the researcher to disseminate the information obtained in the following formats:

- Unpublished thesis
- Conference presentation
- Published manuscript or article



I take cognisance that all documents and recordings will be destroyed at the end of the research process.

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Participant's Name

Date

Researcher's Contact Details

Omega Bronkhorst, University of the Western Cape, Department of Psychology.

Email address: [omegabronkhorst@gmail.com](mailto:omegabronkhorst@gmail.com)

I thank you for your cooperation and you are welcome to contact me for any queries at the address given above.