

Perfectionism: An exploratory analysis of treatment resistant eating disorder clients during intervention.

by

GUILLAUME NEALE WALTERS-DU PLOOY

submitted in accordance with the requirements  
for the degree of

DOCTOR OF PHILOSOPHY

in the subject of

PSYCHOLOGY

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: DR B C VON KROSIGK

MAY 2017

## CANDIDATE DECLARATION

Student Number: 4987-944-8

I declare that "*PERFECTIONISM: AN EXPLORATORY ANALYSIS OF TREATMENT RESISTANT EATING DISORDER CLIENTS DURING INTERVENTION*" is my own work, and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I further declare that I have not previously submitted this work, or part of it, for examination at UNISA for another qualification, or at any other higher education institution.

---

**Mr. G N Walters-du Plooy**

20 May 2017

**Date**

## ABSTRACT

### **Perfectionism: An exploratory analysis of treatment resistant eating disorder clients during intervention.**

By : Guillaume Walters-du Plooy  
Department : Psychology - University of South Africa (UNISA)  
Degree : PhD in Psychology  
Supervisor : Dr Beate Von Krosigk

#### **SUMMARY**

To gain a better understanding of those struggling with severe eating disorders (anorexia nervosa and bulimia nervosa), the inner life-world and subjective experiences of therapy clients were explored within the South African context. This was an empirical qualitative study. Specifically, the study's focus was on the psychological construct of perfectionism as experienced during the respondents' treatment resistant eating disorders. The two objectives of the research were to *describe* and *explain* perfectionism, which served to increase an overall improved *understanding* of perfectionism.

The study's methodology encompassed a combination of phenomenological- and grounded theory methodology, exploring the narratives of six female candidates that were undergoing individual therapy for their eating disorders. These candidates were considered to have a treatment resistant eating disorder, because they had been struggling with this diagnosis for longer than a decade, and/or had previously received multiple treatment interventions without recovering.

The therapy sessions were recorded via digital audio recordings, and used in the data analysis process. The discourses pertaining to the study's focus were transcribed and analysed using phenomenological- and grounded theory methods.

The phenomenological analysis produced individual descriptions of the participants' experiences of their perfectionism, as well as a general description for perfectionism.

The grounded theory analysis produced an emerging theory in the form of a cognitive schema. This schema was named The Perfectionistic Eating Disorder Self-schema (PEDSS), and explains the inner psychological process of perfectionism within a treatment resistant eating disorder client.

The results of this study, in particular the PEDSS, has implications for those trying to understand, assist, and treat those who suffer from treatment resistant eating disorders, as well as helping those who struggle with perfectionism to understand their own problem more.

### **Keywords**

Perfectionism; Eating disorders; Anorexia Nervosa; Bulimia Nervosa; Experience; Schema; Achievement; Drive; Judgement; Self-esteem; Phenomenology; Grounded Theory.

# DEDICATION

IN LOVING MEMORY OF  
OUMA MARIANNE, OUPA NICK AND OUMA AVICE...

(I MISS YOU ALL)

## ACKNOWLEDGEMENTS

Thanks, appreciation and gratitude to the following people during this research:

- Dr. Beate Von Krosigk - your continual encouragement, guidance and wisdom were invaluable. Thank you for not only being a supervisor, but also teaching me about psychology, research, life and the universe.
- Dr. Marietjie de Visser and Dr. Adele Potgieter - life mentors, colleagues, and friends. Your support, guidance, and wisdom through the years have been an invaluable contribution to my life. Your efforts have helped me so much in achieving what I have been able to achieve. Thank you from the bottom of my heart.
- Dr. Beverley Peens - your unending support during this project helped so much. Thank you for your encouragement and proof-reading the document. You are a true friend, and a professional peer in my journey as a clinical psychologist.
- Sherri Symons - thank you for helping with the editing process. I appreciate the late nights and long hours. Your help and commitment was extremely valuable.
- The research participants - thank you for allowing me the privilege to journey with you during your struggle. It was an honour and a privilege.
- My friends - sorry for neglecting you during the times invested in this project. Thank you for remaining by my side through it all. I hope to make up for lost time.
- My Family - Dad, Mom, Rene, Anton, Etienne. Thank you for believing in me and supporting me throughout this journey. To my grandparents - I am sorry that you could not see the final product before your passing. I know you would have been proud of the result.
- God - the road was long and hard. Thank you for carrying me when I could not carry myself.

Guillaume Walters-du Plooy

May 2017

## TABLE OF CONTENTS

<b>List of Figures</b>	<b>Page</b> XIV
<b>List of Tables</b>	XVI
<b>List of Acronyms</b>	XVII

### **Chapter 1** **Introduction**

1.1	Reflecting on eating disorders as complex conditions	1
1.1.1	Eating disorders are a serious global problem	2
1.1.2	Eating disorders within Africa	5
1.1.3	Eating disorders follow a chronic development and course	7
1.2	A personal reflection of the experienced world of those with treatment resistant eating disorders, and its influence in developing the research idea	9
1.3	The problem statement	15
1.4	Objectives of the research	16
1.5	Reasons for the necessity of this research	18
1.6	Layout of chapters	20

### **Chapter 2** **Discourses on Eating Disorders**

2.1	Describing, defining and categorising eating disorders	23
2.1.1	Diagnosing Anorexia Nervosa (AN)	29
2.1.2	Diagnosing Bulimia Nervosa (BN)	31
2.1.3	Diagnosing Other Specified Eating Disorders (Previously 'Eating Disorders Not Otherwise Specified – EDNOS')	33
2.1.4	Making a differential diagnosis	35
2.2	The consequences of eating disorders	38
2.3	The short history of eating disorders	47
2.4	Modern conceptions of eating disorders	51
2.4.1	Prevalence rates	58
2.4.2	Mortality rates	60

## TABLE OF CONTENTS (cont...)

	<b>Page</b>
2.4.3 Onset, course and prognosis of eating disorders	63
2.4.4 Prevention of eating disorders	69
2.4.5 Stigma and secrecy in eating disorders	72
2.5 Assessing eating disorders	75
2.5.1 Clinical interviews	75
2.5.2 Self-report measures and instruments	76
2.6 Managing eating disorders	
2.6.1 Considerations for holistic treatment	78
2.6.2 Health service resources and treatment costs of eating disorders	82
2.7 Treating eating disorders	85
2.7.1 Treatment diagram for anorexia nervosa	86
2.7.2 Treatment diagram for bulimia nervosa	87
2.7.3 Treatment procedures	
2.7.3.1 Initial assessment	88
2.7.3.2 Psychotherapy	89
2.7.3.3 Psychopharmacology	90
2.7.3.4 Nutritional counselling and rehabilitation	93
2.7.3.5 Medical treatment	94
2.7.3.6 Inpatient treatment	95
2.7.3.7 Outpatient treatment	96
2.7.3.8 Day hospital care	97
2.7.3.9 Residential care ('sub-acute facilities')	98
2.8 Psychological treatment perspectives for eating disorders	98
2.8.1 Psychodynamic perspectives on eating disorders	99
2.8.2 Cognitive-behavioural therapy (CBT) for eating disorders	100
2.8.3 Family based treatment (FBT) for eating disorders	102
2.8.4 Dialectical behavioural therapy (DBT) and eating disorders	104
2.8.5 Eating disorders as an addiction - A vicious cycle treated with step programs	106
2.8.6 Interpersonal psychotherapy (IP)	107
2.8.7 Group interventions	107
2.8.8 Self-help approaches	108
2.9 Eating disorders research in South Africa	109
2.10 Eating disorders management and treatment	110

## TABLE OF CONTENTS (cont...)

	<b>Page</b>
<b>Chapter 3</b>	
<b>Discourses on Perfectionism</b>	
3.1	Defining perfectionists and perfectionism 114
3.2	Describing perfectionism 115
3.3	Diagnosing perfectionism 119
3.4	The development of perfectionism as a precursor to eating disorders 123
3.5	Clinical perfectionism in eating disorders 128
3.5.1	Adaptive perfectionism VS Maladaptive perfectionism 131
3.5.2	Conditional self-acceptance VS Unconditional self-acceptance 135
3.5.3	Achieving control through perfectionism 138
3.5.4	Body image problems 140
3.6	Assessing perfectionism 141
3.7	Methodological issues in the study of perfectionism within eating disorders 145
<b>Chapter 4</b>	
<b>Research Paradigm and Methodology</b>	
4.1	Qualitative research methods 149
4.2	The foundational development of the research study design 150
4.2.1	The development from modernist to post-modernist research 151
4.2.2	The nature of qualitative research 155
4.2.3	Post-modernism and qualitative research 156
4.2.4	Phenomenological philosophy and research 157
4.2.5	Grounded theory philosophy and research 160
4.3	The research study design
4.3.1	Personal reflections on my own philosophical position 161
4.3.2	Combining phenomenology and grounded theory research practice 164
4.3.3	Conceptual framework of the research design 166
4.3.4	First research objective: Using phenomenology to describe perfectionism in treatment resistant eating disorders 167
4.3.5	Second research objective: Using grounded theory to explain perfectionism in treatment resistant eating disorders 169

## TABLE OF CONTENTS (cont...)

	<b>Page</b>	
4.4	Selection procedure	
4.4.1	Participant recruitment	170
4.4.2	Participant sampling and selection	172
4.4.2.1	Maximum variation sampling	173
4.4.2.2	Purposive sampling	174
4.4.3	Ethical considerations and protection of participants	176
4.5	Data collection procedure	178
4.5.1	The interaction between participant and researcher	179
4.5.2	Therapy considerations for the participants	181
4.5.3	Audio recordings	182
4.5.4	Reflections of the participants on the research process and results	183
4.6	Data analysis procedure	
4.6.1	Key tenets of the phenomenological approach to data analysis	184
4.6.2	The methodological principles of descriptive phenomenological data analysis	187
4.6.2.1	Intentionality	187
4.6.2.2	Epoché (and the phenomenological reduction)	188
4.6.2.3	Essences	189
4.6.3	Giorgi's method of descriptive phenomenological analysis	190
4.6.3.1	Definition	190
4.6.3.2	Method of analysis	191
4.6.4	Key tenets of the grounded theory approach to data analysis	195
4.6.5	The methodological principles of grounded theory data analysis	200
4.6.5.1	Initial coding and categorisation of data	201
4.6.5.2	Concurrent data collection and analysis	203
4.6.5.3	Writing memos	204
4.6.5.4	Theoretical sampling	205
4.6.5.5	Constant comparative analysis	207
4.6.5.6	Theoretical sensitivity	208
4.6.5.7	Intermediate coding	210
4.6.5.8	Identifying a core category	211
4.6.5.9	Theoretical saturation	212
4.6.5.10	Advanced coding and theoretical integration	213
4.6.5.11	Generating theory	214
4.6.6	Grounded theory method of data analysis according to Charmaz	214
4.7	Issues of generalisability, validity and reliability, as well as rigor and trustworthiness of the research design	
4.7.1	Generalisability	217
4.7.2	Validity and reliability	217
4.7.3	Rigor and Trustworthiness	220

## TABLE OF CONTENTS (cont...)

	<b>Page</b>
<b>Chapter 5</b>	
<b>Presentation of the Phenomenological findings</b>	
5.1	My personal reflections (Epoché) 223
5.2	Procedure for presenting the findings 229
5.3	Demographic profiles of the research participants 230
5.4	Phenomenological descriptions of each participant's experiences
5.4.1	Rochelle -The makeup artist 230
5.4.2	Cathy - The personal trainer 244
5.4.3	Pamela - The concrete specialist 255
5.4.4	Lara - The dietician 265
5.4.5	Jane - The student 276
5.4.6	Tracy - The psychologist 285
5.5	A general structural description of the phenomenon of perfectionism in treatment resistant eating disorder clients 297
5.5.1	Emotions 299
5.5.2	Goals and decisions 300
5.5.3	Thought processes and beliefs 302
5.5.4	Judgement 305
5.5.5	The Self 308
5.5.6	Relationships 312
5.5.7	Behaviours and habits 314
5.5.8	Social and environmental influences 315
5.5.9	Recovery 316
<b>Chapter 6</b>	
<b>Presentation of the findings according to the Grounded Theory analysis</b>	
6.1	Introduction 320
6.2	Grounded theory of perfectionism within treatment resistant eating disorders: The Perfectionistic Eating Disorders Self-Schema (PEDSS)
6.2.1	The Perfectionistic Eating Disorders Self-Schema (PEDSS) 327
6.2.2	Perfectionism: The war with the Self 330
6.2.3	Perfectionism: My problem 333
6.2.4	Perfectionism: My solution - Pursuing an ideal 334
6.2.5	Perfectionism: My plan to become ideal 335
6.2.6	Perfectionism: Pathological drive to achieve an ideal 337
6.2.7	Perfectionism: My result - How my perfectionism and my eating disorder interact 339

## TABLE OF CONTENTS (cont...)

	<b>Page</b>
6.2.8 Perfectionism: My recovery - Learning to celebrate my Self	341
6.2.9 Perfectionism: Conclusion	345
 <b>Chapter 7</b> <b>Discussion of the research findings</b>  	
7.1 Legitimising this study's claims toward valid knowledge through current research	347
7.2 Discussion of the phenomenological findings	348
7.2.1 Emotions	348
7.2.2 Goals and decisions	350
7.2.3 Thought processes and beliefs	352
7.2.4 Judgment	354
7.2.5 The Self	356
7.2.6 Relationships	358
7.2.7 Behaviours and habits	359
7.2.8 Social and environmental influences	360
7.2.9 Recovery	361
7.3. Second phase literature review	
7.3.1 The issue of literature review within grounded theory research	362
7.3.2 Perfectionism defined	364
7.3.3 Perfectionism and its influence in psychopathology: Perfectionism as a transdiagnostic process	369
7.3.4 Perfectionism and its influence in eating disorders	370
7.3.5 Conceptualisations of perfectionism	372
7.3.5.1 Positive conceptions of perfectionism: Dimensional- and Group-based approaches	374
7.3.5.2 The 2 x 2 model of Dispositional Perfectionism	379
7.3.5.3 The Cognitive-behavioural model of Clinical Perfectionism	383
7.3.5.3.1 The Original Cognitive-behavioural model of Clinical Perfectionism	385
7.3.5.3.2 The Revised Cognitive-behavioural model of Clinical Perfectionism	386
7.4 Discussion of the grounded theory findings: Placing the emergent PEDSS theory within the context of existing literature on perfectionism	392
7.4.1 The Transdiagnostic model of Eating Disorders	393
7.4.1.1 The Transdiagnostic model of Eating Disorders: Clinical Perfectionism	395
7.4.1.2 The Transdiagnostic model of Eating Disorders: Core Low Self-esteem	399

## TABLE OF CONTENTS (cont...)

	<b>Page</b>
7.4.2 Theory integration: The Perfectionistic Eating Disorder Self-Schema VS The Transdiagnostic model of Eating Disorders	402
7.4.3 Theory comparison: The Perfectionistic Eating Disorder Self-Schema VS The Transdiagnostic model of Eating Disorders	410
7.4.4 Discussion of the individual PEDSS concepts	413
7.4.4.1 The Self ( <i>i.e. 'The war with the Self'</i> )	413
7.4.4.2 Critical Judgement	415
7.4.4.3 The Ideal: Self-Perfection	419
7.4.4.4 Extreme Achievement	421
7.4.4.5 Pathological Drive	423
7.4.4.6 Recovery	425
7.5 Discussion of the integrated findings: Understanding perfectionism in treatment resistant eating disorder clients through the experiences of the participants and The Perfectionistic Eating Disorder Self-Schema (PEDDS)	427

## **Chapter 8 Conclusions and Recommendations**

8.1 Perfection in treatment resistant eating disorder clients	433
8.2 Results of the phenomenological approach to exploring perfectionism in treatment resistant eating disorder clients	434
8.3 Results of the grounded theory approach to exploring perfectionism in treatment resistant eating disorder clients	435
8.4 Value of the research	437
8.5 Strengths of the research	439
8.6 Limitations of the research	440
8.7 Recommendations for future research	442
8.8 Final conclusions of the research	443

## **Appendices**

Appendix A: Consent Form	447
--------------------------	-----

## **Reference List**

References	448
------------	-----

## LIST OF FIGURES

Figure 1.1: The nature of reality of the Self	13
Figure 1.2: The research path undertaken	21
Figure 2.1: Eating disorder diagnoses	25
Figure 2.2: The stepped care model of eating disorders of the Royal College of Psychiatrists in 1992	79
Figure 4.1: The research design's conceptual framework	166
Figure 4.2: Conceptual ordering of essential grounded theory methods	198
Figure 6.1: The Perfectionistic Eating Disorder Self-Schema (PEDSS)	327
Figure 6.2: Perfectionism: The war with the Self	330
Figure 6.3: Perfectionism: My problem	333
Figure 6.4: The Vitruvian Woman	334
Figure 6.5: Perfectionism: My plan to become ideal	335
Figure 6.6: Perfectionism: Pathological drive to achieve an ideal	337
Figure 6.7: Perfectionism: My recovery - Learning to celebrate my Self	341
Figure 7.1: Common conceptual framework combining both dimensional and group-based conceptions of the two basic forms of perfectionism	375
Figure 7.2: The 2x2 model of Dispositional Perfectionism	380
Figure 7.3: The Original Cognitive-behavioural model of Clinical Perfectionism	385
Figure 7.4: The Revised Cognitive-behavioural model of Clinical Perfectionism	387
Figure 7.5: The Transdiagnostic Cognitive-behavioural theory of Eating Disorders	394
Figure 7.6: Fairburn's Transdiagnostic formulation with Clinical Perfectionism added	397
Figure 7.7: The over-evaluation of achieving and achievement	398
Figure 7.8: Fairburn's Transdiagnostic formulation with Core Low Self-esteem added	401
Figure 7.9: The Perfectionistic Eating Disorder Self-Schema (PEDSS)	402

Figure 7.10: The Perfectionistic Eating Disorders Self-Schema combined with Fairburn's Transdiagnostic Cognitive-behavioural model of Eating Disorders	404
Figure 7.11: The Perfectionistic Eating Disorders Self-Schema combined with Fairburn's aspect of over-evaluation of achieving and achievement	407
Figure 7.12: The Perfectionistic Eating Disorders Self-Schema combined with Fairburn's aspect of Core Low Self-esteem	408
Figure 7.13: The Perfectionistic Eating Disorders Self-Schema combined with Fairburn's Transdiagnostic model of eating disorders, including aspects of Clinical Perfectionism and Core Low Self-esteem	409
Figure 7.14: The Perfectionistic Eating Disorder Self-Schema (PEDSS)	427
Figure 8.1: The Perfectionistic Eating Disorders Self-Schema (PEDSS)	436

## LIST OF TABLES

Table 2.1 Factors determining prognosis in AN	69
Table 2.2: Possible risk factors associated with eating disorder development in children	70
Table 2.3: Levels of preventing the development of eating disorders	71
Table 2.4: List of government- and private psychiatric facilities/hospitals with specialist Eating Disorder Units and ED Programs in South Africa	111
Table 3.1: Benefits and costs associated with perfectionism	134
Table 3.2: General perfectionism measures	141
Table 3.3: Perfectionist-related cognitions measures	143
Table 3.4: Perfectionism in relationships measures	143
Table 3.5: Perfectionism in sport measures	144
Table 3.6: Perfectionism, eating disorders and body image measures	144
Table 3.7: Perfectionism in children measures	144
Table 4.1: The sequential order of analysis	216
Table 5.1: Demographic profiles of research participants	230
Table 5.2: Summary of the experience of perfectionism within treatment resistant eating disorder clients	298
Table 6.1: The six core themes for perfectionism in treatment resistant eating disorder clients, with their corresponding categories, subcategories, and sub-subcategories	321
Table 7.1: Comparing and relating Fairburn's Transdiagnostic CBT model of Eating Disorders with my emerged Perfectionistic Eating Disorder Self-Schema	403
Table 7.2: Comparing and relating Fairburn's Transdiagnostic CBT model of Eating Disorders with Clinical Perfectionism added, with the Perfectionistic Eating Disorder Self-Schema	406
Table 7.3: Comparing and relating Fairburn's Transdiagnostic CBT model of Eating Disorders with Core Low Self-esteem added, with the Perfectionistic Eating Disorder Self-Schema	407
	XVI

## LIST OF ACRONYMS

ED	Eating Disorder
AN	Anorexia Nervosa
n.d.	No Date
BN	Bulimia Nervosa
DSM-5	Diagnosics and Statistical Manual of Mental Disorders (American Psychiatric Association, 5 <sup>th</sup> Edition)
UNISA	University of South Africa
APA	American Psychiatric Association
EDNOS	Eating Disorder Not Otherwise Specified
OCD	Obsessive-compulsive disorder
BDD	Body dysmorphic disorder
CBT	Cognitive-behavioural therapy
GT	Grounded Theory
BMI	Body Mass Index
PEDSS	The Perfectionistic Eating Disorder Self-Schema

# CHAPTER 1

## INTRODUCTION

*“It [bingeing] gives you a feeling of comfort. It’s like having a pair of arms around you, but it’s temporary. Then you’re disgusted at the bloatedness of your stomach, and then you bring it all up again.”*

Diana, Princess of Wales 1961 - 1997

Former wife of Charles, Prince of Wales:

Interview on *Panorama*, BBC1 TV, 20 November 1995

(as cited in Smith, 2010, p. 140)

### 1.1 Reflecting on eating disorders as complex conditions

There are many people who struggle with a unique and complex problem in their lives. This problem is obsessive in nature, and many describe it as being haunted by thoughts about their body shape, weight and the foods they consume. It has many negative consequences for the body and mind, severely affecting the sufferer - this is the life of someone living with an Eating Disorder (ED).

In short, an eating disorder is a debilitating mental disorder which manifests on multiple levels. The core problem involves multiple influencing variables in its development, course, and outcome. They are usually chronic conditions: The sufferer’s emotions and behaviours affect each other negatively almost in a cyclic manner, *feeding* each other as the sufferer tries to reach some form of stability in their life. This cycle can repeat itself for many months, years, or even decades.

On the behavioural front, severe restriction of food is common. Another problem behaviour includes pathological food binges, where the sufferer consumes abnormally large amounts of food. Sufferers usually describe some feeling of *loss of control* during such binges, and thereafter experience a strong need to *fix*, or compensate for the binge. Their compensation methods include, amongst others, self-induced vomiting, excessive exercise, and laxative abuse.

On the personal front, ED sufferers may struggle with issues such as low self-esteem, problematic relationship-dynamics, feelings of *being a failure*, as well as not being able to successfully overcome traumatic experiences in life. Their emotional world is unstable, and they experience extreme emotions almost daily.

### **1.1.1 Eating disorders are a serious global problem**

Regarding eating disorders, international research findings indicate two important emerging trends:

- Eating disorders and disordered eating attitudes and behaviours are becoming increasingly prevalent, not only in Western societies, but amongst others adolescent and young adult populations across cultural and racial boundaries (Fear, Bulik, & Sullivan, 1996; Grigg, Bowman, & Redman, 1996).
- The age of onset for eating disorders is decreasing, thus contributing to an increased prevalence rate (Colborn, 1994; Jones, Bennet, Olmstead, Lawson & Rodin, 2001). Eating disorders as a realised problem has doubled in prevalence since the 1960's. This trend has especially been noticeable in younger age groups, even as young as seven years old. More cases have also been surfacing in different and diverse ethnic and socio-cultural groups where such disorders were previously rare (Eating Disorders Coalition, 2009).

Gordon (2001) highlights the coincidence between the 1990's and the unprecedented proliferation of anorexia nervosa (AN) in countries where it had previously been unheard of, as being related to the global acculturation to a Western lifestyle and value system. The amount of research and information surrounding eating disorders has increased significantly since that time, and research still attempts to reach new ground in the battle to prevent and treat eating disorders. However, there remains a minefield of complexities which eating disorders present for treating professionals, as they attempt to understand the issues that accompany these complex illnesses.

Eating disorders pose serious health risks to sufferers, as well as severe burdens upon global health- and financial institutions. Anorexia nervosa has the highest mortality rate of any mental illness. Since the 1930's, the United States of America has seen significant increases in incident rates for young women aged 15 - 19 years decade upon decade, with 40% of all new cases being identified for that age group. Incidence rates for bulimia nervosa (BN) in women aged between 10 - 39 years have tripled between 1988 and 1993 (National Eating Disorders Association, 2008).

Also, in the United States of America, AN is ranked as the third most common chronic illness amongst adolescents (Eating Disorders Coalition, 2009). The same is true for adolescents in Australia (The Victorian Centre of Excellence in Eating, n.d.). In addition, eating disorders are ranked 15<sup>th</sup> among the top 20 causes of disability in women (when measured in years of productivity lost due to disability). The estimated average duration of illness for AN and BN is eight and five years respectively (Vos et

al., as cited in The British Psychological Society & The Royal College of Psychiatrists, 2004).

When focussing on treatment, only about one in ten sufferers of eating disorders receives treatment. Approximately 80% of sufferers who have accessed care for their ED do not get the appropriate level of intensity of treatment they need to remain in recovery. Healthcare costs are expensive as treatment is specialised and usually long-term. It is estimated that ED sufferers usually need inpatient care for around 3 - 6 months, which equates to high treatment costs. Thereafter, outpatient treatment costs are still to be considered as the sufferer attempts to re-integrate back into society (South Carolina Department of Mental Health, n.d.).

The above statements suggest that ED sufferers would be high consumers of medical and social care, which in turn implies a considerable burden placed upon a country's health care system. As Szabo (2009) states, ED sufferers do not usually seek treatment, and those that do, do not usually engage with it consistently. In the USA, treatment for eating disorders costs businesses approximately \$4 billion annually. When considering the individual, treatment costs may be as much as \$30 000 monthly for in-patient care, and up to \$100 000 for out-patient care (Hanson, 2008). However, as Claude-Pierre (1999) suggests, health care insurers in the USA have started recognising that the primary route of successful recovery for ED sufferers should focus upon specialist outpatient programs, as opposed to inpatient acute care. The costs for these long-term outpatient programs are significantly more economically cost-effective than acute inpatient care: More patients recover fully and have no need for further treatment.

### **1.1.2 Eating disorders within Africa**

One may question whether AN is a culture-bound disorder, which is elicited by a pervasive pressure to diet and which is rare or absent in non-Western cultures. Firstly, there are historical descriptions of cases of self-starvation without weight concern in cultures in which there was no emphasis on slimness (Bemporad, 1996). Secondly, cross-cultural comparison has suggested that body shape indeed is not necessarily the primary motivation in AN (Lee, 1996). Research studies in South Africa (La Grange, Telch & Tibbs, 1998; Wassenaar, Le Grange, Winship & Lachenicht, 2000), Nigeria (Oyewumi & Kazarian, 1992a, 1992b), Ghana (Bennett, Sharpe, Freeman, & Carson, 2004), and Asia (Bhadrinath, 1990; Khandelwal & Saxena, 1990; Lee, Ho & Hsu, 1993), suggest that anorexia nervosa may take different forms in different cultures. The morbid self-starvation may have many motives, such as to atonement for sins, to achieve better results, or for religious practices.

While ED origins have been conceptualised in western cultural roots, by the early 1970's it was acknowledged that AN, which at one time had been quite rare, had reached epidemic proportions in the west, and also in white South African females (Buchan & Gregory, 1984; Norris, 1979). During that time, the extent of the problem was significant. However, the reporting of official clinical indigenous cases of African females only surfaced in Nigeria in 1981 (Nwaefuna, 1981), and only arose in South Africa in 1993. Szabo, Berk, Tlou and Allwood (1995) reported three cases of eating disorders within black African females.

Although research pertaining to eating disorders within the South African context is relatively limited, South African-based research seems to support the assumption that eating disorders are becoming more prevalent within lower socio-economic classes, which includes Black communities (Van der Walt, 1995). Van der Walt (1995) predicted that the prevalence of eating disorders in the Black communities in South Africa would gradually increase, as westernisation and the homogenisation of values takes place.

The first published cases of eating disorders in Black female South Africans appeared in 1995 (Szabo, 2009). In a research study of high-school girls and college students, both Szabo and Hollands (1997) and Le Grange et al. (1998) have found a higher prevalence of abnormal eating attitudes in Black pupils and students than any other ethnic groups participating in the study. In another study by Senekal, Steyn, Mashego and Nel (2001) at the University of the North (North-West Province, South Africa), young Black females demonstrated a higher prevalence of disordered eating attitudes and behaviours than among similar White groups at the same institution. Although findings by Edwards and Moldan (2004) found that some Black females were affected by disordered eating behaviours, the influence was less marked than with their White counterparts. This contrasts with the results obtained by Le Grange et al. (1998) and Senekal et al. (2001).

More recently, research has also highlighted diet-related problems with elite South African female athletes. Up to 62% of female athletes studied suffered from a variety of problems associated with disordered eating habits. These included bingeing and

purging, excessive restrictive eating patterns, as well as the overuse of laxatives and diuretics (Van Heerden, 2009).

Although prevalence rates for those suffering from eating disorders in South Africa are difficult to accurately establish, the above-mentioned findings provide some indication of the extent of eating-related problems in the country. The lack of established prevalence figures is partly attributed to the fact that many cases go untreated and never come to the attention of healthcare professionals. Socio-economic factors would also contribute negatively, as access to healthcare may at times be limited. Diagnosing accurately is hindered by a general lack of knowledge about eating disorders symptom presentation, as well as active attempts by those afflicted by the disorder to conceal their symptoms. Considering this, it is not surprising that many sufferers generally go untreated for long periods of time before they are diagnosed accurately, or receive the necessary interventions.

### **1.1.3 Eating disorders follow a chronic development and course**

Eating disorders are comprised of a range of syndromes encompassing physical-, psychological-, and social features. The impact of an ED on home and family life is often significant and family members may carry a heavy burden over a long period. These disorders frequently follow a chronic development and course, from which recovery is difficult (The British Psychological Society & The Royal College of Psychiatrists, 2004).

Eating disorders themselves present treating professionals with many challenges. Sufferers exhibit rigid cognitive and behavioural structures that hinder treatment

interventions. They require direct assistance on the physical-, cognitive-, emotional- and behavioural spectrum. Full recovery does not allow these aspects to be treated independently, particularly if the disorder has taken significant precedence, and is long-standing. The complexity of eating disorders' chronic nature, its clinical presentation through bizarre cognitive- and emotional phenomena, as well as the numerous co-morbidities and complications associated therewith, indicate the need for specialist multi-dimensional professional treatment interventions. Generally, multiple professional disciplines are involved. In the South African context, these specialists normally encompass psychiatrists, occupational therapists, dietitians, as well as psychologists.

The treatment of eating disorders presents professionals with many unique and intricate challenges: Starvation is the physical state that is achieved through chronic restriction of food intake, and affects the whole person. Not only do sufferers exhibit a low body weight and symptoms of malnourishment in this state, but also rigid cognitive and behavioural structures that hinder treatment interventions. On the other hand, these rigid cognitive and behavioural structures are maintained and perpetuated by a low body weight and malnourishment (Keys, as cited in Brown, 2006). In this sense, an ED is insidious by nature. It is not always clear whether such factors are causes or consequences of the disorder. The physical- and physiological side-effects may be triggered by food deprivation, and in turn become triggers for further complications of the disorder.

## **1.2 A personal reflection of the experienced world of those with treatment resistant eating disorders, and its influence in developing the research idea**

Ever since commencing my formal professional career as a clinical psychologist, I have taken a personal interest in the psychopathology of eating disorders. Personal experiences during childhood with a female friend, allowed me to witness first-hand the difficulties and intricacies of someone living with BN and its treatment. These conditions (i.e. eating disorders) severely impact family members and the sufferer on many levels.

My passion for helping sufferers of eating disorders is strong. At the time of writing this thesis, I had already been practicing in the field of mental health for almost a decade. During this time, I had treated many eating disorder sufferers and had tallied more than 1000 hours of face-to-face consultations with such clients. I had also initiated and facilitated a support group for sufferers of AN and BN for almost four years. It is within these professional consultations and experiences that my pondering and questioning about eating disorders and its treatment developed.

From the beginning of treating those with eating disorders, I struggled to understand thoroughly the emotional functioning of these clients. Although I educated myself with academic writings concerning theoretical conceptualisations and interventions of eating disorders, I was frustrated by the lack of explanation of the disorder itself. Although some theories would attempt to clarify elements of the psychological attributes of the pathology, I was still left wanting a better understanding of the deeper personality contributories. Most theories focussing on these topics were not

extensive, or relied mostly upon hypothetical constructs which were not grounded in proper research data. Some books even described the main intervention as *providing love and attention*, whilst other more formal academic sources focussed mostly on symptom presentation and reduction thereof.

Although I worked at the biggest private mental health care facility in South Africa, my exposure to eating disorders was minimal. Opportunities to work with these individuals were negligible in comparison to the amount of Mood Disorders or Anxiety Disorders which we would treat there. However, as more opportunities to treat clients with eating disorders crossed my path, I continued my pursuit in trying to increase my understanding of the sufferer's psychological world. My knowledge and experience grew with each case treated. As my experience grew, word-of-mouth started spreading between colleagues and the community of my readiness and willingness to engage with such clients, as well as the formation of the ED support group, which I facilitated free-of-charge on a weekly basis. These elements contributed to more exposure to ED clients.

With the influx of treating more ED clients, I was increasingly being confronted with *difficult cases*. These clients presented with extremely complicated eating disorders which had been part of their lives for many years - in some cases decades. The intricacies of their problem, as manifested by their extreme behaviours and thought patterns, were quite overwhelming for a younger therapist. My personal frustrations grew as I came face-to-face with more treatment resistant cases, which presented with extreme rigid personalities that I could not conceptualise properly.

However, as time passed, I started questioning the real influence of strong personality variables in the development and maintenance of treatment resistant eating disorder cases. Addressing these clients' eating disorder symptoms was not enough, as their rigid personality structures holistically dominated not only their pathological eating behaviours, but their lives in general. Within these treatment resistant cases specifically, it was easy to identify the client's own negativity towards themselves, as well as their inability to accept themselves. But why? It was also easy to notice their negativity was not only towards their physical appearance: Weight loss and obtaining some preconceived level of physical echelon was not enough. Their negative thoughts and emotions about themselves went far beyond the level of physicality and into other areas of their lives. It was like their negativity was universal throughout their lives.

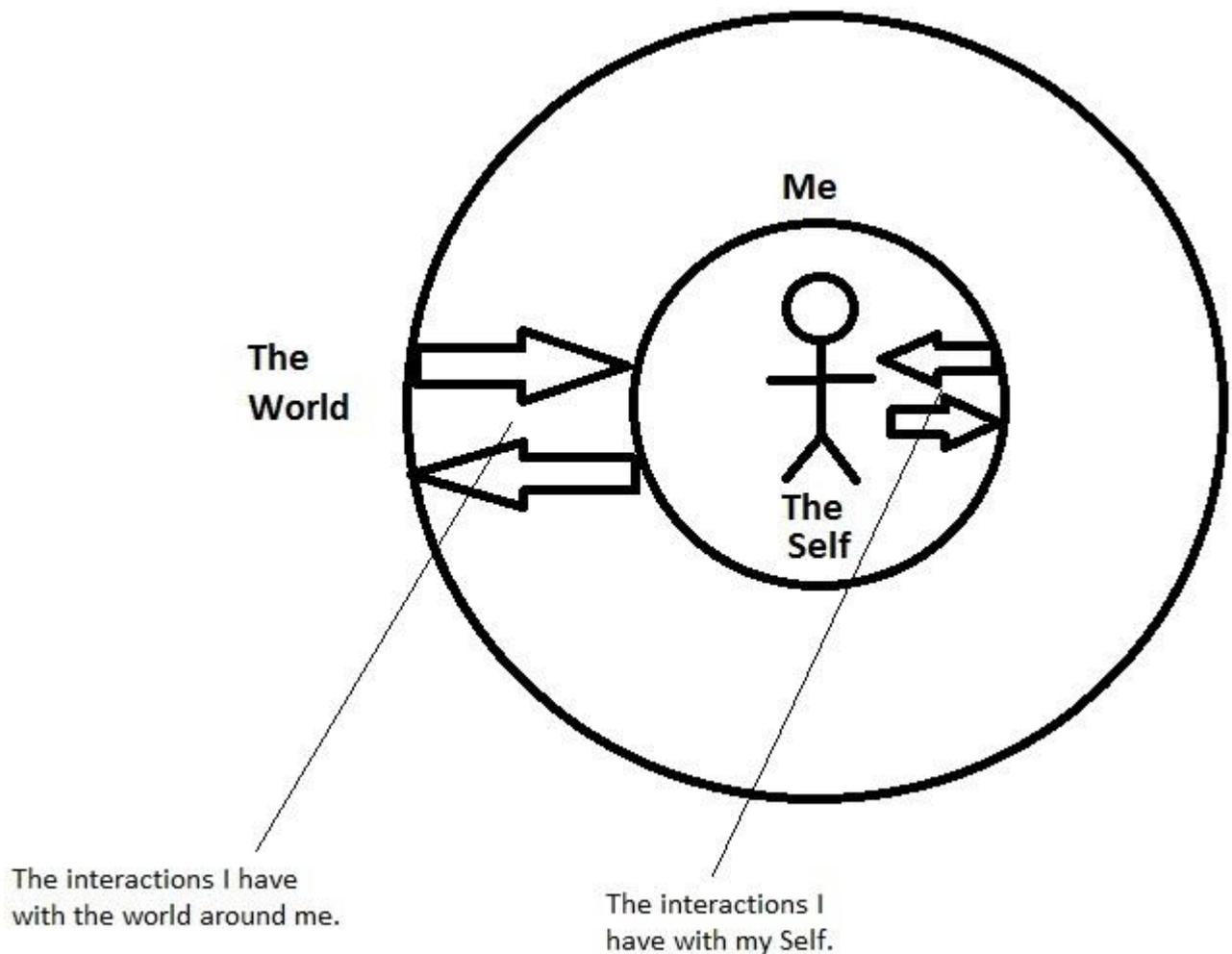
Once again, the research literature disappointed me to *understand* this. The way I viewed the world and myself differed vastly from the clients I was treating. Treatment resistant cases posed problems in therapy for me: Clients were not open to talking about their relationship with themselves, and easily diverted their focus in the discussions to their physical attributes and the perceived problems in those areas. Most of the clients in the *difficult cases* category were well versed as to the therapy processes and psychological interventions, as most of them had already undergone multiple interventions previously. The more I probed for answers in specific areas, the more I was met with resistance, or avoidance of such personal topics.

Within the group of my difficult ED cases, as well as my ED support group, I started investigating the level of influence the clients' relationship with themselves had on

their eating disorders. My investigation validated my thinking that in the most extreme form of a hateful relationship with oneself, an eating disorder seemed a *good fit*, as it created ample opportunities to *abuse* oneself. As I gained more knowledge and information, it was becoming clear that the clients' relationship with themselves was key to understanding how they interpreted their own being, which would ultimately dictate aspects like self-respect and self-esteem, and how they treated or viewed themselves.

Most people today would define themselves in terms of the multiple roles they fulfil in life (e.g. male/female, old/young, married/single, employed/unemployed, rich/poor), as was the case with most of the clients I treated. In my dealings with them, I came to realise that they indeed focussed *mostly* or *only* on these roles. Their own feelings and thoughts about themselves were not as important to them as portraying to the world their competence within these roles they were attempting to fulfil. My exploration of my own thoughts regarding these matters made me question assumptions about life and our own *being*, within the world of an ED sufferer. How we *treat* ourselves; how we *think* about ourselves; how we *define* ourselves; - ultimately determine the *relationship we have* with ourselves: The relationship we have with our '**Self**'. Our being, i.e. our *Self*, would be predominantly defined by the intra-personal interactions we have with our own physical- and emotional world. Thus, the nature of reality would encapsulate the relationships and interactions between the *Self* and the world. That is - the relationship others have with my *Self*, as well as between the *Self* and me.

**Figure 1.1: The nature of reality of the Self**



Delving further into the topic of the *Self* and the sufferer, I noticed how the clients would interact with the *Self*. There seemed a need to constantly change their *Self*. It is upon this need for changing the *Self* that I noticed treatment resistant clients striving for perfectionism. However, in my own thinking and understanding I did not truly know what perfectionism meant for someone living with an ED. In questioning perfectionism with the clients I was treating, some of them admitted their intense need for perfection, whilst others did not even realise they unconsciously yearned for it.

In considering the above-mentioned, I questioned how a treatment resistant eating disorder client experienced the concept of perfectionism in their lives. Living with constant thoughts of attempting to be perfect seemed to have a severe and intense impact on the person: It complicates their lives and is difficult to manage, as self-evaluation is unduly critical and persistent.

When focusing on this area, what does the client think and feel? How do they cope with the stress of constantly having to live up to high standards? What does it mean for them to be *perfect*?

Once again, perfectionism seemed to be a *good fit* with eating disorders. Both share similar outcomes as they start to dominate the person's life through obsessive thoughts that lead to problematic coping mechanisms and behaviours. Although my investigations identified hypothetical connections between perfectionism and eating disorders in my theorising, these links were vague and undefined. It was these vague connections that spurred me on to conduct a formal study of understanding perfectionism within treatment resistant ED individuals.

Edmund Husserl is of the view that individuals do not just experience the world as a *real* state, but that the world experienced is an interpreted world. It is shaped both by built-in biological invariants and by the experience-based psychological beliefs and biases that we continuously generate (Spinelli, 1989). This implies that individuals add their own subjective interpretation to their experiences based upon multiple factors. In gaining in-depth *understanding* about clients with treatment resistant

eating disorders, I came to investigate the relationship they have with their *Self* and the world around them through their perfectionism, within their eating disorders.

This investigation would be no easy task as aspects of perfectionism, *Self* and ED thoughts and emotions are in themselves not physical, or tangible things. To investigate these phenomena through means of objective methods would most certainly only confront me once again with information regarding the defined roles the clients wished to fulfil and portray competence in. This therefore meant I needed to utilise alternative research methods to gain insight into their person; into their relationship with their *Self*. My stance as researcher would have to be more personal; more intimate with the research participants. I made the decision to utilise qualitative research methods in my endeavour to investigate perfectionism within treatment resistant ED individuals, to come to a deeper *understanding* about this phenomenon.

### **1.3 The problem statement**

As a clinician, to become effective in the treatment of eating disorders one would need a good platform of knowledge on different ED perspectives, as well as the skills to effectively apply different treatment strategies to different contexts as the needs of each individual change. Treating an individual with an ED presents many challenges to the clinician. Commonalities exist for different eating disorders in terms of presenting pathology, assessment, diagnosing and treatment. The criteria, as set by the DSM-5 (American Psychiatric Association [APA], 2013), provide a means for clinicians to classify an individual with an ED. However, each specific case would

present with unique elements based on the overall individualistic nature of these conditions.

Psychological research generally focuses on the link between cognition and emotions and their subsequent behaviour within eating disorders. With increased understanding, more treatment options focussing on different aspects of eating pathology emerge. These aspects focus on phenomena such as thinking processes, family and other social influences, as well as broader concepts like the influence culture and societal contributories have. As already described, the world of those with pathological eating disorders who are resistant to treatment, is complex and difficult to describe and understand in-depth. Although international research has previously considered perfectionism in eating disorders, research which pertains to clinical perfectionism in South African ED clients is not forthcoming. The data on this specific subject is limited, and does not offer detailed insight into the essence of perfectionism in ED clients. The manner and degree to which perfectionism is experienced by those living with an ED in our country is unknown. How these individuals regard perfectionism, and what it means for them, is simply mysterious. In this regard, there exists a clear need to research this aspect to come to a better understanding thereof.

#### **1.4 Objectives of the research**

This study aims to explore perfectionism within treatment resistant ED individuals to reach deeper understanding thereof. This understanding attempts to go beyond the current existing body of knowledge on perfectionism and its relation to treatment

resistant eating disorders within the South African context. The two main objectives of the research are as follows:

- First Objective

Explore the life of each participant within the arena of their experience of perfectionism and its relation to their ED, to arrive at a *description* of their perfectionism within their treatment resistant ED.

- Second Objective

Utilise these descriptions of their experience to form a conceptual framework of perfectionism within treatment resistant ED individuals. This conceptual framework will *explain* the phenomenon and in so doing increase our understanding thereof.

The goal is to *describe*, and *explain* perfectionism within treatment resistant ED clients to come to a deeper *understanding* of perfectionism. I wish to obtain deeper insight into the issues of struggling with perfectionism within a treatment resistant ED. The study attempts to bridge the gap between the misinformed and the informed; between the layperson and the ED sufferer's perfectionism. The focus is on gaining a better understanding of perfectionism in ED clients, as well as increasing the understanding of our endeavours to assist those who struggle with eating disorders.

Key tenets of the research objectives include the following:

- To investigate the concept of perfectionism within treatment resistant cases of eating disorders and possibly illustrate its influence in the disorder itself by means of the presentation of cases who participated in the research study.

- To open the life of each participant for exploration as the arena in which their experience of their ED, and its relationship to perfectionism, can be described, explained, interpreted and understood.
- With the use of qualitative research methodology, to investigate and analyse the experience of the participants' perfectionism, to arrive at a detailed description and explanation thereof.
- With the use of qualitative research methodology, to analyse the verbatim descriptions of the participants' experiences of their perfectionism, to generate new theories and further stimulate research.
- To offer benefits within the therapy process for the participants who enrol in the study.
- The focus will be on gaining more *understanding* regarding perfectionism within treatment resistant eating disorders, without any concomitant attempt to generalise about it.
- To regard my personal experience and journey, through introspection and reflection towards developing deeper understanding of the phenomenon under study, which may contribute to the final emerging theory.

### **1.5 Reasons for the necessity of this research**

As stated previously, eating disorders are complex in nature in terms of their aetiology, understanding, and treatment. With its diversities within different cultural and social populations, there exist unique elements to each ED sufferer's case. In my search for understanding the clients I was treating, I came to identify the clear need to develop the construct of perfectionism in the research base for South African ED cases. I list these reasons below:

- Understanding the emotional world of those suffering from eating disorders seems difficult. Although international research has attempted to shed some light

on this aspect, the research data within the South African context is limited. Developing this research base may influence the development of theories and interventions which are tailored to our own indigenous cases, especially regarding treatment resistant cases. Thus, the findings obtained may lead to a better understanding of those suffering from eating disorders in the South African context. It may highlight in which way therapeutic- and intervention strategies may have to be adapted to better suit the unique social-, cultural-, and economic environment of ED clients in South Africa. The information gained could guide psychologists in our country regarding therapeutic elements that are unique to our population.

- Added to this, in my search for a deeper understanding into perfectionism and eating disorders, there seems to be a lack of qualitative, in-depth understanding of the personal experiences of those struggling with treatment resistant eating disorders in South Africa. Studies mostly focus on treatment aspects, or merely the diagnostic elements that encompass eating disorders, but never truly teach one about the difficult subjective world of someone struggling with this problem. Describing their world and attempting to conceive tentative theories about their world is an important endeavour which is under researched in our country. This study could then contribute to enlightening the public at large of how an ED is experienced.
- This research study might also contribute to the broad-based knowledge of perfectionism and ED treatment as a whole. The information gained might improve understanding our endeavours to assist people with these problems, and could also provide guidelines and education for health professionals who are striving to become more knowledgeable, or specialists, in this area of treatment.
- The participants that enrol in this study may gain possible personal benefits by being part of the therapeutic process. Their participation could assist in achieving their goal towards recovery and rehabilitation. Understanding the unique

elements that arise in individual treatment when focusing on treatment resistant clients with eating disorders will enable me to comprehend how the research participants experience their treatment and how they feel or view their tendency to be perfectionists.

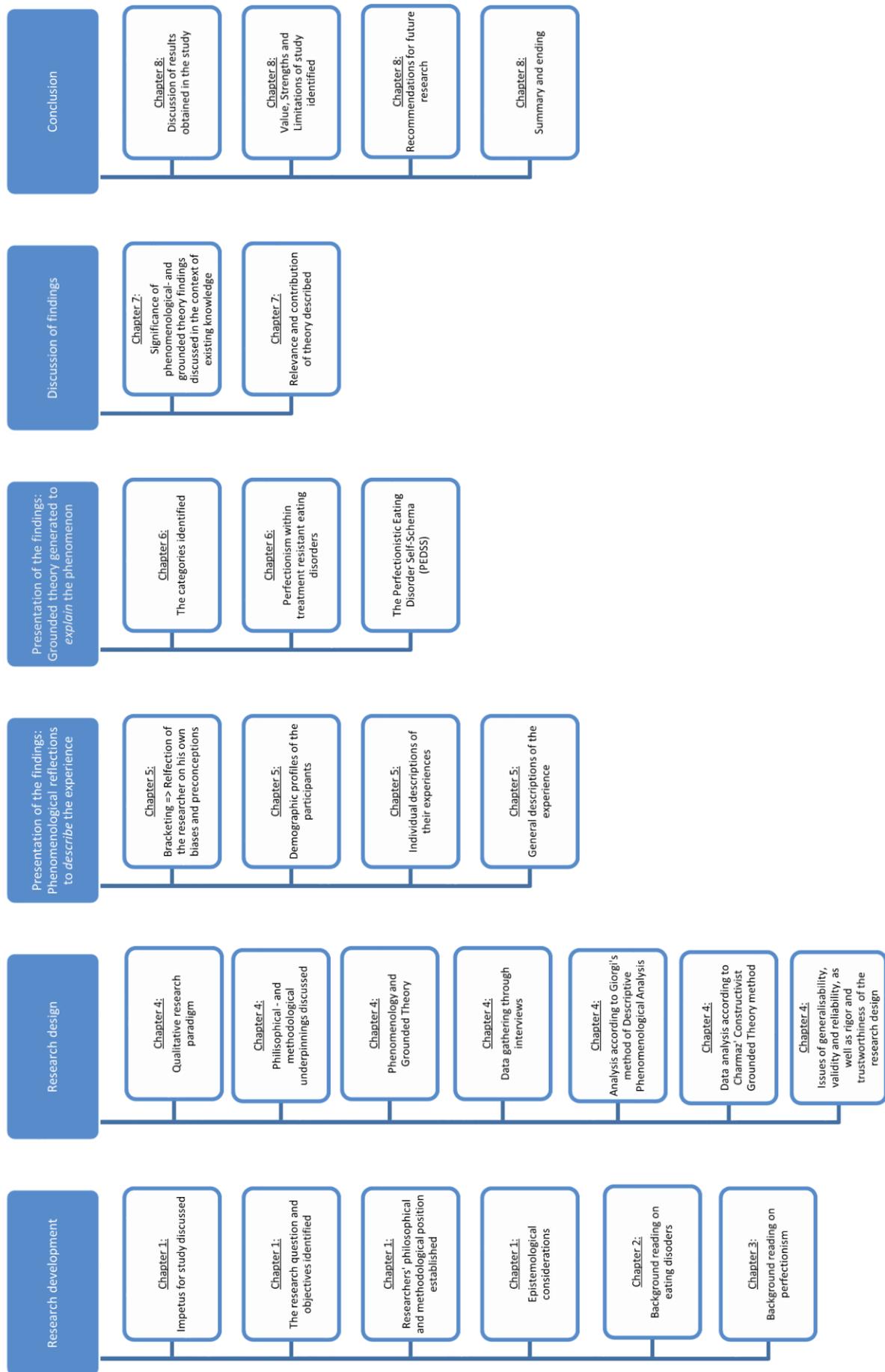
- Formulating a theory or model of perfectionism in eating disorders may emerge from the data obtained in the research. A good model or theory of perfectionism in eating disorders would however need to include alternatives to treating eating disorders. It would also need to generate specific hypotheses to stimulate further research and it would need to stimulate the process of recovery.
- Considering the role that perfectionism may play as a risk factor for the development of eating disorders, it is also possible that it may play a role as a predictor of outcome. Thus, for clinical treatment purposes, it would be valuable to study this relationship between perfectionism and eating disorders.

## **1.6 Layout of chapters**

The reader is provided with a blueprint (Figure 1.2), which traces the path undertaken from the origins of the research development, and lays out the process of how the research endeavour will be conducted and concluded in the chapters that follow.

Chapter 1 presents the background to the proposed study, outlines the research problem, aims and objectives. Background reading on the topics of eating disorders and perfectionism will be completed in Chapter 2 and 3 respectively. This will be done to gain a basic broad perspective on both aspects. It will cover current and past research on eating disorders and perfectionism, its aetiology, treatment and intervention strategies and perspectives from within the South African and

**Figure 1.2: The research path undertaken**



international contexts, as well as cultural and other perspectives. Chapter 4 will focus on the research methodology. Chapter 5 will present the findings of the phenomenological analysis procedure. Chapter 6 will present the findings of the grounded theory analysis procedure, and the emerging theory generated from the data. Chapter 7 will encapsulate the discussion of the integrated findings of both the phenomenological- and grounded theory findings by examining its significance and comparing it to current research. Chapter 8 will conclude with discussion of the results, including the value, strengths, and limitations of the study, as well as offering recommendations for future research endeavours.

Chapter 2 follows with a presentation of the present literature and background information on eating disorders.

## CHAPTER 2

### DISCOURCES ON EATING DISORDERS

*“Tell me what you eat and I will tell you who you are.”*

Anthelme Brillat-Savarin

(as cited in Oxford Dictionary of Quotations by Subject, 2010, p.140)

#### **2.1 Describing, defining and categorising eating disorders**

Although research focussing on eating disorders has become prevalent in recent decades, the occurrence of eating disorders is not a recent phenomenon. Eating disorders such as anorexia nervosa (AN) and bulimia nervosa (BN) are life altering disorders, influencing many spheres of the sufferer’s life. They are classified as psychiatric conditions characterised by excessive concerns about body shape and weight, which impact negatively on the sufferer’s eating habits, eating attitudes and eating behaviours (Szabo, 2009).

Many well-known individuals have succumbed to this unique and complex type of problem. Princess Diana of Wales, for example, admitted that her eating pathology had taken over her life at some stage. As the opening quote of Chapter 1 depicts - according to the description of the ambiguity of her condition, it seems that she found comfort from her illness on an emotional level, whilst at the same time being repulsed at the physical consequences thereof.

Other instances that illustrate just how potentially catastrophic eating disorders may be include the following:

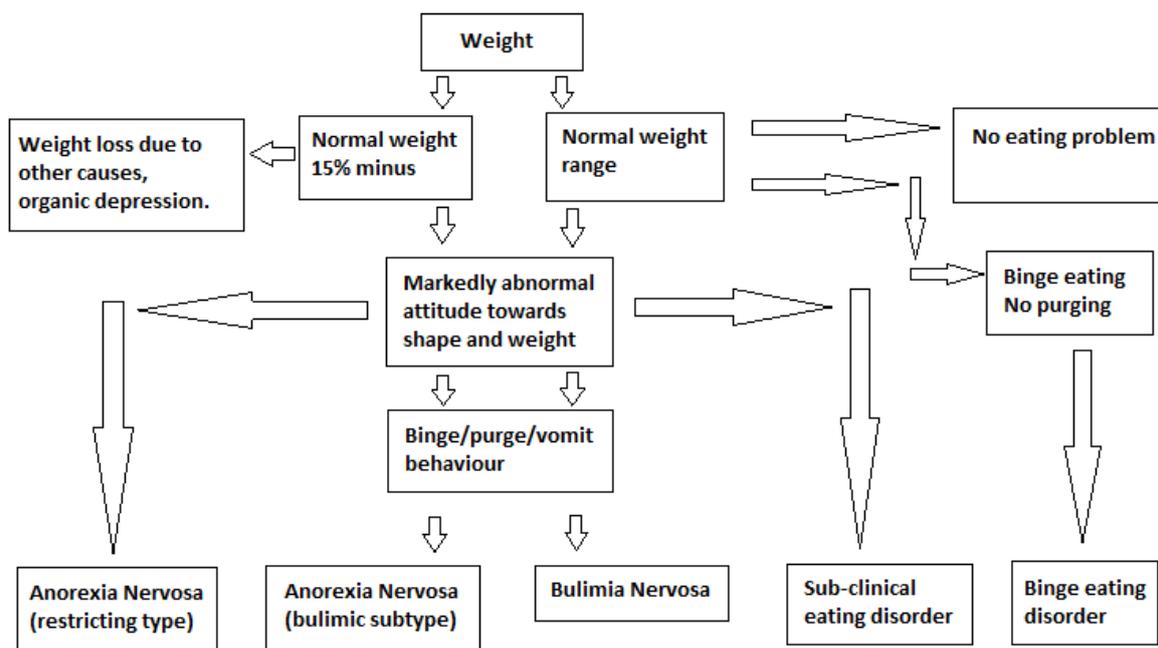
- In 1994 Christy Henrich, who was judged by many as a gymnast of near Olympic-calibre, died of organ failure associated with an ED. A judge allegedly commented that her scores would improve with weight loss, further catalysing the problem (Paul, 2010).
- Karen Carpenter, who died on February 4, 1983 at age 32, was lead vocalist in the famous band 'The Carpenters' in the 1970's and 1980's. Her autopsy revealed elements of cardiotoxicity associated with long-standing AN and laxative abuse (Death of Karen Carpenter - Death from Anorexia, n.d.).
- More recently in 2007, famous catwalk fashion model Eliana Ramos collapsed at age 18, merely six months after her sister Luisel had also died of heart failure during a fashion show. Both Eliana and Luisel's deaths were directly linked to their respective eating disorders. Eliana's passing became a landmark event which sparked an international debate over the use of size zero models on fashion catwalks (Mitchell & Yaqoob, 2007).
- In South Africa, recent research has highlighted diet-related problems with elite female athletes. The data indicated that up to 62.5% of female athletes studied suffered from a variety of problems associated with disordered eating habits. These included binge eating and purging, excessive restrictive eating patterns, as well as overuse of laxatives and diuretics (Robbeson, Havemann-Nel & Wright, 2013).

Eating disorders' prevailing behavioural characteristic encompasses persistent forms of dysfunctional eating or dieting activities. It is not a disorder about dieting: Although weight loss is involved with many cases, this is merely a symptom of the disorder. Sufferers of the condition usually have significant problems with their body image

and excessive weight concerns, which negatively affect their emotional well-being and development. Eating disorders are associated with severe emotional-, cognitive- and interpersonal distress with accompanying physical consequences (APA, 2013; Claude-Pierre, 1999; Klump, Bulik, Kaye, Treasure, & Tyson, 2009).

Freeman (2004, as cited in Eating disorders in Scotland: Recommendations for management and treatment, 2006) offers the following diagram that portrays a diagnostic flow chart for ED diagnoses.

**Figure 2.1: Eating disorder diagnoses**



As with so many psychiatric disorders, the world of those suffering from eating pathology may be characterised by complexity and confusion. They develop preoccupations and obsessions around their body shape and weight, and their ability to control them. The sufferer presents with a distorted image of their own bodies, which appears bizarre to non-sufferers; and the sufferers' subjective worlds seem

governed by outlandish rules and standards, which those living without the disorder struggle, at times, to comprehend (Fairburn, 2008). In this regard, it can be difficult to understand the ED sufferer who prescribes to such abnormal thoughts, strict standards and bizarre behaviours. This is echoed in Szabo's statement:

*Whilst some have conceptualised anorexia nervosa as a form of suicide, this is not the case insofar as that anorexics generally do not want to die but in fact, and somewhat ironically, aim to achieve a better life through their behaviour. In this sense they are seeking change, but clearly in a dysfunctional manner (Szabo, 2009, p. 56).*

Even the general assumption that 'a child's parents know them best', would be questioned in cases of eating disorders. Le Grange and Lock warn parents of children suffering from eating disorders in this regard:

*Children and adolescents with eating disorders see their behaviour – especially behaviour related to food, eating, weight, exercise, and health – quite differently from the way it looks on the outside. Eating disorders alter the logical ways of thinking about food and body image. They distort what your son or daughter sees in the mirror. They implant in your child's mind irrational expectations about the consequences of eating and not eating, exercising and not exercising (Le Grange & Lock, 2005, p. 96).*

Since eating disorders comprise a range of syndromes encompassing physical-, psychological-, and social features, the term 'eating disorders' can be used broadly to encapsulate many different clinical problems. However, for the purposes of this research, the term 'eating disorders' includes the following conditions as described in

the fifth edition of The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM 5) (APA, 2013):

- Anorexia Nervosa
  - There are three essential features of anorexia nervosa: Persistent energy restriction; intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain; and a disturbance in self-perceived weight or shape. The individual maintains a body weight that is below a minimally normal level of age, sex, developmental trajectory, and physical health (APA, 2013, p.339).
- Bulimia Nervosa
  - Individuals with bulimia nervosa exhibit recurrent episodes of binge eating, engage in inappropriate compensatory behaviours to avoid weight gain (e.g., self-induced vomiting), and are overly concerned with body shape and weight. However, unlike individuals with anorexia nervosa, binge-eating/purging type, individuals with bulimia nervosa maintain body weight at or above a minimally normal level (APA, 2013, p.345).
- Other Specified Feeding or Eating Disorder
  - Applies to presentations in which symptoms characteristic of a feeding and eating disorder that cause clinically significant distress or impairment in social-, occupational-, or other important areas of functioning predominate, but do not meet the full criteria for any of the disorders in the feeding or eating disorder diagnostic class (APA, 2013, p.353)
  - This diagnosis was previously known by the term "Eating Disorders Not Otherwise Specified (EDNOS)" in the previous version of The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association [APA], 2000).

Individuals whose symptom presentation is sub threshold (i.e. who meet criteria for 'Other Specified Feeding or Eating Disorder') are most commonly encountered. Fairburn (2008) claims that amongst adult ED outpatients, EDNOS is the most commonly diagnosed (comprising 50% - 60%), then BN which comprises around 30% of all cases, followed by the least most common AN, which compromises 10% - 15% of all ED cases.

Although the three diagnostic entities identified are distinct from one another, there are similarities in their presentation. They share disordered beliefs, attitudes and behaviours regarding food, body weight and shape. Szabo (2009) highlights the commonalities between AN and BN in the following statement:

Anorexia nervosa and bulimia nervosa share common features to the role of body shape and weight in self-evaluation, the existence of binge eating and purging as well as restricting food intake and excessive exercise/activity. All such features are not always present in any given case of either condition, or may in fact all be present. Either condition involves disturbed eating patterns associated with cognitive distortions, and consequent disturbances of both physical and emotional functioning (Szabo, 2009, p.53).

When categorising eating disorders, Fairburn (2008) has suggested a 'transdiagnostic perspective' for eating disorders, which challenges the traditional view that ED diagnoses are distinct and fixed. His view suggests that considering the similarities between the different diagnostic entities in terms of presentation and treatment strategies, eating disorders should be viewed as a single diagnostic category rather than identifying separate distinct disorders. However, Fairburn is not the first to propose this hypothesis. His transdiagnostic view seems to concur with

Keel's (2003) contentions of a continuum of eating pathology, rather than having two distinct diagnostic categories (i.e. AN and BN). The continuum perspective of eating pathology implies that at different times, sufferers' symptom presentations may migrate from one diagnosis to another. For example, a sufferer's diagnosis may be BN, but as their symptom presentation changes, one might find that at a later stage the sufferer's presentation allows for a diagnosis of AN.

### **2.1.1 Diagnosing Anorexia Nervosa (AN)**

Anorexia nervosa's diagnostic focus falls upon those individuals who are excessively, or rather obsessively weight conscious. It is an ED characterised by an intense drive for excessive thinness, and a refusal to maintain a healthy body weight that is normal or expected for the individual's age and height (APA, 2013).

Sufferers of anorexia nervosa ('an' – without, 'orexia' - appetite, or desire) present with a pronounced fear of gaining weight, even in the event of being truly significantly underweight. Their fear is associated with a '*distorted body image*', which makes sufferers perceive their bodies to be larger (or '*fatter*') than what objective measures would classify. This causes pronounced anxiety, and in turn cultivates an obsessive focus on body weight or shape. The sufferer's own negative subjective evaluation of their body has a powerful influence on their self-esteem. Self-imposed dietary restrictions are excessive, and sufferers often refuse to admit or fully acknowledge their weight problem (when severely underweight): The seriousness of weight loss and its health implications are usually minimised, if not denied (APA, 2013).

The diagnosis of AN distinguishes two subtypes, which describe two distinct behavioural patterns. The 'Restrictive Anorexia Nervosa type' (RAN) describes individuals who maintain their low body weight purely by excessive restriction of food intake and possibly, by excessive exercise. The 'Binge-eating/Purging type' (ANBP) describes individuals who usually excessively restrict their food intake too, however they also regularly engage in bizarre compensatory behaviours such as self-induced vomiting or the misuse of laxatives, diuretics or enemas (Alton, 2005; APA, 2013; Sowar, 2015).

The formal diagnostic criteria per the APA (2013) for AN are stipulated in the DSM-5 manual, and include the following (p.338):

- 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 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 current subtype**

**Restricting Type (RAN):** During the last three months, the individual has not engaged in recurrent episodes of binge eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). Weight loss is achieved primarily through dieting, fasting, and/or excessive exercise.

**Binge-Eating/Purging Type (ANBP):** During the last three 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 current severity**

The minimum level of severity is based, for adults, on current body mass index (BMI), or, for children and adolescents, on BMI percentile.

**Mild:** BMI  $\geq$  17 kg/m<sup>2</sup>

**Moderate:** BMI 16 – 16.99 kg/m<sup>2</sup>

**Severe:** BMI 15 – 15.99 kg/m<sup>2</sup>

**Extreme:** BMI < 15 kg/m<sup>2</sup>

### **2.1.2 Diagnosing Bulimia Nervosa (BN)**

Bulimia Nervosa ('bous' - ox, 'limous' - hunger) as a diagnostic entity focuses on regular binge-purge cycles whereby the individual engages in discrete periods of severe overeating (i.e. a 'binge'), usually followed by attempts to 'undo' the consequences of the bingeing episode, through compensatory behaviours such as self-induced vomiting, misuse of laxatives, enemas, diuretics, severe energy-intake restriction, and/or excessive exercising. There can be considerable individual variations in the degree of bingeing; however, the typical nature of the overeating involves the consumption of an amount of food that would be considered immensely excessive in normal circumstances. The sufferer's subjective experience is dominated by a sense of a lack of control over the bingeing episode (APA, 2013; Eating disorder diagnosis, n.d.; Sowar, 2015).

Similarly to AN, profound concerns about weight and shape are also characteristic of those suffering from BN. Self-evaluation is centred on the individual's perception of their own body. Two subtypes of BN are also present: The 'purging type' describes individuals who regularly compensate for binge eating through the use of self-induced vomiting, or by using laxatives, diuretics, or enemas. The 'non-purging type' describes individuals who compensate through excessive exercising or dietary fasting (Alton, 2005; APA, 2013; Eating disorder diagnosis, n.d.; Jordan et al., 2014).

The formal diagnostic criteria per the APA (2013) for BN are stipulated in the DSM-5 manual, and include the following (p.388):

- A. Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:
  - 1. Eating, in a discrete period of time (e.g., within any two-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time under similar circumstances.
  - 2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- B. Recurrent inappropriate compensatory behaviours in order to prevent weight gain such as self-induced vomiting; misuse of laxatives, diuretics, or other medications, fasting; or excessive exercise.
- C. The binge eating and inappropriate compensatory behaviours both occur, on average, at least once per week for three months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

**Specify current severity**

The minimum level of severity is based on the frequency of inappropriate compensatory behaviours. The level of severity may be increased to reflect other symptoms and the degree of functional disability.

**Mild:** An average of 1-3 episodes of inappropriate compensatory behaviours per week.

**Moderate:** An average of 4-7 episodes of inappropriate compensatory behaviours per week.

**Severe:** An average of 8-13 episodes of inappropriate compensatory behaviours per week.

**Extreme:** An average of 14 or more episodes of inappropriate compensatory behaviours per week.

**2.1.3 Diagnosing Other Specified Feeding or Eating Disorder (Previously ‘Eating Disorders Not Otherwise Specified – EDNOS’)**

There are numerous individual variations of disordered eating that do not meet the specific diagnostic criteria or thresholds for AN or BN exclusively, but nevertheless are eating disorders causing significant impairment, and requiring treatment. Individuals with disordered eating behaviours that resemble AN or BN, but whose eating behaviours do not meet one or more essential diagnostic criteria may be diagnosed with Other Specified Feeding or Eating Disorders.

In short, even though they are considered as sub-threshold for diagnosis with AN or BN, these individuals still require help (APA, 2013). Examples of presentations that can be specified as 'other specified' designations of eating disorders include individuals who regularly purge, but do not binge eat; or individuals who meet criteria for BN, but binge-eat less than twice weekly.

The formal diagnostic criteria per the APA (2013) for Other Specified Feeding or Eating Disorders are stipulated in the DSM-5 manual, and include the following (p.353):

**Atypical, mixed, or below-threshold presentations:**

**A. Atypical anorexia nervosa**

All of the criteria for Anorexia Nervosa are met, except that, despite significant weight loss, the individual's weight is within or above the normal range.

**B. Bulimia nervosa (of low frequency and/or limited duration)**

All of the criteria for Bulimia Nervosa are met, except that the binge eating and inappropriate compensatory behaviours occur, on average, less than once a week and/or for less than three months.

**C. Binge-eating disorder (of low frequency and/or limited duration)**

All of the criteria for Binge-Eating Disorder are met, except that the binge eating occurs, on average, less than once a week and/or for fewer than three months.

**D. Purging disorder**

Recurrent purging behaviour to influence weight or shape (e.g. self-induced vomiting; misuse of laxatives, diuretics, or other medications) in the absence of binge eating.

#### **2.1.4 Making a differential diagnosis**

Eating disorders are often associated with high rates of co-morbid existing psychiatric disorders, particularly mood disorders and anxiety disorders (Goh, 2015; Keski-Rahkonen & Mustelin, 2016). Eating disorders have also been linked as part of an 'addictive spectrum', which includes alcoholism, smoking and gambling tendencies (Alton, 2005; Dunne, Freeney & Schipperheijn, 1991).

Eating disorders may have associated co-morbid psychiatric conditions such as depression, generalised anxiety disorder, substance abuse, specific phobias, panic disorder and post-traumatic stress disorder (Keski-Rahkonen & Mustelin, 2016; The British Psychological Society & The Royal College of Psychiatrists, 2004). Research in France reported that 75 - 85% and 80 - 90% of patients presenting with AN and BN respectively, had at least one mood disorder episode during their lifetime (Keski-Rahkonen & Mustelin, 2016). Depressive episodes were the most common amongst these mood disorders. Halmi et al. (2000) state that AN sufferers will experience an estimated 50 - 75% co-morbid prevalence of dysthymia, whilst also having a possible 25% lifetime prevalence of co-morbid obsessive-compulsive disorder (OCD).

Other research has estimated that almost two thirds of cases would struggle with co-morbid anxiety disorders at some stage in their lives, with OCD and social phobia being the most common (Goh, 2015; Young, Rhodes, Touyz & Hay, 2013). A Danish registry-based study highlight that anxiety disorders, particularly OCD, generalized anxiety disorder and social phobia in fact increased the risk of subsequent AN development (Keski-Rahkonen & Mustelin, 2016). Specific to BN, there are increased rates of alcohol- and drug abuses identified, with most those cases

presenting with underlying personality disturbances as well. Approximately one third AN and BN cases present with a history of childhood neglect and/or abuse (Alton, 2005; Department of Health, Social Services & Public Safety, 2002; Goh, 2015).

Personality disorders are also common among individuals suffering from eating disorders. MacGregor and Lamborn (2014) emphasise that personality characteristics can play an integral part in both the aetiology, course, as well as the outcome of eating disorders. Evidence has highlighted how BN sufferers present with increased incidences of borderline personality traits, including impulsivity and sensation seeking (Atiye, Miettunen, & Raevuori, 2014; MacGregor & Lamborn, 2014; von Lojewski & Abraham, 2014). In a review by Grylli, Hafferl-Gattermayer, Wagner and Schober (2005) on personality traits like temperament and character, studies consistently indicated that individuals with AN were characterised with high harm avoidance, high persistence, low levels of novelty seeking, as well as low self-directedness. In a review of BN and personality, Lobera (2011) adds to this personality traits such as introversion, conformity, perfectionism, rigidity and obsessive-compulsive features. Grylli et al. (2005) found those with BN were characterised with high levels of novelty seeking, high harm avoidance, high reward dependence, and low self-directedness. Again, Lobera (2011) adds personality traits such as perfectionism, shyness and compliance and mentions that research has often found BN patients to be extroverted, histrionic and emotionally unstable as the picture for BN is less clear and mixed.

If one zooms in on the individual symptoms, the following differential diagnoses may be considered with presenting ED syndromes/symptoms (Alton, 2005; Department of

Health, Social Services & Public Safety, 2002; Eating disorders: Criteria for organizing resources and activities, n.d.; Goh, 2015):

- Psychiatric Disorders
  - Anxiety disorders that may result in an increase in appetite or anorexia nervosa.
  - Phobias about certain foods, about either swallowing whole or choking.
  - Obsessive-compulsive disorder, when the rituals/compulsions focus on foods.
  - Conversion hysteria, with oesophageal spasms and difficulty swallowing.
  - Paranoid disorders, not eating because of mistrust or fear that food may be poisoned.
  - Melancholy, loss of appetite.
  - Atypical depression, accompanied by an increase in appetite and sleep (i.e. seasonal affective disorder).
  - Dymorphophobia focusing only on the individual's physical appearance.
  - Psychosomatic digestive disorder: Nausea and vomiting in situations of tension and/or stress.
  - Monosymptomatic psychosis.
  - Impulse control disorder, fundamentally in bulimia nervosa.
- Organic Disorders
  - Brain tumour.
  - Hypopituitarism.
  - Gastrointestinal problems.
    - Chronic inflammatory illness (Crohn's disease, ulcerative colitis).
    - Achalasia.
    - Celiac disease
  - Endocrine pathology.
    - Diabetes mellitus.

- Hyperthyroidism.
- Addison disease.
- Any type of cancer.
- Lupus erythematosus.
- Drug abuse.

## **2.2 The consequences of eating disorders**

Eating disorders frequently follow a chronic development and course, from which recovery is difficult (Noordenbos, 2013; The British Psychological Society & The Royal College of Psychiatrists, 2004). Based upon this lengthy and subtle development, it may be assumed that sufferers in many instances do not even realise the real full extent of its effects upon their lives. Whatever the specific ED diagnosis, its consequences is profound and highly destructive to the victims: The physical-, cognitive-, emotional-, and familial impacts of these disorders may result in the exclusion of sufferers from all areas of life (Alton, 2005; Eating disorders: Criteria for organizing resources and activities, n.d.). When the disorder has taken significant precedence, there may come a time when the sufferer plunges into total social isolation, without friends or relations to turn to. The illness halts the individual's personal development and fills their existence with feelings of emptiness (Eating disorders: Criteria for organizing resources and activities, n.d.; Noordenbos, 2013).

When analysing sufferers' perceptions of their own self-induced starvation, Nordbo, Espeset, Gulliksen, Skårderud and Holte (2006) found that they interpreted it as psychologically meaningful - appreciating their symptoms and personal experience significantly. This meaning is expressed in terms of different psychological constructs: Self-starvation provides a sense of stability, security and predictability; it

represents a way of avoiding negative emotions and experiences such as the struggle to live up to their own and others' expectations; it is an expression of inner strength and invulnerability; receiving compliments and praise for achievement allows them to feel worthy, and increases their self-confidence; it helps develop a sense of having a separate and distinct identity and sense of self; it is a means of eliciting care from others; and it is a means of communicating difficulties and a wish to disappear because life seems unbearable.

When focussing specifically on the relationship between the sense of self and AN, Williams, King and Fox's (2016) research highlights that AN can become something by which an individual defines themselves. A sense of self-worth, companionship, comfort, pride and identity can all be provided by the ED, thereby becoming the person's sense of self. The participants in Williams et al.'s (2016) research report a process where their sense of self was *taken over* by AN to the point that it was shared with the ED: The participants feared being no one without AN and that they were unable to let go of the disorder, appreciating AN's ability to protect the self.

On the biological front, the impact upon the sufferer's life due to self-induced starvation, binge eating, or purging of food can cause alterations in brain functioning, impairment in cognitive functioning, poor judgement, emotional instability, restriction in daily life activities, as well as role impairment (Fankhauser, n.d.; Mehler & Brown, 2015). The most significant physical long-term complication for AN sufferers is the increased risk of osteoporosis associated with amenorrhea (Freund, Walsh & Wheat, 2000; Mehler & Brown, 2015). Although some of the complications are reversible when normal eating patterns and body weight returned, if not treated timely, the

prolonged combined effects may lead to even more severe complications, sometimes with fatal consequences (Kaye & Strober, 1999; Mehler & Brown, 2015).

Most individuals with eating disorders also have difficulties in their interpersonal events, circumstances, and relationships. The impact of an ED on home and family life is often significant and family members may carry a heavy burden over a long period of time due to the chronic nature and significant negative impact of the disorder. In general, these interpersonal problems may lessen as the disorder improves (Fairburn, 2008; Noordenbos, 2013).

Due to the impact of the ED, there may be a loss of employment or employability. Although some individuals manage to retain their employment status despite suffering significant impact, many tend towards a state of permanent invalidism. In chronic cases especially, a dependence on family and/or welfare benefits develop. Noordenbos (2013) reports on how eating disorders become a *trap* or *prison* from which sufferers cannot escape. The capacity to develop psychological and financial independence becomes severely impaired, thus further limiting their possibility for integration into the outside world (Eating disorders: Criteria for organizing resources and activities, n.d.; Noordenbos, 2013).

Following is a list that further details many of the negative impacts sufferers of eating disorders may experience on the physiological-, emotional-, cognitive-, behavioural-, and social spheres. It comprehensively illustrates the potential destructive consequences of these disorders (Alton, 2005; Claude-Pierre, 1999; *Consequences*

*of eating disorders*, n.d.; Eating disorders: Criteria for organizing resources and activities, n.d.; Eating disorders coalition, 2009; Noordenbos, 2013; Szabo, 2009):

- General
  - Sad and haggard look.
- Physiological functioning
  - Cardiovascular complications
    - Hypotension.
    - Bradycardia (low pulse rate).
    - Heart muscle atrophy.
    - Heart arrhythmia (irregular heart beat), and/or Congestive heart failure.
    - Reduction in heart size.
    - Altered cardiovascular response to exercise.
    - Pericardial effusion.
    - Superior mesenteric artery syndrome.
    - Mitral valve prolapse.
    - Hypotension (low blood pressure).
    - Loss of subcutaneous cellular tissue, sometimes accompanied by increased pigmentation, carotinaemia, acrocyanosis with cold hands and feet.
    - Cold intolerance.
  - Neurological complications
    - Cerebral atrophy (CAT, RNN).
    - Abnormal Electroencephalogram (EEG).
    - Peripheral neuritis.
    - Convulsions.
    - Altered ANS function.

- Loss of brain volume.
- Slowed reflexes, paresthesia.
- Haematological complications
  - Anaemia: normochromic anaemia, normocytic anaemia, or iron deficiency anaemia.
  - Leukopenia, relative lymphocytosis, thrombocytopenia.
  - Hypocellular bone marrow.
  - Reduction in plasma proteins.
  - Reduction in ESR.
- Renal complications
  - Pre-renal azotemia.
  - Chronic or acute kidney stones and kidney failure.
  - Electrolyte- and mineral imbalances/alterations (hypokalaemia, hypomagnesemia, hypocalcemia and hypophosphatemia), as well as Edema (tissue swelling from water retention due to electrolyte imbalances).
  - Hypothermia, dehydration.
- Endocrinological complications
  - Delayed growth and puberty (adolescents).
  - Reduction in gonadotropins, oestrogens and testosterone.
  - Euthyroid syndrome.
  - Increased cortisol.
  - Increased growth hormone.
  - Disturbed liver (and liver failure) and thyroid functioning.
- Muscular/Skeletal complications
  - Cramps, tetanus, muscular weakness, myopathy.
  - Osteopenia, stress fractures.

- Gastroenterological complications
  - Inflammation of the salivary glands, dental cavities and tooth enamel erosion (with vomiting), lesions to palate.
  - Irritation and ulcerative lesions in the throat, oesophagus and stomach.
  - Delayed gastric emptying, bowel irritation, acute constipation and intestinal obstruction.
  - Long-term disruptions of normal bowel functioning due to laxative abuse, Cathartic (non-functioning) colon, intestinal rupture from excessive use of laxatives, as well as laxative dependence.
  - Oesophagitis, gastroesophageal reflux.
  - Hypoglycaemia and raised hepatic enzyme levels.
- Immunological complications
  - Bacterial infection (staphylococcus, with lung infections and tuberculosis).
- Dermatological complications
  - Acrocyanosis.
  - Dry, rough and fragile hair (as well as extensive hair loss), and dry cracked skin.
  - Lanugo (development of excessively fine hair on the face, arms and legs).
  - Russell's sign (calluses on the knuckles of the hands).
  - Oedemas.
- Gynaecological complications
  - Amenorrhoea (cessation of regular menstruation cycles).
  - Mammary atrophy, atrophic vaginitis because of decreased oestrogens

- Metabolic complications
  - Osteoporosis (i.e. inadequate bone calcium).
  - Hypercholesterolemia and hypercarotenemia.
- Emotional functioning
  - Diminished self-concept.
  - Low self-esteem and poor self-image.
  - Changes of personality.
  - Depressive characteristics
    - Negative overall view of the self and the world around them.
    - Depressed mood.
    - General irritation and quick to anger.
    - Emotional instability (e.g. crying, quick-to-anger).
    - High emotions, tearful, uptight, overly sensitive.
    - Suicidal thoughts.
  - Anxiety
    - Rarely relaxed or comfortable.
    - Generalized phobia or social phobia may appear.
- Cognitive functioning
  - Overall decreased work productivity (capacity and speed).
  - Decreased concentration and attention.
  - Difficulty concentrating and lapses of memory.
  - Obsessive thought patterns (e.g. excessive concern over the possibility of becoming fat).
  - Impoverishment of imagination and creativity.
  - Cognitive errors in thinking
    - Constant mistaken thoughts/beliefs about food, weight and figure.
    - Over-estimation of weight and size.
    - Confusion of feelings of satiety/fullness.

- Errors of thought regarding generalizations, dichotomies, etc.
- Most frequent errors of thinking
  - Polarization
    - “If I am not very thin, I will become very fat.”*
  - Selective abstraction
    - “If people tell me I look better because I’ve put on weight, I must be very fat.”*
  - Attribution of thoughts
    - “If people look at me, it must be because I’m fat.”*
  - Personalization
    - “After eating, I think that everyone is looking at me and can see how much weight I have put on.”*
  - Overgeneralization
    - “All fats are fattening.”*
    - “As I had a bad time at the party, I will always have a bad time at all parties.”*
  - Catastrophic thinking
    - “I haven’t kept to my diet,... I never do anything right.”*
  - Magical thinking
    - “Being slim and skinny means being happy and successful.”*
- Mistaken thoughts and beliefs about a number of areas
  - Thoughts of control/lack of control
    - “I have to control everything I eat, otherwise I will lose control.”*
  - Thoughts about food and weight
    - “Food is fattening.”*

*"There are good foods and bad foods."*

*"If I put on weight, even if it's just a little, I won't ever be able to stop getting fatter."*

- Thoughts about body image

*"My body is not the way I want it to be."*

*"I have to attain the figure I want."*

- Thoughts marked by low self-esteem

*"If I keep my weight how I want it to be, I will feel sure enough of myself to be able to take important decisions in life."*

*"If I am able to change my figure, I will be able to have confidence in myself again."*

- Behavioural functioning
  - Rigid, restricted eating patterns (e.g. no fat or high energy-foods allowed, strict adherence to a certain number of kilojoules per day, or often vegetarianism).
  - Presence of binges.
  - Purging behaviour (i.e. vomiting, laxatives and diuretics).
  - Alterations in the way of eating and rejection of types of foods.
  - Obsessive behaviour and performance of rituals.
  - Impulsive behaviour (e.g. lying, hiding things)
  - Self-injury behaviours.
  - Food rituals (e.g. cutting food into small pieces, or playing with their food, or not allowing certain foods to touch each other).
  - Excessive, compulsive exercise, even in light of physical illness or injury.
  - Excessive, compulsive working or studying.
  - Checking weight frequently (often many times a day).
  - Wearing sweaters and baggy clothes to hide thinness.

- Increased consumption of coffee, tea, and spices
- Food preoccupation
- Collection of recipes, cookbooks, and menus
- Social functioning
  - Social withdrawal.
  - Isolation from family and social context.
  - Difficulties with initiating and maintaining intimate relationships.
  - Obsessive, unhealthy comparisons to others.
  - Avoidance of social situations involving food.
  - Avoidance of eating in public.

### **2.3 The short history of eating disorders**

Eating disorder related problems have been prevalent in history. For example, in the 1st century the ancient Romans detested being seen as *fat*, and set aside so-called 'vomitoriums' where citizens who had stuffed themselves with enormous amounts of food, could go and purge their food to find relief and *not become fat* (Prah, 2006).

Refusing to ingest food in the Middle Ages was seen by many as a method to become closer to a god. For example, during the 12<sup>th</sup> and 13<sup>th</sup> centuries, the dominant interpretations of self-starvation were founded within religion, especially in Western Christianity. Devout Christians refused food as part of their religious practices and women who starved themselves were considered as Saints. One such example describes food abstinence as a religious ascetic ideal, exemplified by miraculous maidens (i.e. women who starved themselves) and fasting saints, such as Saint Catherine of Sienna who lived in the 14<sup>th</sup> century. These women were highly esteemed, and the origins of 'holy anorexia' were thought to be supernatural. In the

case of Saint Catherine, her behaviour was interpreted as a response to the social structural factors and the patriarchal system of medieval Catholicism (Reda, 2001). She died at age 33 of starvation after having survived on eating only bread, raw herbs and water since age 25. However, as time passed these views on 'holy anorexia' changed and by the late Middle Ages women who fasted excessively were thought to be possessed by evil spirits, rather than viewed as fasting saints (Prah, 2006).

During the past few centuries, historians have documented abnormal food abstinences as characterised in AN. However, there exists some uncertainty over the exact origins of when and how AN as a diagnosis realised. Recognising that certain types of food abstinence were representative of a medical problem became evident somewhere in the late 17<sup>th</sup> century. Many believe that AN was first identified as a medical syndrome in Europe in 1689 by English physician Richard Morton (Buchan & Gregory, 1984; Orbach, 1993; Russell, 1995; Tancredi, 2013). The medicalisation and understanding of AN culminated in Morton's textbook *Phthisiologia: or, A Treatise of Consumptions*. In it he described two cases of a 'wasting' disease of 'nervous origins' ('nervous consumption') that could be considered the first clear medical description of AN in both men and women. One such case described an adolescent girl with 'nervous consumption' caused by 'sadness and anxious cares'. Morton managed to rule out any physical cause for the disturbance and underscored 'nervous causes' for the observed weight loss (Gordon, 2000). However, Kaye and Strober (1999) believe that AN was only formally identified in the 19th century by Sir William Gull, who first named self-starvation as 'anorexia nervosa'. Gull was the first to shift attention from the medical

to the psychiatric domain after he could not find an organic cause for the weight loss he witnessed in female patients (Wilson, 2004).

At around the same time, the French psychiatrist Charles Lasegue reported the loss of appetite as a form of 'hysteria linked to hypochondriasis' and emphasised an array of encompassing emotional problems (The history of classification of eating disorders, n.d.). His theory emphasised the role of the family, as he believed that AN was a disease that could only develop in comfortable homes with an abundance of food. He believed women who interpreted their lives as 'suffocating' and could not display emotional distress, would protest by not eating (Engel, Reiss & Dombek, 2007).

In the 1920's and 1930's, the focus on AN nearly disappeared from psychiatric discussions (Cowley, Gibson & Sewell, 2008). Eating disorders were thought to be physical diseases due to medical conditions. Researchers attributed these disorders to hormone imbalances and endocrine deficiencies. Simmond's disease, named after its discoverer Morris Simmonds in 1914, which identified a lack of pituitary gland functioning, dominated popular conceptualisations of ED aetiology of the time. Physicians even thought at one time that AN may be a form of tuberculosis (Engel et al., 2007).

It wasn't until the 1930s that psychiatrists' and physicians' focus became re-engaged as they began to understand that the causes of eating disorders were in part psychiatric, and part emotional - rather than wholly physical. The land-mark case study of Ellen West from 1930 to 1933 provided further support for this shift in

thinking. This paper provided West's perspective, describing the candidate's desperate obsession with food and thinness, which eventually led to her committing suicide (Engel et al., 2007).

In the 1970's, *The Golden Cage* was one of the first books to suggest that eating disorders were becoming a serious problem (Engel et al., 2007). A broader interpretive framework for eating disorders would come in that era with the publication *Eating Disorders* by Hilde Bruch (1973). In Bruch's work (1973), she concluded that patients had delusional proportions of body image and body concepts, a disturbance in their ability to recognise nutritional needs, and a paralysing sense of ineffectiveness which pervades all thinking and activities (Volger, as cited in Cowley et al., 2008). These were key contributions in starting to identify and understand the specific aspects of eating disorders.

The occurrences of AN continued to increase rapidly into the next decade, with some identifying it as '*the disorder of the 80's*'. This notion contributed to suggestions that diseases, particularly psychiatric disorders, could possibly be directly linked to specific cultural contexts. By the mid-1980's, college campuses in the United States of America were instituting counselling or support systems for those suffering from the disorder (Volger, as cited in Cowley, et al., 2008). The release of a feature film named *The Best Little Girl in the World* in 1985 offered the public a glimpse into the life of someone living with an ED. During that same year, public awareness for eating disorders reached a peak when the high-profile pop singer and composer Karen Carpenter died from heart failure brought on by her AN (Engel et al., 2007).

The 1990's saw an increase in the momentum of research and development into eating disorders. In 1992, binge eating disorder (BED) was first recognised as a formal diagnosis. Prior to that, when BED was officially 'introduced' at the International Eating Disorders Conference, individuals with these types of behavioural problems were merely labelled as emotional overeaters, compulsive overeaters, or food addicts (Engel et al., 2007). In that same year, the National Collegiate Athletic Association in the USA also revealed that eating disorders had taken significant precedence in most men's and women's college sports. The 1990's was also the era in which researchers' thinking shifted to a consensus that genetics and brain chemistry could play a significantly larger role than societal pressures in determining whether someone develops an ED (Prah, 2006).

#### **2.4 Modern conceptions of eating disorders**

Aetiologically, eating disorders are elusive. Identifying a single cause for eating disorders is almost impossible, as the disorder is complex in nature and presentation, with multiple influencing factors. There are many societal-, familial-, as well as individual risk factors like identify issues, self-image and self-esteem problems, as well as experiencing traumatic events that may contribute to its development.

In psychological terms, an ED may signal deep emotional difficulties for the sufferer. The underlying factors are multifaceted ranging from genetics to media influences (Culbert, Racine & Klump, 2015), and understanding these aetiological components fully may be difficult and complex. The development thereof in an individual is generally considered to be a combination of variables, as opposed to one identifiable

contributory factor: Whether a person develops an ED depends on individual vulnerability, exposure to risk factors and on the implementation of protective factors. Following the onset of the disorder, a further combination of risk and protective factors may act to maintain the condition and also influence whether the sufferer recovers or not (Noordenbos, 2013).

Certain risk factors have been considered important in the onset of eating disorders. The following list includes some of the more common risk factors that could possibly contribute to developing an ED, but is by no means exhaustive:

- Gender, ethnicity and specified population groups.
  - Female gender, particularly adolescent or young adult women (Alton, 2005; Culbert et al., 2015; Eating disorder risk factors, n.d.; Keski-Rahkonen & Mustelin, 2016; National Eating Disorders Collaboration, 2012).
  - Gender and gender differences in interaction between social-, developmental- and biological factors (Szabo, 2009).
  - Certain ethnic groups such as Asians, Native Americans, and African Americans seem less likely to develop eating disorders than other ethnic groups: Caucasian women seem more prone to the disorder (Eating disorder risk factors, n.d.; National Eating Disorders Collaboration, 2012).
  - High academic achievers, who themselves are goal oriented, or live in goal-oriented families (Anorexia: Overview, n.d.; Keski-Rahkonen & Mustelin, 2016).
  - Certain vulnerable populations where thinness, or particular body types and composition may be somewhat attributed to performance in that professional field, for example ballet dancers, gymnasts, elite athletes and

fashion models (Alton, 2005; Eating disorders: Criteria for organizing resources and activities, n.d.; Szabo, 2009).

- Weight and shape – orientation and efforts to control
  - Excessive focus on shape and weight, as well as focussing on Body Mass Index (BMI) (Eating disorder risk factors, n.d.; Keski-Rahkonen & Mustelin, 2016; National Eating Disorders Collaboration, 2012).
  - Adolescent dieting, or a history of dieting at a young age, which increases the chances of developing an eating pathology by eight-fold (Anorexia: Overview, n.d.; Sogar, 2015; Patton, Carlin, Shao, & Hibbert, as cited in Szabo, 2009, p.35;).
  - Acceptance of western society's general attitudes and aspirations towards thinness, which equates success to the concept of thinness and beauty, as well as promoting prejudice against people who are overweight (Alton, 2005; Anorexia: Overview, n.d.; Kuba & Harris, 2000; Szabo, 2009).
- Co-morbid psychiatric conditions
  - Depression, anxiety, or substance abuse may increase the risk of developing an eating disorder (Eating disorder risk factors, n.d.; National Eating Disorders Collaboration, 2012). 84 % of AN patients have a lifetime prevalence of another psychiatric disorder, with 69% of patients suffering from major depression (Eating Disorders, n.d.; Goh, 2015).
  - Childhood anxiety problems (Alton, 2005; Anorexia: Overview, n.d.).
  - Trauma exposure and trauma-related symptoms are relatively common among ED patients. Eating disorder sufferers are relatively likely to have been abused or neglected as children, or to have been significantly victimised somewhere in their lives (Alton, 2005; Briere & Scott, 2007).
- Individual risk factors
  - Mental- and physical torment, bullying and neglect (Noordenbos, 2013; Patterson, 2000).

- Life traumas experienced - specifically sexual abuses (Bauman, 2008; Eating disorder risk factors, n.d.; Eating Disorders, n.d.; Goh, 2015; Salafia, Jones, Haugen & Schaefer, 2015; Szabo, 2009).
- Individual psychological factors, focusing specifically on the lack of self-esteem and certain styles of personality (Szabo, 2009), as well as the fear of becoming independent (Alton, 2005; Eating disorders: Criteria for organizing resources and activities, n.d.; Noordenbos, 2013).
- Certain generalised personality traits, such as perfectionism or perfectionist attitudes which encourage negative self-evaluation are identified in eating disorders populations (Anorexia: Overview, n.d.; Bauman, 2008; Culbert, et al., 2015; Eating Disorders, n.d.; Eating disorders: Criteria for organizing resources and activities, n.d.; Kim, 2011; Lobera, 2011;).
- Having eating-, digestive- and gastrointestinal problems during early childhood (Anorexia: Overview, n.d.; Eating disorder risk factors, n.d.).
- Having a negative self-image and a high level of negative feelings towards the self in general (Anorexia: Overview, n.d.; Culbert, et al., 2015).
- Stressful events and significant life changes. Examples include the physical and emotional changes associated with puberty, moving house, changing employment (Alton, 2005; Anorexia: Overview, n.d.; Culbert, et al., 2015; Eating disorders: Criteria for organizing resources and activities, n.d.).
- Failure of individuation in adolescence and failure to develop mature autonomy. Developing body shape misperception and body shape disparagement. Independence/autonomy struggles (Alton, 2005).

- Familial risk factors
  - Having a mother or father with psychiatric disturbances, particularly an ED, depression, bipolar disorder, alcoholism (or any other addiction-related problems), psycho-sexual disturbances, obsessive-compulsive disorders in mothers, and personality disorders (Anorexia: Overview, n.d.; Halmi et al., 2000; Keski-Rahkonen & Mustelin, 2016; Noordenbos, 2013).
  - Negative and destructive styles of interaction within the family, specifically elements of inappropriate parental over-involvement and ineffective parental problem-solving abilities (Szabo, 2009). Other parental problem traits include low conflict resolution, lack of communication, over-protectiveness, rigidity, as well as a mixture of family roles (Eating disorders: Criteria for organizing resources and activities, n.d.; Salafia et al., 2015).
  - Having parents with excessive concerns about weight and weight loss (Alton, 2005; Anorexia: Overview, n.d.; Eating disorders: Criteria for organizing resources and activities, n.d. Keski-Rahkonen & Mustelin, 2016;).
  - Parents who themselves are very focused on achievement and performance in general. These include parents with high education who have high expectations of their children (Anorexia: Overview, n.d.; Keski-Rahkonen & Mustelin, 2016).
  - Severe prenatal maternal stress was also found to be influential in the development of eating disorders (Keski-Rahkonen & Mustelin, 2016).
- Biological factors and the genetic basis for the disorder
  - Studies conducted across different populations found moderate to high heritability of AN, BN, BED as well as disordered eating symptoms (Alton, 2005; Eating disorder risk factors, n.d.; Culbert et al., 2015; Szabo, 2009).

- Trans-generational ED and twin studies have previously established that there is probably a five to six times greater chance of developing an ED, if an immediate relative also has an ED (General Information, n.d.). Among female siblings of anorexia patients, 6 - 10% also have the disorder, as compared to 1 - 2% in the general population (Eating Disorders, n.d.). Twin studies indicate heritability estimates of 50 - 90% in monozygotic (MZ) twins, as when compared to dizygotic (DZ) twins (Kaye & Strober, 1999).
- Infections, both viral and non-viral (Szabo, 2009).
- Some gene candidates have been found to be associated with AN and BN specifically, although this research remains relatively inconclusive in terms of genetic effects (Eating disorder risk factors, n.d.; Noordenbos, 2013).
- Certain brain chemicals, such as serotonin, may be abnormal in ED patients (Alton, 2005; Culbert et al., 2015; Eating disorder risk factors, n.d.). Brambilla and Monteleone (2003) observe that during remission, the persistent disturbance of serotonin, noradrenalin and dopamine systems are indicative of pathogenic hormonal dysfunctions.
- Hypothalamic dysfunction is associated with the development of eating disorders:
  - Anorexia Nervosa has been linked with structural lesions of the hypothalamus, temporal lobe hypo-perfusion, a disordered 5-HT system possibly due to increased 5-HT activity (5-HT abnormalities persist even after weight restoration, as well as cholecystokinin (CCK) which may cause dysregulation of satiety (Eating Disorders, n.d.).
  - Bulimia Nervosa has been linked to disordered 5-HT system possibly due to decreased 5-HT activity, as well as dopamine

abnormalities possibly due to reduced CSF HVA, and also Cholecystokinin (CCK) implicated in dysregulation of appetite (Eating Disorders, n.d.).

- Socio-cultural risk factors
  - The contribution from the mass media and its strong focus on external appearances. This also contributes to the development of a cult of thinness which stresses the 'ideal of slimness' - whereby individuals aspire to 'copy' the appearance of fashion models and celebrities. The cult of thinness is the likeliest cause for changes in incidence rates, the form, and the psychological content of eating disorders during the last decades of the 20<sup>th</sup> century (Browne, 1993; Dietz, 1990; Eating disorders: Criteria for organizing resources and activities, n.d.; Salafia et al., 2015; Szabo, 2009).
  - Socio-economic status and its association with eating disorders in upper class populations (Browne, 1993), although this viewpoint has been contested (Szabo, 2009).

When considering that the above list is not even exhaustive, the aetiological explanations and modern conceptions of eating pathology certainly encapsulates almost all contributing factors that make up the sufferer's life: Genetic factors; past experiences and historical factors (including adverse life events and difficulties); personality factors; familial factors and socio-cultural factors. This makes it difficult and confusing to assist ED clients in terms of understanding their problem's exact origin.

### **2.4.1 Prevalence rates**

Accurate prevalence rates for those suffering from eating disorders are difficult to establish. Proper diagnoses may be hindered by a general lack of knowledge from medical professionals about symptom presentation and diagnosing correctly, as well as active attempts by those afflicted by the disorder to conceal their symptoms. Many sufferers present with secretiveness and shame associated with their eating problems (National Eating Disorders Association Fact Sheet, 2008). They may fear they will be criticised for their problems, or be treated unsympathetically (NICE guidelines, 2004). In the case of BN patients, they generally look healthier and so the disorder can be harder to detect (Lobera, 2011; Freund et al., 2000). Considering the above-mentioned aspects, it is not surprising that ED sufferers generally go untreated for long periods before they are diagnosed accurately, or receive the necessary interventions.

There has been a steady increase in the incidences of eating disorders over the last 30 - 40 years (Keski-Rahkonen & Mustelin, 2016). In general, eating disorders are more prevalent in females. The majority (95%) of AN diagnoses are female (Carlat, Camargo & Herzog, as cited in Freund et al., 2000). Girls and women are 10 times more likely than boys and men to suffer from an ED (Eating Disorders, n.d.; Prevalence rates, n.d.). Although most individuals with eating disorders are female, there is an increase in the number of males who are being diagnosed with the disorder (The Royal College of Psychiatrists' Public Education Sub-Committee, 2013). Males constitute 5 - 10% of those diagnosed with eating disorders (Prevalence rates, n.d.), and they tend to be more common in those who are gay or bisexual.

In the USA, the APA estimates the 12-month prevalence of AN among young females at approximately 0.4%, with the 12-month prevalence of BN being higher at approximately 1% - 1.5% (APA, 2013). Overall, around 1% - 2% of adolescents/young adults in Great Britain develop some form of ED, with most cases being much more common among females. Majority cases develop between the age of 13 - 25 years, however, an increasing number of cases are now being reported among those aged less than 10 years (Department of Health, Social Services & Public Safety, 2002). Incidences for AN are around 3 - 7 new cases per 100 000 of the general population per year, increasing to approximately 20 - 40 new cases per 100 000 females aged 15 - 25 years per year for that country (incidence is 8 - 11 times higher among females than males). Prevalence is around 20 - 100 cases per 100 000 (0.02% - 0.1%) of the general population, increasing to 400 - 2000 per 100 000 (0.4% - 2.0%) females aged 13 - 25 years (peak age: 16 years old). Bulimia nervosa is much more common than AN. The incidence of BN is around 10 new cases per 100 000 of the general population per year, increasing to approximately 60 new cases per 100 000 females aged 15 - 25 years per year. Prevalence is around 1000 cases per 100 000 (1%) of the general population (Department of Health, Social Services & Public Safety, 2002).

In Australia, it is estimated that 2 - 3% of adolescent and adult females satisfied the DSM IV-TR diagnostic criteria for AN and BN. In New Zealand the estimated prevalence rate for young adult women meeting the criteria for AN was 0.5% - 3.7%, and 1.1% - 4.2% for individuals meeting the criteria for BN (Facts and findings for eating disorders, n.d.).

Regarding the South African context, no current up-to-date research data exists for prevalence rates (Szabo, 2009). Szabo's extensive work on the subject suggests that a significant increase in the prevalence of eating disorders amongst urban Black youth is very likely (Szabo, 2009). Despite this lack of data, there have however been studies documenting eating attitudes amongst South African women that may give some indication as to the extent of this problem in our society. These studies included adolescent and young adult females from all races, drawn from urban community settings. Measured by an internationally validated questionnaire, the data indicated that 20% of the sample of adolescents studied, and approximately 10% of the sample of young adult females, reported abnormal eating attitudes in four separate studies (Szabo, 2009).

Regarding ethnic differences in these disorders, AN and BN are less common among African American women than in White and Hispanic women (Fankhauser, n.d.).

#### **2.4.2 Mortality rates**

When considering fatalities, eating disorders may be judged as 'killers'. Statistics indicate that they are the most lethal of all recognised psychiatric disorders: 1 in 10 women with AN die of starvation, cardiac arrest, or suicide. This mortality rate is 12 times higher than the annual death rate from all other causes in women aged 15 - 24 years (Arcelus, Mitchell, Wales & Nielsen, 2011; Fankhauser, n.d.). A review of nearly fifty years of research confirms that AN has the highest mortality rate of any psychiatric disorder (Arcelus et al., 2011).

Casualties result from life-threatening complications of the disorder. Death occurs not only because of the severe adverse physical complications of starvation directly related to weight loss (i.e. 50% of cases - medical complications such as cardiac- or renal failure), but also because of a significantly elevated risk of suicide (50% of cases) (Arcelus et al., 2011; Berkman et al., 2006; Crow et al, 2009). It is recognised that such high mortality is, in part, likely to be exacerbated where service provision is inadequate (Crow et al., 2009; Department of Health, Social Services & Public Safety, 2002).

In the USA, cumulative lifetime mortality rates for eating disorders are estimated as high as 20%. Death can occur in BN after severe bingeing, with suicide attempts, depression, as well as severe anxiety also common during the active phase of the disorder (Arcelus et al., 2011; Eating Disorders Coalition, 2009). By other estimates, eating disorders lead to death in around 10% of cases (Anorexia: Overview, n.d., Fankhauser, n.d.), whilst another source claims mortality estimates for eating disorders specifically between 6% and 13% (Natenshon, n.d.). At present, there are no accurate statistics for mortality rates associated with eating disorders in South Africa.

The long-term fatalities associated with anorexia-related causes have been established at 6.6% for sufferers after a 10-year follow-up (Eckert, et al., as cited in Szabo, 2009) and up to 15% for sufferers after 20-year follow-up (Ratnasuriya, et al., as cited in Szabo, 2009). Statistics for AN in the United Kingdom estimate a mortality rate of 6% after a 10-year follow-up, and 13% - 20% after a 20-year follow-up (Howlett et al, as cited in The British Psychological Society & The Royal College of

Psychiatrists, 2004). Literature clearly and consistently identified that the risk of death is significantly higher with AN populations than would be expected in the BN populations (Arcelus et al., 2011; Berkman et al., 2006; Crow et al, 2009). However, Crow et al (2009) found that individuals with EDNOS, which is sometimes viewed as a less severe ED, had more elevated mortality rates than research had previously suggested.

Freund et al. (2000) concluded that mortality is increased in those with a late age of onset, long duration of the illness and severe weight loss. Arcelus et al (2011) added to this alcohol misuse as a strong predictor for mortality. Additionally, a United Kingdom study identified predictors of death as a body weight less than 35kg upon presentation, and more than one inpatient admission. Another study, which followed AN patients for approximately nine years, identified significant predictors for mortality correlating with greater severity of alcohol use disorders, greater severity of substance use disorders, lower levels of overall social adjustment, as well as lower Global Assessment of Functioning (GAF) scores (Kaustav & Basu, 2010). In BN populations, factors associated with increased mortality rates included both pre-morbid and paternal obesity (Alton, 2005; Freund et al., 2000).

Regarding associated suicide, a Danish tracked registry study from 1989 to 2006 revealed that attempts at suicide and deaths resulting from suicides were five times more common in ED patients, as compared to healthy peers (Keski-Rahkonen & Mustelin, 2016). A meta-analysis study also concluded that one in five of the patients presenting with AN who died, had committed suicide (Smink, Van Hoeken & Hoek,

2012). The increased risk of death by associated suicide is thus evident in cases of eating disorders.

Considering all these differing statistics, the overall lifetime mortality rates associated with eating disorders most likely range between 5% - 20% for all ED sufferers.

### **2.4.3 Onset, course and prognosis of eating disorders**

In the USA, AN is the third most common chronic illness among adolescents. Nearly half of all Americans personally know someone with an ED (Eating Disorders Coalition, 2009). The range of severity of eating disorders is wide, and response to treatment is highly variable. The onset, development and course of eating disorders are in most cases insidious and chronic in nature, and the recovery process itself is long and strenuous.

Regarding age of onset, there is a higher chance of individuals developing eating disorders during adolescence and early adulthood (Keel, Baxter, Heatherton, & Joiner, 2007; Mehler & Brown, 2015). Incidence rates peak between the ages of 15 and 19 years, and first episodes are rarely encountered after the age of 30 (Espie & Eisler, 2015; Volpe et al., 2016). In most cases (90%) the onset of the disorder in females lies within 5 years of reaching menarche (Alton, 2005; Volpe et al., 2016). Typically, BN initialises after an unsuccessful attempt to lose weight, or when the person discovers that purging, fasting and exercise can compensate for bingeing episodes (Freund et al., 2000; Noordenbos, 2013). Espie and Eisler (2015) highlight that physical consequences of starvation in adolescents will differ from that in

adulthood. This is because adolescents is a developmentally sensitive period, with the impact of the ED being potentially worse as physical growth is impaired.

Volpe et al. (2016) found no significant differences in their research between age of onset for AN or BN. However, in other research the onset of BN has been found to be later than that for AN, usually in late adolescence or early teens (Alton, 2005; Eating Disorders, n.d.). In the South African context, Van Tonder's (2004) research seems to support earlier data of a mean age of onset of 13.7 years for Black South African populations, presenting with BN symptoms such as uncontrollable eating episodes, attempts at vomiting in order to lose weight, as well as eating or drinking in secrecy.

According to Noordenbos (2013), the earlier the ED is diagnosed and treated effectively, the shorter the duration of the treatment. Experienced treatment programs have good success rates in restoring normal weight, however relapses are common. Most individuals who recover from an ED may continue to prefer a lower body weight and be preoccupied with food and energy intake to some extent. Of those who recover, 25% retain some abnormal eating habits in the long-term (Freund et al., 2000; Mehler & Brown, 2015). Weight management may be difficult at times and long-term treatment follow-up may be necessary to assist in maintaining a healthy body weight (Anorexia: Overview, n.d.; Mehler & Brown, 2015).

A recent literature review conducted by Keski-Rahkonen and Mustelin (2016) highlights how little information exists on the natural course of AN, especially outside clinical settings. They consider a Finnish community-based study which revealed

that 88% of women presenting with AN were weight restored by their mid-30's. Compared to their healthy peers, these women were just as likely to be successful in terms of employment and graduation from university, but were slightly less likely to have children. In another Finnish study, adolescents with atypical AN were more likely to recover than adolescents with typical AN. This suggests that the broadening of the diagnostic criteria for AN may further improve the prognosis thereof. However, in a German community-based study, 47% of adolescents that presented with AN, and 42% that presented with BN, continued to show symptoms of an ED at follow-up assessments conducted after 10 years (Keski-Rahkonen & Mustelin, 2016).

A study by Strober et al. (as cited in Espie & Eisler, 2015) followed a clinical sample of young people who had received specialist inpatient treatment for severe AN during adolescents. Follow-ups were conducted at 10 - 15 years. Results indicated that time to full recovery was between 57 and 79 months. The average duration of AN within the participant sample was measured at 3.4 years (Espie & Eisler, 2015).

Considering longitudinal outcomes, studies suggest that less than 50% of individuals with AN experience full recovery (defined as healthy weight gain and return of regular menses). Menses usually resumes within six months after attaining 90% of ideal body weight. Another 20% to 25% of these individuals show improvement, but 25% remain chronically ill with poor outcomes. About 33% of those who recover from AN will have a relapse (Arcelus et al., 2011; Fankhauser, n.d.). Bulimia nervosa populations tend to run a relapsing and remitting course, with about two-thirds recovering within five years from onset of illness (Department of Health, Social Services & Public Safety, 2002; Noordenbos, 2013). A review of long-term outcome

studies reported that 45% of individuals with BN fully recovered, 27% improved, and 23% had a chronic course. Crossing over to another ED during the course of AN was also reported in 10% to 32% of individuals (Arcelus et al., 2011; Fankhauser, n.d.). This finding did not prevent patients from relapsing into AN. Movement from an initial diagnosis of BN to AN is less common according to Arcelus et al (2011).

There seems to be a differing of opinion over the exact proportions of recovery rates for eating disorders. Some studies suggest that an estimated 40 - 45% of anorexics recover completely, 30% improve somewhat, and around 25% of cases remain chronically ill (Freund et al., 2000). Steinhausen (as cited in Noordenbos, 2013) analysed 119 studies and found that 45% of the AN patients had recovered well, 35% had improved and 20% had a chronic ED, while 5% had died. Other estimates approximate that figure of full recovery for AN at almost one-half of patients, with 33% improving somewhat and 20% remaining chronically ill (Department of Health, Social Services & Public Safety, 2002). Similarly to AN, it is estimated that 50% of BN individuals recover fully, 30% improve partially, and 20% continue to meet full criteria for BN in their lives (Steinhausen, as cited in Noordenbos, 2013). Overall, better outcomes are associated with BN, although high rates of relapse and psychosocial impairment is still prevalent (Eating Disorders, n.d.).

In cases with co-morbid psychiatric disorders, Goh (2015) highlights that ED patients with a BMI less than 16.5 were more likely to recover from their co-morbid psychiatric disorder when successful nutritional rehabilitation and weight restoration had been achieved. A Swedish community-based study examined the prognosis of AN with a lengthy follow-up investigation of 51 adolescents that were diagnosed with

AN. High rates of recovery were found at 18 years' follow-up. Only 3 of the participants met the criteria for AN diagnosis, and a further 3 presented with other eating disorders. Although the recovery rate for AN was high, 39% of the participants presented with a co-morbid psychiatric disorder (Espie & Eisler, 2015). Other studies also emphasised that where patients no longer had an ED on follow-up, they were significantly less likely to be depressed or suffer from an anxiety disorder (except for OCD). One study portrayed a higher relapse rate for those whose duration of therapeutic contact was less than one year. A higher percentage of the average body weight upon intake was a predictor of a shorter time to both full and partial recovery (Kaustav & Basu, 2010).

The consensus seems to be that with adequate intervention a third of all cases recover after their initial episode, a third fluctuates between recovery and relapse and another third suffers chronic deterioration. If sufferers do not receive adequate intervention/treatment, then multiple admissions and re-hospitalisations are common (Eating Disorders Coalition, 2009). Treatments directed at a broad spectrum of goals such as healthy food intake, physical recovery, a positive body image and improved self-esteem, as well as better emotion-regulation and social reintegration, are effective in realising full recovery (Noordenbos, 2013).

Although numerous studies have attempted to identify predictors of the course and recovery of AN, the findings have been contradictory and at times unclear (Course and Outcomes, n.d.; Mehler & Brown, 2015). Overall, a poorer outcome for recovery is associated with the following personal variables (Arcelus et al., 2011; *Course and*

*Outcomes*, n.d.; *Eating Disorders*, n.d.; Freund et al., 2000; Kaustav & Basu, 2010; Mehler & Brown, 2015):

- A late age of onset (late teens or older).
- Having been already continuously ill for several years at presentation (> 6 years).
- A hostile attitude towards one's family, with disruptive relationships between the sufferer and the other members of the family.
- A pre-morbid low self-esteem.
- Poor adjustment at school level.
- A history of poor relationships preceding the onset of the illness.
- Other personality problems before the age of onset.
- Pre-morbid obesity.
- Very low body weight on admission.
- Bulimic behaviours (especially the presence of purging).
- Male gender.
- A high level of personality disturbance.
- An extreme compulsive drive to exercise.
- Worse evaluation scores concerning hypochondriasis, paranoia, and psychopathic deviance.
- Failure to respond to earlier intervention.

The following table shows the factors that determine a good prognosis in AN (left column) and the factors that determine a bad prognosis in AN (right column).

**Table 2.1: Factors determining prognosis in AN (Eating disorders: Criteria for organizing resources and activities, n.d., p.27)**

<u>Good prognosis</u>	<u>Bad Prognosis</u>
Presence of clear triggering event Early onset (at beginning of adolescents)	Late onset (at end of adolescence)
	Chronic illness with repeated hospitalisation
Weight gain at start of treatment	Weight variations Bulimic behaviour Purging behaviour
Histrionic manifestations	Obsessive traits and symptoms (OCD)
State of depressive suffering	Massive ignorance of the illness
Minor prior sentimental failings/failures	Serious sentimental difficulty
Sudden increase in activity prior to treatment	Apragmatism
Recognition of the sensation of hunger	Denial of the sensation of hunger
Lesser intestinal transit disorders	Permanent constipation
	Hypochondriac feelings and worries and/or dysmorphia
Absence of family psychopathological background	Depression in parents, aggravated by anorexia of daughter
	Marital conflicts between parents
Good cooperation from parents Accept existence of illness and are understanding	Rejection of the illness by the parents Somatic complaints by the mother Father "takes action"
Few siblings	Numerous siblings, including brothers
Good social interaction	Poor social interaction
Early diagnosis and treatment	Late diagnosis and treatment

It is evident that the above-mentioned statistics deliver differing presentations of the recovery rates, which is also reflected in the variability and individuality that marks ED clients.

#### **2.4.4 Prevention of eating disorders**

Preventative medicine strategies indicate the need to take a pro-active stance against the development of eating disorders in healthy individuals. As stated previously, indications are that the age of onset of eating disorders is becoming younger, which is why prevention efforts are aimed predominantly at youths.

In Table 2.2, Bauman (2008, p.68) identifies the following possible risk factors associated with ED development in children.

**Table 2.2: Possible risk factors associated with eating disorder development in children**

<u>Individual Factors</u>	<u>Social Factors</u>	<u>Family Factors</u>
Temperament: having negative emotions	Publicity of thin media images	Mothers not having good eating habits
Early puberty in girls	Media messages encouraging losing weight	Criticising a child's weight
Low self-esteem	Peer pressure for needing to be thin	Comparing siblings

Early ED prevention programs seemed to produced limited effects on preventing its development (Pearson, Goldklang, & Strigel-Moore, 2002). In attempts to improve outcomes, researchers started targeting the well-established *risk factors* that underlie eating pathology - which has proven to be more successful. These risk factors include increased perceived pressures to be thin, internalisation of the thin-ideal standards of female beauty, body mass, body dissatisfaction, and negative affect (Shaw, Stice, & Becker, 2009; Sogar, 2015).

In Table 2.3, the three levels of prevention that are traditionally assumed by the health sciences, are presented in the context of aiming to prevent the development of eating disorders.

**Table 2.3: Levels of preventing the development of eating disorders (Criteria for organizing resources and activities, n.d., p.6)**

<u>Levels of prevention</u>	<u>Objective</u>	<u>Method</u>
<b>Primary</b>	Reduce the impact of the eating disorder (prevent appearance of new cases).	Act on vulnerabilities as risk factors.
<b>Secondary</b>	Reduce prevalence (shorten the duration of the eating disorder and the average time between when it appears and when treatment is sought).	Early detection. Early treatment.
<b>Tertiary</b>	Reduce the consequences of the eating disorder.	Avoid the appearance of complications. Appropriate treatment of complications.

In a review of more recent prevention programs, Shaw et al. (2009) concluded that presently multiple programs exist which have successfully decreased risk factors for eating pathology. Those prevention programs that decreased attitudinal risk factors and promoted healthy weight control behaviours were particularly effective. They highlight the following factors and variables for prevention programs that produced larger intervention effects for decreased risk factors associated with eating pathology:

- Selected (vs. universal) prevention strategies focussing on specific risk factors, rather than eating pathology in general.
- Interactive (vs. didactic) prevention strategies allowing for active learning, as opposed to merely providing psycho-education.
- Multi-session (vs. single-session) prevention programs.
- Offering prevention programs to individuals older than 15 years (vs. younger participants).
- Delivered by professional interventionists (vs. endogenous providers).
- Focussing on body acceptance and dissonance-induction, without psycho-educational content.

Although prevention programs exist, it is difficult to administer such programs because ED sufferers usually suffer in silence.

#### **2.4.5 Stigma and secrecy in eating disorders**

A definite stigma is evident and commonly associated with eating disorders which affects the individual negatively (Crisafulli, Van Holle & Bulik, 2008; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Puhl & Suh, 2015).

This stigma towards eating disorders portrays a picture that they are not serious conditions and that sufferers are merely seeking attention, or have trivial dieting problems. This sentiment is echoed in Liu's statement:

*The stigma that surrounds eating disorders paints them as trivial 'girl problems', diets gone awry, adolescent rites of passage, or the acting out of juvenile rebels or 'control freaks'. Anorexia, bulimia and binge-eating disorders are sensationalised by the media as celebrity spectacles. Even the medical profession, by and large, still dismisses disordered eating as a behavioural quirk and thus fails to recognise the serious psychological threat this behaviour represents. Stigma suppresses funding and attention to eating-disorder research and is a primary obstacle to adequate treatment and prevention efforts (Liu, 2011, para. 11).*

Eating disorders are illnesses with a biological basis, modified and influenced by individual emotional and cultural factors. The associated social stigmatisation of ED sufferers has for a long time kept individuals suffering in silence, inhibiting funding for crucial research and creating barriers to treatment efforts. Due to insufficient information, many members of the public, and professionals alike, fail to recognise

their role in the potentially dangerous consequences when ED sufferers shy away from stigmatisation, by rather choosing to hide their ED (Eating Disorders Coalition, 2009).

This stigma may result in sufferers' subjective experiences of low self-esteem, low self-efficacy, social isolation and lowered social confidence. It may even exacerbate the condition through social exclusion and stress and may prevent sufferers from seeking treatment (Ebner, Latner & O'Brien, 2011). Stigma has been shown to act as a barrier to sufferers accessing treatment and may also prolong the recovery process whilst increasing the chance of relapse (Rieger & Zwickert, 2013). In this sense, the stigma keeps individuals suffering in silence, as many sufferers of eating disorders do not come forward with their problem based on the shame they may experience. The extreme behaviours associated with the disorder may also contribute to this feeling of shame and embarrassment.

Research by Roehrig and McLean (2010) also confirms that eating disorders remain highly stigmatised. This stigma is more prominent than for depression. Many people are still of the opinion that ED sufferers are responsible for their own illness and that symptoms are probably not as serious as described by sufferers. These aspects all contribute negatively to individuals seeking treatment and to the overall misunderstanding of eating disorders.

The more common stigmas associated with eating disorders include the following:

- Eating disorders are not real medical disorders of concern - eating disorder individuals are merely seeking attention.

- Beliefs of controllability: Lack of self-discipline causes the disorder, especially in cases of obesity (Ebnetter, et al., 2011).
- Negative parenting contributes to the development of eating disorders (Ebnetter, et al., 2011).
- Individuals suffering from eating disorders are perceived as being responsible for the onset of their illness, and as having a significant amount of control over it (Rieger & Zwickert, 2013).
- Males do not get eating disorders or those that do, are not real serious cases.

In the professional realm, eating disorders themselves do not always obtain the same amount of attention from researchers and academics. Other conditions such as alcoholism, major depressive disorder, or schizophrenia all enjoy more privileges in the form of research and government funding and are not considered 'taboo' topics. These act as barriers to treatment efforts. It is because of insufficient information that the public and many professionals fail to recognise the dangers and consequences of eating disorders (Crow et al., 2009; Eating Disorders Coalition, 2009).

However, a poll conducted in 2005 in the United States with a nationwide sample of 1500 adults indicated that 96% of Americans believed that eating disorders are serious illnesses, 81% believed eating disorders can be successfully treated, and 76% believed that eating disorders should be covered by insurance companies just like any other illness (Eating Disorders Coalition, 2009). These statistics offer some hope that the general attitudes and stigmas associated with these disorders might be changing as more and more people are diagnosed.

## **2.5 Assessing eating disorders**

There are many assessment procedures that can identify and confirm the presence of eating disorders. Several of these allow for the evaluation of personality traits of the patient, confirmation of diagnosis, as well as assistance in treatment planning by highlighting problem areas. Assessments are valuable in re-evaluating the progress as treatment progresses.

The more common assessments used for eating disorders are listed below. They are divided into clinical administered interviews and self-report measures (Constain et al., 2016; Eating disorders: Criteria for organizing resources and activities, n.d.; Grylli et al., 2005; Kaustav & Basu, 2010; Van Tonder, 2004).

### **2.5.1 Clinical interviews**

These two assessment procedures are administered by a trained clinician in the form of a face-to-face interview.

#### **1. Eating Disorders Examination Questionnaire**

This interview allows for a diagnosis of eating disorders per the DSM-5, and is still considered to be the gold standard for the assessment of eating disorders. It has good test reliability and validity.

#### **2. Yale-Brown-Cornell Eating Disorders Scale (YBC-EDS)**

This clinical interview lasts between 10 - 40 minutes, and is designed to assess the severity and type of symptoms observed to be present in patients with eating disorders.

## 2.5.2 Self-report measures and instruments

Self-report measures are helpful for initial screening purposes, but should preferably be supplemented with some form of assessment by a trained clinician. Nine self-report measures and instruments are described next.

### 1. Eating Disorders Impairment Questionnaire (EDI)

The EDI is a questionnaire designed to evaluate psychological and behavioural characteristics common to AN and BN. The EDI is widely used and accepted as a standardised self-report measure of symptoms and concerns characteristic of eating disorders. The EDI provides measures regarding three core subscales: 'Drive for thinness' (which indicates excessive concern with dieting, preoccupation with weight, and involvement in the extreme pursuit of thinness - reflecting both an ardent wish to lose weight as well as a fear of weight gain); body dissatisfaction (reflecting the belief that specific parts of the body associated with shape change or increased 'fatness' at puberty are too large - for example hips, thighs and buttocks); and bulimia (indicating the tendency toward episodes of uncontrollable overeating/bingeing, which may be followed by the impulse to engage in self-induced vomiting or other compensatory behaviours). The bulimia subscale is considered to be an index for disordered eating behaviour.

### 2. Eating Attitudes Test (EAT-26)

The EAT-26 is one of the most widely used standardised self-report measures of symptoms and concerns characteristic of an ED. The EAT-26 is a self-administered questionnaire allowing confirmation of the diagnosis, except in cases where the patient denies all symptoms. It assesses a broad range of symptoms and provides a total score for disturbed eating attitudes and behaviours. The EAT-26 questionnaire is an ideal multidimensional instrument for ED screening in high risk populations. This questionnaire has excellent

reliability, sensitivity and specific values. It can be a useful tool in the early detection and screening of eating disorders.

### 3. The Clinical Impairment Assessment Questionnaire (CIA)

The Clinical Impairment Questionnaire (CIA) is a 16 item self-report measure focusing on psychosocial impairment. It provides a simple single index of the severity of psychosocial impairment secondary to ED features. Considering the last 28 days of the individual, the 16 items cover impairment in domains of life that are typically affected by eating disorders: Mood and self-perception, cognitive functioning, interpersonal functioning and performance at work.

### 4. Self-rate Scale for Bulimia (BITE)

A self-administered questionnaire enabling identification of patients with symptoms of BN.

### 5. Anorexic Behaviour Observation Scale for Parents (ABOS)

A self-administered questionnaire which allows information to be obtained from parents of patients with eating disorders. It can also be used for early detection, as ED sufferers often deny or conceal their symptoms, making objective external observation extremely useful.

### 6. Body shape questionnaire (BSQ)

A self-administered questionnaire allowing information to be obtained from patients about how they perceive their own pattern of eating and their body shape. The questionnaire focuses significantly on the perception of body shape.

### 7. Eating Disorders Examination Questionnaire (EDE-Q4)

A self-report version of the Eating Disorder Examination interview. Assesses the frequency of bouts of overeating (objective and subjective binge episodes).

#### 8. Bulimia Test- Revised (BULIT-R)

Is a 28-items self-report instrument designed to assess a broad range of eating-disordered behaviours, particularly bulimic behaviours.

#### 9. The Body Shape Questionnaire

Is a 5-items yes/no simple screening tool for the evaluation and screening of ED symptoms. Is intended specifically for those who are not specialists in the field of eating disorders.

## **2.6 Managing eating disorders**

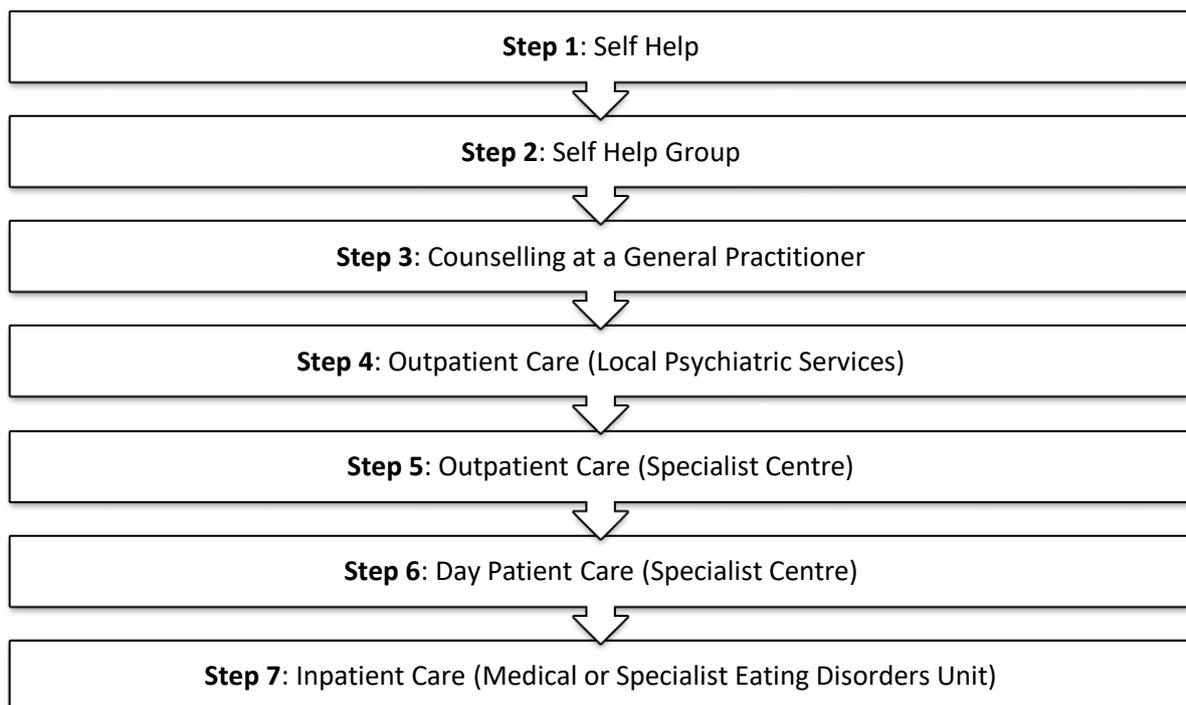
### **2.6.1 Considerations for holistic treatment**

Sufferers of eating disorders require direct assistance on the physical-, cognitive-, behavioural- and emotional spectrum. When considering full and holistic recovery, these aspects should not to be treated independently, particularly if the disorder has taken significant precedence and is long-standing in the sufferer's life. The complexity of eating disorders' chronic nature, its clinical presentation through bizarre cognitive- and emotional phenomena, as well as the numerous co-morbidities and complications associated therewith, indicate the need for specialist multi-dimensional treatment interventions.

A stepped care model of eating disorders was put forward by the Royal College of Psychiatrists in 1992 (The Royal College of Psychiatrists' Public Education Sub-Committee, 2013). Such a model would help with the understanding that recovery is individualised and based upon the unique presentation and severity of each individual's ED. This model illustrates how someone with an ED would seek intervention from the least intensive types of care (i.e. self-help), to having to be admitted to inpatient care (i.e. most intensive types of care). The stepped care

recovery model indicates treatment for sufferers at the lowest appropriate service tier in the first instance, then only 'stepping up' to more intensive/specialist services as clinically required. The level of professional input is augmented gradually, until satisfactory health status is achieved. Figure 2.2 graphically shows the seven steps that are involved in assisting an individual who suffers with an ED (Department of Health, Social Services & Public Safety, 2002, p.22).

**Figure 2.2: The stepped care model of eating disorders of the Royal College of Psychiatrists in 1992 (Department of Health, Social Services & Public Safety, 2002, p.22)**



A stepped care approach would link different patient needs to therapeutic modalities that range from simple advice, to intensive inpatient care. Brief methods, including self-help and psycho-education may be effective for a subset of patients with BN and BED, although, identifying this subset remains a challenge. Note that because AN

typically demands expert and sustained treatment, the lower levels of stepped care are generally not applicable for these patient populations (Wilson, Vitousek & Loeb, 2000).

Upon the individual moving up to either Step 3, or Step 4 in the above-mentioned stepped care model, the immediate treatment goals for eating disorders are aimed at weight recovery and nutritional normalisation. Good results usually occur with weight restoration and individual- and/or family psychotherapy, when the patient is medically able to participate. In cases where severe weight loss is part of the presenting problem, the appropriate target weight is often set at a weight at which the patient previously menstruated (Freund et al., 2000; Noordenbos, 2013).

If an ED client is still severely underweight, this can affect their psychotherapy process as their cognitive- and emotional functioning are significantly compromised (Fairburn, 2008). Motivation is also a key ingredient to the client's recovery process. As mentioned previously, many sufferers of eating disorders deny their symptoms, or their willingness to admit and address their disorders to make lasting changes is minimal. Other hindrances in the recovery process include failure to follow-up in treatment, continued weight loss (or inadequate weight gain) even whilst in treatment, significant frequency of binges/purges, or specified laboratory signs indicating pathology/damage to the body (Freund et al., 2000; Noordenbos, 2013).

Thus, the treatment of eating disorders presents professionals with many unique and intricate challenges. For these purposes, a multidisciplinary team is usually assigned to more serious cases. This team usually consists of a primary care physician,

nutritionist and a mental health care professional - all of whom should communicate and confer regularly. Each team member is allocated a role with certain responsibilities. Due to the individualised nature and presentation of each client, care and treatment should be tailored to the specific needs of each individual. Numerous intervention programs for sufferers of eating disorders exist and each follows its own treatment philosophy. Despite these different treatment philosophies, there does seem to be some common elements among differing treatments, which are highlighted below:

- All interventions seem to target a range of symptom clusters (Szabo, 2009), rather than merely focusing on being underweight.
- All interventions seem to include nutritional rehabilitation (i.e. restore weight) which appropriately addresses the physical consequences of the disorder (Szabo, 2009):
  - For anorexia, addressing the quantity of food and also the range of foods eaten appears to be important, while;
  - For bulimia, stabilising eating patterns and eliminating binge eating and purging appears to be the focus.
- Interventions also seem to focus on cognitive restructuring, which includes stabilising eating behaviour and normalising thought patterns (Szabo, 2009).
- The need for a multi-disciplinary approach for successfully addressing the physical-, cognitive-, and/or emotional aspects of the disorder seem to be a common factor.
- Recovery cannot merely focus on physical stabilisation, since regaining weight does not imply the patient has recovered from their disorder. Focusing *only* on re-feeding and reaching a 'target weight' predisposes the patient to almost certain relapse (Claude-Pierre, 1999), and does not address the cognitive- and emotional aspects of the disorder. According to Noordenbos (2013), full recovery

implicates criteria such as eating healthy amounts of food and maintaining a healthy weight without being afraid of becoming overweight; to have a positive body attitude and increased self-esteem and to have better overall coping strategies.

- Interventions need to involve both the patient, and where appropriate, the family and other significant parties, especially in younger patients (Szabo, 2009).
- Treatment should follow a longitudinal course to fully stabilise the individual's physical problems (Claude-Pierre, 1999; Noordenbos, 2013), whilst addressing the cognitive- and behavioural aspects of the disorder (Szabo, 2009). Eating disorders take time to develop, and thus one may assume that considerable time is needed to reverse the process towards recovery. Changes over time need to occur consistently to ensure meaningful progress. Changes should also be constant and the intervention process should not be interrupted (Claude-Pierre, 1999; Noordenbos, 2013).
- A clear need for inpatient- and outpatient-based treatments should be identified, and applied appropriately according to the patient's symptom presentation and therapy needs (Szabo, 2009).
- Treatment should be administered only by those who are professionally trained in the relevant fields of psychology.

### **2.6.2 Health service resources and treatment costs of eating disorders**

In the USA, eating disorders treatment costs businesses approximately \$4 billion per year. According to the National Association of Anorexia Nervosa and Associated Disorders (ANAD), AN treatment typically spans between 5 - 7 years, with inpatient care for an ED costing up to \$30,000 a month, and more than \$100,000 for outpatient therapy and medical monitoring (Prah, 2006).

These financial costs incurred set the tone for monumental problems when clients attempt to seek specialist treatment. When considering the complexities with which ED treatment presents, it is understandable that ED sufferers would be high consumers of medical and social care, which in turn implies a considerable burden placed upon a country's health care system. In short, treatment is costly because both mental and physical problems are involved. Adding to this problem, Szabo (2009) highlights that ED sufferers do not seek treatment, and those that do, do not engage with it consistently.

Again, I make mention that eating disorders follow a chronic development and course which has a profound effect on the victim. In the USA, AN is ranked as the third most common chronic illness amongst adolescents (Eating Disorders Coalition, 2009). Eating disorders are also ranked 15<sup>th</sup> amongst the top 20 causes of disability in woman for that country (when measured in years of productivity lost due to disability). The estimated average duration of illness for AN and BN was eight and five years respectively (Vos et al., as cited in The British Psychological Society & The Royal College of Psychiatrists, 2004, p.27).

Individuals with AN often require hospitalisation, creating a significant economic burden for health service costs and health care utilisation (Fankhauser, n.d.). A poll in 2005 of 1,500 adults commissioned by the National Eating Disorders Association (NEDA) revealed 76% of respondents were of the opinion that eating disorders should be covered by insurance companies 'just like any other illness'. The results indicated that three out of four Americans agree that not only are eating disorders serious illnesses, but that they also deserve, and demand, treatment and adequate

insurance coverage (Prah, 2006). Despite these findings, access to care and reimbursement for hospitalisations or residential programs are often a challenge for sufferers. Although eating disorders can be successfully and fully treated to complete remission, only about one in ten people with eating disorders receive specialist treatment in the USA (Fankhauser, n.d.).

According to a two-year study by the National Institute of Mental Health (NIMH), more than 50% of those with eating disorders reported receiving treatment for emotional problems at some point in their lives. However, less than 45% sought treatment specifically for their ED. When they did seek treatment, they most commonly went to the general medical sector, rather than seeking specialised care. This indicates the lack of affordable care for eating disorders and highlights the momentous need for the provision of improved treatment options for this population (Eating disorders and the road to recovery, n.d.).

In conclusion, the overall management and treatment of eating disorders may be described as long-term in course, extensive in its efforts to address multiple problems, and expensive in terms of time and costs incurred upon the individual, their families and national health system. Management and treatment of eating disorders includes inpatient and outpatient care, and specialist multi-dimensional professional treatments and interventions are needed for more severe cases. Intensive long-term outpatient based care is however judged as key to ensuring good probability of successful recovery, healing and relapse prevention. Recovery is an individualised and highly variable road, and cannot have a time limit of only a few weeks (i.e. inpatient care). Patience is required from both the helper and the one

being helped, as treatment takes time and could be met with rigid cognitive styles and resistance to change. Overall treatment success is highly dependent upon the orientation with which the ED sufferer enters treatment, as well as their consistent commitment to the long-term goals set within the treatment process itself.

## **2.7 Treating eating disorders**

Effective intervention for the complexity of eating disorders require a range of treatment options. These options may range from basic psycho-educational efforts towards educating on nutritional and symptom-management techniques, to long-term residential-based treatments. Multi-professional treatment of ED sufferers involves clinicians from different health disciplines including psychologists, psychotherapists, physicians, psychiatrists, dietitians and nurses. Clients with severe eating disorders typically require a treatment team consisting of a primary care physician, dietitian, and a mental health professional knowledgeable about eating disorders (Noordenbos, 2013; Treatment, n.d.).

Most of the treatments and therapies for eating disorders focus on the overall psychological improvement of the patient. However, as stated previously, restoring normal body weight and eating habits must also form part of the intervention strategy. Comprehensive treatment usually includes supportive care by health providers, structured behavioural therapy, psychotherapy and anti-depressant drug therapy (Anorexia: overview, n.d.; Noordenbos, 2013). When treatment is directed exclusively at changing patients' eating habits and weight, the underlying psychological factors usually remain. Thus, a negative body attitude and self-

evaluation remains; avoidance of negative emotions and suffering from traumatic experiences persists; as well as increasing the risk of relapse (Noordenbos, 2013).

Treatment steps that illustrate the various components of an ED treatment process for AN and BN respectively are portrayed below. These treatment steps provide guidelines for professionals who are treating clients with a specific ED (Eating Disorders, n.d.).

### **2.7.1 Treatment diagram for anorexia nervosa**

#### 1. Starting treatment

##### a. Initial assessment

- i. Form a good relationship with the patient.
- ii. Educate patient and family
- iii. Admit to hospital if:
  - Weight is less than 65% of standard weight (or BMI below 13).
  - Weight loss is very rapid.
  - Severe depression or suicidal ideation is present.
  - Out-patient care has failed.

#### 2. Restoring weight

- a. Target weight is a compromise between a healthy weight and patient's concept of an ideal weight.
- b. Reasonable target is 0,5kg – 1kg weight gain per week.
- c. Beware of rapid weight gain:
  - i. Patient becomes fearful and distrustful of therapy.
  - ii. Hypophosphataemia and the risk of cardiac failure.
  - iii. Beware of patient 'eating their way out of hospital', with subsequent increases in guilt, feelings of failure, or weight loss after discharge.

### 3. Psychotherapy

- a. Family therapy for younger patients, whereby family actively participates.
  - i. Can improve 1-year outcomes.
  - ii. At 5 years, patients who had received family therapy were doing better.
- b. Cognitive therapy
- c. Self-help groups

## 2.7.2 Treatment diagram for bulimia nervosa

### 1. Starting treatment

- a. Initial assessment
  - i. Form a good relationship with the patient.
  - ii. Educate patient and family
  - iii. Admit to hospital if:
    - Weight is less than 65% of standard weight (or BMI below 13).
    - Weight loss is very rapid.
    - Severe depression or suicidal ideation is present.
    - Out-patient care has failed.

### 2. Cognitive behaviour therapy (CBT)

- a. Has been extensively studied.
- b. Aims to normalise eating habits and modify the concerns about excessive weight.
- c. Two-thirds of patients treated with CBT achieve substantial and lasting change.

### 3. Interpersonal therapy (IP)

- a. Some evidence that this is as equally effective as CBT.

4. Guided Self-help
  - a. Patients are given a comprehensive self-help manual and have a limited number of contact sessions with a trained eating disorders therapist.
  - b. Modest benefits reported
5. Pharmacological
  - a. SSRIs (Fluoxetine).
    - i. Effective in short-term, independent of mood status.
    - ii. Long-term maintenance characterised by high relapse rates.
    - iii. Higher doses (60mg) may be more effective
  - b. Imipramine
    - i. Efficacy established in the short-term.

In comprehensively treating sufferers of eating disorders according to their treatment diagrams, the following procedures are to be considered. They are not in any chronological order, and every procedure would be involved to a varying degree due to the individual nature and presentation of each case.

### **2.7.3 Treatment procedures**

#### **2.7.3.1 Initial assessment**

The initial assessment is usually more formalised and applicable to every case consulted. It is the first step in establishing a diagnosis and treatment plan, as well as initiating a therapeutic alliance (Alton, 2005; Treatment, n.d.).

The initial assessment encompasses a thorough review of the patient's history, current symptoms, physical status, weight control measures and other psychiatric issues or syndromes. Consultation with a physician and a registered dietitian is also

often recommended to obtain a comprehensive analysis of the presenting problem and its physical consequences. Family history should also be obtained in relation to the eating problem and other psychiatric syndromes, alcohol and other substance use disorders (Kaustav & Basu, 2010).

This assessment assists the clinician in determining the specific ED diagnosis, as well as identifying target symptoms and behaviours that need be addressed in the treatment plan.

### **2.7.3.2 Psychotherapy**

There are several different types of psychotherapies with varying levels of effectiveness in individuals with eating disorders. These therapeutic modalities generally include cognitive therapy, interpersonal psychotherapy, family therapy and behavioural therapy. Some of these modalities may be relatively short-term (e.g. merely a few intervention sessions), whilst others may continue for considerably long periods of time.

Individual cognitive-behavioural therapy, group therapy and family therapy have all shown varying degrees of successful results, encouraging clients to improve their overall behaviours and establish healthy eating patterns (Anorexia: Overview, n.d.; Noordenbos, 2013). Other therapy modalities which may be found to be useful include feminist therapies, psychodynamic psychotherapies and various alternative types of group therapy (Noordenbos, 2013; Treatment, n.d.).

If the client is young, therapy should also attempt to involve the family unit. Some therapeutic approaches consider the family as a part of the solution, rather than identifying them as a contributing cause to the ED. Support groups may also be a part of the treatment strategy. Within support groups patients and families meet and share their experiences of living with or through the disorder (Alton, 2005; Anorexia: Overview, n.d.).

### **2.7.3.3 Psychopharmacology**

As there is a biological basis for eating disorders, psychiatric medications have an established role in the treatment of clients with eating disorders. However, research has not shown that they assist directly with decreasing the desire to lose weight (Anorexia: Overview, n.d.). Most of the research to date has involves antidepressant medications such as Fluoxetine (Treatment, n.d.).

Medication nonetheless remains an integral component in ED treatment: Pharmacological treatments may complement psychotherapeutic techniques and assist with the associated psychopathology, particularly depression (Eating disorders: Criteria for organizing resources and activities, n.d.; Noordenbos, 2013). Medications such as antidepressants, antipsychotics and mood stabilisers may help clients when given as part of a comprehensive treatment program. Examples include Olanzapine (Zyprexa, Zydys), Selective Serotonin Reuptake Inhibitors (SSRI's) and Antidepressants (Anorexia: Overview, n.d.). The indicated medications for the treatment of eating disorders include the following (Eating disorders: Criteria for organizing resources and activities, n.d.):

- Antidepressants (may improve mood and decrease obsessiveness, as well as reduce bingeing and vomiting frequencies).
- Benzodiazepines (prescribed for insomnia or intense anxiety, although there is a risk of dependency or withdrawal symptoms).
- Neuroleptics (for their sedative and anxiolytic effects).
- Other drugs used include Clonidine and Opiate Antagonists.

Caution should be exercised when using medications for co-morbid conditions such as depressed and obsessive-compulsive features, as these may themselves resolve with appropriate weight gain alone. The potential side-effects of medications (in particular, cardiac side effects) should also be carefully considered due the decreased physical functioning and increased risk associated with extreme weight loss when specifically treating AN clients (NHS Scotland, 2006). Baseline laboratory assessments such as cell blood count, serum electrolytes, liver function tests, blood urea nitrogen/creatinine ratio, thyroid function and an electrocardiogram should be conducted with patients suffering from an ED (Halimi, 2005).

Broadly speaking, psychotropic medications have been more successful in treatment efforts for BN than AN. There are no pharmacological interventions licensed to specifically treat the psychopathology of AN. However, some treatments may be indicated for the associated psychological symptoms (NHS Scotland, 2006). A systematic review of evidence reports by Berkman et al. (2006) for the scientific literature at the University of North Carolina, concluded that managing individuals with AN *only* with medication, is inappropriate. No specific pharmacological intervention for AN showed a significant impact on weight gain or the psychological features of AN. However, it was suggested that tricyclic antidepressants may

improve a sufferer's mood, even though this outcome is not associated with improved weight gain or recovery. These findings concur with Kaustav and Basu (2010). The review also proposed that the current available medications are not acceptable to individuals with AN because of associated high dropout rates (Berkman et al., 2006). For BN, good evidence indicates that Fluoxetine may reduce core bulimic symptoms (i.e. binge eating and purging), as well as an overall short-term reduction in the associated psychological features of the ED. The report also suggested possible other second-generation antidepressants (Trazodone and Fluvoxamine), an anticonvulsant (Topiramate), and a tricyclic antidepressant (Desipramine) for the treatment of BN. Monoamine Oxidase Inhibitors (MAOI's) may be associated with decreased vomiting in BN treatment, although the client's diet should also be closely monitored (Berkman et al., 2006).

There is evidence supporting the anti-bulimic effects of SSRI's and other antidepressant medications. Fluoxetine in a dose of 60 mg/day is the first drug of choice, due to its beneficial effects and a favourable side effect profile (Halmi, 2005; NHS Scotland, 2006). Administering Fluoxetine showed reduction in core bulimic symptoms of binge eating and purging, and associated features of the disorder in the short term, as well as contributing to decreased relapse at 1-year post-intervention follow-up (Kaustav & Basu, 2010). Double-blind placebo controlled trials of antidepressants have shown that Desipramine, Fluvoxamine, Fluoxetine, Sertraline and Citalopram all reduce binge eating, and are associated with weight loss in the treatment of BED. Other drugs shown as superior to placebo for BED are Phenytoin and Topiramate (Halmi, 2005).

Halmi's (2005) systematic review highlighted randomised controlled trials revealing Fluoxetine in a dose of 60 mg/day added no benefit to inpatient treatment of underweight AN patients. Other research trials did however indicate that Fluoxetine in this dosage may decrease relapse rates in anorexia patients that were partially weight restored during weight maintenance. A third trial, which compared three drugs, Clomipramine, Fluoxetine and Amisulpride, indicated that Amisulpride had the best effect on weight gain in AN inpatients. Pharmacotherapy studies in AN seemed to indicate that antipsychotic medications such as Olanzapine and Quetiapine may be helpful during weight restoration phases. Citalopram may also reduce depression and anxiety during weight restoration, whilst Fluoxetine does not seem beneficial in weight restoration, but may decrease relapse rates in weight restored AN patients.

Anxiolytics may also be helpful in treating the fears associated with loss of control, weight gain, and prescribing them prior to meals may help to reduce the anxiety experienced with eating. Although anti-depressants may be helpful relieving depressive symptoms, the symptoms are usually due to starvation and therefore improve with normalised eating habits (Freund et al., 2000; Noordenbos, 2013). Mineral deficiencies may occur in starvation states and should be treated appropriately with mineral supplementation (NHS Scotland, 2006).

#### **2.7.3.4 Nutritional counselling and rehabilitation**

Clients engaged in recovery need 'slow', regimented diets. Physical recovery is a lengthy process and requires significant re-orientation towards the concepts of food, body and weight (Anorexia: Overview, n.d.; Noordenbos, 2013;). The goals of nutritional rehabilitation include the restoration of weight, normalisation of eating

patterns, the achievement of normal perceptions of hunger and satiety, and the correction of biological and psychological consequences of malnutrition (Kaustav & Basu, 2010).

Contact with a registered dietitian, nutritionist, or food specialist may be an effective source of support and information for clients who are in a weight-gain phase, or who are trying to normalise their eating behaviours. Dietitians assist in conveying insights on healthy fundamentals and understanding regarding adequate nutrition. They may also conduct dietary counselling which is aimed at ultimately changing the nature of the eating behaviours (Treatment, n.d.).

A healthy goal-weight for females is viewed as the weight at which normal menstruation function restores, whilst for males, at the weight where normal testicular functioning is resumed (Kaustav & Basu, 2010).

#### **2.7.3.5 Medical treatment**

As mentioned previously, ED sufferers are subject to a variety of physical and medical concerns. Regular examination of the client's physical health status (i.e. weekly or more often) and monitoring the concerns associated with eating disorders is required for effective outpatient treatment (Noordenbos, 2013; Treatment, n.d.). If their physical health is considerably compromised, admission to a primary healthcare facility may be necessary.

### **2.7.3.6 Inpatient treatment**

Inpatient treatment is the most intensive level of treatment for an individual. It provides a structured and contained environment in which to access clinical support 24-hours a day (Treatment, n.d.).

Determining the need of inpatient care is necessary as eating disorders carry life-threatening symptoms. In general, indications for hospitalisation for eating disorders include the following (American Psychiatric Association [APA], 2006; Kaustav & Basu, 2010):

- Rapid, progressive weight loss, despite intensive outpatient or partial hospitalisation interventions.
- Weight loss of more than 30% of ideal body weight.
- Arrhythmia or Bradycardia.
- Signs of inadequate cerebral perfusion.
- Severe depression and suicidal tendencies.
- Marked fluid and electrolyte imbalances.
- Withdrawal from laxatives, diuretics, emetics, or diet pills.
- Lack of therapeutic response to outpatient treatment.
- Reaching the weight at which the client was medically unstable in the past (previous admissions).
- Co-occurring psychiatric problems that merit hospitalisation.
- Client's severe denial or resistance to participate in his/her own care in less supervised settings.
- The presence of additional stressors (for example, dental procedures) which may interfere with the client's ability to eat.

Although ED patients can sometimes be treated in general psychiatric units, such an approach often poses problems with monitoring and containing ED symptoms. Therefore, many inpatient programs for eating disordered individuals only treat patients with AN, BN, BED, or variants of these disorders (Treatment, n.d.). After discharge from the inpatient treatment program, continual outpatient follow-ups with a day treatment program or regular individual outpatient appointments are necessary (NICE Guidelines, 2004).

### **2.7.3.7 Outpatient treatment**

Outpatient treatment usually involves a coordinated team effort and regular contact sessions between the client and a psychotherapist, physician and a dietitian/nutritionist. Not all sufferers will receive a multidisciplinary approach, as individual variables dictate the severity of the disorder, the treatment plan, and which level of professional care is required (Alton, 2005; Treatment, n.d.).

As previously mentioned, the impact of the disorder on the individual's functioning is significant, affecting multiple areas that, at times, require lengthy treatment. The costs for long-term outpatient programs are significantly more cost-effective than acute inpatient care: More patients recover fully and have less/no need for further treatment. Most treatment efforts for eating disorders lies within the spectrum of regular outpatient therapeutic contact. Expert guidelines dictate that the duration of outpatient psychological treatment should be at least six months (Espie & Eisler, 2015).

Adding to this sentiment, studies that aimed to determine the effectiveness of treatment settings in patients presenting with AN, found that adherence problems in inpatient-treatment streams were evident. Several other studies reported high rates of relapse following initial admission, and even higher relapse rates after subsequent admissions (Espie & Eisler, 2015). Therefore, outpatient treatment, in most cases of eating disorders, are considered the first line treatments options. Claude-Pierre (1999) also highlights that health care insurers in the USA have started recognising that the primary route of successful recovery for ED sufferers should focus upon specialist outpatient programs, as opposed to acute inpatient care.

#### **2.7.3.8 Day hospital care**

For some clients for whom outpatient treatment is ineffective, or inadequate, there may be benefits from the increased structure provided by day hospital treatment programs. Day hospitals constitute both an alternative and complementary option to inpatient units and can form the core of an eating disorders unit. The day hospital may be located within the hospital complex, or in another healthcare building in the area, depending on the local planning needs. It is also serviced by a multidisciplinary team and nursing compliment trained in the treatment of eating disorders; including aspects such as nutrition and looking out for compensatory behaviours (Eating disorders: Criteria for organizing resources and activities, n.d.).

Day hospital treatment programs are generally scheduled between three to eight hours a day and provide structured eating sessions, along with various other therapies, including cognitive-behavioural therapy, body-image therapy and family therapy amongst others. For individuals needing more intensive intervention, day-

patient programs have some advantages when compared to inpatient treatment only. This is not only because day-patient programs allow some continual engagement with the patient's educational, occupational and social aspects of the patient's life, but also because it is easier for active involvement of family members in the treatment (Espie & Eisler, 2015; Treatment, n.d.).

Day hospital treatment programs are recommended for the following client populations: (Eating disorders: Criteria for organizing resources and activities, n.d.):

- Those who have undergone a hospital stay and whose progress is unstable, questionable or limited.
- Those without sufficient family support for ambulatory treatment.
- Those who need intensive treatment but do not necessarily need to be admitted to hospital.

#### **2.7.3.9 Residential care ('sub-acute facilities')**

Residential programs provide longer-term treatment options. These treatment options are generally reserved for treatment-resistant individuals who have been hospitalised on several occasions and have not been able to stabilise to a significant degree of medical- or psychological well-being (Treatment, n.d.). Clients would be admitted to the residential care unit for an extended period to provide them with a high level of support as they continue to work toward recovering from their ED.

### **2.8 Psychological treatment perspectives for eating disorders**

Abnormal eating behaviours in AN sufferers are often viewed as attempts to gain and maintain control over problematic aspects of the sufferer's life. Unlike in cases of BN and BED, no single specific psychotherapeutic model has emerged as the gold

standard of psychological treatment of AN. Both individual- and family treatment modalities have been shown to be of benefit, with family treatments being mostly indicated for younger clients (Freund et al., 2000; Noordenbos, 2013).

As eating disorders are complex with individualistic courses and outcomes, one can infer that multiple psychological treatment perspectives exist. Each of these perspectives has an underlying philosophy on the presenting pathology, its aetiology, as well as its core intervention strategy and treatment mechanisms. A brief description of the major different psychological treatment perspectives considered is provided below, which are aimed at assisting the individual towards recovery.

### **2.8.1 Psychodynamic perspectives on eating disorders**

Generally speaking, psychodynamic perspectives identify the problematic relational dynamics that exist between a ED sufferer and their parents or significant others. These dynamics lay the foundation that may contribute to the individual's belief that pain and suffering are necessary conditions of their lives and that pain exists in all relationships (Lane & Tolman, 2007). These necessary conditions lead to unique interactions within the therapeutic alliance.

In the classical psychodynamic conception, the struggle established between *incorporation* and *rejection* is theorised to be at the core of eating disorders and is revealed within *introjective* and *projective* psychological defence mechanisms (Lane & Tolman, 2007). The specific problems that could subsequently lead to AN commence in early infancy in feeding situations where the mother figure does not react in a way consistent with the state of deprivation, or satiety of the child. This

prevents the child from developing a correct discrimination of internal sensations (such as hunger) and can result in perceptual distortions whereby hunger and pain are confused, or even hunger itself becomes self-satisfying (Eating disorders: Criteria for organizing resources and activities, n.d.). According to psychodynamic theory, the feeling of personal ineffectiveness, which is closely linked to the subjective loss of self-control, may precede pathological syndromes. During therapy the internal conflicts which have encouraged the emergence or perpetuation of the ED symptoms, need to be analysed and resolved (Eating disorders: Criteria for organizing resources and activities, n.d.; Lobera, 2011).

In contrast to behavioural approaches to treatment, psychodynamic psychotherapy is not necessarily symptom-focused. The therapy process is characterised by frequent consultations and a lengthy course of intervention, such that the issues underlying the client's eating symptoms emerge in transference to the therapeutic relationship. The understanding is that once the transference is understood by the therapist, interpreted by the patient, and worked through within the therapeutic alliance, the ED symptoms will remit (Tolbin and Johnson, as cited in Johnson, 1991, p.379).

### **2.8.2 Cognitive-behavioural therapy (CBT) for eating disorders**

Cognitive-behavioural therapy has been the most widely used approach over the last 30 years as an effective therapeutic modality in the initial- and middle phases of treatment for eating disorders. The CBT perspective assumes that the fundamental psychopathology is an attempt by the sufferer to compensate for subjectively perceived deficiencies in self-esteem, through the definition and over-evaluation of

the self in terms of weight, size and shape (Eating disorders: Criteria for organizing resources and activities, n.d.; Noordenbos, 2013).

Central to the maintenance of the disorder is the client's core psychopathology: The dysfunctional scheme for self-evaluation. The other features seen in eating disorders (i.e. dietary restraint, other forms of weight-control behaviour, body checking and avoidance, preoccupation with thoughts of shape and weight) can be understood as stemming directly from this core psychopathology (Fairburn, 2008). The pursuit of slimness becomes the principle around which the individual with the ED organises his or her 'self'. Attitudes, beliefs and assumptions that overvalue their physical appearance dominate the individual's sense of self. This dysfunctional self-schema serves to organise and simplify the individual's world and to provide a system for developing the behaviours of AN and BN (Eating disorders: Criteria for organizing resources and activities, n.d.).

The CBT perspective emphasises the faulty beliefs relating to the overvaluation of eating, shape and weight - particularly the subjectively perceived consequences of loss of control over aspects of eating and weight change (Waller et al., 2007). Within the CBT model, the focus lies on the patient's faulty cognitions and the subsequent consequences it has upon their behaviours (i.e. the link between cognitions and behaviours). In return, the maladaptive behaviours serve as a maintaining mechanism for those faulty cognitions and beliefs about themselves. CBT-based interventions are mostly symptom focused and serve to break the processes that maintain the ED, rather than focusing on the processes responsible for its initial development (Fairburn, 2008).

In studies that attempted to determine the 'active' ingredient of CBT's success, the cognitive component emerged as critical to the positive therapeutic outcome (Kaustav & Basu, 2010). CBT therapy has been associated with reducing the risk of relapse after weight restoration for AN sufferers, whilst having a strong research base indicating good treatment results of BN sufferers (Berkman et al., 2006). Also, it has also been shown that when combining CBT with antidepressant medications, a greater number of sufferers experience good outcomes (Kaustav & Basu, 2010).

### **2.8.3 Family based treatment (FBT) for eating disorders**

Family based treatments generally follow a systemic approach - the common hypothesis being that eating disorders are manifestations of alterations within the family system which fulfil the role of maintaining homeostasis within the family. This in turn serves to reinforce the perpetuation of the disorder. Families of this nature are usually characterised by excessively close relationships, over-involvement in each other's' personal problems, over-protectiveness, rigidity, difficulty resolving conflicts, as well as involving the ED sufferer's marital problems. Family therapy attempts to modify these problematic interactions and communications between the members of the family (Eating disorders: Criteria for organizing resources and activities, n.d.). The approach is firmly established in a general family-systems approach and focusses on family strengths and family narratives. It has evolved into a distinct approach in its application to AN during adolescents (Espie & Eisler, 2015).

Family therapy as a treatment modality originated in the 1970's, with Minuchin, Palazzoli Selvini, and White all developing strong theoretical and practical family-based approaches to the treatment of AN (Rhodes, 2003). Minuchin and Palazzoli

Selvini's aetiological focus on AN focused on families that were seen as dysfunctional. This dysfunction was centred on rigid organisations within the family system, with the anorexic adolescent performing a specific function of maintaining homeostasis within the system. The problematic foundations of parent-child interactions included intergenerational coalitions, enmeshment and the lack of conflict resolution. The intervention process itself saw Minuchin guiding parents to take charge of their child's eating, thereby inviting change into the structure of the family. This tough stance by parents, in turn, prevented conflict avoidance and required them to become less enmeshed with their child. Palazzoli Selvini's intervention process was of a more neutral stance, focusing on breaking patterns of pathological interaction by introducing different types of information regarding the function of symptoms, and prescribing tasks to modify the generational boundaries and facilitating the adolescent's individuation (Dare, as cited in Rhodes, 2003, p.191).

One prominent treatment modality for eating disorders within FBT is the Maudsley Model of family therapy, which was developed by Christopher Dare and colleagues at the Maudsley Hospital in London for the treatment of anorexia (Dare, as cited in Rhodes, 2003, p.191). Dare and his colleagues had come to question the view that family dysfunction was fundamentally responsible for AN. The theoretical stance of the Maudsley model has its origins in Haley's strategic model of family therapy (Haley, as cited in Rhodes, 2003, p.191). The model emphasises a strong agnostic view of the aetiology of psychological disorders, whereby the illness may be *placed outside the family unit* - thus framed as independent of family functioning. It displaces blame for the illness because of family dysfunction, to rather placing the

deviance squarely on the shoulders of the illness itself (Rhodes, 2003). This model integrates principles and skills from many of the major schools in FBT, and is suitable for adolescents where the course of AN has been less than three years (Rhodes, 2003). It aims to break the cycle of parental guilt and resulting criticism upon the child. This modality is still being used to date and was recently published in a manual format (Lock, Le Grange, Agras & Dare, 2001).

In short, the focus of FBT in AN aims to restore weight through normal eating behaviour. It follows a non-blaming stance regarding the aetiology of AN, separates the illness from the client, and empowers the parent to help their child (Chen et al., 2016). Research by Russell, Szmulker, Dare & Eisler (as cited in Rhodes, 2003, p.191) found that family therapy was superior with patients under eighteen years whose illness had endured less than three years, but that individual therapy was superior for patients over eighteen years of age.

#### **2.8.4 Dialectical-behavioural therapy (DBT) and eating disorders**

DBT is a very recent addition to the therapy modes in the treatment of eating disorders. It is based on an emotion-regulation model for ED symptoms, usually experienced during binge-purge episodes in BN. It has its grounding in behavioural principles, dialectics, and eastern philosophy (Wisniewski, Safer & Chen, as cited in Dimeff & Koerner, 2007, p.176).

Originally, DBT was specifically designed to treat individuals presenting with self-harm behaviours, such as self-cutting, suicidal thoughts/ideation, as well as urges towards suicide attempts. DBT is a modification of cognitive-behavioural therapy. In

its development, Dr. Marsha Linehan first tried applying standard CBT protocols on individuals who engaged in self-harm behaviours, made suicide attempts and struggled with severe emotional dysregulation. Being frustrated with the limited success of CBT, Linehan and her colleagues adapted their treatment approach by adding other types of techniques, until they developed a treatment that suited their needs. While the research on DBT was conducted initially with women who were diagnosed with Borderline Personality Disorder, DBT is presently adapted for use with women who binge-eat and present with emotional dysregulation during binge-purge episodes (Astrachan-Fletcher & Maslar, 2009).

From the DBT perspective, patients with eating disorders are conceptualised as using maladaptive means of regulating their emotions. This, in turn, leads to destructive behaviours (e.g. bingeing and purging) that would assist them in dealing with such distressing emotions. Instead of being able to deal with overwhelming negative affective states, patients use ED behaviours to regulate their emotional world (Dialectical Behavior Therapy Frequently Asked Questions, n.d.; Noordenbos, 2013). DBT-based therapy is aimed at teaching more mature adaptive affect regulation skills, and to target problem behaviours resulting from emotional dysregulation (Wisniewski, Safer & Chen, as cited in Dimeff & Koerner, 2007, p.175). Thus, it strengthens an individual's ability to effectively handle distress without losing control or acting destructively.

### **2.8.5 Eating disorders as an addiction - A vicious cycle treated with step programs**

Even though the viewpoint of equating eating disorders with addiction may be somewhat controversial, some professionals have suggested that sufferers of eating disorders have a 'dependence on starvation' (Jasper, 1989). There seems to be links in the behaviour patterns seen in eating disorders, to those identified in substance-abuse disorders or other forms of addiction: Loss of control, preoccupation with the abused substance (or any addictive element), use of the substance to cope with distress, and maintenance of the behaviours despite severe negative consequences for the individual or their families.

Marrazzi, Bacon, Kinzie and Luby (1995) as well as Noordenbos (2013) suggest that anorexics and bulimics may be biologically predisposed to an addiction cycle, which is set in motion by chronic dieting. Self-starvation may cause the brain to release opioids, which causes an emotional 'high'. It is suggested that ED sufferers become addicted to this feeling of euphoria.

Some programs attempt to blend features of addiction-model treatments, such as 'The 12 Steps', with medical-model programs which use cognitive-behavioural approaches. Kaustav and Basu (2010) report that some bulimia sufferers find benefit in attending 'Overeaters Anonymous' and other similar groups as adjuncts to treatment, or for preventing relapses. However, no clear data from short- or long-term outcome studies of these programs has been established.

### **2.8.6 Interpersonal psychotherapy (IP)**

IP is concerned with the interpersonal context of the individual – the relational factors that predispose, precipitate and perpetuate the ED sufferer’s distress (Robertson, Rushton & Wurm, 2008). IP describes a therapeutic technique based on tackling the ‘here-and-now’ of the sufferer’s problems from their own perspective, with a focus on day-to-day relationships. It functions within a precise framework which responds to objectives which are achieved on the basis of the priorities chosen by the individual (Eating disorders: Criteria for organizing resources and activities, n.d.). Addressing these aspects successfully may assist ED sufferers in dealing with the vast interpersonal and relational problems they present with.

### **2.8.7 Group interventions**

Group interventions draw upon the social context of interpersonal learning and experiencing that may facilitate an exit from isolation, and helps in developing interpersonal relationships and sharing experiences and insights. Group treatments, in its various theoretical considerations may be used as a standalone treatment, or to back up individual psychotherapy.

Psycho-education groups are especially useful in the initial stages of ED treatment, with the aim of imparting useful information about the illness and its evolution. Parent groups also offer the opportunity for parents of sufferers to exchange experiences, compare strategies for coping and their effectiveness, reduce feelings of isolation and blame, as well as enabling greater understanding of the illness (Eating disorders: Criteria for organizing resources and activities, n.d.; Noordenbos, 2013).

### **2.8.8 Self-help therapy approaches**

There are several self-help alternatives when considering ED treatments. These approaches offer the sufferer the opportunity to guide him- or herself by engaging in a self-help program aimed in the direction of recovery. Self-help therapy delivery models usually include mediums such as literature, video and other technologies.

The efficacy of self-help approaches has been demonstrated: Carter et al. (as cited in Kaustav & Basu, 2010, p.177) found that both CBT-based and nonspecific self-help approaches led to significant decreases in objective binge episodes and purging in participants. CBT-based self-help was associated with a greater reduction in intense exercise than nonspecific self-help. Another study conducted by Thiels et al. (as cited in Kaustav & Basu, 2010, p.177) compared 16 weeks of only CBT, with guided self-change using a manual. The guided self-change included 16 sessions, where a therapist merely encouraged the use of the manual and addressed motivation, obstacles, and emerging crises. Significant decreases occurred in overeating, vomiting, BITE scores, EAT scores and depression for both groups combined, indicating that self-help approaches of this nature may deliver similar results when compared to other major treatment approaches (Kaustav & Basu, 2010).

The benefits of using a self-help approach include being cost-effective and much cheaper than engaging in therapist-lead treatment, as well as providing treatment options in settings where trained therapists are not available (e.g. rural areas). Thus, self-help approaches are accessible to a larger population of sufferers who cannot,

or are not willing to, engage in therapist-led treatment approaches (Peterson, Mitchell, Crow, Crosby & Wonderlich, 2009).

The potential pitfalls of using a self-help approach include (Peterson et al., 2009):

- High drop-out rates.
- Procrastination (low sense of accountability).
- Education-level may influence the participant's ability to understand the concepts that are being conveyed and thus negatively influence their understanding of complex issues within the realm of eating disorders.
- Long-term recovery rates and treatment effects are difficult to establish.

## **2.9 Eating disorders research in South Africa**

As mentioned before, even though there are no current up-to-date prevalence rates for eating disorders in South Africa, Szabo's (2009) extensive work on eating disorders suggests that the problem is becoming more prevalent, especially in Black female populations who have migrated to urban settings. The acculturation process seems to influence such individuals to change their cultural patterns, emphasising the influence of industrialised society over 'rural- or native populations'. This process was also seen in Tanzania, where a study of women living there found that the incidences of eating disorders were directly related to the degree of exposure to Western culture and media (Eddy, Hennessey & Thompson-Brenner, as cited in Anthony & Swinson, 2009, p.246).

The notion that eating disorders exclusively affect only certain sections of the population is no longer valid. Increasing numbers of cases are being seen in males, women of all age groups and individuals from all races. Szabo (2009, p.34) cites

research that demonstrated 20% of adolescents, as well as 10% of young females studied from all races, drawn from urban community settings, report abnormal eating attitudes.

The actual prevalence rates for eating disorders in South Africa remains a significant research priority. In 2001, Caradas, Lambert and Charlton (2001) conducted research on South African girls ranging from 15 - 18 years. They focussed specifically on body dissatisfaction, and reported that 33% of White, 33% of Black African, and 20% of Mixed Ancestry girls experienced body dissatisfaction. More recently, Gitau, Micklesfield, Pettifor, and Norris (2014) aimed to examine the changes in eating attitudes, body-esteem and weight control behaviours among South African adolescents. They identified trends that adolescent males engaged in muscle gain practices and adolescent females in weight loss practices. Their results showed that more Black African than White African girls in urban settings were at risk of developing eating disorders, which they attribute to the ongoing westernisation in South Africa for changes in eating attitudes and body image dissatisfaction in South African adolescents. They believe this to be indicative of Western norms of thinness as the ideal becoming more prevalent in South Africa. Even though research highlights that eating attitudes and body dissatisfaction is increasing, without up-to-date statistics on prevalence rates the true extent of the problem of eating disorders in South Africa cannot be known.

## **2.10 Eating disorders management and treatment**

Research literature has highlighted that ED sufferers are high consumers of medical and social care. Thus, the complexities of their problems, and the medical financial

costs incurred by eating disorders and their treatment, set the stage for an uphill battle for those seeking specialist interventions in South Africa.

I have already highlighted the complexity of the nature of eating disorders treatment, which indicates the need for specialist multi-dimensional professional treatment interventions. Even though skilled clinical support is essential to diagnose, treat, and support ED recovery, research has indicated that ED specialists are not available in many communities and lack coordinated protocols (Eating Disorders Coalition, 2009).

An expose' of the facilities that publicly campaign their specialist interest and treatment options for eating disorders in South Africa is provided in Table 2.6. This information was obtained from internet searches for facilities advocating their treatment specialties in this field, as well as telephonic discussions with representatives from some of these facilities. This list includes government- and private psychiatric facilities/hospitals with specialist Eating Disorders Units and ED Programs in South Africa (i.e. self-defined 'specialists' services).

**Table 2.4: List of government- and private psychiatric facilities/hospitals with specialist Eating Disorder Units and ED Programs in South Africa**

<u>Institution name</u>	<u>Location</u>	<u>Facility Type</u>	<u>Governance</u>	<u>In-patient Treatment Time</u>	<u>Treatment costs</u>
Crescent Clinic	Johannesburg	Private Psychiatric Hospital with adjacent Eating Disorder Unit	Private Healthcare	3 weeks maximum	In excess of R50 000 for 3 weeks treatment

Tara Hospital Eating Disorder Unit	Johannesburg	Government Psychiatric Hospital	Government.	Chronic treatment offered (patients may be admitted for months)	No costs to the mental health care user
Oasis Counselling Centre	Plettenberg Bay	Registered Drug rehab centre	Private Healthcare	3 months	Not reported
Montrose Manor	Cape Town	Registered rehab centre	Private Healthcare	3 months	±R98 000 per month (quote obtained June 2015)
Imani Secondary care for eating disorders	Cape Town	Secondary care facility (specialising in treatment of eating disorders)	Private Healthcare	3 months	±R50000 per month (quote obtained January 2016)
Tharagay House	Cape Town	Extended Care facility (Specialising in Addictions and Eating Disorders)	Private Healthcare	Minimum 1 month, suggested 3 months	Not reported
Harmony Addictions Clinic	Cape Town	Extended treatment centre	Private Healthcare	1 – 3 Months	Not reported
Kennilworth Addiction treatment	Cape Town	Registered Rehab Facility	Private Healthcare.	Not reported	Not reported

A survey was conducted in Great Britain in 2002 by the Royal College of Psychiatrists of available ED services. They found that the prescribed provisions were *woefully inadequate* (Department of Health, Social Services & Public Safety, 2002).

When comparing the services offered in Great Britain to South Africa, the shortcomings in South Africa are quite obvious. Even though South Africa has healthcare facilities offering treatment options for ED sufferers, the previous table indicates that these are located predominantly in the cities of Johannesburg and

Cape Town. This spread of services hardly encapsulates the national population. Also, all the medium- to long-term treatment facilities are located in the coastal areas, even though Gauteng is South Africa's biggest urban hub. Based on this, within the South African context, multi-disciplinary behavioural health care clinics specialising in eating disorders and their treatment are generally under-developed and neglected, which enhances my reason for engaging in the process of exploring eating disorders in South Africa.

In the next chapter, the specific variable of perfectionism and the available literature will be reviewed.

## CHAPTER 3

### DISCOURSES ON PERFECTIONISM

*“Have no fear of perfectionism, you’ll never reach it”*

Salvador Dali

(as cited in Oxford Dictionary of Quotations by Subject, 2010, p.358)

#### 3.1 Defining perfectionists and perfectionism

Throughout our lives we set goals for ourselves, and standards which we try to maintain. We may wish to become better at a certain skill, excel at a task, maintain a healthy lifestyle, or work to change some aspect of ourselves. Even though such strivings seem normal to most, some individuals become obsessive - improving oneself begins to dominate and control all thoughts and behaviours. Such individuals may be called perfectionists.

David Burn (as cited in Anthony & Swinson, 2009, p.10) defines perfectionism as follows:

*“...people whose standards are high beyond reach or reason.”* and

*“...who strain compulsively and unremittingly towards impossible goals and who measure their own worth entirely in terms of productivity and accomplishment.”*

Whilst Kim (2011, para. 5) defines perfectionism as follows:

*“Perfectionism is a personality trait that is characterised by striving for extremely high standards, determining self-worth based on ability to achieve high*

*standards, and continuing to strive for certain standards despite the negative consequences.”*

### **3.2 Describing perfectionism**

Perfectionism is a construct that, over the years, has been conceptualised in several different ways. Personality traits are viewed as stable characteristics that make people unique (Anthony & Swinson, 2009). Generally speaking, perfectionism is a term ascribed to a personality trait which describes individuals who have very specific ideas concerning personal performance, outcomes, and standards in their lives. Such ideas dictate that individuals invest a lot of energy into that particular area of their life - they regard them as high priority and will usually pursue such priorities insistently, even beyond normal healthy limits.

Perfectionists have an intense fear of making mistakes or being judged. They tend to react negatively to manifestations of imperfection and often have discrepancies between self-expectations/standards and their performance (Ingles, Garcia-Fernandez, Vicent, Gonzalez, & Sanmartin, 2016). For the perfectionist, mistakes and flaws represent failures to live up to their own, or others' perceived expectations of perfection, and may be seen as evidence of personal deficiencies. As perfectionists' standards and evaluations are unrealistically high and stringent, perceived failures and negative self-perceptions become very common (Hewitt, Flett, & Ediger, 1995).

Perfectionism has emerged as an important construct with regard to the aetiology and maintenance of various types of psychopathologies (Flett & Hewitt, 2002; Peixoto-Placido, Soares, Pereira & Macedo, 2015). It is often associated with

specific psychological problems, including excessive anger, anxiety, social phobia, suicidal behaviour, body image problems, depression and obsessive-compulsive disorder (OCD) (Anthony & Swinson, 2009; Egan, Wade & Shafran, 2011). Anthony and Swinson (2009) identify common areas in life in which unreasonably high standards can lead to problems (i.e. areas prone to perfectionism):

- Performance at work or school.
- Neatness and aesthetics.
- Organisation and ordering.
- Writing.
- Speaking.
- Physical appearance.
- Health and personal cleanliness.

Hewitt and Flett (1991b) were amongst the first to conceptualise perfectionism as a multidimensional construct that incorporates self-related and interpersonal trait components, as well as self-presentational components. They identify three types of perfectionism (Flett & Hewitt, 2002):

1. Self-oriented perfectionism

An achievement-based dimension that involves the need for one's own perfection: Unrealistically high self-imposed standards, which are impossible to obtain. These standards are usually associated with self-criticism, and an inability to accept one's own mistakes and faults. Negative life events or perceived failures may lead to difficulties with depression. Expectations are self-imposed.

## 2. Other-oriented perfectionism

An interpersonal dimension that involves the need for others to be perfect: A tendency to demand others to meet your unrealistically high standards. There are thus high expectations which are imposed upon others.

## 3. Socially prescribed perfectionism

An interpersonal dimension that involves the belief that others expect perfection from oneself: A tendency to assume that others have expectations of you that are impossible to meet. Socially prescribed perfectionists usually believe that to obtain others' approval, they must meet these high standards. Unlike self-imposed perfectionism, the high standards are not self-imposed, but are rather believed to be imposed by others around you. A perception is held within the individual that expectations of perfection are imposed upon them.

Hill et al. (2004) identified eight different dimensions of perfectionism. These eight dimensions are:

- Concern over mistakes.
- High standards for others.
- Need for approval.
- Organisation.
- Parental pressure.
- Planfulness.
- Rumination.
- Striving for excellence.

While Szymanski's view (2011) identifies six different types of perfectionism:

- The absence of mistakes or flaws.
- Personal standards which are very high.
- Meeting an expectation, set by ourselves or by someone else.
- Order and organisation.
- Ideals that are *just right* experiences (it looks, feels, and sounds right).
- Absolutes: Knowledge, certainty and safety (to have absolute, complete, and comprehensive knowledge about something - to be convinced that this is the right direction to take. This is a satisfying feeling and comforting - it is a 100% guarantee. Another variation on this is when people chronically doubt their actions).
- Being the best and the *best of the best*.

Anthony and Swinson (2009) view perfectionism rather as a single construct with six dimensions. These dimensions include the following:

- Concern over mistakes (tendencies to be overly concerned about making mistakes).
- Personal standards (to have overly high personal standards).
- Doubts about actions (to doubt whether one has done things correctly).
- Organisation (to have an extreme need for organisation).
- Parental expectations (to have parents with unreasonably high expectations).
- Parental criticism (to have parents who are overly critical).

Regardless of whether one views perfectionism as a single concept, or as consisting of several related dimensions, most definitions appear to share the following features (Anthony & Swinson, 2009):

- Individuals who are perfectionistic tend to have standards and expectations that are very difficult, or impossible to meet.
- Although having high standards is often helpful, perfectionism is associated with having standards that are so high that they interfere with overall performance.
- Perfectionism is often associated with other problems such as anxiety or depression.

In addition to the trait dimensions of perfectionism, Hewitt, Flett and Fairlie (as cited in Hewitt et al., 1995) also describe social facets of perfectionism. This involves self-presentational styles where the individual strives to create an image of flawlessness to others. Their research into perfectionistic self-presentation identifies three major components to this construct:

1. The need to appear perfect.
2. The need to avoid appearing imperfect.
3. The need to avoid disclosure of imperfection.

Taking all the above-mentioned information into account, an operational definition of perfectionism is understood as a desire for perfection, a fear of imperfection, the equating of error to personal defectiveness, or the emotional conviction that perfection is the route to personal acceptance. It influences multiple areas of the person's thinking, with a strong intrinsic need to refrain from being viewed as imperfect, or noticing any personal defect within themselves.

### **3.3 Diagnosing perfectionism**

At the extreme end of this personality trait (i.e. perfectionism) is what may be termed '*clinical perfectionism*'. At this level, the trait is so pronounced that the impairment

caused by perfectionism in the sufferer's life is significant (Shafran, Cooper, & Fairburn, 2002). Anthony and Swinson (2009) associate perfectionism with a range of psychological issues:

- Depression
  - Perfectionistic thoughts and behaviours are often important in the maintenance of depression. Setting high standards and not achieving them contributes to feelings of inadequacy, disappointment and hopelessness.
  - Perfectionism has previously been recognised as a contributory regarding the maintenance of depression and anxiety disorders (Maloney, Egan, Kane & Rees, 2014).
- Generalised anxiety and worry
  - Not meeting the self-imposed standards for yourself (or others) may cause possible anxiety.
- Social anxiety and shyness
  - Fear around people and that one will be judged for not meeting the standards one feels others impose on one.
- Anger
  - Inflexible beliefs and imposing that way of thinking on situations and others (and oneself).
  - When one does not meet the standard, then one can become angry because it is so important for one.
- Obsessive-compulsive disorder
  - Perfectionism helps with maintaining OCD because compulsions need to be repeated over and over until they *feel right*. Also, the order in which activities are repeated or completed may also be inflexible.

- Body-image problems
  - People with eating disorders are inflexible and rigid with their rules about eating and food.
  - The excessive focus can be on aspects of food, weight, or a particular body part.

Anthony and Swinson (2009) stress the importance of understanding to what extent one's beliefs are inflexible: The more inflexible one's beliefs, and the more situations in which one has inflexible opinions, the more likely one is to struggle with perfectionistic thinking. In trying to understand the appropriateness of one's beliefs, Anthony and Swinson (2009) apply four key areas to assess the appropriateness of one's beliefs about standards and performance:

- The excessiveness of the standard.  
*"Can this goal really be met?"*
- The accuracy of the belief.  
*"Is it true that this standard has to be met before someone will accept me?"*
- The costs and benefits of imposing the standard.  
*"Does it help me in life to have this belief or standard?"*
- The flexibility of the standard or belief.  
*"Can I adjust my standards and beliefs when necessary?"*

At the heart of *clinical perfectionism* is the over-evaluation and over-dependence of achieving and achievement. Individuals judge themselves largely, or exclusively, in terms of working hard toward, and achieving personally demanding standards in areas of life deemed as extremely important. Their self-worth is dependent on achievement, and is a core maintaining factor in clinical perfectionism. The efforts

towards achievement are rigorous, despite having adverse effects on actual performance, and being made at the expense of other important areas of functioning in the individual's life (Shafran et al., 2002).

Burns (1980) maintains that perfectionism involves the compulsive pursuit of goals which are unrealistically high, and is learned from interactions with perfectionistic parents. He identified five categories of perfectionists (Burns, 1983):

1. Career perfectionists (compulsive belief that they need to be successful in all their professional activities).
2. Marital- or interpersonal perfectionists (compulsive belief that husbands and wives should never fight, for conflicts reflect badly on relationships).
3. Emotional perfectionists (compulsive belief that they need to be happy all the time and never have any negative feelings).
4. Moral perfectionists (compulsive belief that they need to punish themselves relentlessly whenever they fail to meet any moral standards, as well as not knowing how to forgive themselves).
5. Sexually perfectionistic women (belief that they are defective if they have difficulty in reaching an orgasm, or that their worth depends primarily upon their appearance). Sexually perfectionistic men (belief that they must always perform well during sex).

How one becomes a perfectionist will be described next. Consideration will be made to understanding its influence as a precursor to the development of eating disorders.

### 3.4 The development of perfectionism as a precursor to eating disorders

According to Anthony and Swinson (2009), attempts to find the exact origins of perfectionism have found that both internal- and external factors may be contributors. A review of literature from multiple researchers highlights the following list of factors that may contribute to the development and maintenance of perfectionism, as a precursor to developing an ED:

- Culture
  - Nielsen (2000) stresses the influence of Western standards of beauty and how they have become increasingly focused on a woman's thinness. These standards of beauty seem to have influenced women and men during the time of the emancipation of white women in developed countries after they were granted the right to vote, started working outside the home in large numbers, and became equal to white men in terms of college graduation rates.
  - Browne (1993) highlights the correlation between black women who identify with, or interact with, white upper class culture, and the increased possibility that they are to adopt *white* attitudes to physical appearance. These attitudes are such that among many upwardly mobile black Americans, a woman with a heavy body and large hips is considered more *lower class* looking than a skinny woman.
  - From the general association of extreme thinness with poverty, it may be understood that AN would be more prevalent in people with low income and socio-economic status. However, its high prevalence in middle to upper class and its colloquial label as a *disease of affluence*, are indicative of a paradoxical relationship with economic status. Selvini-Palazzoli (1985) asserts that the culture of affluent consumerism presents a strong contradiction in that as food becomes more abundant, so does

the demand for self-discipline, and the obligation to be thin increases as well.

- The mass media
  - The role of mass media in the incidence and prevalence of AN has been widely contended. Some regard the media as the purveyor of images to the public while others see the media as a symptom of a much deeper underlying cause.
  - Media exposure, perceived pressure to be thin, thin-ideal internalisation and thinness expectancies have all been shown to prospectively predict increased levels of disordered eating thinking and behaviours, such as body dissatisfaction, dieting and bulimic symptoms in adolescent and young females (Culbert et al., 2015).
  - In a study focusing on the relationship between media use and disordered-eating, Harrison and Cantor's (1997) content analysis of television programming revealed that 69% of female characters were thin, compared to 17% male. Similarly, when comparing women's- and men's magazines, on average, ten times more dieting articles and adverts were featured in women's magazines.
  - Dietz (1990) concluded that on an annual average, children and adolescents spend more time watching television than any other activity including being at school, with sleeping time being the only exception. Thus, television serves as a major source of information about the world, behaviour and appearances. By consistently featuring diet adverts and articles, the media is highly implicated in the development of eating disordered attitudes and behaviours.
  - Information and instruction: Being bombarded with standards about physical attractiveness by people in advertising, media, movies, and catalogues. This exposure to information in the media, talking to other

people, or other sources may be information which encourages a perfectionistic outlook on life (Anthony & Swinson, 2009).

- Social learning and influences
  - Parental bonding can be considered one of the most widely recognised aetiological factors regarding perfectionism. Parental expectations as well as parental criticism play an integral role in the development of perfectionism (Maloney et al., 2014). Modelling serves as a mechanism for learning perfectionism from other important people in one's life. This includes developing adverse ways of managing fear or trying to achieve approval from others (Anthony & Swinson, 2009).
  - Harrison and Cantor (1997) used Bandura's 1997 social learning theory to account for the process by which the thin body ideal and extreme dieting behaviour is promoted in the media through prevalence and depiction. They established a positive correlation between the prevalence of diet-related images, adverts, thin-bodied models/characters and the modelling of extreme dieting behaviours. Anticipated external rewards such as social acceptance and fame serve as incentive and reinforcement for such behaviours.
  - Levine (2000) stresses that the association with the thin ideal is more from the internalisation of this ideal, rather than the mere depiction or viewing of such media images. He does, however, acknowledge that by their emphasis on physical beauty, these images foster self-evaluation and self-development along unattainable ideals, which may *pressure* women to attempt harmful means to their attainment.
  - Keel and Forney (as cited in Culbert et al., 2015) report that during the 20<sup>th</sup> century, the idealisation of thinness in women and the incidences of AN and BN have increased significantly. This indirectly supports the

notion that increases in the idealisation of thinness results in an increased risk in developing eating disorders (Culbert, Racine & Klump, 2015).

- Reward, reinforcement and possible punishment: Being rewarded for perfectionistic behaviours by rewards and society, or the individual's attempts to avoid punishment for behaviours and actions, which may include criticism from others. Perfectionism can also be enforced by not doing well enough (Anthony & Swinson, 2009).
- The genetic basis for perfectionism
  - Serretti et al. (as cited in Anthony & Swinson, 2009) have previously indicated that genetics plays a role in the development of various personality traits and evidence suggests that perfectionism is no exception (Tozzi et al., & Serretti et al., as cited in Anthony & Swinson, 2009).
  - The observed direct relationship between perfectionism and AN assisted researchers in establishing the genetic basis for such conditions. A genetic trait was postulated that influences the likeliness for an individual to develop an ED. In focusing on family systems where eating disorders were prevalent in multiple generations, perfectionism was found to be a predisposing personality trait because of how commonly it was found in the background of those with AN. This allowed researchers to suspect that this personality trait could be a possible marker of genetic risk factors contributing to the development of an ED (Livni, as cited in Kim, 2011).

A perfectionistic personality style has been described frequently as a central feature of eating disorders. Several theorists such as Bruch and Casper (as cited in Hewitt et al., 1995) have hypothesised a pathogenic role for perfectionistic tendencies in eating disorders. Previous research by Garner, Olmsted, Polivy, and Garfinkel (as

cited in Hewitt et al., 1995) have supported the view that individuals with an ED have unrealistic standards for physical attractiveness and thinness, as well as having a disposition involving unrealistic expectations and strivings in various situations (Strober, as cited in Hewitt et al., 1995). Also, perfectionism has been highlighted in Fairburn's transdiagnostic model of eating disorders (Fairburn, 2008), as well as the cognitive-interpersonal maintenance model of AN (Lavender et al., 2016).

Since the first descriptions of AN, perfectionism has been identified as a key trait amongst sufferers. Lasegue (1873) described an insistent pursuit of unusually rigid standards of propriety in his AN patients. He also highlighted their extreme sensitivity toward their parents' judgements. Bruch (1973) also focused on the excessive efforts to live up to a perfectionist's standards of achievement, which was viewed as a main contributory in AN. Similarly, Slade (1982) pointed to neurotic perfectionism as one of the major predisposing factors contributing to the emergence and maintenance of an ED. He argued that dissatisfaction with the *self*, restricting food intake to control body weight, and the desire to be perfect, culminates in a need to establish order and exert control over one's life and body.

While it remains unclear to what *exact* extent psychological factors contribute to the development of an ED, Arnold and Walsh (2007) have shown that certain personality traits and cognitive styles are generalised for the ED population. Perfectionism in itself does not imply the development of an ED, although in many cases of eating disorders its presence is significant. They highlight studies indicating that recovered anorexics tend to be more perfectionistic, and have more generalised anxiety than people who were never treated for such a disorder. Such a combination of factors

point to clinical perfectionism in an individual with an ED, which will be described next.

### **3.5 Clinical perfectionism in eating disorders**

Many clients diagnosed with AN present with high levels of perfectionistic tendencies: Overachievers that excel in a variety of aspects, obey authority figures beyond healthy limits, and focus excessively on pleasing those around them (Kim, 2011). Early writings in personality analyses of AN individuals identified a character configuration best described as obsessive-compulsive, with constriction of affect, excessive conventionality, perfectionistic and moralistic tendencies, and a strong achievement orientation (Swift, Bushnell, Hanson & Logemann, as cited in Sutandar-Pinnock, 2001). It has also been previously suggested that AN is a manifestation of OCD (Rothenberg, as cited in Sutandar-Pinnock, 2001).

Slof-Op't Landt, Claes and van Furth (2016) emphasise that perfectionism and impulsivity are two of the core personality features implicated in eating disorders. It has been shown that perfectionism predicts the onset of inappropriate compensatory behaviours as well as the onset and maintenance of eating disorders. Fairburn, Cooper and Shafran (2003, p. 511) assert that *clinical perfectionism* is one of four core mechanisms that maintain ED pathology, and if it were to be ameliorated then "...a potent additional network of maintaining mechanisms would be removed thereby facilitating change".

The influence of clinical perfectionism in eating disorders thus seems evident. Empirical evidence also support this view. In a large study involving 1000 female

twins aged 25 - 65 years, the question was posed as to the possible link between perfectionism and psychological problems. Within the findings, most ED clients reported that their perfectionistic characteristic was present before their AN developed. Perfectionism was identified as a specific trait which increased the risk of developing an ED, but not for other psychiatric syndromes such as depression, alcoholism, anxiety disorders or phobias (Perfectionism linked to eating disorders, 2003). The findings suggested a uniqueness surrounding perfectionism, which predisposes an individual for being at risk to develop an ED.

In the three-factor theory by Bardone-Cone and colleagues (Bardone-Cone et al., 2008), the interaction between high perfectionism, high body dissatisfaction, and low self-esteem are implicated in the development of bulimic behaviour (Bardone-Cone et al., 2007). In support of these theoretical positions, research consistently shows perfectionism to be elevated in people with eating disorders and people recovering from eating disorders, compared to controls. However the precise nature of the construct of perfectionism continues to be debated in the literature (Wade & Tiggemann, 2013).

Clinical perfectionism tends to affect many aspects of those living with eating disorders, but is particularly obvious in the dietary- and weight goals that eating disordered individuals set for themselves (Fairburn, 1995). Anorexic clients also show markedly increased concerns about making mistakes, doubts about their actions and personal standards (Kim, 2011). Research conducted on 322 women in the USA and Europe concluded that there is a direct relationship between AN and perfectionism. The extent of perfectionism was directly associated with the severity of

each individuals' case of AN (Livni, as cited in Kim, 2011). Therefore, when high levels of personal standards seem accompanied by psychological vulnerabilities, problems relating to eating disorders may be prone to develop (Kim, 2011).

One research study (Sutandar-Pinnock, Woodside, Carter, Olmsted, & Kaplan, 2003) attempted to identify the particular relationship between perfectionism and AN. At the University of Toronto (USA), three types of populations were compared to each other: Individuals with AN (restricting type), weight restored AN clients, and a healthy control group. These three groups were compared during an intervention study. Pre- and post-intervention assessments included the Multidimensional Perfectionism Scale (MPS), and the Eating Disorder Inventory - Perfectionism (EDI) Subscale, to measure the aspects of perfectionism. Prior to intervention, the assessment results highlighted that the two groups with an ED scored significantly higher than their control counterparts when focusing on perfectionism. Post-treatment perfectionism ratings for weight-restored participants had no significant difference in comparison to the control group. Additionally, participants in the follow up good-outcome group had achieved significantly lower perfectionism scores than participants in the poor outcome group, and the poor outcome group's perfectionism scores remained significantly elevated above those of the control group. The study's results concluded that individuals suffering from AN are more perfectionistic than healthy controls and scores for perfectionism remain significantly high even for those in remission. The observed association between higher degrees of perfectionism prior to treatment, and poorer overall response, indicated that those who were very perfectionistic tend to be less likely to complete treatment. Thus, the severity of their ED was a reflection of their level of perfectionism (Sutandar-Pinnock et al., 2003).

Forbush, Heatheron and Keel (2007) attempted to investigate the varying degrees of differences of perfectionism between the two subtypes for AN. Although results suggested that fasting in the restrictive-subtype AN was a strong indicator of perfectionism and rigidity, this was countered by purging in the binge-purging subtype AN as an equally strong indicator. Thus, temporal preferential difference (whether before or after) and method (fasting or purging) did not seem to indicate particular varying degrees of perfectionism per sé. This seems to concur with Keel (as cited in Jiyane, 2007) as well as Van der Ham, Meulman, Van Strien, and Van Engeland's (1997) contention of a continuum of eating pathology, rather than two distinct categories.

Next, I consider four important aspects of perfectionism, and their contribution to the development of an ED.

### **3.5.1 Adaptive perfectionism VS Maladaptive perfectionism**

There is a difference between high achievers, who are mostly driven by goals to achieve, and perfectionists, who are driven by fears of failure. The negative reactions to mistakes, as well as the tendency to view mistakes as reflections of personal failures, are judged as one of the most significant contributing factors to the development of an ED (Perfectionism linked to eating disorders, 2003).

Perfectionism per sé is not necessarily a negative personality trait. It may be judged as normal and adaptive, which serves as a motivating factor for success and achievement (Hamachek, 1978; Maslow, 1970). Perfectionism is characterised by an internal desire for success and the motivation to work hard towards realistic and

achievable goals, whilst leaving room for error (Rice & Preusser, 2002). Those who display more healthy forms of perfectionism, are not likely to feel so personally threatened or have their confidence adversely affected by disappointment or failure (Kim, 2011).

Maladaptive perfectionism, however, describes people who experience excessive concern about making mistakes, doubt their actions, and tend to procrastinate, feel tense and anxious, and may report having highly critical parents who had unrealistic expectations for their children (Rice, Ashby, & Slaney, 1998). When perfectionism becomes neurotic and maladaptive, it hinders healthy development by setting unattainable goals and perpetuating a dread of failure, judgement from others, as well as leaving the individual feeling unsatisfied, or never feeling *good enough* for themselves (Hamachek, 1978; Maslow, 1970). Individuals that display destructive aspects of perfectionism have more strict standards of performance and are more likely to feel threatened when faced with the concept of failure. An example of this would be found in very self-critical aspects of AN. These individuals are more likely to create strict rules for their eating habits, weight and appearance (Kim, 2011).

Szymanski (2011) identifies a distinct difference between healthy and unhealthy perfectionism. Between these groups there are differences in intention, strategy, desired outcomes, and actual outcomes:

1. Healthy perfectionism

The rewards are greater than the costs. These are standards set by the individual themselves and there is a high regard for organisation. It is associated with:

- Higher achievement.

- More self-esteem.
- More positive feelings.
- More satisfaction with life.
- An active coping style (versus avoidant).
- More social support.
- More academic success (e.g. higher grades).
- Ease in interpersonal relationships.
- Higher levels of conscientiousness.
- Higher levels of extroversion.
- Less depression.
- Less anxiety.
- Less procrastination.
- Less self-blame.

## 2. Unhealthy perfectionism

The individual's behaviour, choices and strategies are driven by factors such as a fear of failure, chronic concerns about making mistakes, constant self-doubting, attempts to live up to others' expectations of them, anxiety about always falling short of self-made goals, as well as whether the costs outweigh the benefits.

## 3. Non-perfectionists

These individuals seem to care less about the outcomes of their behaviours. They do not have particularly high standards and in many cases they are fine with being average and just contributing to a mediocre effort.

In comparing the advantages and disadvantages of perfectionism, Szymanski (2011) identifies commonly mentioned benefits and costs associated with perfectionism.

**Table 3.1: Benefits and costs associated with perfectionism (Szymanski, 2011, p. 35)**

<b>Advantages of Perfectionism</b>	<b>Disadvantages of Perfectionism</b>
Sense of competence, confidence, and self-esteem	Chronic feelings of anxiety and stress
Increased feelings of satisfaction	Chronic feelings of guilt and disappointment about not achieving something important
Increased feelings of accomplishment and achievement	Chronic feelings of anger and frustration at yourself and others
Viewed by others as dependable	Chronic exhaustion, fatigue, and low energy
Sense of appreciation of others	Low self-esteem
Release of tension	High effort for poor returns
Avoidance of ambiguity and uncertainty	Things become easily undone, even when done right initially
Avoidance of <i>catastrophic</i> consequences of making mistakes (looking stupid, feeling embarrassed, etc.).	High consumption and upkeep demands that you detract from other life goals or experiences
Increased attention and praise from others	False sense of security
Sense of uniqueness or specialness	Rigid and controlling interpersonally
	High levels of task avoidance, procrastination, and missed deadlines.

When focussing specifically on maladaptive perfectionists, Burns (1980, 1983) identified the following cognitive distortions in their thinking:

- All-or-nothing thinking (either totally successful, or a complete failure).
- Over-generalisations (tending to view a mistake or setback as a never-ending pattern of defeat).
- “Should” statements and mental filters (picking out negatives in a situation and dwelling on them so that their reality becomes distorted).
- Disqualifying the positive.
- Jumping to conclusions.
- Magnifying the importance of their errors.
- Emotional reasoning (assuming that their negative emotions reflect the way that they really are).
- Personalisation (blaming themselves for the problems of others because they hold themselves responsible for negative events that they cannot control).

The problem with maladaptive perfectionism in eating disorders is that it sets such high standards, that little is ever good enough, or *perfect enough*. This may trap the person in a cycle of dissatisfaction and self-hatred (Arnold & Walsh, 2007). These self-perceived repeated *failures* can be undermining, especially if self-esteem is already low (Fairburn, 1995). Maladaptive perfectionism also makes change in treatment difficult: Clients are rigid in thinking styles, and may also apply their strict standards to the treatment itself - which tends to complicate matters and slow progression and recovery as a whole (Fairburn, 2008).

### **3.5.2 Conditional self-acceptance VS Unconditional self-acceptance**

Perfectionists are unduly negatively critical of their own performances and have a general need for approval from those around them. They are driven by failure and not by the goals they want to achieve, and are more likely to have negative reactions to their own mistakes, or to view their mistakes as failures (Kim, 2011). In terms of weight, conditional self-acceptance seems to be obtained through attaining a certain weight. Likewise, when considering performance or competence, conditional self-acceptance seems obtainable through attaining self-perceived perfection or exceptionally high achievement.

In Kim's (2011) therapy experiences conditional self-acceptance seems rooted in earlier childhood experiences where the foundation for such thinking was cultivated. Upon educating the individual on this aspect, some may not even be aware of this schema of self-evaluation, as they would claim it has been their way of thinking for most of their lives, which is reminiscent of personality disorder traits.

Hewitt et al. (1995) suggest different mechanisms as to how perfectionism can function in eating disordered behaviour. Firstly, they suggest that perfectionism can influence both the frequency and impact of distressing environmental events. As highly perfectionistic individuals have stringent evaluative criteria, falling even slightly short of a goal, may be viewed as a catastrophic failure. Thus, the probability of experiencing such significant failure is increased. Secondly, other environmental- or developmental events may have a marked negative impact as perfectionists may interpret such events as indicating their lack of perfection. Thus, perfectionism may be relevant to ED symptoms in the sense that individuals may require themselves to meet ideal body- or weight standards that derive from themselves or others. Thirdly, a strong need for perfectionistic self-presentation can influence eating behaviour by not allowing the person to display imperfections, or admit to difficulties. Thus, these sorts of personality tendencies may be relevant in body image avoidance and symptoms that presumably highlight the individual's imperfections.

Hewitt, et al.'s (1995) study suggests that the strong need to present to others an image of perfection, or avoid revealing imperfection in the self, are significantly related to both AN and BN tendencies. Also, the link between a perfectionistic style of self-presentation and poor self-esteem was particularly strong: Striving to appear flawless is an attempt to compensate for low self-esteem. Hewitt et al. (1995) concluded in their findings that self-oriented perfectionism may be specifically linked to dieting and concerns with being thinner, but may not be as involved in other aspects of eating disordered behaviour. Their findings that socially prescribed perfectionism is related broadly to disordered eating patterns and concerns about appearance and self-esteem, lends support to other conceptualisations suggesting

that some perfectionistic striving seen in eating disordered behaviour, is motivated by strong needs to conform to a model or ideal of perfection that is perceived as demanded by the self or others. What seems to be a key determinant of this motivation is the central belief that one must be acceptable to others by meeting their perceived perfectionistic requirements (Hewitt et al.,1995).

Dunkley, Zuroff and Blankstein (2003) distinguish between two dimensions within perfectionism: Personal standards (PS) perfectionism and Self-critical (SC) perfectionism. PS perfectionism involves the setting of high standards and goals for oneself. On the other hand, SC perfectionism involves constant and harsh self-scrutiny, overly critical evaluations of one's own behaviour, an inability to derive satisfaction from successful performance, and chronic concerns about others' criticism and expectations. Their research highlights the specific personality structure of SC perfectionists. SC perfectionists are theorised to quickly blame and condemn their abilities and personal qualities, which they view as fixed and deep-seated. SC perfectionists become preoccupied with their deficiencies and their inability to handle a stressful situation, engaging instead in avoidance of threatening stimuli. SC perfectionists' self-blame and denigration also explain their perceptions of low efficacy and expectations of criticism from others in their dealing with the stressful situation, which also contributes to their use of avoidant coping styles (Dunkley et al., 2003).

The tendency to engage in avoidant coping styles might serve both to impede adaptive coping, and to increase the severity of the stressors that an SC perfectionist experiences. In addition, it is hypothesised that SC perfectionists believe they have

less social support available to them in times of stress. Thus, these individuals lack an important resource to encourage more adaptive coping strategies and make stressful situations seem less overwhelming (Dunkley et al., 2003).

In summary, SC perfectionists are believed to experience chronic dysphoria because of their tendency to perceive that they have much at stake, have daily stressors that they need to disengage from, and that others are unwilling or unavailable to help them in times of stress. Thus, in stressful situations, SC perfectionists blame their perceived deficiencies, thereby becoming preoccupied with their low self-worth, which partly explains their use of avoidant coping. Finally, SC perfectionists lack confidence in their ability to handle stressful situations adequately, which also partly explains their avoidant coping tendencies (Dunkley et al., 2003).

### **3.5.3 Achieving control through perfectionism**

In general, dieters tend to be more perfectionistic in their thinking than non-dieters. Perfectionism affects their thought patterns and increases their drive to be thin (i.e. '*Thinspiration*'). As much as western culture views the drive for thinness as a positive trait, fatness is viewed as a negative trait. Social learning in this manner teaches children from a young age to discriminate against being overweight, which in the end may encourage perfectionism. The failure to maintain self-control required during dieting and the negative feelings that may result from failing to do so, can thus precipitate the development of an ED (Anthony & Swinson, 2009).

Due to the self-critical nature of perfectionism, individuals value their achievements, independence and freedom from control by others; but their achievements are

measured by high internal standards. These unreasonably high standards set them up for feelings of failure, disappointment, guilt and self-blame (Blatt et al., as cited in O'Garro-Moore, Adams, Abramson & Alloy, 2015). These standards, together with overly critical self-evaluation, results in confinement in a self-perpetuating cycle of dissatisfaction in one's performance (Kim, 2011). The most common way to gain control over one's physical appearance is through dieting. Kim states that:

*Forcing themselves to lose weight acts as a source of control for these individuals and also makes them feel successful... Anorexia Nervosa has been common in individuals who want control over eating and weight. In perfectionism, a key component is control (Kim, 2011, para. 12).*

Anthony and Swinson (2009) identify perfectionistic thoughts related to eating and weight:

- "Some foods are forbidden; some are permissible."
- "If I eat a forbidden food, then I have messed up my diet."
- "If I eat a bit of forbidden food, I may as well eat tons of it, since I already broke my diet."
- "If I eat forbidden food, I'll get fat."
- "If I start to eat, I'll lose control."
- "I can never be too thin."
- "I feel fat, therefore I AM fat."
- "If my clothes are too small, it's because I am fat."
- "I have to exercise (purge, take laxatives, and so on) after eating, or I'll get fat."
- "You can't get anywhere in this world if you're fat."
- "I'll never find a boyfriend/girlfriend (or a job, friends, and so on) unless I am thin."

- “I’ll only be special and unique if I’m thin.”
- “If I gain a few pounds, I’ll keep going until I’m obese.”
- “I have to look like...” (model, actress, etc.).

Addressing perfectionistic thoughts would mean teaching individuals to recognise their own needs, wants, and limits - which would generate a more flexible lifestyle for them (Zucker, 2003). This way of thinking is in stark contrast to the high standards they live by through stringent control of their food intake and weight. They believe their drive to be thin is a positive trait, and assists them to avoid becoming overweight, their own self-criticism, feelings of failure, or guilt.

#### **3.5.4 Body image problems**

Anthony and Swinson (2009) identify how some individuals may have perfectionistic beliefs on aspects of physical appearance other than the concept of weight. They may become very focused on a particular part of their body which they view as imperfect. These beliefs may interfere to such an extent with the individual’s functioning, that it may contribute to the development of Body Dysmorphic Disorder (BDD). BDD is associated with extreme rigid and perfectionistic thinking regarding physical appearance.

Studies have attempted to identify the way in which perfectionism relates to the risk factors for eating disorders. This is particularly true for body dissatisfaction which is considered to be a robust risk factor for eating pathology along with a related construct of weight concern (Wade & Tiggemann, 2013). Boone et al. (as cited in Culbert et al., 2015) suggests that perfectionism interacts with body dissatisfaction to

predict increases in drive for thinness and over-evaluation of weight and shape. These constructs have been found to predict the development of disordered eating in adolescent samples across a number of studies, resulting in their status as *the best confirmed and most potent risk factor* for eating disorders (Jacobi & Fittig, as cited in Wade & Tiggemann, 2013).

### 3.6 Assessing perfectionism

Many different self-report measures have been developed to study perfectionism, each based upon the conceptualisation of perfectionism held by the authors of that measure. Egan, Wade, Shafran, and Antony (2014, p. 50) offer the following self-report measures for perfectionism, divided into sub-fields of General Perfectionism Measures, Cognitions, Relationships, Sport, Eating Disorders and Body Image, as well as Children.

**Table 3.2: General perfectionism measures (Egan et al., 2014, p. 61)**

<b>General Perfectionism Measures</b>			
<b>Measure</b>	<b>Purpose</b>	<b>Length</b>	<b>Comments</b>
<i>Almost Perfect Scale-Revised</i> (APS-R; Slaney et al., 2001)	Assesses three dimensions of perfectionism: (1) high standards, (2) order, and (3) discrepancy.	23 items	<ul style="list-style-type: none"> <li>Well researched; strong psychometric properties.</li> <li>Distinguishes between adaptive and maladaptive perfectionism.</li> <li>Translated into multiple languages.</li> </ul>
<i>Behavioral Domains Questionnaire</i> (BDQ; Lee et al., 2011)	Assesses the behavioural expressions of perfectionism across five life domains: (1) housework, (2) work, (3) social, (4) hobbies, and (5) appearance.	37 items	<ul style="list-style-type: none"> <li>Assesses seven different types of perfectionistic behaviours.</li> <li>Preliminary evidence supports clinical utility.</li> </ul>
<i>Burns Perfectionism Scale</i> (BPS; Burns, 1980)	Assesses clinical perfectionism.	10 items	<ul style="list-style-type: none"> <li>One of the first published perfectionism measures.</li> <li>Widely cited but little is known about its psychometric properties.</li> </ul>

<i>Clinical Perfectionism Questionnaire</i> (CPQ; Fairburn et al., 2003a)	Assesses clinical perfectionism.	12 items	<ul style="list-style-type: none"> <li>• Scale has well-supported psychometric properties.</li> <li>• Useful scale for assessing in perfectionism across sessions.</li> </ul>
<i>Consequences of Perfectionism Scale</i> (COPS; Kim, 2010)	Assesses perceptions of perfectionism as being either adaptive or maladaptive.	10 items	<ul style="list-style-type: none"> <li>• Preliminary research supports reliability and validity.</li> </ul>
<i>Frost et al. Multidimensional Perfectionism Scale</i> (FMPS; Frost et al., 1990)	Assesses six dimensions of perfectionism: (1) concern over mistakes, (2) doubts about actions, (3) personal standards, (4) parental expectations, (5) parental criticism, and (6) organization.	35 items	<ul style="list-style-type: none"> <li>• One of the two best-studied and most popular scales for measuring perfectionism.</li> <li>• Good support for psychometric properties, except for mixed evidence regarding the number of factors.</li> <li>• Translated into multiple languages.</li> </ul>
<i>Hewitt and Flett Multidimensional Perfectionism Scale</i> (HMPS; Hewitt & Flett, 1991b)	Assesses three dimensions of perfectionism: (1) self-oriented perfectionism, (2) other-oriented perfectionism, and (3) socially prescribed perfectionism.	45 items	<ul style="list-style-type: none"> <li>• One of the two best studied and most popular scales of measuring perfectionism.</li> <li>• Strong support for psychometric properties.</li> </ul>
<i>Neurotic Perfectionism Questionnaire</i> (NPQ; Mitzman et al., 1994)	Designed to measure perfectionism in people with eating disorders, though content of items is general.	42 items	<ul style="list-style-type: none"> <li>• No data on psychometric properties.</li> <li>• Scale is not widely used.</li> </ul>
<i>Perfectionism Inventory</i> (PI; Hill et al., 2004)	Assesses eight domains of perfectionism: (1) concern over mistakes, (2) high standards for others, (3) need approval, (4) organization, (5) perceived parental pressure, (6) planfulness, and (7) rumination (8) striving for excellence.	59 items	<ul style="list-style-type: none"> <li>• Original journal article suggests good psychometric properties.</li> <li>• Not widely used or studied</li> </ul>
<i>Perfectionistic Self-presentation Scale</i> (PSP; Hewitt et al., 2003)	Assesses the desire to appear perfect in front of others across three dimensions: (1) perfectionistic self-promotion, (2) non-display of imperfection. (3) nondisclosure of imperfection	27 items	<ul style="list-style-type: none"> <li>• Preliminary research supports psychometric properties.</li> </ul>
<i>Positive and Negative Perfectionism Scale</i> (PANPS; Terry Short et al., 1995)	Assesses positive and negative aspects of perfectionism.	40 items	<ul style="list-style-type: none"> <li>• Psychometric support is mixed.</li> <li>• One study suggests that a briefer (19-item) version may be more useful.</li> </ul>

**Table 3.3: Perfectionist-related cognitions measures (Egan et al., 2014, p. 63)**

<b>Perfectionist-related Cognitions</b>			
<b>Measure</b>	<b>Purpose</b>	<b>Length</b>	<b>Comments</b>
<i>Perfectionism Cognitions inventory</i> (PCI; Flett et al., 1998)	Assesses the frequency of automatic thoughts involving themes of perfectionism.	25 items	<ul style="list-style-type: none"> <li>• Preliminary research supports psychometric properties.</li> </ul>
<i>Multidimensional Perfectionism Cognitions Inventory-English</i> (MPCI; Kobori, 2006)	Assesses cognitions associated with self-oriented perfectionism and socially prescribed perfectionism along three dimensions: (1) personal standards, (2) pursuit of perfection, and (3) concern over mistakes.	15 items	<ul style="list-style-type: none"> <li>• Preliminary research supports psychometric properties.</li> </ul>

**Table 3.4: Perfectionism in relationships measures (Egan et al., 2014, p. 63)**

<b>Perfectionism in Relationships</b>			
<b>Measure</b>	<b>Purpose</b>	<b>Length</b>	<b>Comments</b>
<i>Dyadic Almost Perfect Scale</i> (DAPS; Shea & Slaney, 1992)	Assesses perfectionistic beliefs about one's partner along three dimensions: (1) high standards, (2) order, and (3) discrepancy.	26 items	<ul style="list-style-type: none"> <li>• Preliminary research supports psychometric properties.</li> </ul>
<i>Family Almost Perfect Scale</i> (FAPS; Wang et al., 2010)	Assesses beliefs regarding family members' standards along three dimensions: (1) family standards, (2) family order, and (3) family discrepancy.	17 items	<ul style="list-style-type: none"> <li>• Preliminary research supports psychometric properties.</li> </ul>
<i>Multidimensional Parenting Perfectionism Scale</i> (MPPS; Snell et al., 2005)	Assesses perfectionism in context of parenting (includes eleven subscales)	65 items	<ul style="list-style-type: none"> <li>• More research needed on psychometric properties.</li> </ul>

**Table 3.5: Perfectionism in sport measures (Egan et al., 2014, p. 64)**

<b>Perfectionism in Sport</b>			
<b>Measure</b>	<b>Purpose</b>	<b>Length</b>	<b>Comments</b>
<i>Sport Multidimensional Perfectionism Scale-2</i> (Sport-MPS-2; Gotwals & Dunn, 2009)	Assesses perfectionism in the context of sport along six dimensions: (1) personal standards, (2) concern over mistakes, (3) perceived parental pressure, (4) perceived coach pressure (5) doubts about actions,	42 items	<ul style="list-style-type: none"> <li>• Preliminary research supports psychometric properties.</li> </ul>

	(6) organization.		
<i>Sport Perfectionism Scale</i> (SPS; Anshel et al., 2009)	Assesses sport-related perfectionism.	35 items	<ul style="list-style-type: none"> <li>• Preliminary research supports psychometric properties, including unidimensional factor structure.</li> </ul>

**Table 3.6: Perfectionism, eating disorders and body image measures (Egan et al., 2014, p. 64)**

<b>Perfectionism, Eating Disorders and Body Image</b>			
<b>Measure</b>	<b>Purpose</b>	<b>Length</b>	<b>Comments</b>
<i>Eating Disorders Inventory-Perfectionism Subscale</i> (EDI-P; Garner, 1991)	Assesses perfectionism in the context of eating disorders.	6 items	<ul style="list-style-type: none"> <li>• Part of the EDI-3, a popular and well-established measure for eating disorders.</li> </ul>
<i>Physical Appearance Perfectionism Scale</i> (PAPS; Yang & Stoeber, 2012)	Assesses perfectionism about physical appearance along two dimensions: (1) worry about imperfection, and (2) hope for perfection	12 items	<ul style="list-style-type: none"> <li>• Preliminary research supports psychometric properties.</li> </ul>

**Table 3.7: Perfectionism in children measures (Egan et al., 2014, p. 65)**

<b>Perfectionism in Children</b>			
<b>Measure</b>	<b>Purpose</b>	<b>Length</b>	<b>Comments</b>
<i>Adaptive/Maladaptive Perfectionism Scale</i> (AMPS; Rice & Preusser, 2002)	Assesses perfectionism in children ages 9 to 12 years, along four dimensions: (1) sensitivity to mistakes, (2) contingent self-esteem, (3) compulsiveness, and (4) need for admiration.	27 items	<ul style="list-style-type: none"> <li>• Preliminary research supports psychometric properties.</li> </ul>
<i>Child and Adolescent Perfectionism Scale</i> (CAPS; Flett et al., 2000)	Assesses perfectionism in children along two dimensions: (1) self-oriented perfectionism, and (2) socially prescribed perfectionism.	22 items	<ul style="list-style-type: none"> <li>• Preliminary research supports psychometric properties.</li> </ul>
<i>Childhood Retrospective Perfectionism Scale</i> (CHIRP; Southgate et al., 2008)	Assesses childhood perfectionism retrospectively, with an emphasis on obsessive-compulsive personality traits.	20 items	<ul style="list-style-type: none"> <li>• Two versions available (20 items each)-one for the individual to report on his/her own perfectionism in childhood, and one for an informant to complete.</li> <li>• Preliminary research supports psychometric properties.</li> </ul>
<i>Perfectionistic Self-</i>	Assesses perfectionistic	18 items	<ul style="list-style-type: none"> <li>• Preliminary research supports</li> </ul>

<i>Presentation Scale-Junior Form</i> (PSPS-JR; Hewitt et al., 2011)	self-presentation in children and adolescents across three dimensions: (1) perfectionistic self-promotion, (2) nondisplay of imperfection, and (3) nondisclosure of imperfection.		psychometric properties.
--	--	--	--------------------------

### 3.7 Methodological issues in the study of perfectionism within eating disorders

As it became clear that perfectionism was emerging as a common personality characteristic amongst individuals with eating disorders, researchers started investigating whether perfectionism, as a personality trait, would persist with weight restoration and recovery from the disorder. In this chapter I have already highlighted the theoretical considerations as to how perfectionism is a contributing personality construct of eating disorders. The evidence presented indicates that perfectionism might improve as weight regain is achieved. It would therefore be important to consider the relationship of perfectionism to eating disorders, especially with respect to the influence of weight regain on perfectionism, to determine if there are any correlations or significant insights that may be relevant in understanding the interplay hereof in eating disorders.

Investigations on personality with respect to AN sufferers needs to consider the effect of acute starvation on such aspects. Several studies have shown changes in personality with weight restoration, including lower obsessiveness and increased sociability and extroversion (Strober, as cited in Sutandar-Pinnock, 2001). In a study of personality traits associated with AN, Strober (1980) found that participants with AN had a more obsessive character structure, a higher propensity for social approval seeking, were inclined to excessively conform and regiment their behaviour, were

more industrious, and felt more responsible than their healthy control counterparts. However, weight restoration was coupled with a significant decline in obsessional symptomatology, as well as a diminished need for social approval. With this in mind, Strober (1980) warned that certain phenomena are only transient reactions to the starved state of AN and may therefore not actually constitute a particular personality trait per sé. He emphasised that the question of whether or not various characteristics are truly stable phenomena, must be put to the test in further comparative studies of participants over longer periods of prospective follow-ups.

Although perfectionism has not been followed up extensively in long-term studies of AN, some studies *do* examine perfectionism cross-sectionally in weight restored, and in remitted samples of individuals who suffer from AN. In a study by Sullivan, Bulik, Fear, and Pickering (as cited in Sutandar-Pinnock, 2001), female patients who were treated 12 years ago at an ED treatment centre in New Zealand, were compared to a random community sample. They discovered that 90% of the former patients no longer met the criteria for AN, but still presented with higher EDI perfectionism scores than the control group, indicating that their perfectionism tendencies persisted even after recovery.

Bastiani, Rao, Weltzin and Kaye (as cited in Sutandar-Pinnock, 2001) studied perfectionism in AN using the EDI, the Hewitt and Flett MPS, and the Frost MPS. 11 Inpatients with restricting-type AN were compared to eight AN patients (who were assessed within four weeks after weight restoration), as well as to 10 healthy controls. Their findings indicated that patients with AN were strongly perfectionistic and that perfectionism persisted even after weight restoration.

Srinivasagam et al. (as cited in Sutandar-Pinnock, 2001) also studied whether perfectionism as a construct changed with clinical status. By utilising the EDI and Frost MPS, they compared 20 participants who had recovered from AN, to 16 healthy controls. Recovery was operationally defined as reaching normal weight and menses for over one year. It was found that the recovered group had higher scores on the EDI perfectionism subscale, as well as on Frost's overall perfectionism scale. This was indicative of perfectionism persisting even after what the authors described as a good outcome and recovery.

While recovery from the disorder may have an attenuating influence on the comorbid symptoms of personality disorders in eating disordered patients, such personality disorders do seem to persist in some recovered patients. Even after taking the starvation-effect into account, obsessive and inhibited tendencies may remain at high levels and therefore cannot be explained as entirely due to starvation alone. Nilsson, Gillberg, Gillberg and Rastam's (as cited in Sutandar-Pinnock, 2001) research found that at 10 years after the first reported onset of their AN patients, persistent problems with obsessions and compulsions were still characteristic of a substantial minority of weight-restored individuals (Sutandar-Pinnock, 2001).

Considering the above-mentioned research, complexities and potential difficulties faced during the process of identifying and researching AN individuals from the chosen population become clearer. It is also necessary to keep in mind the attenuating influence that their biological variants of weight and eating patterns could possibly have on the actual data and descriptions that are gained in their narratives

when conducting research, as these physical aspects could have improved during treatment and during the duration of the research study.

The literature on perfectionism as a personality characteristic presented in this chapter highlights how perfectionism is involved as a predisposing risk factor for the development of an ED, as well as its maintenance. It has also shed light on how sufferers of eating disorders tend to have higher standards of perfectionism than the general population, even after they have regained the weight they had previously lost.

The next chapter presents the research paradigm and methodology of the research study.

## CHAPTER 4

### RESEARCH PARADIGM AND METHODOLOGY

*“This world does not stand still, nor will it conform to the scientist’s logical schemes of analysis. It contains its own dialectic and its own internal logic. This meaning can only be discovered by the observer’s participation in the world.”*

Norman Denzin (1989, p.25)

#### 4.1 Qualitative research methods

Research methodologies are plans employed in the pursuit of seeking answers and gaining new knowledge. These methodologies lay out previously developed paths, which, if systematically followed by researchers, may lead to the generation of valid knowledge. These paths are drawn on *maps* based on assumptions about the nature of human understanding. In this research study, the map employed to discover new knowledge is that of an alternative methodology: A qualitative research design, following the descriptive phenomenological method and the constructivist grounded theory method.

As Polkinghorne (1983) highlights, a research method refers to a collection of practical tools and processes of empirical data collection and strategies for analysis and interpretation, which is employed in pursuit of knowledge and understanding of meaning. Strauss and Corbin (1990, 1998) refer to a qualitative enquiry as any type of research enquiry that produces findings not arrived at through statistical

procedures or other means of quantification; and Leedy & Ormrod (2007) highlight that qualitative methods can be successfully employed to obtain intricate details about a phenomenon such as feelings, thought processes and emotions that are difficult to extract or learn about through more conventional research methods. The foundational idea of qualitative research is to learn about the problems the research participants experience. The researcher obtains information through the participants' stories as it explores and brings understanding of the human phenomena and problems (Creswell, 2009). This translates into research about peoples' lives, lived experiences, behaviours, emotions and feelings.

To achieve the two research objectives of *describing* and *explaining* perfectionism in treatment resistant eating disorder clients, two specific methodologies will be employed. The philosophical underpinnings of these methodologies, along with their assumptions concerning the nature of human understanding, as well as their applicability to the study will be discussed next. It is, however, not within the scope of this study to offer a complete philosophical discussion of their foundations, and attention will only be given to their key assumptions.

#### **4.2 The foundational development of the research study design**

Spiegelberg (1975) highlights a main problem question for social researchers:

*“How do we obtain direct access to another human person and their consciousness?” (p.40).*

To better comprehend the rationale for utilising phenomenology and grounded theory in this chosen research design, I questioned how access could and/or would be

achieved in gaining new knowledge about perfectionism, which is viewed as a complex subjective problem in the life of someone with a treatment resistant eating disorder. As the basic review of literature in Chapter 2 and Chapter 3 have highlighted, eating disorders themselves are not simple disorders. I needed to consider a research methodology that could scientifically explore a specific personal aspect (i.e. perfectionism) of a particular subset of individuals (i.e. treatment resistant eating disordered sufferers) in detail in such a way that accurately describes and explains it, so as to be able to provide the reader with a comprehensive understanding of the phenomenon in question.

To this end, I chose to utilise phenomenological and grounded theory research methods. Both are qualitative research methods with origins contained in post-modern philosophy. In the following discourse, I consider both methods in an exposé of their defining elements and their philosophical developmental contributories. This explication sets the tone to underscore the rationale for utilising these methods during the research as they attempt to achieve the objectives of the research and to depict the study's overall design.

#### **4.2.1 The development from modernist to post-modernist research**

To understand post-modernism one must first consider its roots from whence it developed: Modernism. The basic philosophical underpinnings of modernism pose an orientation where social reality is deemed to have an empirical and independent existence, and where guiding logic can be measured with objective certainty (Neuman, 2000).

Bogdan and Taylor (1975) describe that during the period of modernism philosophers and scientists such as Plato, Galileo and Newton advocated the need for an epistemology through which a clear distinction could be drawn between beliefs and definite truth. That is, the notion of whether a *belief* was indeed knowledge or truth was being questioned. During this period, it was also posited that nature, including humans, varied in a systematic way and by utilising mathematical formulae and experimental evidences, it would be possible to discover and describe these patterns of nature and being. The dominant thinking of that time was that the discovery of laws of human behaviour would allow humans to establish a *perfect society* by merely applying these proven laws of behaviour.

Guided by the modernist worldview, social research was based upon aspects of *objective, value-free* and *culture-free* truths. Which meant that the beliefs regarding knowledge about human behaviour could be derived from using solely *empirical* methods. It was from this empirical orientation that quantitative social research was predominantly undertaken and praised for its ability to produce *ultimate* knowledge. This was based on the prediction of cause-and-effect relationships in human behaviour.

However, as Parker (1992) highlights, in any society the various discourses between members of that society have a constitutive effect on how people live their lives. People, their behaviours, and their thinking are influenced by more than mere cause-and-effect relationships. Their lives are the sum of a lifetime's experiences, cultural views, traumatic experiences, religious beliefs and more. The complexities people

present with are surely influenced by their social realities, and generally modernist research does not take such aspects into account when attempting social research.

It was against this reasoning that the evolution to post-modernistic thought developed, as rising discontent with modernist assumptions were presenting themselves. Within this new period, it was asserted that social reality does not exist only in isolation or outside human experience, but is also because of human action through symbolic forms of human interaction and meaning. With social researchers increasingly recognising the influence the *inner world* had on a person, mounting calls were being made for a methodology that could encompass the fullness of human experience, which included values and meaning (Polkinghorne, 1983).

It can therefore be inferred that post-modernist research is relatively opposite to the modernist's fragmentation of social reality. Rather than denying the existence of social reality, post-modernism attempts to highlight society's complexities and argues that there cannot be a *single* and *final* truth about social reality (Kvale, 1992). Czarniawska (2004) identifies the following distinguishing characteristics of post-modernist social research:

- It contests the correspondence of the theory of truth: It denies that statements are true where they correspond to the world, on the basis that it is impossible to compare words to non-words.
- It challenges the operation of representation, revealing the complications of any attempt to represent one phenomenon by another.
- It pays specific attention to the use of language, which is a tool of constructing reality, rather than its passive mirroring (in a sense of any system of signs, numbers, words or pictures).

- Its merit is found in telling a narrative that may stimulate experiences, provoke a response or arouse curiosity within the people who read or encounter the narrative.
- It acknowledges that individuals offer mere accounts or narratives, rather than full explanations of their experiences, actions and motivations.

With the notion that there is no clear window into the inner life-world of an individual, the interpretation thereof within this era (i.e. post-modernism), started to be done in new and multiple ways. The post-modernism era is characterised by multiple paradigms, strategies of inquiry and methods of analysis. The interpretation of *subjective reality* (i.e. what is real) was posited to be located in the world of-and-between the observer and the observed (Kvale, 1992). In this way, post-modernist researchers object to presenting research results in a detached and neutral way and insist that the researcher should not be hidden (as in modernist social research). The researcher should become exposed and his presence evident in the results derived.

Accordingly, the term *post-modernism* thus describes an evolved understanding of the contemporary world and has its roots in philosophical movements including phenomenology, existentialism, nihilism and anarchism, as expressed in the ideas of inter-alia, Husserl, Heidegger, Nietzsche, Sartre and Wittgenstein (Neuman, 2000). Denzin (1989) adds that post-modernism represents a response to the development of the world's larger and more complex social structures. These structures contain people of different cultural traditions, who all influence each other in differing ways, since the developed world is a modern society of multinational corporations, satellite communications and interdependent world economies.

#### 4.2.2 The nature of qualitative research

Each research tradition would argue that the frame of thought *they* promote, provides the best means for acquiring new knowledge. Unlike quantitative research, which is more focused on identifying causal relationships described in terms of statements of observations, verification and prediction, qualitative research aims rather to explore human behaviours and actions on a deeper, subjective level in its search for understanding (Porter, as cited in Maggs-Rapport, 2001). Kirk and Miller (as cited in Krefting, 1991) suggest their definition of qualitative research to be as follows:

*“...a particular tradition in social science that fundamentally depends on watching people in their own territory and interacting with them in their own language, on their own terms.”*

Schmid (as cited in Krefting, 1991) portrays qualitative research as the study of the empirical world, from *within* the viewpoint of the research subject. He highlights two key underlying principles which dictate qualitative research:

1. Behaviour is influenced by the physical-, socio-cultural-, and psychological environment - which is the basis of any naturalistic enquiry.
2. Behaviour goes beyond what is observed by the researcher: Subjective meanings and perceptions of the subject are of vast importance in qualitative research. During the research, it is part of the researcher's aim to access these meanings and perceptions.

It is important to understand how qualitative research methodologies would differ in terms of philosophical underpinnings, theoretical-, ontological- and epistemological orientations, as well as shared understandings and purpose. Incorporating an

interpretive, naturalistic approach to its research participants (Denzin & Lincoln, as cited in Koch, 1996), qualitative research offers an alternative approach to investigating humans with the aim of producing knowledge and understanding. It contrasts the general quantitative approach to scientific enquiry (emphasising the standardisation of language, rules, and procedures for obtaining and analysing data, and as such, ensuring replicability and validity of the findings); by emphasising the irreplicability and uniqueness of the research process and product (Sandelowski, 1986).

Thus, the focus in qualitative research significantly lends itself to subjectivity. By obtaining descriptions (observed, verbal or written) of aspects of experiences from participants, it gives recognition to essentialism (i.e. the belief that there is an essential given core to people that makes them what they are) and considers that the knowledge individuals have, is a product of their experiences, history and culture (Langdrige, 2007). Qualitative research methods such as phenomenology and grounded theory, accentuate discovery, description and meaning, rather than traditional natural science criteria of prediction, control and measurement (Osborne, 1994). In the qualitative researcher's efforts, he communicates richness and diversity of human experience, by giving attention to the meaningfulness of the research product.

#### **4.2.3 Post-modernism and qualitative research**

Qualitative enquiry is commonly described as having evolved to counter the inadequacies of positivist quantitative enquiry (Sandelowski, 1986). The growth of qualitative methods in psychology during the 1970s began with what is now termed

the 'crisis in social psychology', which was marked by a critical challenge to mainstream predominant quantitative social psychology. More and more a need was growing to supply researchers in psychology with alternative methods of gaining knowledge and insight into human behaviour and understanding. Langdridge describes this crisis in the following statement:

*"The crisis marked the beginning of a philosophical and methodological challenge to the assumptions underpinning most quantitative social psychology, notably the a-historical/a-cultural, essentialist, dualist, and scientific nature of, predominantly experimental, social psychology" (Langdridge, 2007, p.154).*

Qualitative research is consistent with the assumptions of a post-modern paradigm: The qualitative inquiry process seeks to understand a social- or human problem which is based on building a complex, holistic picture about that problem, reporting on the detailed views of informants that are acquired in a natural setting (Creswell, 2009). Both phenomenology and grounded theory are based on, and are consistent with a post-modern paradigm.

#### **4.2.4 Phenomenological philosophy and research**

Lester attempts to provide a broad definition of the concept of phenomenology:

*"Phenomenology is a philosophy concerned with the study of experiences from the perspective of the individual person, identifying assumptions and the usual ways of perceiving and interpreting. Phenomenological approaches are based on personal knowledge and subjectivity, and emphasize the importance of personal perspective and interpretation. As such, these methods are powerful tools for understanding subjective experiences, gaining insight into people's motivations and actions, and cutting through the clutter of general assumptions and*

*conventional wisdom. Phenomenological methods are particularly effective at uncovering the experiences and perceptions of individuals from their own perspectives, and therefore, at challenging structural or normative assumptions” (1999, p.11).*

Phenomenological philosophy's roots are traceable back to the early 1900's to the work of Edmund Husserl (1859 - 1938), a German philosopher. However, phenomenology's premises only started gaining momentum in psychological research in the 1960's. In short, phenomenology is concerned with placing the philosophy of lived experience on centre stage, thereby attempting to understand a person more by focusing on studying and understanding their experiences and how the world appears to them. This includes studying descriptions of the person's lived experience, by employing specific methods to illuminate the lived world of the participant (Langdrige, 2007).

According to Moustakas (1994), the main purpose of phenomenology is to reduce individual experiences of the phenomenon to a description of universal essence, which is a combination of textural descriptions of the experiences (*what* was experienced) and the structural description (*how* it was experienced). Thus, its focus is on people's subjective perceptions of the world - their own perceptions of the *things in their appearing*. By exploring the inner world of a subject's experience, phenomenology enables researchers to reclaim that part of being human that has long been neglected due to the prevailing view that human science must be a distant, natural, measurable and normative science (Osborne, 1994).

With this understanding, phenomenologists clearly resist the classic subject-object dualism which is so central to positivistic science, which encourages one to separate oneself from the world and perceive the world as it truly is (i.e. objectivity). Phenomenologists disagree with this position by claiming that subjectivity (and one's perception) is not separate from the world and the objects within it. Objects enter our reality (and consciousness) when we perceive them. It views human behaviour as a product of how the subject understands their world, and the perceptions we have of objects are thus influenced according to the context, the position of the perceiver in relation to the object, the mood of the perceiver, as well as many other variables (Langdrige, 2007). In seeking to understand the inner *life-world* of its subjects, the phenomenologist researcher concerns him- or herself with "understanding human behaviour from the actor's frame of reference" (Bogdan & Taylor, 1975, p.2), and to "understand the behaviour within the context of the experience" (Giorgi, 1983, p.137).

Thus, the pursuit of new knowledge is not to summarise in the form of concepts what is given to you in some or other way, but rather to create an entirely new domain which yields, for the first time, full reality. The researcher's fundamental task is to uncover and engage with what is really going on beneath the surface of the research participant (Lessem & Schieffer, 2010).

Considering the above-mentioned descriptions, and from within a psychological perspective, I understand the person's *subjective experience* to be focal point of phenomenology. We as human science researchers cannot directly observe others' subjective experiences of consciousness, whether they be emotional, cognitive or

otherwise. Phenomenology is the focus, study and understanding of these processes of consciousness and hence seems to be an adequate method of gaining insight into the experiences of those undergoing a process of exploration of their perfection within their treatment resistant eating disorder.

#### **4.2.5 Grounded theory philosophy and research**

Grounded theory (GT) is a systematic qualitative research method which allows for generating theory from data, following specific systematic procedures of data collection, analysis and theorising (Strauss & Corbin, 1998). The origins of GT research methodology are credited to the American social scientists Anselm Strauss and Barney Glaser in the 1960's. Strauss was a social anthropologist and sociologist, and Glaser a social psychologist and social statistician (Lessem & Schieffer, 2010). Strauss was studying and examining the experience of dying when he recruited Glaser as part of his research team. It is during this study that GT methodology as we know it today, was born (Birks & Mills, 2011).

Today, GT is an established social research methodology, with multiple contributing theorists in the dictum of GT. It aims to generate theory around complicated issues about:

*"...persons' lives, lived experiences, behaviours, emotions, and feelings as well as about organizational functioning, social movements, cultural phenomena, and interactions between nations" (Strauss & Corbin, 1998, p.11).*

Grounded theory urges the researcher to immerse him/herself in the lives and situations of the persons whom he/she wishes to study to develop deep understandings (*verstehen*), that result in descriptions of experience (*erlebnis*), or

lived experience (Gilgun, 2010). The spirit of GT is open-ended and flexible; a form of research that seeks to understand individuals involved in social interactions of various types, within contexts that range from the micro to the macro (Gilgun, 2010).

The term 'grounded' in grounded theory refers to the idea that the theory product that emerges after analysis is derived from, and *grounded in*, data that has been collected using qualitative methods, as opposed to data taken from literature studies or preconceived hypotheses (Allan, 2003). When one refers to GT as *emergent*, it refers to the process, rather than the products of the research: Grounded theory does not spontaneously arise, rather, it is generated, developed and integrated by the researcher through the application of essential GT methods (Birks & Mills, 2011). Grounded theory is used in introductory, exploratory, and descriptive studies for phenomena where little research has been done (Glaser & Strauss, 1967). Therefore, it can be used to understand the contextual factors that may affect perfectionism within treatment resistant eating disorders.

### **4.3 The research study design**

#### **4.3.1 Personal reflections on my own philosophical position**

In the preceding sections I have provided an explication of the basic philosophical tenets of qualitative research and post-modern philosophy. Porter (as cited in Maggs-Rapport, 2001) describes qualitative research as being founded on four levels of understanding, namely ontology, epistemology, methodology and methods.

For this research study, Porter's model is adapted to include those questions and how they relate to the phenomenon being researched. In answering Porter's

questions, I posit my own philosophical position on reality, what counts as knowledge, and how truth is obtained. My answers to the questions also further qualify the rationale for using a qualitative research method in this study.

### Level 1: Ontology (What is reality?)

Question: *“What constitutes ‘reality’ for treatment resistant eating disordered clients who struggle with perfectionism?”*

My answer: *Each participant’s reality would be individual and specific to them according to their own history and culture (thus, in line with post-modern thinking).*

### Level 2: Epistemology (What counts as knowledge?)

Question: *“What should be counted as information and knowledge with respect to the treatment of resistant eating disordered clients who struggle with perfectionism?”*

My answer: *The subjective expressions of the participants’ experiences, as well as my psychological analyses of these statements should be counted as information and knowledge (thus, the participants’ subjective portrayal of their experience with the phenomenon, as well as the researcher’s understanding of their portrayal – both the participant and the researcher are co-contributors to the generation of knowledge).*

### Level 3: Methodology (How can we understand reality?)

Question: *“Are there means of accessing knowledge about the ‘reality’ of treatment resistant eating disordered clients who struggle with perfectionism with respect to how they understand themselves and their world?”*

My answer: *Through the analysis of the participants' verbal and written expressions, such information could be obtained (thus, qualitative research methods).*

Level 4: Methods (How can evidence be collected about reality?)

Question: *“How can evidence be gathered about the reality of treatment resistant eating disordered clients who struggle with perfectionism?”*

My answer: *Unstructured interviews would be most useful in gaining insight into the participants' inner-world, since the stance would not be predictive, but rather explorative in nature (thus, utilising phenomenological and grounded theory methods).*

In general, mainstream research in the field of psychology usually subscribes to a positivist philosophy of science, which follows a belief in the *real world*: A world of sensory experience which is perceived, touched, smelt and seen. Sensory experience is, therefore, judged as the exclusive source of all authoritative knowledge and suggests that true and valid knowledge can only be derived by studying such experiences. Within this positivist thinking, researchers gain knowledge by utilising naturalistic scientific methods such as quantification and statistics (Langdridge, 2007). This means that in studying human behaviour and thinking, gaining knowledge on such aspects falls predominantly on utilising data of sense experiences.

However, the objectives of this research study were not in measuring a simple aspect of behaviour, but rather committed to exploring a complex subjective phenomenon of participants' perfectionism within treatment resistant eating

disorders. Utilising sense data would seem vastly inadequate to understanding such a phenomenon, as one would only be able to make limited inferences. In following the reasoning by answering the above-mentioned questions, I posit that I would not be able to gain a comprehensive understanding about the research topic using sense data, but rather through utilising qualitative research methods - that being phenomenology and grounded theory's epistemology, which lies within experience or narrative, and are not tangible or measurable things.

#### **4.3.2 Combining phenomenology and grounded theory research practice**

In this research study the two philosophies of phenomenology and GT were combined in the research design to form a more holistic *understanding* of perfectionism within treatment resistant eating disorders. As the two research objectives (i.e. *describing* and *explaining* perfectionism in treatment resistant eating disorders) are distinct, this necessitated that each be treated separately, which would then heighten the final understanding of perfectionism within the study's focus.

Both phenomenology and grounded theory advocate qualitative data gathering procedures, specifically interviewing procedures with respondents who have direct experience of the phenomenon in question. Post-modern qualitative researchers rely on the subjective, verbal and written expressions of meaning given by studied individuals. The use of language and conversation provides for access to the cultural world of social discourse, where inter-subjective meaning is created and sustained (Kvale, 1992). Within this study, the interviews with participants were then brought to the phenomenological- and GT analyses procedures to achieve both objectives of the research respectively.

Both phenomenological and GT research are exploratory methods. However, whilst phenomenology emphasises the *description* of the subjective meaning of an experience for a participant, GT moves beyond phenomenological description towards the discovery of a theory, shaped by the subjective views of the participants. In so doing, it aims to systematically develop a conceptual framework that *explains* the process, actions and interactions of the phenomenon in question. Grounded theory shares the same interest with phenomenological research in describing and understanding. However, theory development is integrated into grounded theory - there is a focus on the inductive development of theory to explain the phenomenon of interest (Osborne, 1994). Charmaz (2006) supports the possible relationship between phenomenology and grounded theory: She emphasises that whilst grounded theory points to the *meaning* of an experience for participants, its critical intent is to go beyond *description* of the experience (i.e. phenomenology), towards the generation, or discovery of, a *theory* which is shaped by the views of the participants.

In phenomenological research, the descriptions of the participants are understood before they are clustered. Thus, phenomenological research seeks trans-contextual structures of experience, whilst GT aims to develop theoretical explanations of the relationships between categories of data as the research progresses. GT enunciates more formal successive hypotheses as the data collection and understandings proceeds - developing these tentative hypotheses about relationships among categories of data, which are then checked for goodness of fit (Osborne, 1994). These hypotheses encompass the variability within the categories and the participants.

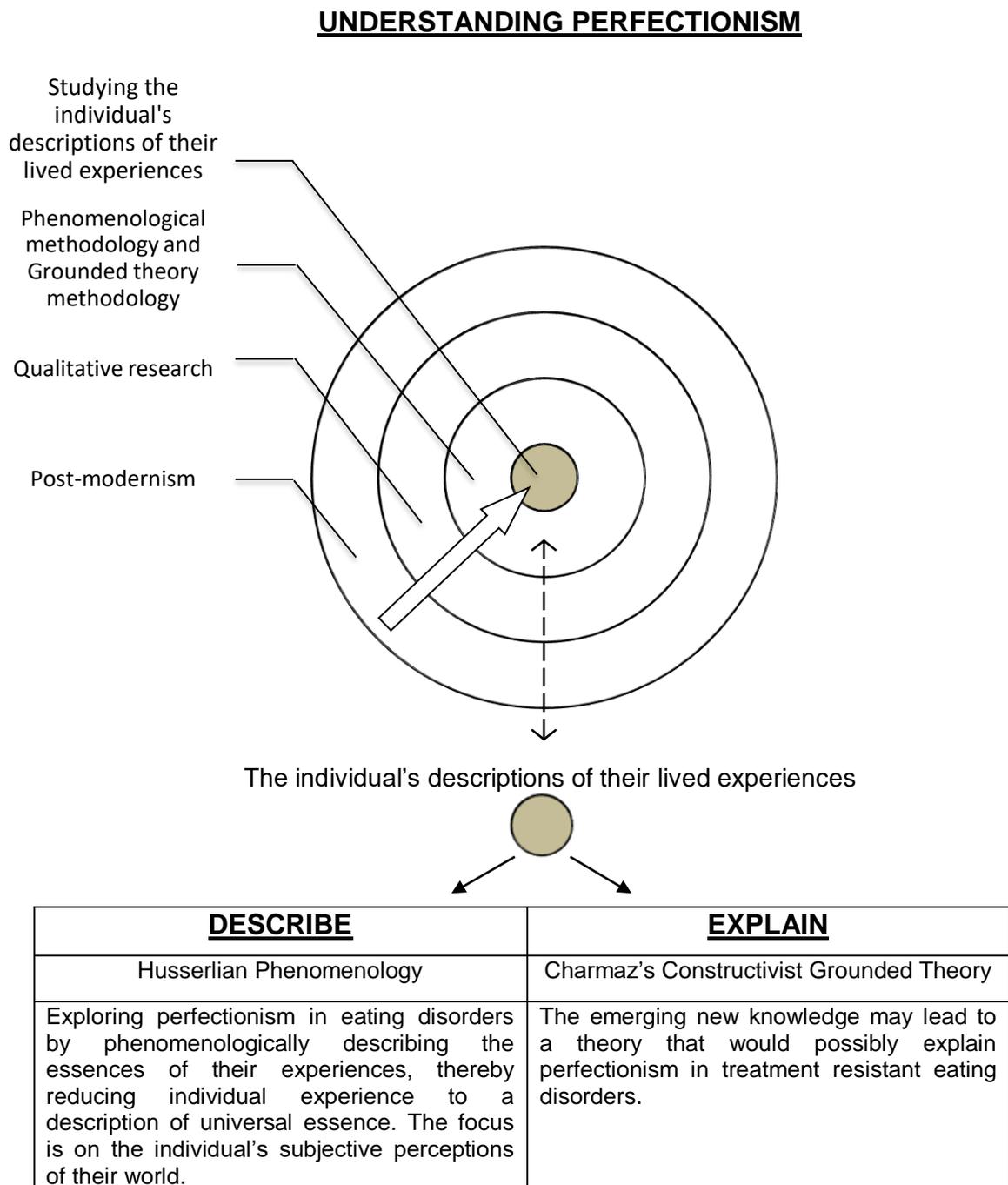
When considering the above-mentioned, the combination of these two qualitative research methods thus complement each other in their pursuit of their own individual objectives, whilst adding legitimacy to each other's claim to have reached their objective successfully.

### **4.3.3 Conceptual framework of the research design**

This research endeavour is an exploration of perfectionism within treatment resistant eating disorders to come to a deeper *understanding*. The knowledge gained is an attempt to go beyond the current existing body of knowledge of eating disorders and its relation to perfectionism within the South African context.

Figure 4.1 shows the conceptual framework from which the research design was conceived. The point of departure for the research objectives is that of qualitative research within the post-modernist paradigm. For the first research objective, Giorgi's descriptive phenomenological research method was followed. Charmaz' constructivist grounded theory approach was utilised for the second objective to see new knowledge emerge from the data that is grounded in the research participants' accounts of their experiences.

**Figure 4.1: The research design's conceptual framework**



**4.3.4 First research objective: Using phenomenology to describe perfectionism in treatment resistant eating disorders**

To achieve the first research objective of *describing* perfectionism in treatment resistant eating disorders, I will employ a phenomenological research method of

collecting and analysing the data. As already described, phenomenological research is a qualitative research approach which seeks to understand the life-world of its subjects, primarily *describing* rather than *explaining*, and starts from a perspective free from hypotheses or preconceptions (Moustakas, 1994). The phenomenologist seeks “to understand the behaviour within the context of experience” (Giorgi, 1983, p. 137). According to Lessem and Schieffer (2010), phenomenology operates in the following manner:

*“Whilst it is theoretically oriented, it does not generate deductions from propositions that can be empirically tested. It operates on a meta–sociological level, demonstrating its premises through descriptive analyses of the procedures of self, situational, and social constitution” (p.126).*

According to Giorgi (1994), phenomenology is an alternative qualitative research methodology that can be employed to answer research questions relating to the structure of consciousness in a way that other methodologies struggle to do. Phenomenological research embraces the idea that unique characteristics of consciousness require a distinct kind of science, utilising data-gathering procedures and processes designed specifically for developing descriptions of experiential processes (Spiegelberg, 1975). Its set of epistemological principles is different to the set used in positivist psychology.

In considering the differences between Husserlian Phenomenology and Heideggerian Phenomenology, I chose rather to follow the Descriptive Phenomenological research method of Husserl. This decision came after consideration of the phenomenological literature and the general *fit* of this method to the needs and goals of the research study. When considering the method of data

analysis, phenomenology methods of analyses range from unstructured whole impression analyses (Alapack, as cited in Osborne, 1994), to systematic thematic analyses employing tabular presentations of data (e.g. Giorgi, 1975; Osborne, 1990). Giorgi, Van Kaam, and Colaizzi's methods of data analysis were all deemed to be appropriate potential methods for this research study because of their strong psychological orientation (Maggs-Rapport, 2001). However, Giorgi, in particular, emphasises the interdependence of the disciplinary perspective of the researcher with the research question. His method of data analysis has been utilised as a tried and tested method, and seems flexible enough to endure adaptation without undermining its values (Giorgi, as cited in Maggs-Rapport, 2001). Based on the afore-mentioned elements, I selected Giorgi's method of phenomenological data analysis to achieve the goals set out by Husserl's Descriptive Phenomenology.

#### **4.3.5 Secondary research objective: Using grounded theory to explain perfectionism in treatment resistant eating disorders**

To achieve the second research objective of *explaining* perfectionism in treatment resistant eating disorders, I will employ the GT method of data analysis according to Charmaz's constructivist approach. The challenge in this research project is that actualities in the participants' real world concerning their perfectionism, is part of a treatment resistant eating disorder.

According to Lee (1999), the underlying assumption of GT is that social phenomena are complex, and consequently the steps taken to study these social complexities in themselves need to be flexible and reflexive. Essential GT methods do not merely seek to *describe* a phenomenon, but is unique in that it serves to *explain* the

phenomenon being studied. The data collection and analysis strategies utilised in GT result in the emergence of a theory that explains a phenomenon from the perspective, and in the context, of those who experience it (Birks & Mills, 2011). In using multiple-participant research protocols, pieces of the data overlap with each other and are in close relation with each other. Therefore, the researcher gains deeper insights and a better understanding of that phenomenon.

Thus, GT can generate theory from data sources gathered from qualitatively real experiences in the lived world. Also, from a qualitative perspective, limited knowledge exists in the area of study, and the generation of a theory with explanatory power would serve to advance the current body of knowledge on perfectionism within treatment resistant eating disorder clients (Birks & Mills, 2011). Stern (1994) advocates the deployment of grounded theory methodology for ‘testing the water ... in new situations’; that is, investigating in a substantive area that has not been empirically examined previously. Little is known about the subject of perfectionism within treatment resistant eating disorders in South Africa. The GT approach is thus appropriate for this research study, because it facilitates investigation of that phenomenon where little was previously known or researched (Creswell, 2009).

#### **4.4 Selection procedure**

##### **4.4.1 Participant recruitment**

As previously described in Chapter 2, the nature of eating disorders and the individuals struggling with them infer that many do not readily seek intervention, as compared to other psychiatric disorders. One of the diagnostic features for AN

includes inter alia, a person's lack of insight or denial of the seriousness of their problem (APA, 2013). Previous research and understanding about eating disorders (Russell, 1995; Sadock & Sadock, 2003) indicates how patients' capacity for denial of an illness may be so serious as to conceal their fear of fatness. Also, within the South African context, access to knowledge on specialist psychiatric conditions such as eating disorders may be limited. These statements imply difficulty in finding research participants within this field, as they would not be inclined to admit their problems, or readily seek help for them, or even realise they have an eating disorder.

To overcome these barriers, an internet website, as well as professional referrals and personal contacts were utilised for recruiting individuals with eating disorders for the research.

1. The internet website included the following:

- I, the researcher, designed and created an internet website which focused on providing information to the public on eating disorders within the South African context.
- One page on this website was allocated to discussing the research endeavour. On this page, volunteers were invited to come forward and enrol in the research study.
- As sufferers of eating disorders are not easily inclined to seek assistance for their problems, utilising a website seemed an appropriate way to access those who have serious eating disorders, but still prefer the anonymity of the internet when seeking information and assistance for their condition.

2. The professional referrals and personal contacts section included the following:
  - Colleagues and personal contacts, which were aware of individuals who were struggling with eating disorders, were requested to recruit volunteers for this research endeavour.

As part of their indicated willingness to participate in this research study, possible participants consented by means of an email and were asked to provide their contact details. I then contacted them directly by telephone to discuss basic information about the research process and to schedule a face-to-face interview.

During this face-to-face interview, each candidate was provided with an orientation to the research study and what it would entail, as well as assessing their eligibility. The orientation to the research included aspects of the research itself, the therapy that would be provided during the process, what the information would be used for, as well as who would have access to the data. It also emphasised that the gathering of data would happen via audio recordings of the discussions.

If the individual qualified as a candidate (as set by the participant criteria), an offer to become part of the research endeavour was presented, upon which everyone made a voluntary decision to enrol or not. This contract (Appendix A, p. 448) included signing a voluntary consent form to become part of the research endeavour and enter psychological treatment for their condition. No costs would be incurred by the participants in becoming part of the research study or for receiving psychological treatment. To this end, six participants qualified, and agreed to become part of the research study.

#### **4.4.2 Participant sampling and selection**

During the research study, two forms of sampling were utilised: Maximum variation sampling and purposive sampling.

##### **4.4.2.1 Maximum variation sampling**

In this sampling method, the researcher seeks out participants who have the experience under investigation in common, but who vary on as wide a variety of demographic characteristics as possible (Polkinghorne, as cited in Langdrige, 2007).

The target population for the present study was defined as treatment resistant eating disordered individuals, including all the DSM-5 sub-types of AN and BN. The decision to be inclusive of all sub-types was informed by the high degree of co-morbidity among the subtypes (Keel, 2003; van der Ham et al., 1997). Also, based on the research objectives, it would not be prudent to exclude participants based on their sub-typing. Most importantly I, the researcher, realised that this inclusive approach could enrich the understanding of this phenomenon within the participant sample.

The goal of the above-mentioned specific subject selection was to obtain rich and varied descriptions, not to achieve statistical generalisation of the research results. In this regard, I tried to find an array of individuals who provided a variety of experiences on a very specific aspect of eating disorders, namely perfectionism. For this reason, participant sampling was purposefully delineated as needing to include treatment resistant candidates, who had previously been diagnosed and treated for

an eating disorder by a suitably qualified professional. The main areas of concern for the research endeavour focused on whether good therapeutic rapport could be established and on the degree to which rich data could be obtained from the participant (e.g. willingness to engage in therapeutic tasks), as well as the candidate's willingness to express themselves for the purposes of the research.

#### **4.4.2.2 Purposive sampling**

Purposive sampling starts with the purpose of the research in mind and selects individuals based on their fit with that purpose and/or to access a particular population group. The purposive sampling technique was therefore utilised to select candidates based on my, the researcher's assessment, which was guided by the following inclusion criteria:

- The prospective candidate needed to present with an active eating disorder that meets the diagnostic criteria for one of the eating disorder categories in question, according to the DSM-5.
- The candidate's eating disorder had to have been resistant to recovery. This would be indicative of those who had previously received professional treatment, and who would still be struggling with significant aspects of the disorder (i.e. remain symptomatic); or could include individuals who had been suffering intermittently with the eating disorder(s) for more than 10 years.
- The candidate's use of the English language needed to be adequate for the purposes of qualitative research whereby in-depth verbal information would form the main mechanism of interaction between researcher and subject.
- Candidates needed to be 18 years or older.
- A good rapport and trust relationship would need to be able to be established between the researcher and the candidate.

- The candidate should not currently be in treatment for their eating disorder with another psychologist/therapist/counsellor.
- The candidate would need to be able to make regular consultation visits to the office where the research was being conducted.
- The candidate needed to be willing and able to express themselves appropriately for the purposes of the research within a process of therapy. The candidate would need to be able to express their views and provide a full and sensitive description of the experience under investigation, as well as express themselves in a clear and logical manner so that I could obtain rich and accurate data for the research.

With maximum variation within the research participant sample group, there is a higher probability to ascertain those aspects of the experience that are invariant across the population of eating disorder clients (i.e. the essential structure underpinning all experiences of that kind), as well as those that vary across the population of eating disorder clients (i.e. those that vary across people and are therefore idiosyncratic). However, as Langdridge (2007) highlights, even though the researcher attempts to achieve the highest maximum variation in the participants, it is ultimately unlikely that he will fully achieve this goal.

Regarding sample size, Langdridge (2007) highlights that sample sizes in phenomenological research are usually small due to the time-consuming nature of the analytical process. In this research study, the number of research participants was determined by the point at which saturation of the data was achieved. This is the point in the research process where data gathering and analysis becomes redundant and repetitive, and sampling more data will not lead to additional information related

to the research questions. The study included six research participants in total. Redundancy in the phenomenological analysis was achieved during the analysis of the fourth participant, whilst saturation of the categories during the GT analysis was achieved during the analysis of the fifth participant.

#### **4.4.3 Ethical considerations and protection of participants**

Denzin and Lincoln (2000) highlight the importance of ethics in social science by calling for a collaborative social science research ethics model that makes the researcher responsible for those being studied, rather than some far-removed discipline or institution. Echoing this sentiment, Clandinin and Connelly (as cited in Denzin & Lincoln, 1994) highlight the possibility that when entering a research relationship within qualitative research, where participants are requested to share their personal life stories with us, there is the potential to shape and influence their lived, told, relived and retold stories, as well as our own.

The research material gathered for this study was considered private and therefore needed permission prior to commencement. For this reason, the study sought ethical approval from the University of South Africa's (UNISA) ethical committee after providing all the details of the procedures that would be followed. Additionally, each research participant was required to sign a letter of consent before participating in the research study (Appendix A, p. 448). As previously described, informed consent was obtained by briefing each participant about the details of the study. Emphasis was placed on the study participant's voluntary participation and reassurance was given that they could cease participation at any time, at their own discretion. If they wished to withdraw from participation, they could do so without providing a reason.

Whilst keeping in mind that a significant part of the research process itself was conducted within the confines of psychological therapy I, the researcher, had to be vigilant of not causing discomfort or harm. The participants were viewed as being *vulnerable* because they were suffering from a psychological disorder. In this regard, I highlight that at the time of the research procedure I had already had six years of therapeutic experience in treating psychiatric clients, and I attempted always to keep the research within the boundaries of the ethical code of conduct I adhere to (as set out by the Health Professions Counsel of South Africa for Clinical Psychology). Key principles of decision-making and behaviour that guided the research study in all the interactions and dealings with the research participants were:

- Beneficence (do good).
- Non-maleficence (do no harm).
- Respect (for their person, as well as mutual respect in the researcher-participant relationship).
- Autonomy (participants' own choice and right to choose).
- Veracity (be honest).
- Fidelity (be trustworthy, as well as maintaining confidentiality).
- Responsibility (being responsible in one's decision-making processes).
- Justice (be fair).

During the contact sessions, the research process itself could be viewed as an inherent 'conflict of interest' in terms of each participant's therapy process. This implies that the goals of therapy (i.e. allowing healing and recovery from an eating disorder) could at times possibly conflict with the goals of the research (i.e. eliciting deep meaningful explications of personal experiences). In this regard, treatment and therapy took primacy within each contact session: I had to remain committed

primarily to the goals of the participants' therapy, keeping their health, treatment and therapeutic goals as my highest priority. Although the research goals commanded my secondary consideration, they were still adhered to with diligence.

To safeguard participants' identities, pseudonyms were used in the reporting stage to provide participants with anonymity. Prior to conducting the research, the participants were informed that any personal information would be dealt with in a professional and private manner. This included who would have access to the data. Only myself, the researcher, and my research supervisor would have access to the data obtained from this study. All material resulting from the data collection process will be kept safe as agreed upon in the terms and conditions for participating in the research project, as well as to the rules and standards of The University of South Africa (UNISA).

#### **4.5 Data collection procedure**

The data sources in phenomenological and GT research consist of concrete descriptions of the participants' experiences (i.e. their writings about their experiences, such as their life story) and/or in-depth interviews (Langdrige, 2007). The qualitative aim during data gathering is to elicit naïve descriptions of the actuality of experience as it is lived (Osborne, 1994).

The descriptions within interviews are called narratives through which the researcher attempts to reach understanding of their experiences. Denzin (1989) defines a narrative as a story that tells of a sequence of events and experiences that are biographically significant, because they have an internal logic that makes sense for

the narrator. It facilitates understanding of coherent organising of experience through the help of a scheme that recognises the intentionality of human action. By holding human beings accountable for their conduct, intentionality renders human conduct intelligible. As a paradigm of communication, narratives allow individuals to tell stories, to teach and learn, to ask for and to offer an interpretation. In this way, it renders what is known and available for intelligibility and further scrutiny.

In short, a life story or narrative serves as a gateway into the identity of the narrator (i.e. the sense of self) and reveals clues to the kind of life that has been lived by the narrator, whether a happy fulfilled existence, or a depressing and burdened tragedy. For this reason, narratives are viewed as tools that communicate the creation of meaning, which in this research study focuses on ultimately creating a better understanding of perfectionism in treatment resistant eating disorder clients.

#### **4.5.1 The interaction between participant and researcher**

The interactions between participants and the researcher are located within discourses. These discourses take the shape of unstructured interviews that allow for as much exploration of ideas and events as possible, so that understandings of meanings can emerge. It also allows for further exploration of concepts and ideas where necessary.

As mentioned previously, the research interview process was conducted within the confines of the participants' therapy process. The researcher had to maintain awareness and constantly reflect to elicit information about the topic of interest, but also to keep the therapeutic needs of the participants in mind. The discussions

remained primarily loyal to each participant's therapy goals, and secondarily to the research agenda concerning perfectionism. Therapy- and research notes, as well as observations were kept throughout the data collection process, and contributed to data that was later used for analyses. The participants' own written accounts, autobiographical writings and diaries, or other general documents they produced during therapeutic interventions and during the research process, were also included.

The contact sessions were conducted in the researcher's office, providing the participants with consistency in their surroundings. Within some contact sessions, specific questions were posed to merely frame the discussion and to focus attention on the topic of interest. Therapy work was then completed to explore the participant's understanding and to encourage the goals of recovery. Thus, no interview schedule was constructed, and the contact sessions were much more conversational in style, as opposed to the interviewing style usually used during therapy, which was seen as a major advantage for the data collection process. In conducting the research in this manner, it allowed enough time and opportunity for the participants to trust me, to lose their shyness and/or the need to hide something or deliberately attempt to deceive me, and to produce good descriptions of their experiences. Many contact sessions over the course of weeks and months during which this exploration was conducted, enabled me to continually reflect on the information that was being elicited during the previous sessions. These reflections were then used as a springboard for follow-up conversations in consequent sessions which elicited more information. Over the course of the research study, conversations became a natural

process for the participants, which freed them of anxiety and led them to reveal and discuss personal information.

The range of issues that were explored within the broad frame of the research topic was always taken into consideration. We discussed many topics and occasionally I veered more towards specific information to gain a deeper understanding of the participants' descriptions and what they were implying. If I wanted to explore the participants' responses more, further questions were asked for clarification. If further exploration was deemed inappropriate at that time, such questions (or topics) were noted and returned to at a later stage.

#### **4.5.2 Therapy considerations for the participants**

The overall treatment goal of the contact sessions during therapy was to guide the candidate towards recovery. As already mentioned, the research process itself formed part of each participant's therapeutic intervention. Essentially, participants were therapy clients who availed themselves for qualitative research and observation, whilst attempting to seek intervention and recovery from their eating disorder. As is normal in any therapeutic alliance, therapeutic rapport was sought as a priority throughout the process - not only for the therapy process itself, but also for assisting in gaining good descriptions of the topic in question for the research.

In this regard, the research undertaking had to maintain a constant balance between the therapeutic needs of the participants and the researcher's needs for good experiential descriptions. Therapy was the primary priority, whilst the research goals were pursued as a secondary goal. Conversations were thus predominantly guided

by the participants' therapy needs although the nature of the exchanges was entirely open. Listening actively and being open to the participants' narratives encouraged me to understand their experiences through probing, to achieve thick descriptions in minute detail.

Although some of the treatment models for eating disorders (e.g. cognitive-behavioural therapy for eating disorders) dictate some or other set structure that is followed during an intervention, I was guided more by a client-centred approach. This approach dictated a therapeutic style that was adapted to the needs of each participant, as well as a response to specific interventions (most of the sessions did not even focus on aspects of perfectionism). Topics would include, amongst many others, aspects of pathological eating habits, behavioural problems or obsessive thinking patterns.

Each contact session was at least 30 minutes in length, although the mean length was almost one hour. The amount of contact sessions varied for each client. These ranged between 8 - 25 sessions.

#### **4.5.3 Audio recordings**

Due to the nature of the study I, the researcher, could not rely solely on mental recollections or field notes of the conversations. To fulfil the research goals, digital audio recordings were made of each session which formed the main method of data collection. The participants were made aware when giving informed consent that the contact sessions would be recorded.

Due to the nature of the research and the vast extent of the discussions within the context of the therapy sessions, it would be nearly impossible to transcribe all the recorded conversations of every contact session from audio to written format. Therefore, transcriptions were only made of the parts of the audio recordings that were relevant to the study of perfectionism in treatment resistant eating disorder clients. Verbatim transcriptions were made and after I, the researcher, analysed these transcriptions, a better understanding of the participants' experiences emerged. The verbatim transcriptions were thus used to fully grasp the participants' subjective experiences of their eating disorder in relation to perfectionism.

#### **4.5.4 Reflections of the participants on the research process and results**

In qualitative research, participant feedback may be included as part of the evaluative criteria of the data analysis procedure, to encourage rigor (Langdridge, 2007). In sharing research interpretations and therapeutic feedback with participants, the participants reflect on the accuracy of the researcher's understanding and description of their inner world. In this process, one acknowledges that there is no one true and final meaning to the experience in question, or one universal therapeutic answer to their psychological distress.

However, in the present study participant feedback on the process, and phenomenological- and grounded theory analyses of their experiences, was not sought from the participants. My reasons for this decision are as follows:

- The research process was primarily a therapeutic process. The power dynamics of the therapist-client relationship, as well as maintaining the therapeutic relationship and alliance (i.e. if they ever need help again in case of relapse), was considered of a higher priority than obtaining feedback. I, the researcher, gave consideration for the

possibility of a participant reading the results of the data analysis (i.e. reading what I, the therapist, had written about them) and that it could potentially *spoil* the therapeutic relationship that had been established through months of therapy sessions. This, in turn, could invariably cause psychological and emotional harm to the participant.

- Reflecting on the work could be biased, as a therapeutic relationship had been formed between researcher and participant. Thus, their position as therapeutic client could possibly influence them not to want to be brutally honest with their feedback, thereby overstating or understating their true opinions.
- It could possibly hinder them from seeking help from me (or another psychologist) in the future, as well as possibly forming a negative opinion of psychotherapy, psychology and psychologists after such a feedback procedure, if in such case it had caused them harm.

## **4.6 Data analysis procedure**

### **4.6.1 Key tenets of the phenomenological approach to data analysis**

The phenomenological approach is descriptive (Ihde & Silverman, 1985) and qualitative (Bogdan & Taylor, 1975) and has a special realm of inquiry in that the structures that produce meaning in consciousness are explored (Valle & Halling, 1995). The process behind this exploration involves the collection of naturalistic first-person accounts of experience, whilst recognising the possible influence the researcher might have on the processes of data-collection and data-analysis (Langdridge, 2007).

As explained previously, the basis of phenomenological research is to explore human experience, and it approaches the topics of interest through the presence of

conscious awareness. It investigates and describes phenomena as consciously experienced, without theories about their causal explanation, and is as free as possible from unexamined preconceptions and presuppositions (Spiegelberg, 1975). Its emphasis is essentially on *descriptions* rather than on *explanations*, by focusing more on *what* rather than on *why*.

Contemporary phenomenological psychology does not appear to require the universal eidetic structures which Husserl himself originally envisaged, but rather, focuses upon “structures [meanings] that are typical or general to groups of people” (Polkinghorne, as cited in Osborne, 1994). The identification of the essential structures of an experience is usually done through the explication of thematic meanings. This accounts for a *translation* of the philosophical methods developed by phenomenologists into functioning research practices for psychology (Polkinghorne, as cited in Osborne, 1994).

There are six key tenets of phenomenology which portray the path of the research analysis process. Lessem and Schieffer's (2010, p.108) illustration thereof, with corresponding explanations after each step, is depicted below:

1. Engage in a process of radical inquiry

Phenomenological research must pay attention to the nature of consciousness as actually experienced, not as described by common sense or philosophical tradition. It must make a fresh interpretation of phenomena, *bracketed off* from customary outlooks and conventional assumptions.

2. Immerse yourself in a life world of immediately lived experiences

Phenomenological research has, as its exclusive concern, intuitive experiences as found in their essence, not empirically perceived and treated as empirical facts. Further, it seeks to avoid all imposing explanations bestowed unto an experience from the beginning - whether these are drawn from religious or cultural traditions, from everyday common sense, or indeed from existing science. Explanations are not to be imposed before the phenomena have been understood from within.

3. Concentrate on illuminating the nature of the *inner self*

Phenomenology grounds the study of culture, or *spirit*, with a proper scientific footing. In this manner, the participant's *life world* underlies their intentional experiences. The scientific endeavour views such a life world as the universal framework of human endeavour.

4. Focus on the subjective view of experience

Phenomenology emphasises the importance of the subjective view of experience as a necessary part of a full understanding of the nature of knowledge.

5. Locate every unique cultural history as an episode in the larger history of humanity

The phenomenologist will need to attend through the research to the researcher's particular approach to experiencing the world. It is also critical, that the researcher is aware of what kind of individual and societal essential *intentionality* one brings to the research.

## 6. Go beyond Reductive Positivism and Naïve Empiricism

Phenomenology emphasises a very special theoretical attitude - one of detached playfulness and curiosity. If the objects produced in this play are uncritically asserted and without reference to their subjective intent as the real objects of our experience in our life world, serious problems will arise.

### **4.6.2 The methodological principles for a descriptive phenomenological data analysis**

As previously explained, the hallmark of a genuine phenomenological enquiry is that its task is 'a matter of describing'. Three essential notions of descriptive phenomenology are:

- Intentionality
- Epoché (and the phenomenological reduction)
- Essences

Each of these notions will now be explained.

#### **4.6.2.1 Intentionality**

Husserl's thinking was that the mind is directed towards an object, and this directedness is termed *intentionality*. This idea was founded upon the assumption that our conscious awareness was one thing of which we could be certain of. Thus building our knowledge of reality should start with this conscious awareness (Koch, 1995).

The term intentionality does not encapsulate the usual sense of what it means today (i.e. intending to do something). Instead, it refers to the fact that whenever we are conscious of something (i.e. awareness), it is always to be conscious (or aware) of something. There is always an object of consciousness - whether physical (for example a chair) or non-physical (for example an idea).

Thus, when we perceive something, phenomenology does not view it as something conceived in the mind (i.e. a projection of the occipital lobes of the brain) but rather a conception of an object out there in the world itself. It strikes to the heart of the philosophical debate concerning the notion of a mind being separate from the body. The phenomenological method focuses on the way consciousness is turned out on to the world, as it intentionally relates to objects in the world. It zooms in on the relationship between the person's consciousness and the world - the correlation between the way the world appears and the experience of it (Langdrige, 2007).

#### **4.6.2.2 Epoché (and the phenomenological reduction)**

Husserl insisted on returning *to the things themselves* through the clearing away of assumptions and preconceptions about experience. In order to do such investigations, Husserl emphasised the need to *eliminate all preconceived notions*, insisting on an initial *suspension of beliefs* in attempting to study and describe a phenomenon (Koch, 1995).

During this process, the researcher is to set aside his natural attitude (i.e. his taken-for-granted assumptions about experience), in his ultimate attempt to describe the *things themselves*. This is done by letting things we experience appear in our

consciousness *as if for the first time*. This freshness of vision requires the researcher to be aware of his presumptions and prejudices and subsequently examine the object of consciousness from different perspectives. This ability to view phenomena from different perspectives is crucial in uncovering the essences of the phenomena (Langdridge, 2007).

This clearing away, or 'Epoché', promotes an attitude of *openness towards phenomena* for the researcher. Husserl conceived the procedure of 'phenomenological reduction', which is similar in meaning to 'Epoché':

*"It refers to the procedure a researcher engages in so as to bracket one's everyday beliefs in the existence of realities independent of us." (Halling & Nill, 1995, p.7).*

Husserl's idea of phenomenological reduction was very influential. The purpose of the reduction was to prepare us for the critical examination of what is undoubtedly given, before our interpreting beliefs enter it. Indeed, Husserl also used the term *epoché* for this concept, however its use has been altered drastically through the decades. In the research tradition, *epoché* now refers to how an investigator must *bracket out his prejudices*. Researchers must first examine themselves to determine their own pre-judgements, personal commitments and so on before investigating a phenomenon (Cohen, 1987).

In short, phenomenological reduction is the process by which the researcher continues to identify his presuppositions about the nature of phenomena and to set them aside (i.e. *bracket* them), in order to fully see the phenomenon as it is. This principle encourages the researcher to suspend his preconceived thoughts and

notions concerning a field of study, and to bypass past habits of thought and intention that may lead him to confuse his own theories with genuine knowledge.

#### **4.6.2.3 Essences**

As mentioned, one of Husserl's goals with phenomenology was that it should *return to things themselves* and to the essences that constitute the consciousness and perception of the human world. Thus, these essences referred to by Husserl, are the ultimate structures of consciousness which may be isolated, identified and studied (Koch, 1995).

This principle involves moving from the description of the phenomenon of the individuals' experiences, to exploration of the structure underlying such experiences. Hence, experiential descriptions of multiple participants enable the researcher to discern the essence of an experience (Langdrige, 2007). These essences emerge through rigorous examination and reflection of the experience itself, as it arises in consciousness among the participants in the investigation.

#### **4.6.3 Giorgi's method of descriptive phenomenological analysis**

The first research objective focuses on an accurate *description* of what it is the respondents feel and experience. To this end, the audiotape recordings are to be analysed phenomenologically per Giorgi's method, to form a good conception of what was said by the participants regarding perfectionism.

#### **4.6.3.1 Definition**

Giorgi's descriptive phenomenological method is one of the most traditional approaches to phenomenological research and psychology. It emerged in the 1970's with the work of Amedeo Giorgi and his colleagues (Giorgi, 1985; Giorgi & Giorgi 2003), and is referred to as Husserlian Phenomenological Psychology, or the Duquesne School.

Giorgi's technique focuses on descriptive analysis of the lifeworld of the participant by identifying the essence of the phenomenon through the utilisation of epoché and phenomenological reduction. It is primarily concerned with the lived experience, with its philosophical underpinnings established by Husserl. It moves away from subject-object dualism, towards a *noema-noesis* correlation (the *what* of experience and the *how* of experience). The core of this method is to *return to things themselves* and focus merely on describing phenomena (rather than explaining them). In this technique no attempt is made to find the psychological causes of the phenomena. Simply describing the *things in their appearing* is considered enough (Langdridge, 2007).

#### **4.6.3.2 Method of analysis**

Within the data analysis process, Giorgi (1997, p.237) describes how the philosophical method of phenomenology encompasses three interlocking stages:

1. The phenomenological reduction

The reduction directs the researcher to step back and describe the examining experience as a presence. Everything that is present in the natural attitude is retained within the phenomenological reduction. Another requirement of the phenomenological reduction is that the researcher needs to *bracket* his past

knowledge and assumptions about the phenomenon encountered (i.e. epoché). One *puts aside* or *discards* all prior knowledge that may be associated with the present given object, so that it has a chance to present itself in its fullness. This is done to encounter it freshly and describe it precisely as it is intuited or experienced.

## 2. Description

For pure phenomenology, the task is to describe the intentional objects of consciousness from within the perspective of the phenomenological reduction.

## 3. Search for essences

Through a method Husserl refers to as 'free imaginative variation', one seeks the essence of the phenomenon that is researched. This technique is dependent on the researcher's abilities to awaken possibilities. It means that the researcher freely changes aspects or parts of the phenomenon or objects that are studied, and then observes whether the phenomenon remains identifiable with the part that was changed or not. In addition, Giorgi (1997) highlights that the researcher needs to analyse the description with a special sensitivity towards the perspective of his or her discipline (i.e. in the present research endeavour: Psychology) and with a sensitivity towards the phenomenon being researched (i.e. perfectionism within treatment resistant cases of eating disorders).

Overall, Giorgi's descriptive phenomenological data analysis process entails the following procedure (Langdrige, 2007, p.86):

1. Obtaining first-person accounts of the experience being researched.
2. Engaging in a process of analysis that seeks to discern the underlying structure of an experience. When analysing the data, the data is separated into different

parts based on meaning discriminations. These parts are known as Natural Meaning Units (N.M.U.'s). N.M.U.'s are defined as:

“...a statement made by the subject which is self-definable and self-delimiting in the expression of a single, recognisable aspect of the subject's experience” (*Cloonan, 1971, p. 117*).

Each N.M.U. conveys a different meaning which emerges spontaneously from the recordings. These N.M.U.'s will then be clustered into common categories/themes. The textual descriptions of the experiences will be developed using these clusters.

3. The production of findings that describe the universal structure (i.e. essence) of the experience, as well as the individual idiosyncratic meaning.

In identifying the above-mentioned stages in Giorgi's descriptive phenomenological method, he offers the following four steps involved during a descriptive phenomenological data analysis procedure (Giorgi, 1985; Giorgi & Giorgi, 2003):

### **Step 1**      Reading for overall meaning

Read and re-read through the transcriptions of the participants and attempt to grasp the overall sense of what it means. Do this in conjunction with the phenomenological reduction (i.e. bracketing of one's preconceptions about the subject matter in question). When reading, engage with the data with a sense of discovery, avoiding the temptation to impose meaning by engaging in the phenomenological reduction.

**Step 2** Identifying the meaning units

The data/text is broken down into smaller units of meaning. The researcher works through the data systematically and attempts to discern discrete meaning units (i.e. N.M.U.'s). The researcher should adopt a psychological attitude towards the data as he reads through the data, with an eye for where the experience relates to issues appropriate for a psychological investigation.

The researcher also excludes the other topics of discussion from the data analysis procedure that are not of relevance to the research study (e.g. if the topic of discussion is not of relevance to the set that is the focus of the study - those topics are of little consequence to the analysis of the relevant topic).

**Step 3** Assessing the psychological significance of each meaning unit

Some will have no psychological significance and will be ignored, whilst others will be focused on in detail. Multiple readings of the meaning units and constantly reflecting on the information are done to determine the psychological meaning of the discrete units identified in the previous step. In this step, it is important to attempt to move from the idiosyncratic details, to the more general meaning. The suggestion is to stick to the data and not to start forming grand psychological theories.

**Step 4** Synthesising the meaning units and presenting them in a structural description

This involves working through the psychologically significant meaning units to produce the individual structural description for the

participant's experience of their perfectionism. Redundancy is removed along with idiosyncratic variations to produce a description containing the invariant properties of the experience (i.e. a description that would be appropriate for anyone who experiences the same phenomenon).

Firstly, one produces individual structural descriptions for each participant on their experience and *lifeworld*. Thereafter, one produces a general description of the structure of the experience. This means the researcher synthesises the psychological units of meaning by identifying the key elements for the phenomenon being described, and then firstly writes it up as a brief (chronological) account for each participant (i.e. the individual structural descriptions). Following the completion of the individual structural descriptions, the researcher then identifies the invariant properties across the descriptions (referring back to the meaning units where necessary), so as to produce a general psychological structural description of the phenomenon. In the general description, the key is to identify those features of the experience that *do not* vary across participants and separate these out from those features that *do* vary.

This general description is the culmination of the analytical work described so far and represents the essence (invariant core to all similar experiences) of the phenomenon being investigated. It forms the basis of further discussion about the extant literature and individual structural descriptions (where appropriate).

The findings from the phenomenological data analysis procedure were obtained by using Giorgi's descriptive phenomenological approach, and result in a focus on the essence of the participants' experience. These findings are presented in Chapter 5.

#### **4.6.4 Key tenets of the grounded theory approach to data analysis**

The groundwork for the development of a theory of perfectionism within treatment resistant eating disorders will be done utilising the GT approach. The aim of the GT approach is to allow categories to emerge from the data. The theory product regarding perfectionism in treatment resistant eating disorder clients is therefore rooted in the reality of the participants' experiences. Any theory which results from a GT approach can thus be understood as theoretical constructs which constitute the essence of living with perfectionism within a treatment resistant eating disorder.

Overall, GT analysis is categorical in its intent. The basic procedure of grounded theory consists of four simple steps: Obtaining data, coding, comparison and then generation of theory (Mills & Morten, as cited in Fox, 2014). Data analysis in GT is a process of sorting the data into coded categories. Usually in GT the collection and analysis of the data occurs simultaneously (Strauss & Corbin, 1990). The method prescribes that the researcher constantly compare the different categories identified with new incoming data analysed, to see that the data are disseminated in a meaningful way.

The successive formulation of theories about the interrelationships among categories involves a trial-and-error process, which leads to a final theory that fits the data (i.e. it is *grounded* in the data). As the research data are being categorised, the

relationships among those categories are noted and compared to the theoretical codes. Later, the categories are integrated into a cohesive theory (Glaser, as cited in Osborne, 1994). The process thus continues until the relationships among categories produce a final inclusive theory. Data generation continues until all the categories become saturated (i.e. categorical redundancy is achieved). The determination of the relationships among categories is an interpretive procedure of the verbal descriptions of the experience, which aims at uncovering the meaning of the phenomenon in question.

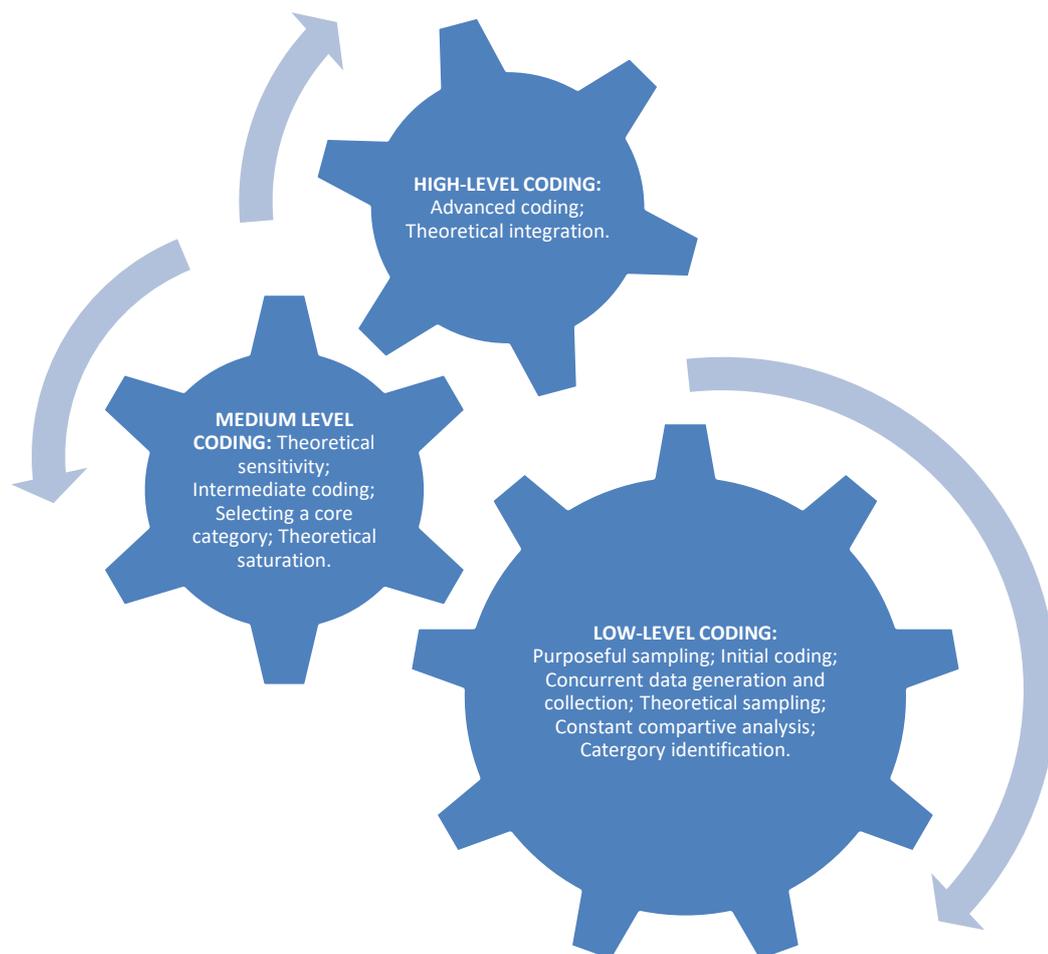
In following the grounded theory method described by Birks and Mills (2011), the researcher analyses the narratives of the participants to arrive at the conceptual framework. The GT analysis includes the following three levels of analyses:

1. Initial coding (low-level concepts)
  - Fractures the data to identify different categories.
  - Constant comparative analysis (i.e. comparing incident with incident).
2. Intermediate coding (medium-level concepts)
  - Theoretical sensitivity and selective coding, where attention is turned to generating codes around an identified core variable.
  - Linking together or integrating core categories.
  - This is done until theoretical saturation is reached (i.e. no new categories can be identified from the data).
  - A core category is identified that encapsulates the process apparent in the other categories and sub-categories constructed.
3. Advanced coding (high-level concepts)
  - Application of advanced analytical strategies to raise the analysis to the highest conceptual level possible.

- Theoretical integration: The core category is analytically powerful and therefore able to explain the phenomenon under study.

The same authors also offer the following Figure 4.2 to illustrate the conceptual ordering and placement of the methodological principles within GT methods. This conceptual ordering may be divided into low-level concepts, medium-level concepts and high-level concepts, each containing specified principles (Birks & Mills, 2011, p.91).

**Figure 4.2: Conceptual ordering of essential grounded theory methods (Birks & Mills, 2011, p.91)**



As illustrated above, the three levels of data analysis build upon each other. During low-level coding, data is scrutinised for commonalities that reflect categories or themes, and further examined for properties, specific attributes or subcategories (Strauss & Corbin 1998). The data is reduced to small sets of themes that appear to be describing the phenomenon, or breaking down and examining discrete parts through microanalysis (Allan 2003). In this research study, the points regarded as reflecting elements of perfectionism in eating disorders were identified in each of these statements transcribed manually (this analysis was not computer aided). At that stage, data was scrutinised and relevant data identified, highlighted and given an identifier.

Medium-level coding focuses on establishing interconnections among categories and subcategories. One attempts to determine more about each category in terms of the condition that gave rise to it. Movement becomes back-and-forth among data generation and analysis, with low-level coding and medium-level coding continually refining the categories and their interconnections as additional data is analysed. In this research study, medium-level coding further developed the categories and assisted in identifying concepts that were not directly related to the rest, which then formed the sub-categories to the categories.

High-level coding encompasses combining the categories and their interrelationships to form a theory that describes what happens to the participants in this study, how it happens, and what they think can assist them in their fight with their eating disorder. In this research study, the high-level coding combined the categories into their

respective core themes, and through theoretical integration, produced the final theory product of the GT analysis.

#### **4.6.5 The methodological principles of grounded theory data analysis**

Grounded theory data analysis is a systematic approach of theory generation from data that contains both inductive and deductive thinking and reasoning (Martin & Turner, 1986). It calls for the researcher's creativity and critical thinking.

Particular attention and effort was invested into ensuring that this research study is not merely a qualitative descriptive analysis of a particular phenomenon, but rather judged to be of proper rigour and quality as a grounded theory. The analytical procedures offered by Birks and Mills (2011) informed my analysis of the data, and systematically guided me in my attempt to develop the conceptual framework that explains the processes, actions and interactions concerning perfectionism within treatment resistant eating disorder clients. In coming to understand GT methodology, I list the following 11 methodological principles that constitute the essentials of the GT method, as identified in Birks and Mills (2011):

1. Initial coding and categorisation of data.
2. Concurrent data generation or collection and analysis.
3. Writing memos.
4. Theoretical sampling.
5. Constant comparative analysis using inductive and deductive logic.
6. Theoretical sensitivity.
7. Intermediate coding.
8. Identifying a core category.
9. Theoretical saturation.

10. Advanced coding and theoretical integration.

11. Generating theory.

In the following sections, I reflect on each of these 11 principles in the grounded theory method. Adherence to these steps as far as possible positively influences rigor and validity. I reflect on their formal definitions, my personal understanding of them, as well as their influence in the research in my attempts to adhere to them as far as possible.

#### **4.6.5.1 Initial coding and categorisation of data**

In conducting grounded theory, one utilises the idea of *concepts* or *coding*. Holloway (2008) defines a *concept* as a descriptive or explanatory idea with its meaning being embedded in a word, label or symbol. Differences between concepts and how they operate in grounded theory relate to their function in the analytical process and levels of sophistication of which both are interconnected. Coding is the active process by which the researcher identifies incidents of recurring actions, characteristics, experiences, phrases, explanations, images and/or sounds. In this manner, the researcher identifies the concepts that underlie incidents of the data, and it is to these concepts to which a code can be applied (Birks & Mills, 2011).

Coding is the first step in the GT analysis process. It is the mechanism by which the theory is *accessed*. It is the pivotal link between collecting data and developing an emergent theory. In discussing GT in the different stages of analysis, Birks and Mills (2011) refer to the different phases as initial-, intermediate- and advanced levels of coding. These analytical processes directly relate to the level of conceptual

abstraction the researcher is developing at that time. Initial, intermediate and advanced coding correlates with and feeds into low-, medium-, and high-level conceptual development. There is a recursive nature within GT analysis which sees researchers alternate between phases of coding throughout the study, as they concurrently generate data and analyse it. The fully integrated developed GT is a high-level conceptual framework that possesses explanatory power supported by advanced analytical processes.

Although coding paradigms exist, which attempt to assist researchers in their exact approach to *how* coding is done (Corbin & Strauss, 2008), Glaser (1992) rejects the use of the coding paradigms as a useful adjunct to analysis. He perceives it will force data into theoretical framing of the researcher's making, as opposed to allowing theory to emerge inductively from the data. It is with this thinking in mind that I chose rather not to follow a specific coding paradigm, but instead to follow principles of GT during the coding and analytical process.

During low-level coding in this research study, the focus was more on the raw data from the participants (i.e. transcriptions of interviews, field notes, documents and elicited materials). In this research study, coding commenced after therapy terminated. During any qualitative study, generating large amounts of data for analysis is inevitable. Vast amounts of data had to be analysed, as some of the respondent's therapy processes continued for more than a year. The interview process itself was not controlled by when saturation of data for that respondent was achieved, but rather by their therapy process, emotional needs, and overall recovery.

The process of initial coding continues until comparison of each code produces commonalities. These codes are then analysed and grouped under a higher order commonality, the concepts. The concepts are further regrouped into even higher order commonalities called categories (Allan, 2003). Birks and Mills (2011) state that codes are a form of shorthand that researchers used to identify conceptual re-occurrences and similarities in the patterns of participants' experiences. Thus, groups of codes that represent a higher-level concept later, ultimately form a category.

During the GT analysis, categories were identified because of regrouping the concepts. Each interview had an initial set of categories which were constantly compared to either merge them, or to create a new category. The subsequent interview concepts were compared to the previous ones, building onto the existing category. The categories from other interviews and observations were constantly compared until common categories that were representative of the findings emerged.

#### **4.6.5.2 Concurrent data collection and analysis**

Multiple data collection sources all contributed to the richness of the data obtained from the participants. The following list comprises all the sources of data that were used in this research study:

- Interviews.
  - Oral histories.
  - Personal experiences.
- Solicited data/purposeful interviewing.
  - Specific questions on specific topics.
  - Filling in self-report questionnaires.

- Written documents (including email correspondences).
- Journal entries and food diaries.
- Participant observations and therapy notes.

The main method of data collection consisted of unstructured interviews during a therapy process. Less structure is better as the conversation can lead. During these conversations, I acted primarily as therapist, secondarily as researcher, with the aim of collecting data for the development of theory. Even though there was not a structure during the interviews (conversations) of perfectionism, there remained therapeutic goals and priorities which did' impose structures, always, upon the process and the discussion topics.

#### **4.6.5.3 Writing memos**

Birks and Mills (2011) emphasise that writing memos is the cornerstone of any GT research. Memos are records of thoughts, feelings, insights and ideas in relation to a research project. They enable one to articulate, explore and question one's interpretations as one engages with the data. They provide mental pictures that chronicle one's study experience and the internal dialogue which is essential when conducting any qualitative research, particularly those with an interpretive component.

This study was undertaken in the field, which means that the interviewing of participants took place during therapy sessions. Observations and notations were made during these therapy sessions as part of the data gathering process. Initially, my memos were short and only highlighted my basic concepts about the research.

Later, they contributed to developing longer detailed ideas about the research participants and their experiences, which ultimately contributed towards developing the emerging theory. By further immersing myself in the data, thoughts and ideas would sporadically develop as I attempted to understand the data. These ideas came at random, sometimes when I was talking with one of the participants, or when listening to the audio recordings. Some nights I would even wake from my sleep to ideas about the data - and I would rush to make a memo about them, debating their applicability to the research the following day.

#### **4.6.5.4 Theoretical sampling**

Glaser and Strauss (1967) originally defined theoretical sampling as:

*“...the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges” (p.45).*

A key tenet of implementing classic GT is the use of theoretical sampling. It involves being guided by the data in determining where and what data needs to be collected next. Glaser (1998) explains that prior to discovery, researchers cannot know what to sample for and where it will lead them to, suggesting that the data analysis should guide the researcher whom to interview next. Theoretical sampling determines how data will be collected, from what sources and in what locations as the study progresses. Application of theoretical sampling in its purest form would see you undertake a single data collection event at a time. One would analyse that data set first, then come to decide where to pursue one's next data source to investigate the phenomenon further (Glaser, 1998).

In reality, this may not always be possible. Geographical constraints, availability of participants and other access issues may limit one's ability to conduct an analysis intermittently with every episode of data generation or collection. In this study, I was limited in terms of practical and ethical considerations to utilise theoretical sampling because the participant population was restricted to treatment resistant eating disorder sufferers. As discussed earlier, such individuals do not enter therapy easily and may be resistant towards sharing their deep-seated feelings and problems. In this study, some of the participants took hours of therapeutic contact to reach a point of trust in the process to open up about their personal feelings and experiences. Also, the constraints that therapy places on your role as clinical therapist negatively influences one's freedom in fulfilling the dual role as researcher to *find* new cases. Thus, lack of access to data sources influenced my ability to source treatment resistant eating disorder sufferers, as well as struggling to convince them to enter a therapy process. In conjunction to this, the research priorities were superseded by the participants' therapy needs, which at times prevented further investigation into specific topics during the discussions. Balancing the needs of the participants' therapy process with the needs of the research remained a constant difficulty throughout the study.

When considering these practical issues of studying the specific research population, the GT analysis and the emerging grounded theory was determined by maximum variation sampling and purposive sampling of participants for explaining and understanding perfectionism in treatment resistant eating disorder clients. Data collection was done upfront and analysed separately, which contradicts essential GT principles about theoretical sampling. Thus, theoretical sampling was not utilised to

*steer me in the direction of my next participant* during data collection. In this regard, my analysis and emerging grounded theory may have suffered because of this.

#### **4.6.5.5 Constant comparative analysis**

GT is inductive in nature because it is a process of building theory up from the data itself. Induction of theory is achieved by the process of repetitive successive comparative analysis. Constant comparative analysis is the process during concurrent data collection and analysis in which the constant comparison of incident to incident, incident to codes, codes to codes, codes to categories, and categories to categories happens. Codes are compared with codes and groups of codes are collapsed into categories with which future codes are then compared, and categories are subsequently compared with categories. It is through constantly comparing the different conceptual levels of data during the process of data analysis that makes theoretical sampling and the ongoing collection of data very difficult. It is a continual process that repeats itself until a grounded theory is fully integrated (Birks & Mills, 2011).

Generating GT entails the concomitant actions of collecting, coding and analysing the data (Glaser & Straus, 1967). All three these steps should be performed together in such a way that the activity allows a continuous intermeshing and smudging of the data to occur. Usually in GT, after a researcher has utilised theoretical sampling to identify a source of data for the phenomenon they are studying, he/she would analyse the data from that source, before moving on to the next source. This process would happen concurrently, the interplay between theoretical sampling, followed by

constant comparative data analysis which contributes to the theory development until saturation of the data has been reached (Birks & Mills, 2011).

During my data collection process, no constant comparative analysis was conducted. Instead, my data collection process was done concurrently to the participants' therapy process. As the process of therapy with the participants was so lengthy, data collection took more than two years to complete. Interviewing multiple participants at times overlapped, while at other times was only done at a later stage after previous participants had already exited the study.

It was only during the data analysis phase that I utilised constant comparative analysis in developing the theory. During the phase of data analysis, I continually compared incident with incident, which lead to the development of codes. Any future data analysed was then compared with existing codes, which later lead me to identify the different concepts and categories. It was a constant process that repeatedly took place during the data analysis phase. In so doing, similarities and differences were drawn out and data was categorised based on similarities. Thus, constant comparison helped me to evaluate these categories.

#### **4.6.5.6 Theoretical sensitivity**

Theoretical sensitivity is a multidimensional concept that includes the researcher's level of insight into the research area, how attuned the researcher is to the nuances and complexities of the participants' words and actions, his/her ability to reconstruct meaning from the data generated with the participants, as well as a capacity to "separate the pertinent from that which is not" (Strauss & Corbin, 1990, p.44).

In short, it refers to the researcher's ability to recognise and extract from the data, elements that have relevance for the emerging theory. It highlights the researcher's level of insight into both themselves and the area of enquiry. Also, a researcher's level of theoretical sensitivity reflects his/her intellectual history, the type of theory that he/she has read, absorbed and presently uses in everyday thought. Researchers are the sum of their experiences and the concept of theoretical sensitivity acknowledges this fact and accounts for it in the research process.

Glaserian GT requires that the researcher enters the field of inquiry with as few predetermined thoughts as possible. This enables him/her to "remain sensitive to the data by being able to record events and detect happenings without first having them filtered through and squared with pre-existing hypotheses and biases" (Glaser 1978, p.3). There is a reliance on the researchers' immersion in the emerging data to increase their theoretical sensitivity. Glaser's stance equates to that of 'tabula rasa', or a blank slate, when entering a field of inquiry (Clarke, 2005), to legitimately develop theoretical sensitivity.

It was therefore a priority for me to maintain an open mind when entering this area of study, as I reflected to what extent my personal knowledge and qualifications can, or indeed would, influence my approach to the study. Maintaining an open mind whilst being theoretically sensitive to identify concepts of theoretical significance throughout the process of data collection and analysis, was imperative. I attempted, as best I could, to not impose my own preconceptions on the developing theory and tried to ensure that the knowledge and experience I already possessed prior to the

study was used effectively in its application of essential GT methods, to compliment the quality of the emerging theory.

#### **4.6.5.7 Intermediate coding**

During the second stage of data analysis, intermediate coding followed from initial coding. Birks and Mills (2011) describe that as the data analysis progresses, theoretical sensitivity automatically heightens as you immerse yourself more with the data. A key task of intermediate coding is the linking together or integration of categories. By constantly comparing the data, categories and subcategories are compared with each other while the researcher questions the relationship between these medium-level concepts.

Intermediate coding allows for identification of patterns and relationships during the process of category development. GT categories are multidimensional, which may consist of several subcategories that together explain the broader concept. In GT, the researcher moves between initial- and intermediate coding during the process of concurrent data collection by constantly comparing the data. Intermediate coding is used to develop individual categories by connecting them to subcategories, fully developing the range of properties and their dimensions of those categories, as well as linking categories together. Through the grouping of codes, formation of categories begins to identify explanatory conceptual patterns through their analysis (Birks & Mills, 2011).

During intermediate coding, I immersed myself fully in the data. Much time was spent with coding and forming concepts, and with constant comparison of the analysed

data, these concepts were then linked to categories through conceptual linkages and patterns.

#### **4.6.5.8 Identifying a core category**

During the later stages of analysis, the core category becomes the hub of the developing theory. Strauss and Corbin (1990) identify a core category as “the central phenomenon around which all the other categories are integrated” (p. 116). Reichertz (2007) explains that researchers in GT use a combination of inductive and abductive thought that accounts for the conceptual leaps of analysis that occur to move a GT away from being a qualitative descriptive account, and towards being an abstract conceptual framework, which is developed from the core categories.

Bryant and Charmaz (as cited in Birks & Mills, 2011) define inductive thought as “a type of reasoning that begins with the study of a range of individual cases and extrapolates patterns from them to form a conceptual category” (p. 95). However, in abductive reasoning the research begins with the researcher describing and understanding participants’ accounts of their everyday social lives, forming hypotheses and then testing the hypotheses through further data collection and theorising. Compared with other strategies of research and reasoning such as induction and deduction, which rely upon linear logic (Norton, 1999), abduction relies on cyclical processes of data collection, hypothesis formation, testing and theorising (Blaikie, 1993). Something is only significant to researchers if the researched informs them that it is of significance to the participants’ social reality (Stern, 1994).

By utilising a combination of inductive- and abductive reasoning in this research study, the core categories were achieved through full theoretical saturation of the core categories, their subsidiary categories, as well as their properties. This ensures that the core categories are then the most plausible interpretation of the observed data.

#### **4.6.5.9 Theoretical saturation**

Strauss and Corbin (1990) define theoretical saturation as occurring when there are no new codes identified in later rounds of data generation or analysis that pertain to that category, and the categories are conceptually well-developed to the point where any subcategories are clearly articulated and integrated.

This research project is unique as it happened under the auspices of therapy for people struggling with a disorder. I therefore needed to customise the research design to fit in with the research objectives. Every decision regarding the research had to be made primarily from the position of a therapist for the participants. Even in questioning and probing for information, the participants' health concerns were always prioritised. Hence, any relevant information gained from the therapy sessions was mostly sporadic in nature. Sometimes there was the need to investigate something further, although it was influenced by their therapy priorities and process. This then influenced comparative analysis as I did not necessarily probe for more information during the process of analysis, but rather allowed the data to reach a natural point of saturation in time. The participants' therapy process did not have time constraints, which allowed enough time for saturation of the data to eventually occur.

#### **4.6.5.10 Advanced coding and theoretical integration**

As described previously, interaction between initial- and intermediate coding, concurrent data generation and analysis, as well as theoretical sampling for the GT approach is cyclical, as opposed to linear in design. Theoretical integration requires the application of advanced analytical strategies which raise analysis to the highest conceptual level possible. Advanced coding is at the heart of theoretical integration and it is through these processes that data ultimately becomes theory (Birks & Mills, 2011).

The more one finds concepts that work, the more the core category becomes *saturated* (Glaser, 1978). Grounded theory is based on multi-indicator concepts and not single indicator concepts. A core category is a main theme and it sums up a pattern of behaviour by pulling together identified concepts which have a relationship to each other. It is the substance of what is happening in the data. Glaser (1978, p.95) summarises the criteria a core category must meet:

- It must be central and account for a large proportion of behaviour.
- It must be based on recurring themes drawn from the data.
- It must relate meaningfully to other categories.
- Analysis should be based on the core category.
- It should be modifiable.

With the low-level and medium-level coding completed, I moved towards high-level coding which included theoretical integration and the generation of a plausible theory. Through the GT data analysis procedure, six core categories were identified, which all achieved theoretical saturation after analysing the data of the fifth research participant and simultaneously meeting Glaser's above-mentioned criteria.

#### **4.6.5.11 Generating theory**

The final product of a GT study is an integrated theory which is comprehensively *grounded* within the data that explains a process or scheme associated with the phenomenon under study. According to Strauss and Corbin (1994), a *theory* is a set of relationships that offers a plausible explanation for the phenomenon under study. Morse (as cited in Goulding, 1999) expands upon this interpretation by proposing that “a theory provides the best comprehensive, coherent and simplest model for linking diverse and unrelated facts in a useful and pragmatic way. It is a way of revealing the obvious, the implicit, the unrecognised and the unknown” (p. 25).

The final level of the data analysis stage was the development of the emerging theory, which is a process that not only conceives ideas (concepts) but also formulates them into a logical systemic and explanatory scheme (Strauss & Corbin, 1998). The propositions derived from the data analysis were constantly compared against incoming data, modified, extended or deleted if it did not match any of the established properties, until the collection of propositions represented what was going on in the research setting. These were finally combined to form the grounded theory of perfectionism within treatment resistant eating disorder clients, which will be presented in Chapter 6.

#### **4.6.6 Grounded theory method of data analysis according to Charmaz**

In GT research, one should attempt to adhere to the procedures of GT as far possible to ensure rigor. This process of theory construction involves being open to the emerging data without imposing any external framework on it. Being open to the emerging data of perfectionism within treatment resistant eating disorder clients

implies that I, as therapist and researcher, remain open to a range of questions that could lead to the discovery of important features concerning perfectionism.

I tried to adhere to GT methodological principles as far possible (as described in the previous sections), although the participants' therapy needs remained the primary focus always during the study and when having to make decisions. This might have compromised the data and results obtained as adherence to GT principles may at times have been neglected because of therapeutic priorities.

Even though some social researchers will demonstrate stringent adherence to either a traditional Glaserian or an evolved Straussian version of grounded theory (Birks & Mills, 2011), I chose to not adhere to strict procedural codes and rules in the method of analysis. By understanding how I interacted with the data generated from the research, I could philosophically identify myself with the constructivist position to grounded theory as posited by Charmaz (2006). I was however conscious that this understanding would merely serve as a guide on the research path as opposed to a detailed prescription.

Table 4.1 below illustrates the sequential order and purpose of the stages of analysis that I adhered to during the GT data analysis (adapted from Allan, 2003, & Strauss & Corbin, 1998). The initial stage of coding broke down the data and assembled it in new ways. Coding was used to identify anchors in the data that allowed the key phrases to be gathered and these were subsequently constantly compared and contrasted with new data in the process of developing the concepts. Similar concepts were further compared to form categories, which were broader groups.

**Table 4.1: The sequential order of analysis**

<b>Coding level</b>	<b>Process</b>	<b>Purpose</b>
Low-level coding	Codes	Identify anchors that allow the conceptualisation of the underlying issues within the data.
	Concepts	Grouping of codes of similar content.
Medium-level coding	Categories	Broad groups of similar concepts that are used to generate the conceptual propositions.
High-level coding	Theory	Collection of explanations that explain the subject of the research.

During the analysis, I listened in depth to the recordings of each therapy session, also considering written texts which the participants had submitted, as well as therapy notes I kept during the therapy process to gain a general sense of all the information at hand. It was during this phase of analysis that I could extrapolate the verbatim accounts relevant to the research focus of perfectionism, which would then be subjected to both phenomenological- and grounded theory analysis respectively.

During the GT analysis, I considered all the information at hand generated from the study; with the verbatim accounts, reading and re-reading the participants' narratives leading me into the coding of the data. Conceptual ordering started to take place where ideas, phenomena and patterns were noted, coded and categorised. I constantly compared the different categories with new incoming data to see that the data be discriminated and delineated in a meaningful way. As the research data were being categorised, the relationships among those categories were noted. These categories were then later integrated into the emerging theory. Thus, the process continued until the relationships among categories produced a final emerging theory.

## **4.7 Issues of generalisability, validity and reliability, as well as rigor and trustworthiness of the research design**

### **4.7.1 Generalisability**

When conducting qualitative research, generalisability of the results may be of concern due to its in-depth focus on only a few individual cases, rather than focusing on the statistical average of many participants.

Exploring and trying to understand perfectionism within a much-defined population group of treatment resistant eating disorder sufferers, seeks to understand perfectionism rather than generalising perfectionism to all treatment resistant eating disorder sufferers. In addition, the qualitative study design furthermore encouraged expansive and deep reflective accounts of the participants involved, zooming in on their subjective realities of their problem, as opposed to attempting to project the results to the population group of all eating disorder sufferers.

Denzin and Lincoln (2000) highlight that theories/conceptual frameworks produced by GT are not suited to the traditional positivist evaluation criteria of validity, generalisability, bias and reliability. This is because GT aims at analytical generalisability, as opposed to the statistical generalisation of positivist research.

### **4.7.2 Validity and reliability**

Validity in research refers to the degree to which an instrument measures what it is designed to measure. However, validity in the qualitative research sense refers to gaining accurate knowledge and understanding of the nature (i.e. the meaning, attributes and character) of the phenomenon under study (Leininger, as cited in

Krefting, 1991). Reliability is not seen as a strength in qualitative research because of the instability and inconsistency of responses from participants over time (Creswell, 2009).

There remains considerable debate about the criteria for judging validity within qualitative research. The debates are due to the creative characteristics of qualitative methods, as well as the diversity of methodologies. As Yardley (as cited in Langdrige, 2007) highlights, the diversity is both a necessity and a strength of qualitative methods, which influences the way validity is judged, as it also needs to develop diversity to be methodologically appropriate to the research.

*“The unwillingness of qualitative researchers to converge on a unitary set of methods, assumptions and objectives can lead to confusion and scepticism about the validity of their work. But a pluralistic ethos is central to the non-realist philosophical traditions underpinning most qualitative research... But if this is the case, there can be no fixed criteria for establishing truth and knowledge, since to limit the criteria for truth would mean restricting the possibilities for knowledge, and would also privilege the perspective of the cultural group whose criteria for truth is deemed ‘correct’.”*

Incorporating field journal data, responses to the topics of discussions, having multiple data sources (participants, conversations, audio recordings, journal/field notes), as well as data from observations, the information gleaned in this study serves to produce the best possible construction of the participant’s experience and meets the goal of legitimacy for obtaining valid qualitative data (Koch, 1996).

Birks and Mills (2011, p.37) list three determinants influencing the quality of GT research. I add my own personal reflections to each determinant as a motivation to the validity and overall quality of this research study:

#### 1. Research expertise

This relates to personal and professional characteristics of the researcher and includes prior experiential knowledge of the research topic, as well as the expertise and skills of the researcher himself for being able to conduct GT research.

Regarding research expertise, my levels of previous expertise within the field of psychology, psychological therapy, research and eating disorders as a whole, satisfy the personal and professional characteristics, expertise, and skills of the GT researcher.

#### 2. Methodological congruence

Methodological congruence is the foundation of a credible research study. By being honest, forthright and transparent about one's thinking, decision-making and procedures followed during the study, one creates trust in oneself, one's research and the outcomes of the study. Methodological congruence occurs when there is accordance between:

- One's personal philosophical position.
- The stated aims of one's research.
- The methodological approach employed to achieve those aims.

Regarding methodological congruence, I have reflected upon my own philosophical position within the field of qualitative research, as well as explicated my efforts to follow the principles of phenomenological- and GT methods.

### 3. Procedural precision

Glaser (as cited by Birks & Mills, 2011) emphasises that careful attention to the rigorous application of GT methods is critical in developing a theory that is judged as a quality product. Procedural precision focuses almost exclusively on processes related to the generation and collection of data, which should be done according to GT methodological procedures. To ensure procedural precision, attention should be paid to the following:

- Maintaining an audit trail (especially of one's decision-making).
- Maintaining a record of research activities, changes in research direction and a rationale for making choices.
- Transparent accountability.
- Managing data and resources.
- Demonstrating procedural logic.

Regarding procedural precision, I have provided accounts of my research activities in the study and have been transparent in my reflections on the topic in question. I also provided an audit trail with details about the study for replicability by other researchers.

#### **4.7.3 Rigor and trustworthiness**

Qualitative methods have frequently been viewed as failing to achieve reliability, validity, and objectivity - all criteria needed for adequacy or rigor in scientific research (Sandelowski, 1986). In the last two decades, the issue of rigor (initially referred to as validity and reliability) in qualitative research has persisted to challenge researchers shifting to alternative research paradigms (such as phenomenology and GT). Legitimacy of knowledge claims are dependent upon demonstrating that the research procedure itself is trustworthy and believable.

Literature on the subject has expanded the concept of rigor in qualitative research. According to Koch (1996) the inquirer needs to engage in the literature and select or develop the most appropriate criteria with which to judge the level of rigor for a particular study. The researcher thus needs to show in a clear and precise manner the way in which a study attempts to address the issue of rigor.

In terms of research practice, this refers to recording the way in which the study is accomplished; clearly describing procedures (for e.g. theoretical notes), methodological decisions, plans for analysis and interpretive frameworks. These are all essential parts of the rigorous research process. For the purposes of such an inquiry, trustworthiness is developed when events, influences, decisions and actions of the researcher can be audited. Thus, a trail of the decisions (whether theoretical-, philosophical- and/or methodological decisions) has the potential to clarify the research process and establish trustworthiness in the research itself. These auditable decisions are then recorded as part of the research study, and form the basis of the study's claims for legitimacy in terms of rigor, reliability and trustworthiness (Koch, 1996).

To provide the highest level of rigor possible, I have attempted to portray these decision-making processes and frameworks as thorough as possible in this chapter. Although Burns (1989) contends that audit trails in qualitative research should be so detailed that it results in other authors being able to replicate your processes and reach similar conclusions, Birks and Mills (2011) reiterate that each GT researcher will contribute an individual perspective on a piece of research (i.e. have a unique

relationship with the data). Thus the outcome of a second researcher's experience with the data is unlikely to mirror that of the first.

GT processes include describing data, creating categories and building theory. GT is adaptable for studying an array of diverse phenomena, since it is a general methodological way for conceptualising and thinking about data (Casey, 1998; Glaser & Strauss, 1967). GT methods are inherently logical: The correct application of essential GT methods safeguards your procedural logic, thereby preventing credible gaps in the research when conceptual leaps are made. Conceptual leaps into theory are supported by the original data (Birks & Mills, 2011).

In this regard, and to maintain qualitative reliability, I consistently documented all the steps in the study in detail to provide a clear depiction of the research process followed. To further ensure reliability, the recordings were thoroughly compared with all written information and therapy notes and the data, and codes were constantly compared with each other to ensure that the codings have consistent definitions and meanings. These codings were cross checked to ensure their appropriateness to the verbatim accounts of the research participants, which formed the basis for making conceptual leaps into the emerging theory.

In the following chapter the findings for the phenomenological analysis will be presented. A report on each participant's protocol will be presented, as well as a general account for the participant group, to come to a *description* of perfectionism within treatment resistant eating disorder clients.

## CHAPTER 5

### PRESENTATION OF THE PHENOMENOLOGICAL FINDINGS

*“In every bit of honest writing in the world, there is a base theme. Try to understand men, if you understand each other you will be kind to each other. Knowing a man well never leads to hate and nearly always leads to love.”*

John Steinbeck

(Quotations Page, n.d.)

#### 5.1 My personal reflections (Epoché)

As the researcher is definitional to the task, this account of the participants' experiences is one that is quintessentially layered and laced by my own personal encounter and lived experience of eating disorders. My reflections on my own ideas and thoughts regarding perfectionism and eating disorders represent recognition of my role as researcher in the co-construction of the topic of perfectionism within eating disorders, and builds on an understanding of the way in which all experiences must be understood in context (i.e. personal, historical and cultural).

As outlined in Chapter 4, *epoché* refers to how an investigator must *bracket out his prejudices*. Researchers must first examine themselves to determine their own pre-judgements, personal commitments and so on before investigating a phenomenon (Cohen, 1987). In this process, a researcher becomes conscious of, and reflects on the ways in which their questions and methods and their own subject position (as

White/Black, male/female, young/old, etc.), might have impacted on the psychological knowledge produced in the study. It recognises the role of the researcher in co-producing psychological knowledge and stands in stark contrast to the traditional view of the researcher being detached and as being the objective observer in search of new knowledge within the context of scientific research. The researcher reflects on the choices and questions he poses and presents as much of the participants' responses and stories of the experiences as possible (Langdrige, 2007). This process allowed me the insight to *bracket* my own ideas and thoughts, to not influence the data analysis process negatively.

Therapeutic process notes formed the basis of keeping track of the logistics of the present study, as well as citing decisions made within the therapy process and data collection. These notes reflect my thoughts, feelings, ideas and hypotheses generated by contact with the research participants. In utilising these process notes, I attempted to constantly be aware of my own biases and preconceived assumptions.

In recognising that I am a co-producer of the knowledge generated during this study, I reflect on how my presence, in fulfilling the combined role of therapist and researcher, could possibly have influenced the data gathering process:

- I am a male therapist, which may be to my benefit in the respondents' therapy process (because I am male, the female respondents cannot engage in body comparison with me), or to my detriment (because I am male, they may feel that I am not knowledgeable about eating disorders which is predominantly a disorder suffered by women).

- Although I have experience with treating eating disorders, perfectionism within eating disorders is a topic I know little about. I do not struggle with aspects of being perfect, or with obsessive thoughts about my body and weight.
- I view eating disorders more as a problem the person has with themselves, which is then projected onto aspects of the sufferers' physical- and emotional dysfunction: The sufferer's thoughts cause him or her to act out behaviours that are destructive to the body and mind. Those behaviours become repetitive and habitual and the sufferer falls into a cognitive and emotional *cyclic trap*, where negative emotions and destructive behaviours feed into each other, and maintain the disorder.
- My style as a therapist within the therapeutic space is more *directive*. Thus, I choose to work towards symptom reduction of the ED, instead of waiting until the client decides to do so. The reason for this is that many sufferers can stagnate in their attempts to work on their problems, and need to be strongly encouraged or directed to act against their illness. Eating disorders are complex and can make one believe that one cannot address the problem. They are usually chronic conditions, and the willpower to face that which one fears is sometimes difficult to develop. Thus, much of my therapeutic effort is invested in initiating good momentum in the healing process and to maintain that momentum as strongly as possible.
- Fulfilling the combined role of therapist and researcher could, at times, clash with each other. As a therapist, my role is to treat clients and regard their health problems. As a researcher, my role is to gain a better understanding and to delve into the unknown of eating disordered and perfectionistic behaviour and thinking. However, if a situation were to arise where these two priorities seem to oppose each other, I would place the respondent's health and therapy concerns as the

priority by choosing to treat their wellbeing. Finding in-depth information about the ED and perfectionism is only a secondary priority.

- At times, I view eating disordered therapy patients as strong-willed and difficult to work with, due to their strongly held beliefs about food, body and weight. Although I am attempting to better understand perfectionism within their ED, I am first and foremost trying to assist with changing destructive beliefs and behaviours thereof. Thus, there may be differences in how the respondents reflect on their personal thoughts and beliefs concerning aspects of perfectionism as opposed to their ED. I view all this data still relevant to the research topic, as such differences contribute to the understanding of processes of change within the beliefs and thoughts of perfectionism in individuals with eating disorders. Even if the participants' opinions change during the therapy process, those opinions are still noted in the data.
- In challenging their strongly held beliefs, any therapist would first listen intently to understand those beliefs as best as possible. The same applies to interviewing therapeutically. The therapist would first listen intently to gain some understanding before encouraging the client to change those beliefs. Thus, the process of first understanding the beliefs and thoughts prior to intervention does not influence the therapy process, nor does it influence the data gathering process negatively.
- Most of my therapeutic efforts are based on cognitive-behavioural intervention strategies, whilst having a client-centred approach in my attempts to understand the individual specifics of their problem. However, other principles and interventions from different psychological schools of thought are also applied (for example interpersonal psychology, psychodynamic interventions, and narrative therapeutic approaches). I feel these strategies complimented the research in terms of providing a therapeutic space where the participants could come to build trust in the researcher, and share their personal experiences and feelings.

The following reflections serve to illuminate my personal viewpoints about the constructs of perfectionism and an eating disorder:

- For me, there seems to be a possible interaction between perfectionism and people who struggle with eating disorders. Especially with treatment resistant or long-term cases, I assume that perfectionism influences the ED even more so and contributes to the maintenance of the disorder over an extended period.
- I view perfectionism as an intense inner drive set by someone who aims to achieve high standards in their way of life, which they believe is strongly necessary and correct. As time passes, they become emotionally *dependent* on living a *perfect life*, becoming distressed when they cannot achieve their own goals or standards. Thus, their emotional functioning becomes significantly linked to their ability to achieve their high goals and standards of living.
- Sometimes, these goals and personal standards of living can serve as *rules* that must be adhered to. If they do not meet their own goals or adhere to their high standards of living, they are prepared to face negative consequences, such as punishing themselves on purpose.
- Perfectionism gives one a false sense of *correctness* as one believes one aims for the ideal and perfection. One's thinking essentially becomes very *inflexible*, seeing something in a specific way and struggling to find answers from different perspectives. Within eating disorders, I view this as especially true for important topics like the sufferer's views on weight, body shape, dieting, making mistakes, and their self-esteem.
- My experiences with eating disordered clients have led me to believe that at the core there is a person with a low self-esteem, who is struggling to accept themselves. They do not like, or even hate, who they are on a physical level, which can also foster intense dislike for who they are at the intellectual and/or emotional level. A low self-esteem is almost always present.

- People with eating disorders who struggle with aspects of perfectionism, present with a form of *conditional self-acceptance*. I believe they cannot accept themselves or learn to love themselves *unconditionally*, and rather set *conditions* which must be met before they become acceptable or lovable to themselves and/or others. An example of this would include: “I will only accept my body if I weigh a certain weight”. Only until these self-set *conditions* are met successfully, and to a stringent degree, is self-acceptance *allowed*.
- Thus, self-acceptance is essentially only temporary. Making mistakes, and learning to live with such mistakes is difficult. As soon as one or more of their own *conditions* are neglected, or failed to be met anymore (for example weight gain), then self-acceptance is rejected and ultimately self-esteem becomes problematic.
- Even in times when they do meet/achieve some of their *conditions* and goals, their drive for perfection may adjust that standard of living to become even more stringent and difficult. In this regard, the goals they achieve today become tomorrow’s standard.
- The idea of what *the perfect body* is, is usually influenced by strong beliefs in agreement to society’s norms and standards of beauty. People pleasing behaviours and seeking others’ approval strongly influence the sufferer’s thoughts and behaviours regarding the ideal. Essentially, they are very worried, or even paranoid, about what others think of them.
- In my view, perfectionism makes one aim for *perfection* and an ED helps one achieve that picture of perfection. Meaning one aims to achieve, among others, the *perfect diet*, the *perfect weight*, *perfect relationships* and the *perfect way of living*.

Before I commenced with the process of data analysis, I completed the process of epoché to bracket ideas and thoughts that I personally held. This was done to best guard against the data analysis process being contaminated with my personal beliefs about the interaction between perfectionism and eating disorders.

## **5.2 Procedure for presenting the findings**

The phenomenological findings were obtained by using Giorgi's phenomenological approach to data analysis as set out in the methodology chapter, and results in a focus on the essences of the participants' experience. Genuine phenomenological research is a *matter of describing* the experiences of others by making readers of such descriptions become a part of the participant's life. The representation consequently relies on using the actual words of the participants who had the experience, whilst bracketing out the researcher's ideas and preconceptions (Koch, 1996).

The full summaries for all the participants' phenomenological data analysis as described above are not included in this research report. These summaries may be viewed on request from the researcher.

The findings in this chapter will be presented as follows:

- The participants' demographics are presented in Table 5.1. Thereafter, each participant will be presented in turn.
- Each participant will be introduced with a short biography, including details of their eating disorder.
- The report of the *individual* participant's essential findings is then presented by listing the themes identified from the psychological units of significance. The report

provides a description of that participant's individual experience, and serves to provide a deeper understanding of the data that was gathered.

- After the six individual participants' findings have been presented, the chapter concludes with a *general* phenomenological description of perfectionism within treatment resistant eating disorders for the group of participants.

### 5.3 Demographic profiles of the research participants

**Table 5.1: Demographic profiles of the research participants**

Pseudo Name	Age	Language	Ethnicity and Nationality	Relationship Status	Occupation/ Industry	Current ED Syndrome	Number of years living with an ED	Previously sought treatment for ED
Rochelle	26 yrs	English	Coloured South African	Married; 1 child	Make-up Artist	Bulimia Nervosa	± 8 yrs	Yes
Cathy	48 yrs	Afrikaans	Caucasian South African	2 <sup>nd</sup> Marriage; 2 children	Personal Trainer	Bulimia Nervosa	±21 yrs	Yes
Pamela	39 yrs	English	Caucasian South African	Committed relationship; 2 children	Concrete Specialist	Anorexia Nervosa (Binge-Purge Subtype)	± 23 yrs	No
Lara	28 yrs	English	Caucasian South African	Single	Dietitian	Bulimia Nervosa	± 11 yrs	Yes
Jane	22 yrs	English	Caucasian South African	Committed relationship	Student	Anorexia Nervosa (Restricting subtype)	± 10 yrs	Yes
Tracy	33 yrs	English	Black South African	Committed relationship	Clinical Psychologist	Bulimia Nervosa	± 17 yrs	No

### 5.4 Phenomenological descriptions of each participant's experiences

#### 5.4.1 Rochelle - The makeup artist

Rochelle responded to the internet advertisement calling for research participants.

She is a 26-year-old English speaking, married, Coloured woman and mother of a

young baby girl (less than a year old). She claims that since having her child her bulimia had become significantly worse.

Rochelle presented with a long-standing, treatment resistant BN which had been part of her life for most of the last decade. Binges were prevalent almost daily and her main compensatory behaviours were purging and infrequent laxative use. She was employed in the beauty industry as a make-up artist, which added to her emotional burdens as she was constantly around people who are extremely focused on external appearances. She was also surrounded by mirrors daily at her place of work, which forced her to look at her body constantly.

Although Rochelle had previously sought help from psychiatrists and psychologists, this was not only for an ED. She presented with a significant co-morbid history of strong alcohol/drug dependence. Alcohol and drug abuse were prevalent in her life since adolescence. She was admitted to psychiatric units twice in 2010 and 2011 respectively, and received long-term outpatient therapy prior to these admissions. She had also attempted suicide previously and was being treated with psychiatric medications for mood- and anxiety disorders. She also had a history of self-harm behaviours (i.e. self cutting). Rochelle struggled with constant low-energy and some gastrointestinal problems which she believed were consequences of her ED. She experienced severe stomach cramps irregularly.

Although she gained control over her alcohol and drug dependence (she has been sober for almost 2 years now), the ED remained a problem in her life. She had

received psychological treatment for her BN symptoms since 2007. Even though she believed that the therapy had helped to some extent, it had not resolved the ED.

Rochelle was considered a chubby child since birth. Her mom was always health-conscious and on diets. Added to this, Rochelle had 2 older sisters who were, and always had been, extremely skinny. She grew up constantly comparing her own body to that of her older siblings. As a child, Rochelle described how she ate a lot and had a strong emotional connection with food. Even when family members had upset her, they would buy her junk food as peace offerings or bribes. Food made her happy.

Rochelle described herself as having an *addictive personality*. Throughout her life she engaged in destructive behavioural habits. She struggled to set healthy personal limits, and believed that life lived with morals and standards was boring. She described wanted things her way, and did not like *stability*. She enjoyed instant gratification and struggled to work towards long-term goals. She also claimed to struggle with addictive shopping tendencies, and excessive promiscuity before her marriage. Even after getting married, she still thrived on attention from other men and engaged in affairs.

Rochelle was positive towards finding help. She claimed she was desperate to find the answers, as her ED was taking more and more control over her life. She felt that she was addicted to food and could not stop herself from eating. She was excessively critical in her self-evaluations daily, and projected these on her husband

in their marriage. She felt that he would not love her unless she was skinny, according to her own expectations.

Her attitude was open towards receiving feedback, and she presented with good motivation within her therapy sessions. She completed the homework tasks as assigned and seemed honest and open during the process. Rochelle's therapy was characterised by a constant yearning to gain control over her weight, rather than addressing the ED itself (i.e. bingeing-and-purging, poor self-esteem, critical self-evaluation, etc.). She struggled to come to terms with working towards these medium- to long-term goals, and yearned for *quick fixes* for her problems.

The following 15 themes were drawn from Rochelle's audio files, interviews and notes. Each theme includes an example of her verbatim statements made during the interview process.

### **1. Perfectionism and the link to food, weight and shape**

*"I want to be skinnier - definitely. That's the main thing. But then, other than that - I just feel like if that's ok, then everything else will be okay...I just feel like that would change a lot of stuff. Like how I feel, I probably would be less wound up anyway. My whole life would change."*

Life is about being thin and slim. It's the focus point of life. If one is thin, then one can cope with other problems, and life changes for the better. Strong beliefs about body shape and weight guide thinking and decision-making processes. These beliefs influence how one views one's body, what one wears and ultimately how satisfied

one is with oneself. One admires those who can starve themselves and avoid food at will. These are positive things because of the vast amount of weight one loses.

Accepting one's shape and weight remains a constant difficulty. Even if one tries to reject it, or ignore the concerns over one's appearance, these concerns return quickly. Obsessions about food dominate one's thoughts and feelings. It is a love-hate relationship with food. On the one hand one loves food, and uses it as a crutch to help one through life's difficulties. On the other hand, one hates it and wants to rid oneself of it. Self-acceptance is difficult because of this love-hate relationship with food.

Setting realistic dietary goals is difficult because one must let go of being extremely strict with certain foods, whilst trying to avoid others. This is daunting, as becoming relaxed with certain foods allows one to eat them at will, which means you could possibly binge on them. But in doing so, one ultimately releases oneself from some of the emotional bonds one places upon oneself. When one can remove one's excessive focus on food and appreciate all the other areas of one's life, one gains a better perspective of oneself. This helps one deal better with weight gain. This perspective also helps one to criticise or ridicule oneself less.

## **2. Perfectionism and how it influences relationships**

*"Sometimes with my husband I'm like: "Ah he hates me because I'm fat". But everyone does that. And I asked him permission to eat food, and he's like: "Have it if you want it. Why are you asking me?". And then I'm like: "No, but then you'll be angry.". And he's like: "I don't care.". I feel like I need permission. From my mom especially, because my mom is like a health freak. And I try to hide from her*

*what I'm really eating. Because – she won't be angry with me or cross – but she'll be disappointed, I think. Because she obviously wants me to be slim, so I'll be happy.”*

Strict rules and regulations over food choices impact relationships. Insecurities about one's body affect the intimate relationships one is involved in. One may start to question the relationship itself, as one struggles to understand what that person sees in one, or whether they find you physically attractive.

It is common to seek approval for choices made from those people who are close to one, as their approval is important. At times, one may also lie about one's choices to not have to face others' negative judgements. One believes that losing weight and reaching one's ideal qualifies one to receive more love and attention from others. However, this is not how love functions, and these beliefs can lead one to focus on the trivial aspects of one's relationships.

### **3. External environmental influences**

*“I don't obsess about how I look too much. But because of what I do, yeah there's like a mirror in every direction where I work. So everyone there is quite image-conscious as well. Somehow I ended up in something like this. But it's nice for now. I just do feel judged a lot of the time, but, like, I over-compensate for that by just being the opposite of feeling insecure.”*

External environments can influence one to become more focused on one's appearance. This affects one's emotions negatively as one may feel judged or insecure. The need exists to actively engage with these emotions to resolve them.

#### **4. Society's perfectionist views on women, beauty and sexiness**

*"I don't want to look like a rake. But I'd rather look like a rake than what I look like now, if I had a choice. Because no one's ever like: "Oh my God, you're so skinny, I don't want to be like you.". It's always like: "Ah you're so skinny, you're so lucky.". And no one's like: "Ah you're fat, I wish I could be like you.". I think it's more attractive to be slim and if I could, it would be great to have a gap between my thighs, and straight arms and a flat stomach."*

Slim people are idealised and most people want to be slim. Looking slim is more attractive than being overweight.

#### **5. Perfectionism and the link to low self-esteem and low self-worth**

*"Shape and Weight highest importance. Beauty = Happy, success, confidence. Thin is Beauty. Fat is Funny! Poem: "Coffee & smokes & cold diet cokes, that's what pretty girls are made of..."."*

When evaluating oneself, being beautiful is the highest priority. Being thin means achieving beauty. Being beautiful, in terms of shape and weight, is the main aspect by which one judges one's self-worth. When one is beautiful, one is happy, successful and confident in life.

Accepting oneself and one's uniqueness remains a difficult task. If one is of low weight, then one sees oneself as acceptable through others' opinions, as well as one's own. However, if one is failing in one's weight goals, this may contribute to one feeling nothing of value, or not being admirable to others. In response to this, one

may be fake to others, presenting oneself in a more favourable light than what one views oneself. How one presents to others is important.

In finding a perspective beyond that of materialistic needs, one starts to recognise that one's self-worth is based on more than mere outward appearances. One can appreciate more of what one is, instead of always focusing on trying to be perfect (which one is not), or what one perceives to be lacking in one's life. Recognising one's own self-worth from multiple perspectives influences one's motivation and excitement about one's own life. If one's self-worth is judged only on appearance and being beautiful, one misses opportunities to find self-worth in other areas of one's life.

## **6. Perfectionism and the link to the Self**

*"I just get irritated with myself. I don't think I understand – if I'm all, like, calm and nice to myself, then it's like: "I shouldn't be because I do all these things"... I deserve to treat myself like this. Because I shouldn't be doing everything I'm doing, the way I'm doing it...I can't accept myself. Definitely not."*

Repeating ED behaviours like bingeing and purging keeps one from developing self-acceptance. One holds oneself accountable because one keeps breaking one's own strict rules and regulations surrounding food and weight. Excessive self-criticism, self-pitying and avoidance all contribute to not actively and constructively dealing with one's problems. This contributes to feeling negative about oneself, and struggling with self-acceptance, which in turn affects one's food choices.

The desire to make perfect food choices all the time affects one's actual choices negatively. When one's inner drive for perfect choices subsides, so one's ability to negotiate food choices becomes more mature, realistic and less emotional. This also helps when having to deal with making mistakes in the choices made, and being obsessive about such mistakes.

Perfectionistic thinking focuses on what one is lacking, instead of being able to recognise what one already has. When one changes this way of thinking one gives superiority to who you are, instead of your perceived shortcomings.

## **7. The obsession of being perfect**

*"It's just so much stress as well. Like, there's other things I want to do than spend my days like: "Urg, god I ate this, and now...". Like, I just have to focus my energy from now on."*

Perfectionistic thinking can be draining. It pre-occupies one's mind with food choices and the consequences thereof. Freeing oneself from such thinking lightens the negative emotional baggage in one's life. When one can release oneself from perfectionistic thinking, a vast improvement is noticed in one's overall outlook on oneself and one's choices and life. When one has managed to distance oneself from perfectionistic thinking, it is easy to fall back into it. One must be acutely aware of such cognitive traps and deal with them pro-actively.

## **8. Perfectionism and the link to anxiety**

*“Every now and again I panic: “Like oh my god!”. Because I feel very far gone from that. But then I’m, like, and if I think about it a little bit - I have to, like, I literally have to shake it off because I literally enter into a state of panic.”*

Obsessive thoughts can be very intrusive, pushing one into states of anxiety, or even panic. One must deal with these emotions directly and pro-actively, whilst trying to remain calm and not engage in eating disordered behaviours.

## **9. How one judges oneself and one’s own performance**

*“I sat and looked at the pie for ages, then didn’t eat it. Then I went back and did! Sigh! I went to a cafe by myself and ate a waffle so quickly so no one would see me eating it. I wanted to vomit, but I was at work.”*

Achieving stringent dietary goals makes one feel positive and more confident about oneself. Especially when others notice one’s *good* behaviours, it has a positive effect on one’s self-esteem. However, shameful feelings about bingeing are still a part of one’s life, and one tries to hide this from others as best possible.

One creates quite clear guidelines and standards of what one expects to achieve in one’s eating patterns. However, in setting these standards, one can easily lose control and engage in bingeing. Adhering to these stringent dietary principles is, at times, difficult. When one fails to adhere to them, it affects one’s feelings significantly. Engaging in a binge results in self-ridicule and self-judgement. One judges oneself negatively, even feeling disgusted with oneself and one’s actions. It is something to feel ashamed of. Compensatory mechanisms are then used to correct

the mistake. After bingeing, purging results from the guilt one experiences. One judges oneself harshly for what one has done, and the need to correct the behaviour drives one to purging/compensating.

### **10. Evaluating one's body by perfectionist standards**

*"Been looking at my body so much in the mirror and it is disgusting!! No shape! I've just ballooned and I'm out of control. I can't see my collar bones at all!! Even when I hold my breath in my stomach is HUGE and I can't see any ribs. My body has gone from bad to worse. It's so gross. I don't know how my poor husband can even look at my body, let alone fuck it!! I'm disgusting! Urgh! I'll never be beautiful or sexy. I am PATHETIC and ruined everything by eating like a PIG! Weighed 64kg this morning, I'm gaining weight – just going backwards. Have put on 4kg since November last year. I'm a huge pug!! Hate myself and my body. I give up – just going to be fat forever and have to accept it. I can see how fat I am in every mirror. I'm disgusting. No one will ever find me attractive EVER!! Weighed in at 65kg!! OMG!! It's the beginning of the end. I am going to be fat forever, should never have stopped throwing up. WTF. I feel like giving up and accepting that I am and will always be fat. May as well eat eat eat! I have lost my mind with food again. I think I'm just accepting fatness forever. I am pigging out!"*

Wearing certain types of clothing is risky, as they reveal parts of the body. Seeing oneself in photos has the potential to confirm fears of how one looks in a piece of clothing, or to calm anxieties about it. One's perception of oneself in certain clothing influences one's mood and experience within a given situation. When perceiving bodily flaws, one is repulsed by oneself - criticising one's flaws at length. These

feelings are intense. When comparing oneself to others, one feels inadequate to them.

One's self-judgement is harsh and critical. These judgements are based predominantly on one's interpretation of one's physique and eating patterns. If one perceives one's eating to be in line with what is believed to be healthy, then one views oneself as having strong willpower. If one does not adhere to healthy eating patterns, then one believes one deserves the consequences of an overweight physique, and ridicules oneself for having poor willpower. Noticing weight gain and changes in one's body encourages self-criticism extensively, as one is not obtaining one's weight goals. This results in forming an extremely negative opinion about oneself, one's life and the ability to change one's future for the better. In gaining weight, one becomes estranged from oneself, battling with oneself - one blames oneself for one's problems, and becomes one's own worst enemy.

When one is overly-critical about one's appearance, one probably over-inflates physical flaws more than what they are perceived by others. This causes emotional distress as one worries a lot about something which is probably insignificant or not noticeable.

## **11. Comparing oneself to others**

*"I always feel better or more confident around people bigger than me. Often feel threatened, judged, insecure, and need to overcompensate around skinny people. I'm more bitchy with attractive people because I feel less of a person... I am an extremely sociable person to the outside world – very confident and*

*personable. All through life I've been a 'funny' person with personality – bubbly – like fat people have to cover up and make up for their looks."*

Comparing oneself to others can develop from a young age. Comparing oneself to siblings may lead one to conclude one is the outcast of the family, because one is not as beautiful as they are. This makes one feel less worthy than they are, as being beautiful is a mechanism to judge self-worth, and is the means to happiness in life.

Not meeting one's own standards of eating, or comparing oneself to others who one perceives to be thinner, encourages feelings of disappointment. This feeling may contribute to even further loss of control over eating at a later stage.

When comparing oneself to others, one's perception of them in comparison to oneself affects one's feelings and behaviours towards them. When one feels superior to them, because they are less beautiful than you, you feel more confident. When one feels inferior to them, because they are more beautiful than you, you feel judged and insecure.

## **12. Portraying the perfect person to others**

*"I'm very insecure in myself, but I actually project a very confident exterior to hide my real feelings. I analyse what I eat, worried if people see me eat unhealthy. They think and say that's why I'm fat, which is true."*

Portraying confidence and competence to others is important. Even if there are feelings of insecurity or one makes mistakes, the best is done to not let others see

this *real insecure* you. It remains worrisome that others might notice the *real you* instead of the *confident you*.

### **13. Achieving goals perfectly**

*"I feel good, and happy. Not eaten any bad food today. I'm craving something sweet but I keep visualising myself as a fat pig forever if I do eat something bad..."*

*Feel good – I miss my junk but I have to remember what my options are - junk and fat and ugly OR healthy food and slimmer and beautiful."*

Visualising oneself as overweight and using negative self-talk are methods one uses to adhere to one's own dietary guidelines. Excessive self-criticism is utilised to initiate and maintain stringent standards, or to avoid thinking about oneself (because one perceives oneself as ugly), or to punish oneself for not keeping to one's own stringent standards. These visualisations and self-criticisms help to avoid giving into cravings, which ultimately results in weight loss and obtaining beauty. These results make one feel good about oneself.

When one attempts to live without mistakes, one struggles to deal with the emotions that accompany making mistakes. Analysing the error, or re-correcting one's behaviours is difficult, because one cannot cope with the emotions of having made a mistake. When making one mistake, you inevitably then choose to make many because of this inability to cope.

### **14. Perfectionism in the recovery process**

*"Weigh-in was okay, still very high though. Haven't gained so that's okay I guess."*

*Following our chat in session, I'm going to be less aggressive and mean to*

*myself. It does make sense, that I will never be comfortable in myself if I keep breaking myself down.”*

When one is unable to meet one's weight goals, self-ridicule and self-judgement follow. These thoughts are negative and break one down, as one feels one deserves them. However, if one manages to break free from the harsh criticism normally engaged in, it frees one to apply one's mind to self-analysis, which makes it possible to better understand why one over-indulged in the first place. This negative self-talk is destructive and one needs to end such self-talk, as logically it blocks one from starting the recovery process.

## **15. Perfectionism and the need to control**

*“Damn it – I’m trying not to, but still am being a bit of a bad eater I guess. Now I’ve gone too far – for fuck sake!! Urgh - annoyed at me. But I’m not going to be mean. Wondering why I did all that bad eating and all I can think of is that it smelled and tasted so good and the reason I had so much is because while I was eating I almost got lost in what I was doing, and lost control and couldn’t stop until I felt stuffed.”*

One believes setting stringent dietary goals and achieving them helps one gain control over bingeing and purging. Although possibly difficult to implement, it is worth it because one can stop gaining weight and end purging behaviour.

### **5.4.2 Cathy - The personal trainer**

Cathy responded to the internet advertisement calling for research participants. She is an Afrikaans speaking Caucasian woman in her 40's, and a mother of two

children. At the time of the first meeting, Cathy had been involved in a difficult divorce process for the previous 2 years. However, she had met someone new and was happy in her new relationship. She and her new partner had also recently become engaged.

Cathy presented with a long-standing treatment resistant BN which had been part of her life since she was 17 years old. At the time of contacting myself as therapist, her main compensatory behaviours were purging and excessive exercise. At the worst of times, bingeing-and-purging cycles would happen 5 - 10 times a day. She was self-employed in the health-and-fitness industry as a personal trainer, which she claimed added to her excessive focus on her body's shape and weight. She had also previously competed in body-building and fitness competitions, where she had achieved well.

Cathy had previously sought help from psychiatrists and psychologists, and reported that although these interventions had helped her in managing her symptoms, she felt that they never addressed the foundations of the illness. Cathy struggled with a spastic colon, which she attributed to her BN. She had also suffered a lot of damage to her teeth, for which she had extensive reparations conducted. In addition to these, she also suffered irreparable damage to her vocal cords and kidneys, as well as possible heart damage (unconfirmed). She claimed that her ED almost caused her to commit suicide at one point in her life, and that her suicidal thoughts became ever-stronger in 2009 where she wished she would be killed in a motor vehicle accident.

Cathy noted that her eating disorder behaviours did remit at times during her history, and there were extended periods where she did not engage in bingeing or purging episodes. She claimed she healed herself in 1986 and stayed binge and purge free for more than 20 years. However, she relapsed and struggled with BN once again. Even after months or years of no eating disordered behaviours, she always seemed to relapse and return to active bingeing-and-purging cycles. She felt frustrated at this, as she had never been able to understand why she could never fully recover from her disorder.

Cathy was positive about finding help and trying to finally eradicate the ED from her life. Her attitude was open about receiving feedback and she presented with good motivation within her therapy sessions. She claimed she wanted to understand more about her BN, and enjoyed the freedom of therapy which allowed her to talk about it.

Cathy's therapy was characterised by a burning desire to understand her problem more in-depth. Her answers to questions posed included vivid descriptions which provided for rich data. She completed the homework tasks as assigned and seemed sincere in her honesty and openness towards the process.

The following 10 themes and verbatim statements were drawn from Cathy's audio files, interviews and notes. Each theme includes an example of her verbatim statements made during the interview process.

## **1. Perfectionism and the link to anxiety**

*“I was afraid to take risks and always stayed on the safe side of everything. I missed out on a lot of crazy teenage fun. I was really quite a serious, diligent child. My home environment was one of fixed routine, fixed structure and an unhealthy amount of control. My mother was a perfectionist who ran the household her way.”*

Fixed and rigid self-imposed structures, and obligatory rules set to control, become the means to deal with anxiety. These limit one's life. It's an ideal that does not exist, and in retrospect one can look back on one's life and describe how one has not lived to the fullest, or how one would have truly wanted to live.

## **2. Perfectionism and the link to low self-esteem and low self-worth**

*“Jy weet, mens het hierdie belaglike ideale vir jouself opgestel somewhere along the line, waar mense vir jou goed gesê het, of watookal. Jy't jouself oortuig jy's nie goed genoeg nie. En jy't jou lewe rondom hierdie nonsens gebou eintlik. So dit kom so geleidelik af van my af, soos sulke layers. Ja, ek voel ek shed baie van die goed.”*

One's problems with self-esteem form the foundation of one's eating disorder. Being self-defeating and overly self-critical develop from this poor self-esteem, and to improve upon this low self-esteem, one constantly attempts to achieve impossible ideals.

### 3. Perfectionist principles of 'health-conscious' living

*“Ek is voos geprobeer! I’ve done it and got all the T-shirts. Nou kan ek myself glad nie meer kry om myself te disiplineer nie. Dis asof ek heeltemal in hierdie impulse oorgegee is. Ek het half opgegee. Dit is waar ek is met kos. Ek is heeltemal buite beheer met kos. Ek kan vanoggend opstaan en besluit ek gaan dit en dit en dit doen. En by nege uur tien uur vanoggend het ek dit klaar opgevoeter. Maar nou’s ek op hierdie stadium waar ek nie eers wakker word en besluit dit gaan ek doen, of dat gaan ek doen. Ek word net wakker en ek’s op auto-pilot. I don’t know where I’m gonna end. Ek kan nie goed uitlos nie. As dit daar staan, dan is dit vir my soos ‘n impulse van: “Ek moet dit eet, dit staan daar! Ek kan dit nie weerstaan nie. I couldn’t be bothered actually om dit nou te probeer weerstaan. Ek is net moeg vir disipline! Dis asof ek ‘n totale rebellie teenoor al die disipline en goed het wat ek geprobeer het, veral die laaste twee jaar.”*

Food intake, adhering to dieting principles, and maintaining one’s goal weight have a direct influence on self-evaluation. This self-evaluation affects the input one invests into choices, actions, behaviours and habits. The principles of dieting and restricting food intake add to one’s emotional burdens. This burden is constant and intense.

Living with self-discipline is very important. When one has lost some of the self-discipline one previously had, it impacts one’s thinking about one’s body, and how others’ comments about one’s body are interpreted.

All-or-nothing thinking influences behaviour towards eating and the attitude one has towards oneself: To be *good* is to adhere to strict rules and be disciplined, which is a

way of feeling normal and good about oneself. To be *bad* is when one does not act in accordance with rules and discipline. In this *bad* stage, one does not worry about the responsibility of having to live a healthy lifestyle.

At times, one may rebel against strict health-conscious principles, as one wants to be freed from such burdens. As the pre-occupation and obsession with *health-conscious living* may reach breaking points, rebelliousness sets in and one does the unhealthy choice on purpose. During illness, one battles with this dichotomy as one constantly strives to be *good*. However, recovery is only made possible when one can incorporate both aspects in one's thinking and behaviour (i.e. good and bad) and find harmony within despite making mistakes with eating correctly. Maintaining high standards of living a healthy life makes one feel good about oneself. These include proper eating and good exercise as well as no binging and purging. When one does not maintain these standards, it makes one feel worse about oneself.

#### **4. Society's perfectionist views on women, beauty and sexiness**

*"Dit laat my dink aan lank gelede op varsity, het ek hierdie ding baie intens beleef by bokjolle en so. As jy by die bokjol kom en jy lyk awesome dan vra almal jou om te dans. En as jy vet raak, dan staan jy teen die muur. Dan dink ek: "Jy weet, daar's net een manier om 'n gelukkige lewe te hê, en dis as jy amazing lyk." Dit is waar dit vandaan kom. En ja, ek het 'n issue daarmee, want ek is half fed-up met dit, want ek sien dit elke dag in die mense wat ek train. Dis nie net ek nie, ek praat van ons almal. En dit is hoekom mense hier beland. Dit is hoekom, dit is net te veel pressure. Almal kla oor dieselfde ding."*

One experiences society as being conditionally accepting of one and women in general. Society sets specific standards which must be achieved otherwise one is viewed as *not good enough*. People and society lack depth and people judge each other mostly on how they present themselves to others, which includes how one looks and how successful one is perceived to be. Women over-evaluate the importance of their bodies' shape, being sexy and being desirable, which is more important than all other qualities and facets in their lives.

Being accepted by others is based mostly on one's physique looks. One experiences immense pressure from external influences to obtain a level of physical beauty, otherwise people will reject you. If one wants to be perceived as beautiful and desirable in a relationship with a partner, it means that one must conform to high standards of beauty as defined by cultural norms. One's happiness and overall quality of life are mostly dependent on looking beautiful.

The definition of *beauty* consistently evolves into more stringent and more specific standards of achieving the perfect outward appearance. The influence of media and pornography change the image of female beauty and how the dynamics between men and woman, desirability and attraction are manipulated. The standard of beauty in society is based on whatever is the most difficult standard to achieve, according to the current settings and circumstances in that environment. Society sets tough standards for perfection and sexiness. If one wants to be noticed, or have any social standing, then one must move towards extremism. Being average is not good enough. Thus, one needs to strive for an extremely low BMI (Body Mass Index).

One should distinguish between the drive for sexiness and the drive for thinness. Anorexia sufferers seem predominantly focused on achieving thin ideals, whilst bulimic sufferers possibly focus more on achieving an ideal of sexiness.

## **5. Evaluating one's body by perfectionist standards**

*“Ek weeg nou 74kg, en ek voel ongemaklik want in my werk kan ek dit nie hê nie. Ek is restricted in die goed wat ek kan aantrek. Ek moet heeltyd worry oor hoe ek lyk op die verhoog. Ek het ander goed om oor te worry. Ek wil nie daar staan en wonder of iets hier uitpeul, en of hier iets uitpeul. Mens voel altyd asof mens 'n goeie voorbeeld moet stel. Mens is die heeltyd onder die vergrootglas in die gym, en mens staan die heeltyd voor 'n spieël. Dis net baie duidelik dat die milieu waarin ek myself bevind het baie te doen met my pre-occupation met my voorkoms.”*

Happiness is dependent on being able to accept one's own physical appearance. Especially when one gains weight, it decreases one's happiness. Acceptance of one's physical appearance is difficult and it remains a constant concern. Retaining the mental image of how one believes one *must* look, instead of allowing it to change with age as it inevitably does, causes a lot of internal struggle and negativity within the self. The environmental circumstances one is exposed to can also contribute to a pre-occupation with body shape and weight. These thoughts can be constant or never-ending.

## **6. Achieving goals perfectly**

*“Ek dink dis miskien my eie judgement oor myself, eerder as wat ander mense van my dink. Want mense sê: “Man, jy lyk altyd goed!”. Of jy groot is en of jy klein*

*is. Jy weet, ag obviously, mens lyk beter as mens minder body fat het. Ek weet ek lyk nie sleg wanneer ek gewig optel nie. Dis nie, soos in, obesity of iets soos vet rolle wat uitpeul wat ander mense kan sien. Maar ek is my eie grootste vyand. Ek onderwerp myself aan vreeslike standaarde. Uhm, ek dink ek distansiëer van die feit ek weet ek is goed genoeg in baie opsigte. Jack vertel dit die heelyd vir my. Ek weet dat ons verhouding fine is sonder dat ek amazing lyk. Maar ek kan net soveel meer relax, en net oor ander goed worry, as wat ek nie nog hierdie ding het nie.”*

The effort one invests in achieving to look thin and fit come at a high personal sacrifice, but the reward is satisfying. The drive to achieve high standards and to be perfectionistic is more intrinsic than being imposed upon by others. Although society and people around one may also impose such pressures upon one, the conflict with the self remains the driving force behind achieving perfectionism. The closer one is to achieving this goal, the less anxiety one has about oneself and one's life. If one does not strive to achieve perfection, there is a void in one's ability to maintain goals that one sets for oneself. Without the drive that accompanies perfectionism, thoughts and behaviours are not consistent and can easily be influenced by moods or circumstances. One will then start to distrust oneself because of one's inability to set and maintain goals.

As the level of inner drive for perfection subsides, there is an overall improvement in subjective feelings towards the self, as well as one's habits. At this point it becomes easier to get in touch with oneself and how one feels.

## 7. Perfectionism and the link to exercise

*“Lekker in my terme is goeie straf. Ek het nie ‘n normale uitkyk daarop nie [exercising]. ‘n Lekker oefen sessie is waar jy half dood is en styf is die volgende dag. Dan is dit lekker. Ek dink nie ek het al ooit geoefen omdat dit vir my lekker is nie. Dis hoekom ek die laaste twee jaar op die couch sit want ek het net nie lus daarvoor nie.”*

Exercise is only enjoyed when one’s body is pushed in such a way that significant stiffness and discomfort is felt afterwards. Exercise is not something one inherently enjoys - it is something one does to push oneself to improve.

## 8. Perfectionism and the link to food, weight and shape

*“Dit is sad. Ek praat vir die vroue mensdom. Ek dink byvoorbeeld aan Lady Vex wat ‘n suksesvolle DJ is, wat altyd met haar gewig sukkel want sy sê al vir my heelwat: “I can never be happy unless I get this thing right”. Sy’t nou al gedink nou dat sy ‘n baba gehad het sal dit dalk beter gaan. Dit maak haar nie gelukkig nie. Niks maak haar gelukkig nie, want dit sny ‘n hele stuk van haar lewe af. Sy was nog nooit in shape nie. Ek het haar getrain vir ‘n lang tyd. Sy’s maar een van baie wat nog nooit daar was nie en wat selfs so voel. Dis ‘n nare lewe vir vrouens om dit te leef hierdie.”*

Weight loss is the only mechanism to become happy in life. Achieving a thin, ideal weight and shape results in self-acceptance and happiness. This shape and weight is what society expects of a woman. In this regard, losing weight is a powerful mechanism to feel better about oneself and to feel more in control of one’s world. However, extreme weight loss has potential pitfalls in that it makes one have

obsessive thinking patterns. One's self-confidence and feelings of sexiness are in direct proportion to weight loss. As weight loss is achieved, self-confidence and feelings of sexiness increase significantly, to the extent of almost feeling like a new person.

Worry sets in as the fear of gaining weight becomes significant. This fear is based on the doubt of what is appropriate choices for losing weight, because losing weight is a constant goal. One's own decisions about food and diet are then easily scrutinised. After relapsing into old ways and gaining weight, self-confidence and feelings of sexiness decline. It is difficult to accept gains in weight. Perceiving oneself as overweight causes great distress and self-blame results.

## **9. Perfectionism and the link to self**

*“As jy so maer word, dan ontdek jy goedjies wat jy nie geweet het ontstaan nie. Dis hoekom ek vir jou sê, dis altyd so moeilik as 'n mens al daar was, om vrede te maak met iets minder as dit. Dit sal die res van my lewe beïnvloed.”*

Finding acceptance and peace with yourself is difficult when continually being able to notice how your body and fitness levels have declined.

## **10. Perfectionism and the need to control**

*“My ma het altyd vir my gesê, as jy onder 70kg kom, dan begin jy regtig goed lyk. As ek op diëet wou gaan, dan maak sy nou alles wat ek moet eet. Maar as ek dan kroek, dan sê sy vir my: “Ag nou wat is die punt? Nou doen ons al hierdie moeite, en dan?”. Van daar af het dit erger begin raak, want ek het agter haar rug begin eet. My ma is taamlik in shape, en sy's 'n totale control-freak. Totaal, met*

*als! Sy't alles onder beheer. They [ma en pa] never indulge. They never overdo things. En hulle motto in die lewe is: "Hou matigheid voor oë".*

The feeling of having control and being-in-control are important for eating disorder sufferers. A diet gives one an inherent structure. This structure helps in creating a perception of being in control when adhering to the diet. If one follows a diet plan, one is a good person. If one does not follow it, then one faces much ridicule and judgement from oneself. However, adhering to this diet is not a long-term solution to finding peace with food and eating.

#### **5.4.3 Pamela - The concrete specialist**

Pamela responded to the internet advertisement calling for research participants. She is a 39-year-old, English speaking, Caucasian woman qualified with an honours degree in psychology. She works in the construction industry as a concrete specialist.

Pamela has struggled with long-standing AN since she was 16 years old. She described that she initially started engaging with her ED after having watched a film about it as a youngster. For 23 years, she has actively restricted her food intake and constantly battled with her body weight.

Even though Pamela presents with a significantly low weight as compared to others of the same age, she still feels a clear need to actively attempt to lose more. She avoids her body, avoids weighing herself, avoids food as far possible, as well as bases her self-worth and self-esteem predominantly on her weight. At the time of

making contact, she engaged in active bingeing and purging episodes. Purging episodes would happen multiple times in a week. She would also use excessive exercise as a compensatory mechanism if she believed she ate too much. Setting a therapy goal of three meals a day was very difficult for Pamela, as she was used to only consuming one meal, or two at most, during a normal day.

Pamela claimed that she had always been a fussy eater. Between the ages of 16 and 18 years, she was regularly threatened by her family to be sent to a long-term rehabilitation facility for an ED. They believed her weight was too low. To avoid being sent to rehab, she became very deceptive about her purging habits. As a teenager, she believed receiving treatment was for people who have serious mental problems, and at that time she believed she had none of those. She claimed her lowest weight had been almost 40 kg and her highest weight was 55 kg when she was pregnant. She currently forces herself to stay around 45 kg, although she would like to be below 45 kg. As soon as she goes 1 kg above 45 kg, she starves herself.

Pamela's remote familial history is quite downbeat. In short, her biological parents completely rejected her as a baby. She was subsequently sent from family member to family member, neglected and abused, until finally adopted by her aunt at age six. She knows her biological father struggled with drug addiction and alcoholism, and her biological mother struggled with depression. Throughout her entire upbringing she claims her aunt and her uncle rubbed into her face the fact that they adopted her - making her feel guilty that she *owed them something* in return for *saving her*. At the time of enrolling in the research she stated she does not make much contact with her family, and rather focuses on her own partner and children.

Pamela is currently involved in a long-term committed relationship. She and her partner have two children together. She does not believe in the institution of marriage, and stated she would never marry him. Her partner has an extensive history of substance abuse. During her participation in the research study he experienced multiple relapses, which she claimed had an impact on her eating disorder.

Regarding interpersonal relationships, Pamela presented with major commitment and trust issues. She does not trust anyone in totality, as she claims she has learnt to become *chameleon-like* with those around her, meaning she can adapt her personality to different groups and people as needed, so that they form a positive opinion about her. She admits to being manipulative and deceitful at times, using people for her own gain. She used her relationship with her partner as an example (she knows which behaviours would cause her partner to relapse into drug addiction), so that no one would focus on her and her ED, but rather on him and his substance relapse.

Pamela was positive towards finding help and finally trying to start addressing her long-standing ED. Although she knew that therapy would be difficult, she claimed she was well motivated to start changing herself for the better. Her strong avoidant tendencies made personal development difficult, and she presented emotionally detached from her own feelings and self-esteem. She was in the habit of avoiding problems and issues in her life when they arose, and this was prevalent in her therapy process when the topics of discussion confronted her to face these problems.

Pamela's verbal ability was good. She provided lengthy answers and vivid descriptions to questions posed. She completed the homework tasks as assigned satisfactorily.

The following 10 themes and verbatim statements were drawn from Pamela's audio files, interviews and notes. Each theme includes an example of her verbatim statements made during the interview process.

### **1. Perfectionism and the link to low self-esteem and low self-worth**

*"I'd like to start becoming more positive about things. I tend to be sucked into the negative world all the time. About me and life. Because obviously me being negative about myself is flowing into everything else, especially my self-esteem."*

Negativity is constant and influences one's views of oneself and the world. This affects one's self-esteem negatively.

### **2. Perfectionism and the link to the self (i.e. self-acceptance)**

*"So you would like to be something. It's not a concept that you have, which you've got to prove that you can first be that person. So there's certain steps in-between that you can achieve... I would like to work towards a goal. It's like everything, you work towards a goal. Once you've achieved that goal, then you can say that you fully accept yourself. It's like a runner. He wants to run a comrades marathon. His goal is to finish it. Once he has finished it then he can say, "I've actually achieved something.". Same as in this, acceptance is something you need to work for... So I believe acceptance are acts. You've got to*

*prove yourself. It's not just acceptance. It's anything in life – you've got to prove yourself."*

Self-acceptance is something one must work for. One must earn it by proving to oneself that one is acceptable. This is done through achievement and achieving self-defined goals.

A constant negativity and a *feeling of failure* accompany one for a long time. One's outlook on life is very much influenced by how one perceives one's physical appearance, as well as the negative reinforcing comments of others about one's shape and weight. One is predominantly negative about oneself, one's decisions, and life in general.

Negative thoughts about the self are easily triggered, especially when noticing physical aspects of one's body which one disapproves of. When such thoughts are triggered one becomes pre-occupied with them, possibly exacerbating the problem. Even if one realises one should not think such negative thoughts, it is still difficult to counter such thinking. Changing this negativity about oneself is very difficult, as one's negative focus is already strongly internalised, developing in intensity over a long period in life. When one looks at one's own body, or even hears others' comments about it, one easily falls back into that negative way of thinking.

Because of the strong negative view of the self, it is difficult to recognise the person others see in one. This negativity one has towards oneself influences one to restrict, essentially constantly punishing oneself. One restricts oneself in all the positive

areas in life, not allowing oneself those privileges. However, one does not restrict on the negatives as one uses them to punish oneself constantly, because one feels deserving of them.

Instead of one being appreciative of what one has, one questions why one is the way one is. Not being happy with what one is, one easily questions and criticises oneself. One personifies all problems, blaming oneself as the reason why things in one's life is not good enough, or that one's body is not good enough. One can foster mental self-abuse towards oneself for a long period. The battle with the self is self-inflicted, which denies one reaching inner peace. Changing this for the better is difficult, because it is so pronounced and long-standing in one's life. Peace is found by ending the internal fight with who and what one is, and accepting and liking oneself. With inner peace comes personal happiness and enjoyment of life.

### **3. Evaluating one's body by perfectionistic standards**

*"I don't see perfectionism in this. You know what I'm saying? The concept that it's [perfectionism] in all of this [eating disorder]. But it's something that I do need to spend time thinking about. It's not gonna happen right now... That's why I put question marks there. Because the personality traits are there. The perfectionism one is the one that you've brought to my attention. It's not one that I've ever thought about, or seen myself in that way."*

One may not even be aware of one's own perfectionistic tendencies and one needs to consider whether it influences one's ED. One easily judges one's own and others' bodies harshly by setting high standards of achievement. If these standards are not met, one is having little self-control and not being good enough.

#### **4. Perfectionism and the link to food, weight and shape**

*“I got these pair of pants that I always test my weight with – these pair of pants. That’s how I do it. So I don’t have my little crappy scale. I wear these pants, and when they start to get tight, I seriously stress out. I’ve had them for years. But yeah - I’d be very upset if anybody threw those away.”*

Measuring one’s body is an important element by how one judges oneself. If the measurement indicates weight gain, a lot of distress and negativity result, and vice versa. Weight gain is avoided at all cost, even if the cost of weight gain can have serious long-term health effects. Caring for one’s body and its physical health is not a priority. One avoids caring for one’s body and does not like to become aware of its health struggles. One would rather live with possible negative health effects, than having to face weight gain associated with becoming more physically healthy.

One judges oneself harshly and interprets any perceived bodily flaws very negatively. This judgement encourages self-hatred, as one feels only looking perfect would be good enough. These feelings are very intense. Being convinced one is overweight encourages negative self-talk, and one convinces oneself that weight loss will bring about self-acceptance and happiness.

Keeping to one’s dietary rules is of the utmost importance. One dare not go against them, even punishing oneself with exercise (or another mechanism) if one contemplates going against them. Punishment is a regular occurrence, as one battles to maintain one’s stringent dietary rules and regulations. One must adhere to these at all cost. Eating food is not something pleasant and it carries negative emotional consequences.

## **5. Perfectionism and the love one receives from others**

*"I've always been very hard on myself. I don't think I've said it ["You're good enough just the way you are"] to myself. So hearing something like that [from the therapist] was really, very annoying. I know where it's coming from, and I understand – but for me it hit a nerve. It hit a serious nerve, and it bugged me. Because when I think about it during the week, I feel tense. I feel like I want to hit something. When hearing it, you push a button... No, I don't think I'm acceptable. No, no - right now I don't think I'm acceptable."*

Receiving positive feedback and compliments from those around one is difficult and can make one uncomfortable about oneself, as one may feel one is undeserving of such comments.

## **6. Perfectionism in the recovery process**

*"That's why I could never really sit and watch my kids, and they would be having fun, I would sit and think about negative things. The last month, I can sit and I can watch them, and I could see things, and I actually feel a happiness I didn't feel before. And it makes me feel good inside, because it's kinda like now a way of, you're starting to see life again. But you're starting to see it through others' eyes, so it's opened a door... You've [therapist] had me thinking quite a lot since I've been here. It's nice to have a different way of thinking. I can argue stuff in my mind more constructively, because now I'm seeing I've got a long-term goal that I want to get to. But before, I made no sense in my brain... So now you start challenging. You start challenging your thought processes. You start challenging why there are things in there that I've forgotten that I've actually done. And then you start thinking: "Why did I do that? Was that the right thing to do at that specific point in my life? Why was I doing that at that point in my life?". So it's*

*opening up, like I say: “Yes, acceptance will be there. It’s not here now, but if I carry on like this I know I’m going to get to that point.”. But I’m not going to be able to do it alone. I do need you to help me get to that point... There’s a difficultness in it. But then there’s also an enlightening side of it.”*

Food serves as a trigger to become negative about oneself. This, in turn, can influence one to engage in eating disordered behaviours. Becoming acutely aware of how one feels is important in starting to deal with these issues constructively. The ability to start challenging one’s own self-critical and negative thinking patterns is difficult, yet enlightening and liberating. It encourages self-acceptance, allowing one to free oneself and to be true to who one is, instead of always questioning who one is not.

Placing focus on the self, and putting one’s own needs and wants first is confusing and difficult. Even if one understands the need to do so, one still struggles to change it. Placing others first has been an engrained way of life, and changing that way of living is difficult.

## **7. Perfectionism and how it influences one’s relationships**

*“You see, that’s what I can’t understand about myself. Because I am so critical of things about myself, but yet with my kids I don’t force them to do things. I don’t even say anything bad about their image. Like, my little girl has started this thing - she’s got small little feet. She’s three years old. I mean, I’ve also got small feet. Now she’s got this thing: “I don’t have small feet. I have big feet.”. And when I say to her: “Carla, your feet are perfect for you. For your size, your height, your feet are perfect. They’re proportioned. Look at mommy. Mommy’s feet are*

*proportioned to her body.”. Or her bum, I said to her: “You’ve got such a sexy little bum.”. Because I know what people used to say to me: “My little bum is as sexy as your little bum.”. So, you know? I do the opposite with them, to what I do to myself. Because I’ll be saying to her: “You’ve got such a sexy little bum.”. But then when John says to me: “Look how pretty you look today.”. I say to him: “I’m not pretty. Don’t! Don’t do that! I’m not.”... I don’t do well with compliments. I’ve never been able to accept compliments.”*

One lives by double standards, complimenting and accepting others as they are and how they look. However, accepting oneself and receiving compliments from others are not allowed. Breaking oneself down is a constant and engrained pattern. To free oneself from this is difficult, and those negative personal opinions one may have cause clashes with the positive opinions that others may, at times, voice about one. Even though one wants to believe what others say, it is difficult as one’s own negative beliefs about oneself are deeply engrained. Finding the will to change this is difficult, but important.

## **8. Portraying the perfect person to others**

*“My personality has changed dramatically over the years. I’ve become a negative person, always looking for fault, judgemental, destructive, can’t keep friends. Don’t allow family or friends close. Hurt people before they hurt me. Feel like I have to act all day to try and be someone I’m not.”*

Negativity is something constant and universal. One is negative about oneself and one’s relationships with others, as one becomes very judgemental in general. One

does not allow others close to one, and one portrays a persona to them which is not the *real you*.

## **9. Comparing oneself to others**

*"I used to compare myself to others. But have stopped doing that as they are perfect and I'm just some ugly, fat woman. I have no good qualities and comparing myself just makes me feel worse."*

When comparing oneself to others, one's self-judgement remains abusive, negative and harsh. One struggles to identify much good in one, and feels that others are better than oneself in every way.

## **10. Achieving goals perfectly**

*"Feeling bad for eating so much. Ended up vomiting so to feel not so guilty about eating more than one normally does. Felt terrible afterwards as if I had let myself down and my kids. Tried so hard this week not to vomit, but looks like I gave in once again."*

Making even one mistake can affect one's emotions negatively and encourage compensatory behaviours. Making a mistake is a failure, and is seen a reflection of one's own weakness.

### **5.4.4 Lara - The dietician**

Lara volunteered to become a research participant after she was referred by a colleague (counsellor) who had been counseling her for relationship problems. She is an English speaking, Caucasian woman. She is 28 years old and works as a full-

time registered dietitian at a hospital. At the time of making contact, her relationship of seven years to her boyfriend was coming to an end.

Lara presented with a long-standing problem with bulimia nervosa, which had been part of her life for the past 11 years. At the time of making contact, she engaged in binge-purge cycles almost daily. Her main problem compensatory behaviours were purging and excessive exercise. Her weight was stable at around 64 kg, although severe weight fluctuations had been experienced in the past.

Lara previously sought counselling and psychological help for her ED, although she felt this had minimal positive effect. She never admitted to any of her close friends, boyfriend or family that she suffered from an ED, suffering in silence because of the shame she experienced. Becoming part of the research endeavour was another attempt for her to try and address her ED. Although she worked in dietetics daily, and could advise others on healthy eating habits, she believed that resolving her own problem was a lost cause. She thought that if she could not stop bingeing and purging after four years of intense study in dietetics, then this proved there was no hope for her overcoming her ED.

After dating each other for seven years, Lara and her long-time boyfriend decided to end the relationship. During her counselling process with my colleague, she had come to realise they were not compatible and it was futile to continue the relationship. She claimed that part of the reason she never admitted her BN to him was because she knew he would not support her, as he was a womaniser and emotionally abusive. After being referred, and subsequently becoming part of the

research study, the breakup of the relationship culminated in her being admitted to a psychiatric facility for the first time. She experienced an intense negative reaction to this breakup and could not function properly in her daily routine.

Lara would use several problems in her relationship as justification for her ED behaviours. These dynamics fed into her mood, her outlook on her life, her future and her ED. Much of the therapy focused on trying to divorce her emotionally from her ex-boyfriend and the verbal abuse she used to receive from him. In their relationship, he played silent warfare with her. He would ignore her for days, or even weeks, whilst she would hurt emotionally, obsessing about their relationship, the problems in their relationship and whether she should leave him or not. These problems affected the ED, especially her binge–purge cycles. The issues between them consumed her on an emotional level, as if she was being eaten up from within. At times, her anxiety would become so intense she would move into states of panic before indulging in a binge.

Although the breakup was very difficult for her to process, starting to actively focus on her BN gave her a new sense of purpose. The bulk of Lara's treatment took place during her hospital admission. She lives far from hospital, which made follow-up sessions after the admission difficult. Initially there was difficulty convincing her that the ED could be addressed successfully. Her motivation for therapy was low, because of the relationship issues with her boyfriend (and their subsequent breakup), as well as struggling with BN for so long even though she is a qualified dietitian. However, after making initial gains in therapeutic momentum, her

motivations improved because she could focus on herself through the ED treatment, and in so doing, find some elements of healing.

The following 12 themes and verbatim statements were drawn from Lara's audio files, interviews and notes. Each theme includes an example of her verbatim statements made during the interview process.

### **1. Portraying the perfect person to others**

*"I don't feel well about what's been happening. The longer I'm not in his company, the more I'm realising things about me and my eating disorder. I hate sounding like a victim. I don't like when people want to make pity parties for themselves because of things they've experienced. You should be able to deal with your own shit. But, I don't know, this issue has just really gotten out of hand the last while."*

Even though one may be struggling with an ED, one might try to avoid sympathy from others as one believes one should be able to cope with it, and resolve the issues oneself. A lot of energy is invested into portraying to others someone who is strong, confident, competent and stable. Even when one is going through the most difficult of personal times, one does not communicate this well to one's loved ones.

### **2. Perfectionism and the love you receive from others**

*"I managed to restrict my eating to the point where I was underweight in my mind. To everyone I was either 'fat' or 'skinny', neither of which have positive connotations. Thus, never good enough. This thought spiralled out of control leading me to believe that if only my weight was perfect, I'd be perfect. But at any*

*weight I never found perfection. Instead of focusing on other areas of my life that really mattered, for example my career, my position became food and fat.”*

By losing weight, one believes that others will stop commenting about one’s body and weight, as one is sensitive about such things. Even though others’ comments about one’s body are normal reactions, this might influence one to try and achieve the perfect weight. One becomes obsessed about achieving this perfect weight, trying to appease everyone around you, which comes at the detriment of other areas of one’s life.

### **3. Evaluating your body by perfectionist standards**

*“I’ve been writing a lot in my journal since coming to the hospital. The entries, sort of, it always seems to descend into me saying negative things about myself. And then I stop because it doesn’t feel like it’s doing anything good at all. And obviously I know I should be saying things like – I don’t know what I should be saying, because I can’t say things like: “I forgive myself.”. Because I certainly don’t. And then I sort of think: “Well I should be saying something positive.”. But I can’t think of anything positive right now. And when I notice fat or flab, it just makes everything worse.”*

Putting oneself down and judging oneself harshly causes one to disengage from oneself. This contributes to misunderstanding one’s own emotions, or not being able to support oneself through difficult times.

#### **4. Perfectionism and the need to control**

*“I tried to follow my own eating plan where and if possible. I keep carbohydrates to a minimum and only eat no/low fat foods. Compared to the amount of exercise I do that day, I might allow myself to eat ‘normally’. I ignore my body pangs for nourishment, and when I do feel physically hungry I see that as a lack of self-discipline and self-control. I still restrict carb-intake if I can help it. I always take note of the fat content in food – it must be fat free. Low-fat is cheating a bit. No sugar in beverages at all. If no artificial sweetener is available, I won’t drink it unless I’m probably bingeing.”*

Strict dieting and maintaining control over food choices is very important. These aspects have a direct impact on one’s judgement of self-discipline and self-control. One wants to be able to exert control over food choices, even if one acknowledges that one’s own thoughts are unstable, or that one is making poor decisions to the detriment of one’s own health.

#### **5. Perfectionism and the link to food, weight and shape**

*“I used to restrict as much as possible and exercise so I could try to lose weight whenever I felt strong and in control. A good day is eating three meals and snacks and not beating myself up if I slip up by eating non-diet foods, even if the portion size is normal.”*

Weight is a defining factor in judging how successful or not one is in life. Weight fluctuations have a direct bearing on how one feels about oneself, one’s life and self-worth. Weight loss is a constant goal, as weight is always something on one’s mind. A good day is experienced when one adheres to a strict diet, and one does not

become negative or use abusive self-talk. Weight loss may encourage moments of happiness, but are not lasting at all. With weight gain, feelings of disappointment and failure preside.

How one feels about one's weight has a direct bearing on the outlook on oneself and one's life. Being thin makes one feel confident, competent, purposeful and worthy in life. Being fat makes one feel like a useless failure. The uglier one perceives oneself to be, the harder it is to become motivated about oneself, one's recovery and finding self-respect. Simple tasks like dressing oneself in the morning can remind one of how ugly one perceives oneself. These feelings make one more distressed, as one desperately wants to feel beautiful for oneself. By putting oneself under the microscope one constantly notices imperfections. This makes one feel more and more worthless, and one loses perspective about oneself. One focuses on imperfections, rather than understanding that one is unique and priceless.

The drive for weight loss is intense, more than the normal person experiences. One easily self-sacrifices in the name of pursuing weight loss. Even if one knows weight loss is to one's own serious detriment, one still easily pursues it. There is a significant difference between what normal people find physically attractive and what eating disorder sufferers find attractive. ED sufferers prefer severely skinny bodies and being very underweight. However, with recovery the definition of beauty may change towards a more *common* standard, whereby extremes are not beautiful any more.

## 6. Achieving goals perfectly

*“I’m scared I’m going to lose my drive if I don’t insult myself. I wonder if I’d put in as much effort if I didn’t try and push for a high standard, and force myself in that direction. It’s the same with my food. If I don’t try to do it very strictly, then I don’t really do much effort at all. I need to criticise myself constantly so as to do it right.”*

A combination of harsh self-criticism and wanting to do things perfectly are motivations to achieve one’s stringent goals and one’s high standards. There is doubt whether one would invest as much effort as one’s achievements if one did not invest in harsh self-criticism or perfectionism. Self-ridicule and abuse are mechanisms utilised to achieve goals in life, or to become a better person. Negative feedback and self-abusive comments motivate one to perform better in life, working harder at improving oneself. One may even purposefully look for abuse from others. Even though compliments are also motivating, criticisms and abusive statements drive one to achieve more.

Unless one succeeds in all one’s goals for fitness and health for that day per one’s own stringent standards, then the day is a failed attempt. If one cannot keep to the stringent dietary rules, one might as well not invest any effort at all. Either eat perfectly, or eat with no self-control. Achievement and achieving goals significantly affect one’s mood.

Gaining insight on how one prefers self-abuse affects how one perceives oneself, as one might come to understand how one prefers negativity in life.

## **7. Perfectionism and the link to the self (i.e. self-acceptance)**

*“The psychiatrist gave me a good explanation today about eating disorders. It really rang true to me and what’s going on with my life. I see my eating disorder as a tree. A complicated tree. At the bottom of the tree is the self-loathing and the self-hatred - the roots. And then the trunk of the tree is the eating disorder, the bingeing and purging that keeps repeating itself in its own cycle. From that flows all my emotions and thoughts, my anxieties and my obsessions into the branches of the tree. The thoughts and emotions are kinda like the fruits of my eating disorder. So, I’m still trying to figure out what part of the tree needs to be attacked first. But what I’m learning is that it should probably come from the roots. Because even if I manage to cut down some of the fruits, or branches, or even the trunk itself, it has the potential to re-grow.”*

Self-loathing and self-hatred are at the base of the destructive ED behaviours. Engaging in these repetitive behaviours encourages self-loathing and self-hatred. Regularly engaging in these behaviours maintains negative emotions, obsessions and anxieties.

## **8. Comparing oneself to others**

*“I compare myself a lot to other people. The size, shape, dress sense, hair, company they’re in. I’m always at the short end. I have nothing, I’m such a loser. What guy would want to be with me now? What person would want to befriend me? Nobody.”*

One constantly measures oneself in comparison to others, and then concludes that one is lacking in worth. Comparing oneself to others, or seeing photos of oneself, can encourage feelings of negativity as one feels larger and less attractive than

others. This creates negativity about oneself, causing one to question why people would want to have relations with one.

### **9. Perfectionism and the link to low self-esteem and low self-worth**

*“What a disappointment I’ve grown up to be – nothing but a big fat bulimic!”*

Negative self-esteem is something that develops over a long period and is deeply ingrained. The fear of failure is ingrained in one too, as one constantly worries about how others judge one. This encourages the feeling that everyone is better than one and not worthy enough for others.

### **10. Perfectionism in the recovery process**

*“Every day I try to convince myself: “Okay, yesterday was the last day of bingeing. This shit has to stop now.”. And lo-and-behold not even hours later I’m already making a mistake. I hate myself for that. Why can’t I have a day where I do this right? From there on it’s all downhill. I get so upset and angry with myself and I feel: “What’s the use?”. From there on I stuff my face with whatever I can get, followed of course by my face down the toilet...”*

The will to address an ED may be difficult to foster. Even in the light of impending damaging consequences, this does not necessarily mobilise one to cease those behaviours. In fact, one might even *want* those damages, so that it *forces* one to start dealing with the ED.

The repetitive cycle of bingeing and purging is difficult to end. One tries so hard to eat according to what one thinks is good and right. But after making a mistake, one

feels that one failed the goal and self-judgement is harsh. This is destructive to one's self-esteem. This might trigger a full binge-and-purge episode.

Structure within the ED can positively affect an ED. Structure, when utilised and applied in a healthy and constructive manner, may contribute to the recovery process. Forming habits of ritualised eating patterns helps to prevent triggers and keep destructive eating behaviours to a minimum. However, one is quite dependent on a strict structure, as even just veering from it in a small manner may result in a relapse.

Achieving binge-free and purge-free days may foster the belief that one is successfully recovering from the ED. However, even just engaging in those behaviours once, humbles one to realise it is not that easy and that recovery takes time.

## **11. Perfectionism and the link to exercise**

*"It's bad to notice with age that you get wrinkles and cellulite, and they don't disappear... It's really difficult for me. Really, really difficult. And that's why I think the only way that I'll be okay with it, is if I can exercise again and have a clear weight goal... If I can use my body for something at least. Geez, it's [exercise] still something I crave and miss so much. Because it's something I really enjoy. I really enjoyed the running so much."*

Noticing the signs of ageing in the body is very difficult to accept. Keeping one's body active is one possible way of dealing with the discomfort and accepting the

body's changes. But one can again become obsessive about these health and fitness goals.

## **12. How one judges oneself and one's own performance**

*"Try your best to stick to the program here! Get your act together... Eat properly damnit - no vomiting!!! I ate too much salad!... Stop eating those fucking biscuits!!! Okay, well then finish the fucking biscuits will you!!! And be done with it!!! Eat the whole packet and then just get rid of it later... Get it over with you fat pig! Thinking about food this much is not normal. Stop pretending you're trying so hard. Just do what you always do – have whatever you feel like and chuck it up later!"*

Even though one tries to motivate oneself to do the correct thing, making mistakes is hard to deal with. During bingeing-and-purging episodes self-talk is negative and harsh, which encourages one to break oneself down emotionally and foster a negative self-esteem.

### **5.4.5 Jane - The student**

Jane volunteered to become a research participant after being referred by a colleague (dietitian) who had been consulting her. She is an English speaking, Caucasian 22-year-old woman. At the time of becoming a research participant, she was studying full-time at university, and was involved in a committed relationship with a boyfriend.

Jane presented with treatment resistant AN. She had first been diagnosed with the disorder when she was only 12 years old. Her lowest weight she had ever achieved

was 29 kg. Jane had an extensive history of psychiatric and psychological interventions. Throughout her adolescence and early adulthood, she had multiple admissions to psychiatric hospitals treating her for AN and other co-morbid conditions. Presently, she was being treated with psychiatric medications as she also had a history of suicidal ideation and -attempts.

Although Jane experienced times where her AN symptoms felt less intense, her pre-occupation with weight, shape and food never subsided completely. For almost half of her life she had struggled with an ED. In 2013 she experienced a positive shift where she decided for the first time in her life that she truly *wanted to live*. This signified a turning point, where she chose to start moving forward in life.

At the time of becoming a research participant, obsessive thoughts about food and its preparation were the most difficult aspects for her to deal with. Jane experienced constant coldness, low energy and poor overall physical health which were attributed to her AN. She lived alone and had to prepare her own food, which was extremely difficult for her. Whenever different foods would touch each other, or food utensils were perceived to have been contaminated with calories, she struggled to cope with the immensely intrusive obsessions regarding these, as well as intense accompanying anxiety. Preparing just one meal could take many hours. Even though she was on a strict eating program and being weighed regularly, she struggled to maintain a target weight.

During the research process, she was once again admitted to a psychiatric hospital. This was due to a relapse in her mental- and physical state. Convincing Jane to be

admitted to this facility was difficult, as previously she had been admitted to another psychiatric hospital where she claimed the staff had been verbally- and physically abusive. She was admitted to that hospital for 9 months in 2012. That admission was followed by a suicide attempt and was also coupled to her being fed through a nasogastric feeding tube, due to her extremely low weight at that time. Low weight and restriction of food intake remained serious problems throughout her treatment process.

Jane's therapy process was difficult and slow. Allowing others to exercise control over her food choices or its preparation was difficult for her. She was highly resistant towards therapeutic input and struggled to make the necessary changes in her diet and overall behaviours. She was verbal during her consultations, giving rich descriptions about her difficulties with her illness, anxiety and the unending obsessive thoughts she would experience. These had significant negative impacts in most areas of her life, especially her relationships with family members and her boyfriend.

The following 10 themes and verbatim statements were drawn from Jane's audio files, interviews and notes. Each theme includes an example of her verbatim statements made during the interview process.

### **1. Perfectionism and how it influences one's relationships**

*"I'm really conscious of it [eating disorder]. That's why I do like being with Craig because it really challenges me of who to choose – him or my anorexia? Like, is Craig gonna be more important in my life than anorexia? I do feel it, because if he wants to lie on the couch and he wants me to come lie down next to him, I*

*immediately start timing how long I'm lying down. And then for every hour I lie down, I miss a carb [carbohydrate] off my meal plan – let's say if it's not within like the proper sleeping hours or whatever the rules are. And it gets in things like that. I wouldn't be able to focus properly."*

Eating disorders influence close relationships. One may experience pressure between having to choose which has priority, as the needs of one's interpersonal relationships may clash with the stringent boundaries set by an ED. Others may be unaware of its affects in one's life. Portraying to others the real degree to which one's disorder consumes one is difficult, and not something one necessarily does.

## **2. Perfectionism provides structure and rules to live by**

*"I just feel like, in the morning when I wake up, and I've never been a morning person to start off with, like I would never sleep in until ten or whatever, but don't give me a five 'o clock morning; and I just feel like: "Another day." And I live until breakfast, and then until tea, and then until lunch. Like, that's what my day's based on. Umm, even if I'm doing something so nice, I just feel like: "Hmm, we'll do this now."; and then at 4 o'clock, or whenever snack time is, then: "You've made it through that part of the day, almost.". And it's almost like, I feel an achievement if I can get through those sections of the day, like: "I made it until tea time, I didn't eat anything.". Well I ate breakfast, but I didn't eat since that, I didn't eat any snacks."*

Strict rules are formed from strongly held personal beliefs. These beliefs may be based upon selective pieces of information. Adhering to these rules is important as guidelines and rules are an integral part of living with an ED. The structure an ED

provides, makes one feel safe. Moving beyond that structure into the unknown is anxiety provoking - so anxiety provoking that one does not attempt to start recovering from the ED.

The focus is on surviving on as little food per day as possible. This is the goal - restricting food as much as one can. This is what cultivates a sense of achievement and gives one purpose in a day.

Weight fluctuations are used as indicate whether one has adhered to the strict rules set by the ED. Only upon successfully meeting these standards, may the reward be food. In this way food is viewed as a reward (allowed to eat), or punishment (not allowed to eat).

Submitting to the rigorous standards of an ED is extremely exhausting and can have a negative effect on energy and motivation.

### **3. Perfectionism and the need to control**

*"It's totally dark to me. What the hell is gonna happen to me if I'm not with anorexia. It's very much a control issue! My life is gonna be so all over the place. How do I even plan my day? Like, what defines my day? Like, I can't just have a day lying on the couch – like you're being such an unproductive person."*

An ED's set structure provides mechanisms for exerting control over one's life. Being in control is important, as losing control would result in chaos. Thus, living without an ED would result in a chaotic life, being lazy and unproductive.

#### **4. Perfectionism versus happiness and a normal life**

*“I think living with anorexia is never like just ‘maintaining’. It’s never like: “Okay now I’m not living for it. But I’m kinda walking with anorexia.”. But you know anorexia is not satisfied until you’re dead. So there’s no way you can keep it for a few years, appeasing it, because you regress a little bit, little bit, little bit, little bit and then just go back. Because I did that. That’s why I’ve been to so many places because I keep going back, and I keep living with it... It’s not gonna be a straight path if I keep walking with anorexia. Because it’s already going skew.”*

One cannot satisfy both the ED and trying to live a healthy happy life. Maintaining a healthy life with an ED is impossible. Over the long-run an ED will continue to lead one’s behaviours and choices astray. Portraying oneself as anorexic is important. This is done by challenging treatment guidelines. Even when others are encouraging one in the recovery process, remaining ill remains priority, as one legitimises one’s diagnosis.

The obsession of wanting to measure and eat perfectly can be disruptive to one’s life. It can keep one from enjoying many experiences to the fullest.

#### **5. The obsession of being perfect**

*“It came to me last night. I just felt like, enough! Enough is never enough. That’s why the feeling of being happy when I lose weight lasts five seconds, because then I’m like: “Ah just a little bit more and I’ll be happy.”. And the goalposts just keep moving. And when I think of it – and it may sound sick when I say it, but it’s not even, like, a shocking thought to me that if I died, like, as a bettering for anorexia, that feels like I should be proud. I know that anorexia’s end-goal is*

*death, but that doesn't scare me because it feels like: "Wow I fought, like, for my country.". You know, like, for war. And you're like: "I was a martyr.". And I feel like, that when I die - if I die from anorexia, that anorexia would be so proud of me. I know it's a very sick thought, but I tend to lose touch with reality so much that death seems fine... It's hectic, because it feels like this plate of food is more important, more of a tragedy, than death."*

Obsessions about food and energy intake can consume one's way of life. They dominate thoughts and influence behaviours negatively. It is emotionally draining to live this way. The obsessive nature of an ED is strong and can dominate in situations where one is supposed to apply positive motivations, therapeutic insights and not engage in anorexic tendencies. Confronting and overcoming these obsessive thoughts may feel impossible in these situations.

Achieving perfection is always a changing process. One can always go further, higher and do more through one's efforts. Enough is never enough. If death is achieved by reaching for perfection, that would be the ultimate sacrifice which gives meaning to life and a legacy.

## **6. Perfectionism in the recovery process**

*"I don't eat anything that's not measured... I need, like, guidelines to do it [recovery]. Like, if it's not, like, measured, then do I just eat, like, six potatoes, or do I take half a baby potato. I don't know what to eat. Unless it's like: "I have to eat it [according to guidelines]"."*

Free-will regarding choices is disallowed. Even in the recovery process, adhering to strict rules seems a way of life that cannot be swayed from. Adherence to strict rules is part of an ED which requires perseverance and diligence. These may be traits that can be utilised during the recovery process, if the person has chosen they indeed want to recover.

## **7. Black-and-white thinking**

*“It’s so hard, because my thinking is so black-and-white Guillaume. Like, there’s not a grey area. The grey area is just like – nothing. There’s just a black, and a white, and then a no-man’s-land, a big hole and you drown.”*

Black-and-white thinking causes distress when having to make decisions. One cannot find a compromise between the two opposing elements.

Black-and-white thinking influences one’s experiences of love from others. It creates the belief that if one is a high achiever, then one will receive attention and love. However, if one does not achieve, then one will not receive love or attention from others.

## **8. Perfectionism and the link to anger**

*“You know like when a child doesn’t want to go bath. But then when they’re eventually forced to go bath, then there’s toys there and they play. But when my mother says: “See, I told you you could bath.”. Then the little kid gets angry. So that’s, I’m not saying you’ve done it, but that’s what makes me angry. Like, if my brain can’t respond to it: “See you don’t have an eating disorder, see you’re eating this now”.”*

Anger can become a difficult feeling when attempting to overcome an ED. When one initially resists food, but then later gives in to eating it, anger may be an intensive reaction. Especially when one is reminded by another that food can be eaten and that one does not have to resist food so much, anger results. This anger is towards the self.

### **9. Making personal decisions whilst trying to be perfect**

*“Sometimes I struggle with knowing what is right, and knowing what is wrong in very grey areas where maybe there is nothing right and nothing wrong. And so I either listen to anorexia, or maybe that’s why I trust the dietitian so much... I would ask the dietitian questions like: “Okay coffee is a free food, but how many cups can I drink a day?”. I needed some sort of guideline because I don’t even know if I used to like coffee. And I don’t know how often people should drink it. And maybe you should or shouldn’t... I always follow the dietitian’s plan, but that doesn’t make me better.”*

Intuitive decisions and personal preferences are difficult, as one does not trust one’s own judgement. This results in a feeling of confusion, as one does not know how to decide. This is because of always seeking to follow the *correct* answer, instead of ‘*what do I prefer?*’ Or ‘*what do I want?*’. When having to make personal choices, strict rules and high standards are the guiding principles, instead of following one’s own intuition, wisdom, preference and knowledge.

### **10. Perfectionism and the love you receive from others**

*“When I was in hospital, it was kind of mentioned by everyone – and it’s because of the reasons I came in. I mean, I said: “I’m not coming in because I’m forced to*

*come in, because I'm not eating. I'm coming in to get help with my obsessions around food, and compensation, and washing hands, and what not.". But hearing the words – and I'm not blaming anyone, because obviously that was the truth but anorexia twisted it – but hearing the words from the dietitian, from you, from whoever else that: "The weight is not the issue, let's not focus on the weight.". I was like – anorexia was like: "You're not properly anorexic. Your weight is not an issue. Best you show them you can make it an issue, because they don't believe that you need that much help"."*

Being *almost anorexic* is not good enough. Even in illness, it is important to obtain and maintain high standards, which warrant the attention one may receive from others.

Achieving a difficult goal is not enough. One must achieve even higher than that by overcoming adversity, more so than others. This earns one respect and admiration from others.

#### **5.4.6 Tracy - The psychologist**

Tracy responded to the internet advertisement calling for research participants. She is a 33-year-old, English speaking professional Black woman. She is qualified as a clinical psychologist and works within the corporate environment.

Tracy presented with a long-standing ED since the age of 16 years. She struggled with treatment resistant BN. Tracy's ED had been remittent at stages in her life as she had experienced periods of her life without active symptoms. However, self-acceptance and self-induced pressure to perform had always been an internal

struggle for her. In the active phases of her disorder, her main problem compensatory behaviours were purging and excessive exercise. At the worst of times, bingeing-and-purging cycles would happen multiple times a day.

Tracy lives in extremes - either starving herself or losing total control. She struggles to maintain a healthy constant weight and eating pattern, as self-induced stress and pressure influence her emotions to such an extent that she cannot cope. This self-induced stress would then influence her behaviours in the form of binges, which in turn perpetuates her illness further. Tracy has always been emotionally hard on herself as she attempts to achieve high goals to alleviate this internal pressure. She believes that achieving high goals is the way to happiness in life, even becoming anxiety stricken at the thought of not being able to achieve goals.

Tracy had never previously sought help from a psychiatrist or psychologist for her eating disorder, although she had previously been diagnosed and treated for major depressive disorder, including suicidal ideation. Aspects in her past that contributed to this mood problem were enduring two violent traumatic events, as well as ending a long-term emotionally abusive relationship. Part of the reason for not seeking help was because of her belief that necessitated she resolve the ED problem herself.

As her perfectionist thoughts had been so prevalent since early childhood, she did not completely grasp the extent of her problem or recognise that her behaviours were something that needed specialised intervention. She had always just focused on her perceived weight problem, engaging constantly with diet regimes such as SureSlim™ to control her weight.

Tendencies towards self-induced high standards had been prevalent from a young age. Tracy decided to attend primary school two years before children her age normally would (i.e. at the age of four, instead of six years). She also took part in school athletics, competing with people two years older than her, and still winning most of her events. In adulthood, road running became something that helped with feelings of being overwhelmed. Running made her feel positive and not so overwhelmed by the problems in her life and her ED. However, she struggled to acknowledge her own achievements, even if they were truly well-deserved.

One of her major focal points in her physique were her buttocks, which she thought were always too big, even since early childhood. She was very pre-occupied and almost obsessed with them as a youngster.

Tracy was saddened at the thought of finding help for her ED. She claimed she was exhausted with her eating disordered lifestyle and felt the treatment would expose how she is hurting, and confirm weaknesses within her. Change would take much effort because she needed to learn how to *be* in a different way to what she had been for over 20 years. However, she knew she needed this change to happen as it would be for her own benefit and a requisite for her to enjoy life.

She completed the homework tasks as assigned and seemed honest and open towards the process. Tracy's therapy focused on her self-induced pressure, as well as her destructive behavioural patterns. A core therapy goal was for her to start recognising who she is, rather than focusing on that which she is not.

The following 10 themes and verbatim statements were drawn from Tracy's audio files, interviews and notes. Each theme includes an example of her verbatim statements made during the interview process.

### **1. Perfectionism and the link to the self**

*"I've always been like that. But I think it was more, not even about, achieving as such, but I've always felt, like, emotionally it can't be it. You know what I mean? Like, the feeling I've always had growing up and being me, that there's more to it. That a person cannot feel so emotionally empty, or detached. I feel like I'm always constantly searching for that thing to be resolved. That feeling within. It has become better, I must say. But whether it's actually resolved I'm uncertain."*

Self-acceptance remains difficult throughout life, which can cause emotional detachment from oneself. One is much harder on oneself, and does not regard one's own feelings as much. One's opinion of oneself seems predominantly negative. One does not necessarily even like oneself and can be quite disconnected from oneself. Self-judgement towards the self is very strict, harsh and constant. Even if one is aware of it and has no reasons to be hard on oneself, one still is. Despite achieving in life, or good things happening around one, one's own self-evaluation and self-worth remains deficient.

The attitude of criticism towards the self is constant, intense and overwhelming. It is difficult to explain the phenomenon to others, as one does not fully understand it. Regard for others' feelings and problems are done with empathy and at ease. However, treating oneself in the same manner and with the same regard is difficult. The harsh self-judgement interferes with living in the moment and enjoying life to the

fullest. It may make one not recognise one's own self-worth, or one's own accomplishments.

Struggling with self-acceptance causes inner discomfort which is persistent. In trying to resolve this, one constantly strives to achieve goals. Achieving success and goals is a way to feel better about oneself, or to resolve this uncomfortable feeling, albeit temporarily. One feels incongruent as one attempts to portray confidence and competence to the world, whilst constantly feeling inadequate; or not coping with the pressure one places on oneself, or being placed on one by others. Even though one continuously and successfully performs per high standards, or achieve difficult goals, one questions one's own self-competence as one struggles with simple things like eating food.

Focusing on being perfect inhibits one to know oneself in the truest form. Knowing the self does not happen by knowing how one must satisfy others, but rather coming to understand how one experiences oneself, even as others may experience one.

## **2. Perfectionism and how it influences one's relationships**

*"I had always had the need to make people feel better. Even now as an adult, I mean, when I lost my friend I remember going to the mom's house. I mean, the way that I was just going there, wanting to remove her pain, not even as a psychologist, but almost wanting to bring her [friend] back [from the dead]. I feel like I'm always wanting to do these things. Even now my brother is going through a crisis. He lost his job. You know, I feel like I literally want to go out there and get a job for him, you know. And I think that's why I also hurt when I see my dad and*

*I'm so helpless and I can't do anything to help him. So I think I've always had this need - I want to see others okay, and even my friends."*

An intense need to help others, coupled with a strong focus on others' feelings and life situations, contributes to investing intense efforts into positively affecting the lives of others. Their feelings such as happiness, pain and sorrow, are important - more so than one's own. Even though one constantly invests energy into others, being aware of their feelings and thoughts still makes one feel of little worth inside. To recognise one's own worth is a difficult thing to do if one is not constantly pleasing others. By principle, one's problems are not to be shared with others. One is hard on oneself and easily forces oneself to keep engaging with one's problems, even though support from those around one could assist greatly.

### **3. How one judges oneself and one's own performance**

*"I've always felt what I'm doing is ordinary, for a lack of a better word. I mean I didn't see the hype, as I said, when I started school at four. They did a lot of assessments - I think probably IQ assessments to see if they could keep me back. So even when I went to the model C school, which was in standard one, grade three, I was a high performer and they kept me there... But I didn't think it was such a big deal. I just thought anybody could do it. Any 4-year-old could go to school."*

Being able to judge one's own performance and recognise one's own good achievement does not come naturally. In general, one sees one's own performance as quite average, not exceptional. Giving oneself credit, where credit is due, is viewed as selfish and narcissistic. Breaking oneself down, or constantly belittling

one's own achievements are not allowed, so as not to be seen as selfish or narcissistic.

When having to deal with stressors, one may feel like a failure when one cannot appropriately deal with such stressors or triggers. When this happens, this contributes to a binge-purge cycle, or falling back on excessively controlling/restricting food intake. Experiencing stress, and dealing with it in an appropriate manner, is made cumbersome by perfectionistic tendencies. This pressure is self-inflicted, and hinders dealing with stress properly and efficiently.

Fluctuations in weight, or dealing with problems of eating disordered behaviours are difficult, as the margin for error or making mistakes is less than the average person's. Even though one is aware of one's own self-critical judgements, ending such thoughts is difficult. One must replace one's self-criticism with kindness, which is difficult as the self-criticism has been part of one's thinking for a long time.

#### **4. The obsession of being perfect**

*"It's not even about, or specifically to the eating. But I also think that that plays a role, because I think I want to look in a certain manner. But it really affected my entire being, in all areas of my life."*

Striving for perfectionism is not only on the physical level, but encapsulates all aspects of life, to the core of one's being. The self-imposed pressure and putting oneself down is intense and constant. It brings negativity into one's daily existence and influences one's thoughts and feelings continuously. Even when one is aware of

it and realises the need to change its influence in one's life, it remains difficult as it has become a habit. It happens without one wanting it, almost automatic.

Self-imposed pressure imposes on situations whereby one's high achievements are recognised by others. Once one's achievements have been recognised by others, one feels pressured to improve on those achievements. Achieving and receiving recognition becomes ambiguous - even though one likes being recognised, it adds pressure to then perform even better still. The internal struggle with self-inflicted pressure is intense and very personal. One becomes good at hiding it from others, as they view one as competent and problem-free. Even though one focuses intensely on presenting oneself as such, within one's emotional world the *battle* rages on.

## **5. Evaluating one's body by perfectionist standards**

*"I never looked in the mirror. I could never stand looking at myself in the mirror. I remember when it actually got severe, when I left school, then I went to varsity, then everybody was just commenting about it... I think they were compliments, but it really felt they were just putting attention on this thing [body] I don't like, and I can't do anything about it. But they would actually comment about my entire body saying: "That's a nice body, and a nice huge ass.". But I did not feel nice. I did not feel at all nice. That's when I think the eating disorder was severe, in first year when I got to varsity... The eating disorder was a way to make my ass disappear. But then I was looking very unhealthy."*

Body avoidance is a mechanism to deal with one's discontent towards one's body. It is easier not to consider one's body. However, people's comments about one's body

remind one of it, which triggers one to remember how much one disproves of it. One remains sensitive to how other people perceive one and one's body. Comments from others about one's body is never-ending, whether one gains or loses weight. One invests a lot of energy into not being overweight or underweight. Maintaining a body that looks normal and of good shape is a priority. It feels emotionally distressing if one feels one's body is different to society's norms. One might even tell lies just to get those people to divert their attention. However, during the healing process one becomes more at ease with one's body's flaws, and with the fact that others will always comment on these flaws.

## **6. Making personal decisions whilst trying to be perfect**

*"I guess I'm scared I'll make the incorrect decision. Yes, I guess that's again the pressure I put on myself. I feel I'll make the incorrect one. I think I'll make the incorrect one. So that makes me feel uncomfortable, to some extent... I want to make the perfect decision. I want to buy the perfect house... I think, for me, that is my problem. I don't think it's society or other people. I think the issue is more the pressure I put on myself. I don't think it stems from anybody else except me. I've always said, when I was working at things I write, I would say things like: "I think I'm aware sometimes that I put pressure on myself, and then I'm my worst enemy.". Because I'm literally just the one who hammers on, and wants me to be this thing."*

Decisions and decision-making are done with self-doubt and distrust. Self-imposed pressure is inflicted constantly and intensely, as there is no room for making errors or wrong decisions. By pressuring oneself constantly, one believes that perfect decisions are more likely, which relieves the pressure of not making mistakes.

## **7. Perfectionism and the need to control**

*“I’ve gotten to a point where I’ve – as much as I want to see beyond – I think I’m very rigid when it comes to me. Really limited in my thinking, and how I feel, and how I do things... I think it’s that control. Not necessarily of things outside, but I think maybe the world scares me. And then I’m the only thing that I think I can control.”*

Exerting excessive control is a way of dealing with the fear and anxiety one has about the world. Changing those thoughts and behaviours surrounding control is thus difficult, as it serves an important purpose in one’s life.

## **8. Perfectionism in the recovery process**

*“Looking at what has been happening, I think now I am more aware of that. That’s the standards. Even if they might still, sort of, want to come back, then I, sort of, talk myself out of it... I’m more aware of it even today the lady at work said something which previously would have just gotten me. Shame, she’s just an old woman, one of the cleaners where we work. She was saying something about my face being fuller, or whatever. But shame, I don’t think she meant any harm. But previously it would have set the alarm bells going... Usually I would then ask her” “But how does my body look?”. Or something, you know? It would carry on to other things. Yes, but, or then I’ll try to come up with the reasons, you know? It will be a whole conversation about nothing.”*

Receiving treatment can be difficult, as the intervention process highlights or confirms problems that one struggles with, but might not want to acknowledge.

Increased self-awareness of one's self-imposed strict standards of living is an integral part of starting to address, confront and challenge these thought patterns. Awareness of one's perfectionist thoughts and how one imposes strict standards of living on oneself, helps in one confronting such thought patterns. This encourages a more positive outlook on oneself. Releasing oneself from one's own self-induced pressure and high standards of living is part of the recovery process. Ending the striving for perfection, one becomes more loving of the self and improves the relationship with the self.

Self-appreciation and reducing the self-imposed pressure one has been putting on oneself is necessary for the recovery process. It is a learning curve, which takes time to incorporate into one's life. Confronting one's own self-criticism brings about feelings of relief and a more positive attitude towards oneself. Usually there would be strong and intense self-imposed responses when one feels one has neglected something important. However, positive- and supportive self-talk helps one to resist these urges to compensate for failures, mistakes, or things one feels one has neglected.

Dealing with incoming stressors and triggers is important in eating disorder recovery. Relaxing one's standards and not creating false illusions for oneself helps in dealing with triggers. Accepting positive remarks and information from others is difficult, as they might conflict with one's strongly held personal negative beliefs. Learning to truly consider these pieces of feedback from others is important. Triggers can set off an emotional reaction that can ruin the rest of one's day. However, being able to

logically debate over things that were usually anxiety provoking, helps one gain better perspective on these triggers.

### **9. Perfectionism and the link to food, weight and shape**

*“I’m sensitive around my weight. Because I’m struggling with it. So, it’s not nice when someone points it out... I’m struggling with the perception of my weight. So I don’t like people telling me I’m fat. Especially people who I don’t know. Not many people know actually what it is I’m going through... The minute I perceive myself as being big, I’m uncomfortable. And when someone points it out, I struggle to – you know, I’m able to brush other things off – but that I struggle to brush off. I really do.”*

One remains sensitive about one’s shape and weight during an ED. One’s own perception of one’s shape and weight is fragile, and one may feel defenceless against others’ comments and judgements about one’s body.

### **10. Perfectionism versus happiness and a normal life**

*“I’m always on my toes... I think I’ve always felt I need to prove myself. Because I’m seen as too young, you know? I’ve always been seen as young. They wanted to take me back, because I was two years younger than everybody [at school]. Every year they wanted to take me back. They had this thing that they must hold me behind to see if I am coping... I think I’ve always had to constantly prove myself, for whatever reason. And unfortunately, or fortunately I don’t know, they had the feeling, or people felt that my mom was helping me with my psychology work. Then again, I had to prove myself that I am actually - have something to offer. So it’s been like that until I actually graduated. One lady said to me, when they had a spontaneous case study, she actually verbalised that, you know. She*

*took it seriously, because it was felt that mom took over for me. So yes, it's always been that I've had to prove myself. So, I've never actually been comfortable in myself because of that."*

There is an underlying constant urge to prove to others that one is good enough. Because of one's efforts to portray to others that one is competent enough, one's internal response is a personal battle to be comfortable and at peace with oneself. Putting others' interests and needs ahead of one's own forms the foundation for becoming hyper-sensitive towards others' opinions, rather than focusing on one's own happiness. Intense and constant effort is then invested in constantly pleasing others, or meeting their expectations and needs first. In the long-run, this contributes to the development of depression and a negative outlook on one's own life.

### **5.5 A general structural description of the phenomenon of perfectionism in treatment resistant eating disorder clients**

During the process of phenomenological research, beginning from the description of the phenomenon of perfectionism of the individuals' experiences, exploration of such descriptions may yield the general structure underlying such experiences. From the experiential descriptions of multiple participants, the researcher may discern the essence of an experience.

In this section, all the individual experiential descriptions of the participants were utilised to arrive at one conclusive general experiential description. A summary of the general experience of perfectionism within treatment resistant eating disorder clients is presented in Table 5.2.

**Table 5.2: Summary of the experience of perfectionism within treatment resistant eating disorder clients**

<b>The experience of perfectionism</b>	<b>Eating disorders clients</b>
<b>Emotions</b>	
➤ Perfectionism and the link to anger	Jane
➤ Perfectionism and the link to anxiety	Cathy, Rochelle
<b>Goals and decisions</b>	
➤ Achieving goals perfectly	Cathy, Rochelle, Pamela, Lara
➤ Perfectionism provides structure and rules by which to live	Jane
➤ Making personal decisions whilst trying to be perfect	Tracy, Jane
<b>Thought processes and beliefs</b>	
➤ Perfectionism and the need to control	Rochelle, Tracy, Jane, Lara
➤ Perfectionism and the link to food, weight and shape	Cathy, Rochelle, Tracy, Pamela, Lara
➤ Black-and-white thinking	Jane
➤ The obsession of being perfect	Rochelle, Tracy, Jane
<b>Judgement</b>	
➤ Evaluating one's body by perfectionist standards	Cathy, Rochelle, Tracy, Pamela, Lara
➤ How one judges oneself and one's own performance	Rochelle, Tracy, Lara
<b>The Self</b>	
➤ Perfectionism and the link to low self-esteem and low self-worth	Cathy, Rochelle, Pamela, Lara
➤ Perfectionism and the link to the self (i.e. self-acceptance)	Cathy, Rochelle, Tracy, Pamela, Lara
➤ Perfectionism versus happiness and a normal life	Tracy, Jane
<b>Relationships</b>	
➤ Perfectionism and how it influences one's relationships	Rochelle, Tracy, Jane, Pamela
➤ Perfectionism and the love one receive from others	Jane, Pamela, Lara
➤ Comparing oneself to others	Rochelle, Pamela, Lara
➤ Portraying the perfect person to others	Rochelle, Lara
<b>Behaviours and habits</b>	
➤ Perfectionism and the link to exercise	Cathy, Lara
➤ Perfectionist principles of 'health-conscious' living	Cathy
<b>Social and environmental influences</b>	
➤ External environmental influences	Rochelle
➤ Society's perfectionist views on women, beauty and sexiness	Cathy, Rochelle
<b>Recovery</b>	
➤ Perfectionism in the recovery process	Rochelle, Tracy, Jane, Pamela, Lara

The experience of perfectionism in treatment resistant eating disorder clients consists of nine aspects, namely *Emotions*, *Goals and decisions*, *Thought processes and beliefs*, *Judgement*, *The Self*, *Relationships*, *Behaviours and habits*, *Social and environmental influences*, and *Recovery*. These nine aspects of the general experiential description of perfectionism will now be presented.

### **5.5.1 Emotions**

Jane, Cathy, and Rochelle experience a link between their perfectionistic thinking and their emotions. The two central emotions identified are anger and anxiety.

Cathy and Rochelle's perfectionism serves to help them deal with anxiety. Anxiety is an intense part of the experience of an eating disorder. They become anxious about how others perceive them, or not being able to deal with the pressures of life. They fear not being able to achieve what's expected from them by themselves, or others in life.

The anxiety is intrusive, and finding mechanisms to deal with it is important. In this regard, their rigid self-imposed structures help in reducing their anxiety, by providing them with a sense of being able to exert control over their lives through rules and structures, which contributes to feelings of 'being in control'. This feeling of being in control helps them deal with most anxiety they experience - it serves as a coping mechanism.

In Jane's case, perfectionistic thinking serves to create anger towards the self. Her anger responds to things that happen during the eating disorder or during her daily life. It is particularly present in situations where Jane wants to let go of control and just relax. In everyday life, there are times when her strongly held beliefs should be able to give leeway to specifics in the situation. However, she struggles to give herself any grace as she becomes angry, because of the rigidity of those beliefs and in her inability to 'let things go', and not be so strict on herself.

### 5.5.2 Goals and decisions

For Cathy, Rochelle, Pamela, Lara, Jane, and Tracy perfectionism influences the goals they choose to *aim* for, and to which *degree* they hope to achieve them. These goals are not merely for goals of weight or diet within their eating disorder, but pertain to life in general. These goals appear to be more intrinsic in nature, rather than imposed from significant others.

Cathy, Rochelle, Pamela, and Lara all describe how they attempt to achieve goals to a perfect degree. The predominant force behind this self-imposed drive to achieve perfectly is the experience of conflict with the self. Achieving such high goals comes at an immense personal cost. But even though this personal sacrifice is high, they experience the reward as immensely satisfying. The closer they come to achieving their goals, the less anxious and nervous they are about themselves and their lives. They also experience doubt that if they do not strive to achieve their goals perfectly, they would be unsuccessful in maintaining such goals in the long-run, after having worked so hard to achieve them in the first place. Without the immense drive that accompanies their perfectionism, thoughts and behaviours are not consistent and can easily be influenced by mood or circumstances. This, in turn, causes further problems in their view of self, as they start to distrust themselves by believing that they cannot set goals or maintain them successfully.

Putting themselves down and self-abuses are mechanisms by which Cathy, Rochelle, Pamela, and Lara attempt and achieve goals in life, or try to become better. A combination of harsh self-criticism and wanting to do things perfectly are the motivations that enable them to set immensely high standards and achieve

goals. Negative feedback and self-abusive comments drive them to perform better in life, as such negative criticisms force them to work harder at improving themselves. Negative self-talk in the form of excessive self-criticism helps initiate and maintain stringent high standards, or to avoid thinking about themselves (because they perceive themselves as ugly), or to punish themselves for not keeping to their own stringent standards. It also helps them avoid giving in to food cravings, which ultimately results in weight loss and obtaining the level of beautiful. This, in turn, helps with their negativity they have towards themselves, and it makes them feel good about themselves.

For Jane, trying to live without making errors is difficult, and dealing with the emotions that accompany such mistakes tough. Analysing the error of her ways, or correcting her behaviours, is difficult because she cannot deal with the intense negative emotional reactions to making mistakes. Making even one mistake can cause her to engage in compensatory behaviours. She experiences making a mistake as a failure and a reflection of her own weakness. She believes that either one does something perfectly, or it proves one has no self-control at all.

In Jane, strict rules are formed from strongly held personal beliefs. Adhering to these rules is essential, and they are an integral part of living with an ED. Moving beyond the structure that these rules and boundaries create is anxiety provoking - so anxiety provoking that she does not attempt recovering from the eating disorder. The experience of adhering to this structure as perfectly as possible gives her a feeling of safety. The strict structure helps her cope with anxiety, and makes her feel she has

purpose. She uses weight fluctuations as indicators for whether she has successfully adhered to the strict rules and achieved the goals set by the eating disorder.

Tracy and Jane make decisions from a position of self-doubt and self-distrust. They impose a lot of constant and intense pressure on themselves, and believe there's no room for making errors or wrong decisions. By pressuring themselves constantly, they believe that perfect decisions are more likely, which relieves the threat of possibly making mistakes.

Tracy and Jane also use strict rules and high standards as guiding principles when having to make choices, instead of following their own intuition, wisdom and knowledge. They do not trust making decisions through intuition and personal preferences, as they do not trust their own judgement. They are easily confused when having to make a personal choice, because they rather establish what the *correct* answer is, instead of establishing '*what do I prefer?*', or '*what do I want?*'.

### **5.5.3 Thought processes and beliefs**

Striving for perfectionism is not only on the physical level, but encapsulates all aspects of life, to the core of one's being. The self-imposed pressure and self-ridicule is intense and constant. It brings negativity into one's existence and influences thoughts and feelings. Even if one is aware of it and knows that one needs to change its influence in one's life, it's difficult because it's become a habit which happens without one wanting it - it happens almost automatically.

Achieving perfection is always an evolving process. One can always go further, higher and do more in your efforts - enough is never enough. On the physical level, life is about being thin and slim. It's all that matters in life. If one is thin, then one can cope with all other problems, and one's whole life changes for the better. Strong thoughts and beliefs about the body's shape and weight guide thinking and decision-making processes. These thoughts impact how one views one's body, what one wears and ultimately how satisfied one is with oneself. One admires those who can starve themselves and avoid food at will. Stringent self-control in the form of avoiding food is laudable, and seen as a positive because of the vast amount of weight lost.

Rochelle, Tracy, Jane and Lara experience a feeling of self-discipline by maintain control over their food through strict dieting. Maintaining control over food choices is critically important for them. They believe that losing control results in chaos. In short, their thinking leads them to believe that living without an eating disorder results in a chaotic life, being lazy and being unproductive.

The obsessions over food and energy intake can dominate thoughts, affect feelings negatively, and influence behaviours. It is emotionally exhausting to live this way. It is a love-hate relationship with food. On the one hand, food is loved and used as a crutch to help one through life's difficulties. On the other hand, food is hated and one wants to rid oneself of it. Self-acceptance is difficult because of this love-hate relationship with food. Confronting and overcoming these obsessive thoughts may feel almost impossible.

For Cathy, Rochelle, Tracy, Pamela and Lara weight loss is the mechanism to becoming happy in life. The experience of achieving a thin, ideal weight and shape results in self-acceptance and happiness. It is something they strongly believe society expects of a them as women. Thus, losing weight is a powerful mechanism to feel better about oneself, to feel more accepted by others, and to feel more in control of one's world. Self-confidence and feelings of sexiness are in direct proportion to weight loss: As weigh loss is achieved, self-confidence and feelings of sexiness increases significantly, to the extent of almost feeling like a different person. The opposite is true for weight gain, resulting in feeling like a failure and low self-worth.

For Jane, weight is a core factor in judging her level of success in life. How she experiences her weight has a direct bearing on the thoughts and beliefs she has about herself and her life. Weight fluctuations have the potential to impact how she feels about herself, her life and self-worth. She experiences her shape and weight as a constant battle, as she struggles to accept it. Even if she tries to reduce her beliefs in the importance of weight in life, or ignore her concerns over appearance, her concerns return quickly. Her experience of being thin makes her feel confident, competent, purposeful and worthy in life. Her experience of being fat makes her feel like a useless failure. The uglier she perceives herself to be, the harder it is to become motivated about her self-respect and recovery. She experiences simple tasks like getting dressed in the morning as a reminder of how ugly she perceives herself to be. These feelings make her feel more distressed and despondent, as she wants to feel beautiful. By putting herself under the microscope constantly, she notices perceived imperfections. This makes her feel more and more worthless and

adds to losing more perspective about who she is. In this regard, she rather focuses on her own imperfections than understanding her own uniqueness.

Weight loss is a constant goal for Rochelle, Tracy, and Jane. Weight is always on their mind - including the fear of weight gain. The drive to lose weight is very intense, more than the normal person experiences. Almost every thought about food is geared towards weight loss. They easily sacrifice themselves in the name of pursuing the need and want to lose weight. Even if they know weight loss is to their own detriment, they still easily pursue it. A good day is experienced when they adhere to their own strict diet, and do not engage in negative or abusive self-talk. A bad day is experienced when they lose control over their food or weight, and they engage in abusive self-talk. Even though weight loss brings about moments of happiness, they are not lasting at all as the anxiety of weight gain persists. With weight gain, thoughts of disappointment and failure preside. This negatively affects their self-confidence and feelings of sexiness.

#### **5.5.4 Judgement**

For Cathy, Rochelle, Tracy, Pamela, and Lara, experiencing themselves as beautiful is a priority when evaluating themselves. Being thin means achieving beauty and being beautiful; and in terms of shape and weight, it is the main aspect by which they judge self-worth. When they see themselves as beautiful, they believe they will be happy, successful and confident in life.

Overall, one's self-judgement is harsh and critical. The self-judgement is based strongly on interpretation of looks (body shape and weight), and how one judges

one's own performance in life. When living by stringent standards of achievement, the judgement of one's own body and others' bodies can be harsh. If these standards are not met, it means one has little self-control and not being good enough. Self-ridicule and harsh self-judgement contributes to one becoming more disengaged from oneself. This, in turn, contributes to not understanding one's own emotions, or not being able to support oneself through difficult periods.

Rochelle, Tracy and Lara struggle to judge their own performance accurately, or recognise good achievement. They do not experience it as a natural process in themselves. They judge their own achievements as quite average, not exceptional. Giving personal credit where credit is due, is experienced as a selfish and narcissistic thing to do. Breaking oneself down or constantly belittling one's own achievements is experienced as something that must take place, otherwise one is indeed selfish or narcissistic.

Cathy, Rochelle, Tracy, Pamela, and Lara experience their happiness as strongly dependent on being able to accept their own physical appearance. Being convinced they are overweight encourages negative self-talk, and they continually convince themselves that weight loss will bring about self-acceptance and happiness. Especially with weight gain, this impacts self-acceptance and happiness. They judge themselves harshly and interpret any perceived flaws in their bodies negatively, encouraging self-hatred as they feel only looking perfect is good enough. Self-hatred is continuously reinforced by negative judgements of perceived bodily flaws.

Rochelle, Tracy and Lara have clear ideas and standards of what they expect themselves to achieve in their eating patterns. Achieving stringent dietary goals make them more confident and feel positive about themselves. If one judges one's eating to be in line with dietary goals and what one believes are 'healthy eating habits', then one concludes that one has strong willpower, and one feels in control. If one judges that one has not been eating healthily, then one engages in self-ridicule and harsh self-judgement, and one feels like a failure. One feels deserving of the negative consequences of weight gain, as one concludes one has poor willpower.

Judging oneself is also dependant on measuring one's body. If measurements indicate that there is weight gain, distress and negativity results (and vice versa). Weight gain is avoided at all costs, even if the cost of weight gain can cause serious long-term health effects. Care for the body and its health is not a priority. It is better to live with any possible negative health effects, than having to live with weight gain (associated with becoming more physically healthy during recovery). Noticing weight gain and changes in the body results in harsh self-criticism. In turn, an extremely negative opinion about oneself results, fostering the belief that one cannot change one's future for the better.

Situations where one is exposed to body measurements are endured with apprehension or discomfort. Also, wearing certain types of clothing is risky, as it shows revealing parts of the body. Seeing personal photos has the potential to confirm one's fears of how one looks in an outfit, or can sometimes calm your anxieties about it (when you look good to yourself). How one looks to oneself in clothing may influence mood and experience within a given situation. When

comparing oneself to others, one may feel strongly inadequate to them. Situations like the afore-mentioned have the potential to make one aware of one's own bodily flaws. One may have a specific ideal of how one should look, and when bodily flaws are noticed you repulse yourself - criticising them at length. Even small differences between one's perception of one's ideal body and what is perceived, is not acceptable. In this regard, one may avoid your body to not have to deal with the discontent towards your body.

When having to deal with stressors, there is a danger of judging oneself as a failure when one cannot find solutions to problems. Experiencing stress and dealing with it in an appropriate manner is made cumbersome by perfectionistic tendencies. Even though attempts are made to motivate oneself to do the right thing, making mistakes are very hard to deal with. Self-talk is extremely negative, which encourages the further breakdown of oneself emotionally and fosters a negative self-esteem. The pressure experienced from perfectionism is self-inflicted and does not aid in dealing with stress more efficiently. In fact, it hinders it.

#### **5.5.5 The Self**

In Cathy, Rochelle, Pamela, and Lara the experiences of perfectionism has strong links to their experiences of low self-esteem and low self-worth. Being self-defeating and overly self-critical develop from this poor self-esteem, and to improve upon this low self-esteem, constant attempts are made to achieve their own illogical ideals.

Cathy, Rochelle, Tracy, Pamela and Lara's perfectionistic thinking predominantly focus on what they *lack* in their self, instead of recognising who they already *are* as

individuals. Instead of appreciating of who they are, they question why they are the way they are. Being unhappy with they are leads to constant questioning and self-criticism. They personify all problems, blaming themselves why things in life are not good enough, or that their bodies are not good enough. They can foster their own mental abuse towards the self for a long period. This battle with the self is self-inflicted, which deters inner peace and self-acceptance.

They experience differing standards in how they approach themselves and others. In one's perfectionism one is much harder on oneself than others, and one does not regard one's feelings as much. Others' feelings and problems are much easier, and valued more than one's own. Opinions of oneself is mostly negative. One does not necessarily even like oneself and can be quite disconnected from the self. Personal judgement is of a very strict, harsh and constant standard. Even if one is aware of it and there is no reason to be hard on oneself, one still is. Changing this is difficult, because this method of judging oneself is so pronounced and long-standing in one's life. Despite achievements and achieving throughout life, or being surrounded by positive things, self-evaluation and self-worth remains deficient.

Cathy, Rochelle, Tracy, Pamela and Lara's struggle to accept their self, results in an inner negativity which is constant and persistent. In trying to resolve this, constant attempts are made to try achieving goals. Self-acceptance is thus experienced as something to be *worked for*. It must be *earned* by proving to oneself that one is good enough. This is done through achieving high goals and maintaining stringent standards of living.

Achievement is a mechanism to feel better about oneself, or to temporarily resolve the inner negativity. Despite the personal issues one has with oneself, portraying confidence and competence to others is important. Even if one feels insecure or makes mistakes, it's best not to let others notice this 'real insecure' person. Great amounts of energy are invested into portraying a person who is strong, confident, competent and stable. There is constant worry that others might see the 'real you', instead of the 'confident you'. Based on this, even when one is going through the most difficult of personal times, one does not necessarily communicate this to one's loved ones. At times, one feels fake as one attempts to portray confidence and competence to the external world, whilst constantly feeling inadequate, or not being able to cope with pressure. Even though one might continuously and successfully perform to stringent standards, or achieve difficult goals, self-competence is questioned when struggling with simple things, like eating food or maintaining a certain weight. The attitude of criticism towards the self is relentless, intense and overwhelming.

Recognising one's own uniqueness is difficult. One focusses more on the external world and how one presents to it. There is a constant urge to want to prove to others that one is good enough. When one weighs little, then one sees oneself to be recognisable through others' opinions, as well as one's own. However, if one is failing with personal weight goals, this may contribute towards feelings of lacking anything of value, or not being appreciated by others. In response to low self-value, one may be fake to others, portraying oneself in a more positive light than what one feels. Because of extreme efforts to portray to others that one is competent and worthy enough, one's internal response is a clash to become accepting of oneself.

Putting others' interests and needs ahead of one's own creates sensitivity towards others' opinions of one, rather than focusing on one's own happiness. Intense and steady effort is then invested in constantly pleasing others, or meeting their expectations and needs foremost.

Negativity is constant and influences how one views oneself and the world. A negative self-esteem is something that develops over a long period and may become deeply entrenched. The fear of failure is also engrained as one constantly worries about how others judge one. This encourages the feeling that everyone is better than one, and that one is not as worthy as the others.

For Tracy and Jane, negative thoughts about the self are easily triggered, especially when noticing perceived defects in their bodies. When such thoughts are triggered, one becomes pre-occupied with them, possibly exacerbating the problem. Because of this strong negative view of self, it is difficult to recognise the person others see in you. This self-negativity influences one to restrict oneself of positive things, essentially punishing oneself constantly. One controls oneself in all the positive areas in life, not allowing any privileges. However, one does not limit the negatives, as they are used to constantly punish oneself, because one feels deserving of them.

Repeatedly engaging in eating disorder behaviours like bingeing and purging keeps one from developing self-acceptance. One holds oneself accountable because one keeps breaking one's own strict rules and regulations surrounding food and weight. Excessive self-criticism, self-pitying and avoidance all contribute to one not actively

and constructively dealing with these problems. This contributes to one feeling negative about oneself and struggling with self-acceptance.

### **5.5.6 Relationships**

Rochelle, Tracey, Jane and Pamela experience their strict rules and regulations over food impacting their relationships negatively. This adds pressure in terms of having to choose which is higher priority, as the needs of relationships may clash at times with the stringent boundaries set by an eating disorder. Others may not even be aware of the strict rules' effects in one's life. Portraying to others the real degree to which an eating disorder consumes one is difficult, and not something necessarily done.

Approval from others remains an important element in life. One may seek approval in one's choices from those who are close to you, as their approval of one's choices and behaviours is imperative. Their feelings, such as happiness, pain and sorrow are a priority - more so than one's own. Recognising one's own worth is difficult if one is not constantly pleasing others.

Jane, Pamela, and Lara experience attention received from others as only deserving when maintaining stringent standards of living through achievements and perfection. Earning the respect and admiration from others, or even their concern in times when help is needed, is only justified in the most extreme forms. Even receiving positive feedback and compliments from others is difficult, and can make one feel uncomfortable as one may feel undeserving of them. Only perfection or severe illness permits one to receive attention, support and love from others.

Eating disorder sufferers live by double standards. They easily compliment others and accept them as they are. However, accepting themselves or receiving compliments from others is not allowed. Breaking themselves down is a constant and engrained cycle. To free themselves from this cycle is difficult, and their negative opinions they have about themselves clash with the positive opinions that others may, at times, voice about them. Even though they want to believe what others say, their negative beliefs are deeply engrained. These negative beliefs about themselves can affect their relationships negatively.

A perfectionist approach to one's body adds to personal insecurities and affects intimate relationships. One believes that losing weight and reaching one's ideal qualifies one to receive love and attention from one's lover. One may even question the relationship at times, as one struggles to understand what that person sees in one, or whether they find one physically attractive.

Rochelle, Pamela and Lara constantly measure themselves to others and conclude they lack in worth. Comparisons can be made with almost everyone - siblings, colleagues, friends, etc. The experience of comparing oneself to others focusses on aspects of beauty which are used as a gauge to judge a person's worth. Most comparisons result in one feeling unworthy to others. Abusive and harsh self-judgements can then be the result. Struggling to identify good in oneself, as well as feeling unworthy of others results in negativity, and questioning why people would want to have relations with one.

Avoiding one's body is a mechanism to deal with the discontent towards one's body. It is easier not to think about one's body. However, people's comments about one's body can remind one once again of how much one disapproves of it. Comments from others cannot be avoided - whether gaining or losing weight. The sensitivity to how other people perceive oneself remains. It feels uncomfortable if one feels one's body is different than the norms of society, and one might even tell lies just to get those people off one's case.

### **5.5.7 Behaviours and habits**

Engaging in strict dieting and restricting food intake adds to the burden of one's emotional world. This burden is constant and intense while living with the eating disorder. For Cathy and Lara, food intake, adhering to strict dieting principles and maintaining a specific weight have direct influence on self-evaluation. This self-evaluation affects the input one invests into choices, actions, behaviours and habits in one's life.

Living self-disciplined in behaviours and habits is important. One continuously strives to aim for, and maintain, habits of healthy living to an excessive degree, as self-discipline reflects self-worth and competence. Even when facing potential serious negative consequences, one does not forsake these habits. Adhering to strict rules of diet and food intake remains a priority, and must be adhered to at all costs. One dare not go against them, otherwise one deserves punishment (for example, not allowing eating or pursuing excessive exercise). Punishment is a usual consequence of making mistakes, or helps in the attempts to maintain stringent standards of living.

All-or-nothing thinking influences one's behaviour towards eating, and the attitude fostered towards oneself. To be 'good' is to adhere to strict rules and be disciplined, and results in an experience of feeling normal and good about oneself. To be 'bad' is when one does not act in accordance to rules and discipline, and results in an experience of self-judgement and impacting self-esteem.

Noticing weight changes or signs of ageing in one's body is difficult to accept. Engaging in excessive exercise is a mechanism to deal with such emotions. Exercise is only satisfying when one's body is pushed to an intensity where stiffness and discomfort is felt afterwards. Exercise is not necessarily something inherently enjoyed; it is something done to push oneself. When *pushing* oneself to the extreme of exercising, it is felt to be compensating for one's body's imperfections, or 'correcting' one's flaws.

### **5.5.8 Societal- and environmental influences**

Being accepted by others is based mostly on how one looks. There exists immense pressure from external influences to obtain a level of physical beauty, otherwise people will reject one. Society's definition of 'beauty' consistently evolves into more stringent and more specific standards of achieving the perfect outward appearance. Happiness and overall quality of life are mostly dependent on achieving these standards.

Cathy and Rochelle experience society at large as being very harsh on women. Society defines standards which they need to achieve, otherwise they are viewed as 'not good enough'. Society judges them on how they look and how successful they

are perceived to be – only these things are important. The importance of their body's shape and being sexy and desirable is more than all other qualities in life.

Slim people are idealised, and one's desire to look slim is strong. The pressure experienced from the external environment can influence one to become more focused on one's appearance. However, if one feels one is not slim, social settings are difficult as one may feel insecure.

### **5.5.9 Recovery**

Rochelle, Tracy, Jane, Pamela and Lara all experience perfectionism impacting their recovery process. Receiving treatment can be difficult, as the intervention process highlights or confirms problems one struggles with, but might not want to acknowledge. Gaining insight on how one prefers self-abuse affects how the self is perceived, as one might come to understand how negative one is. As the level of inner drive for perfection subsides, there is an experience of overall improvement in subjective feelings towards the self, as well as behavioural habits. At this point, one can also become more in touch with oneself and how one feels. When this way of thinking realises itself, priority is given to who one *is*, instead of one's *perceived shortcomings*.

The ability to start challenging self-critical and negative thinking patterns is difficult to develop, but enlightening and liberating when introduced. It encourages self-acceptance, allowing freedom to be who one is, instead of always questioning who one is not.

Increased self-awareness of self-imposed stringent standards of living is an integral part of addressing and challenging an eating disorder. Awareness of perfectionist beliefs, and how they impose strict standards of living upon one, helps in confronting such thoughts. It is a learning curve which takes time to incorporate into one's life. Confronting one's own criticism and releasing oneself from self-induced pressure and high standards is part of the recovery process. Usually there are strong and intense self-imposed responses when feeling something important has been neglected. However, positive- and supportive self-talk helps in resisting the urges to compensate for failures, mistakes, or things one feels have been neglected. In terminating the strive for perfectionism, a more positive outlook is encouraged. One inevitably starts improving the relationship with the self, becoming more accepting and loving of oneself.

When one fails at one's weight goals, or fails to adhere to strict dietary standards, harsh self-ridicule and self-judgement results. These break oneself down with negative thoughts one feels one deserves. However, when one manages to free oneself from this harsh criticism, one can apply one's mind to self-analyses. During the recovery process, even though setting realistic dietary goals is difficult, one must let go of being extremely strict with certain foods, whilst not trying to avoid others. This is a daunting experience, as becoming relaxed with certain foods allows eating them at will, which means there is a possibility of overeating or bingeing. Even so, by relaxing one's stringent standards of living and food choices, one ultimately releases oneself from the emotional pressure one places oneself under constantly. When the excessive focus on food diminishes, a better perspective of oneself develops. This

helps one deal better with weight gain, if any. This perspective also helps one to criticise or ridicule oneself less, and appreciate all the other areas of one's life.

Placing focus on oneself in the healing process is confusing and difficult at times. This requires that one prioritises one's own needs and wants. Even if one understands the need and importance to do so, one still struggles to implement it. Placing others first (or valuing their opinions more) has been an engrained way of life, and changing this is difficult. Accepting positive remarks and feedback from others is hard as they might conflict with one's strongly held negative personal beliefs. Learning to truly consider positive feedback from others is important for the recovery process.

During the healing process an intense drive to want to achieve and maintain extreme standards of health and beauty relaxes. One becomes more at ease with one's body's flaws and that others will comment on these flaws. One replaces self-criticism with self-kindness - which is difficult as the self-criticism has been part of one's thought patterns for a long time. In finding a new perspective beyond that of materialism, one recognises that self-worth is based on more than outward appearances. One comes to appreciate who one is holistically, instead of always focusing on trying to be perfect (which one is not), or compensating for what one perceives to lack in life. Recognising self-worth from multiple perspectives (i.e. physical, emotional and spiritual) influences one's motivation and excitement about life positively.

When inner drive for perfect choices subsides, so one's ability to negotiate food choices becomes more mature and realistic and less emotional. This also helps when having to deal with making mistakes regarding choices and being obsessed about such mistakes. During illness, one battles with this dichotomy as one constantly strives to be 'good'. Maintaining high standards of living makes one feel good about oneself. These include proper eating and good exercise, as well as no bingeing or purging behaviours. When the standards are not maintained, it makes one feel worse. However, recovery is only made possible when both aspects can be incorporated into thinking and behaviour (i.e. good and bad) and harmony found when making mistakes with eating.

Focusing on being perfect inhibits one to get to know oneself in the truest form. Knowing oneself does not happen by knowing how one must satisfy others, but rather coming to understand how one experiences oneself, even as others may experience one. Peace is found by accepting and liking oneself and not questioning who and what you are. Inner peace and self-acceptance results in more personal happiness and enjoying life to the fullest.

This chapter presented the data findings after the phenomenological analysis for each individual participant, and ended with a general structural description of the phenomenon of perfectionism in treatment resistant eating disorder clients. In Chapter 6, the findings per the grounded theory analysis will be presented.

## CHAPTER 6

### PRESENTATION OF THE FINDINGS ACCORDING TO THE GROUNDED THEORY ANALYSIS

*“Somehow, we have lost the human and passionate elements of research. Becoming immersed in a study requires passion: Passion for people, passion for communication, and passion for understanding people...the individual is not only inserted into the study, the individual is the backbone of the study.”*

Valerie Janesick

(1994, p.217)

#### 6.1 Introduction

The grounded theory (GT) method allows for identifications of links between variables and themes, to arrive at new ideas and theories regarding the research topic. This chapter portrays the findings of the GT analysis of the participants' interviews during their therapy process.

The GT analysis indicated a connection between perfectionism and the participants' eating disorders. This connection became clear when six core themes emerged:

1. The Self
2. Critical Judgement
3. The Ideal: Self-Perfection
4. Extreme Achievement
5. Pathological Drive

## 6. Recovery

These core themes are presented in Table 6.1.

**Table 6.1: The six core themes for perfectionism in treatment resistant eating disorder clients, with their corresponding categories, subcategories, and sub-subcategories**

<b>1. The Self</b>		
What I think about me.	Low self-esteem.	<ul style="list-style-type: none"> <li>• Low worth.</li> <li>• I'm fat, unattractive.</li> <li>• Not worthy anything (despite all my blessings and achievements).</li> <li>• Don't feel good enough for myself or for the world.</li> <li>• Avoidance of self.</li> </ul>
	Negativity.	<ul style="list-style-type: none"> <li>• Self-hate.</li> <li>• Mistakes make me become negative.</li> <li>• Food/Weight/Body/Shape (noticing changes and fluctuations; or even ageing).</li> <li>• Difficult to become motivated about myself, or to improve on myself.</li> </ul>
	How I view myself.	<ul style="list-style-type: none"> <li>• Do not like to focus on myself =&gt; rather focus on the world (Perception and Ideal).</li> <li>• Do not feel worthy.</li> <li>• Look down upon myself.</li> <li>• I should be further, or more in control (I should meet a higher expectation of me).</li> <li>• I should be better than what I am now.</li> </ul>
The relationship I have with myself.	Self-hate.	<ul style="list-style-type: none"> <li>• Conflict with the Self continually (endless and extremely draining).</li> <li>• Emotionally detached from my own feelings (pathological drive and extreme achievement are higher priorities than my own feelings).</li> <li>• Never come to love myself (conditional self-acceptance and conditional self-love).</li> <li>• Always put others ahead of myself (others and their priorities are more important than I am).</li> </ul>
	Food/Weight/Body/Shape.	<ul style="list-style-type: none"> <li>• Very sensitive topics in their lives.</li> <li>• Feeds into the eating disorder.</li> <li>• Very specific/rigid expectations.</li> <li>• Negative changes/fluctuations =&gt; severe Negativity.</li> <li>• Ageing process =&gt; Negativity.</li> <li>• Mundane things such as getting dressed.</li> </ul>

		<ul style="list-style-type: none"> <li>Any negative focus on Food/Weight/Body/Shape =&gt; Negativity.</li> </ul>
	Feeling like a failure.	<ul style="list-style-type: none"> <li>Anxiety.</li> <li>Negativity.</li> <li>Criticism.</li> </ul>
What I believe about me and my world.	Beauty equals Happiness.	<ul style="list-style-type: none"> <li>Goal of low weight/lose weight.</li> <li>Being admirable and acceptable to others.</li> <li>Feeling worthy (can look others in the eye).</li> <li>Low weight is the only important thing in life (and thus becoming beautiful).</li> <li>Increased self-confidence.</li> <li>Gives me a purpose.</li> <li>Feel sexy and like a real woman.</li> </ul>
	The need to improve myself.	<ul style="list-style-type: none"> <li>Achievement through intense and unhealthy drive.</li> </ul>
	Strong beliefs about myself and my world.	<ul style="list-style-type: none"> <li>Must not show weakness.</li> <li>My problems are not that big and I must resolve them myself without help.</li> </ul>
	Mistakes.	<ul style="list-style-type: none"> <li>They reflect who I am (i.e. myself).</li> <li>Not acceptable.</li> <li>Feeling like a failure. <ul style="list-style-type: none"> <li>Overindulge/binge.</li> <li>Compensate for it later (vomiting/ exercise =&gt; <i>fix</i> my mistake).</li> </ul> </li> <li>Easily recall failures, easily forget achievements. <ul style="list-style-type: none"> <li>Failures carry much more weight.</li> <li>Achievements carry much less weight.</li> </ul> </li> <li>Mistakes impact severely, causing extreme negativity.</li> <li>Because mistakes are severe, my achievements must be severe as well (extreme; high standards).</li> </ul>
	Rigid (not flexible or adaptable).	<ul style="list-style-type: none"> <li>Things must happen in a certain way.</li> <li>Mistakes are not tolerated.</li> </ul>
	Comparing myself to others.	<ul style="list-style-type: none"> <li>Not worthy.</li> <li>Not good enough.</li> <li>Mostly on the level of Food/Weight/Body/Shape (especially weight and body).</li> <li>My achievements are insignificant compared to others.</li> <li>Double standards =&gt; I invest and help others a lot, but not myself.</li> </ul>
Trust.	Distrust in others and myself.	<ul style="list-style-type: none"> <li>I distrust what others say about me.</li> <li>I distrust anything I feel positive about.</li> </ul>
<b>2. Critical Judgement</b>		
Judgement.	How I judge me.	<ul style="list-style-type: none"> <li>Not good enough.</li> <li>Overly self-critical.</li> <li>Extreme harsh judgement.</li> </ul>

		<ul style="list-style-type: none"> <li>• Self-abuse.</li> </ul>
	How I judge others.	<ul style="list-style-type: none"> <li>• Focus on achievements.</li> <li>• People's worth (strongly based on aspects of Food/Weight/Body/Shape).</li> </ul>
	How others judge me.	<ul style="list-style-type: none"> <li>• I am judged by my worth to others and society.</li> <li>• How I look.</li> <li>• Food/Weight/Body/Shape.</li> </ul>
	Comparison to others.	<ul style="list-style-type: none"> <li>• Others are always better than me.</li> <li>• Based mostly on achievements and Food/Weight/Body/Shape.</li> </ul>
	Mirrors and photos.	<ul style="list-style-type: none"> <li>• How others see me.</li> <li>• Avoidance thereof.</li> <li>• Negativity.</li> </ul>

### 3. The Ideal: Self-Perfection

The Ideal: Self-Perfection	Distorted perception of myself.	<ul style="list-style-type: none"> <li>• My physical attributes and beauty.</li> <li>• Downplay my achievements.</li> <li>• How others perceive me and how I perceive myself is inconsistent.</li> </ul>
	I need to be perceived as...	<ul style="list-style-type: none"> <li>• Competent.</li> <li>• Confident.</li> <li>• Admirable.</li> <li>• Desirable.</li> <li>• Worthy enough for others.</li> <li>• Acceptable.</li> <li>• Lovable.</li> </ul>
	Perceived as good.	<ul style="list-style-type: none"> <li>• Must not show weakness.</li> <li>• Must be able to resolve my own issues without help from others.</li> <li>• Do not want to be seen as selfish or self-involved.</li> <li>• Do not want to be seen as narcissistic or boasting about my achievements.</li> <li>• Do not want to be seen in any other way than the ideal I would like to present.</li> </ul>
	Awareness.	<ul style="list-style-type: none"> <li>• Even being aware of my own perfectionism does not stop it from happening (even if I know I should stop it).</li> </ul>
	How I present to others.	<ul style="list-style-type: none"> <li>• The masks I wear.</li> <li>• Making people think I am something of worth, but in the meantime, I am having major problems with myself.</li> <li>• Must be able to handle my own issues without support or help.</li> </ul>

### 4. Extreme Achievement

Achievement.	Feeling better about me.	<ul style="list-style-type: none"> <li>• Instant gratification to feel better about myself.</li> <li>• Changing myself for the better.</li> <li>• Gain worth (achievement is one of the only mechanisms I can use to gain self-worth).</li> </ul>
--------------	--------------------------	---

		<ul style="list-style-type: none"> <li>• Instant gratification (instantly feel better about myself).</li> <li>• If I have achieved, I may reward myself (e.g. nourishment, slight indulgences, no self-abuse). <ul style="list-style-type: none"> <li>○ Only temporary, or for that day.</li> </ul> </li> <li>• Recognition and affirmation from others of high worth (I deem their opinion important enough).</li> </ul>
	Goals/achievements are extremely important.	<ul style="list-style-type: none"> <li>• They make me a better person.</li> <li>• If I cannot achieve them =&gt; reflection of my poor self =&gt; Negativity; I struggle to become motivated about me and my world.</li> </ul>
	Addictive.	<ul style="list-style-type: none"> <li>• Very strong desire.</li> <li>• I miss it when I cannot achieve goals/achievements (e.g. during pregnancy or illness).</li> </ul>
	Exert control.	<ul style="list-style-type: none"> <li>• Achieving =&gt; feeling in control.</li> <li>• Reflection of self and that I am coping.</li> <li>• Feel strong and in control.</li> </ul>
Goal setting.	Achieving extreme low weight.	<ul style="list-style-type: none"> <li>• Only at extreme low weight will I be good enough for myself and others.</li> <li>• Unhealthy drive to succeed.</li> </ul>
	Extremely difficult goals.	<ul style="list-style-type: none"> <li>• Goals must be extremely tough.</li> <li>• They must be difficult to obtain.</li> <li>• Makes me feel worthy when I obtain difficult goals.</li> </ul>
	Setting high goals.	<ul style="list-style-type: none"> <li>• Dependent on being goal-driven.</li> <li>• I must be a person with aims and goals, constantly, every day, always! <ul style="list-style-type: none"> <li>○ Non-negotiable.</li> <li>○ Doesn't matter what's going on in my life.</li> </ul> </li> <li>• Today's goal is tomorrow's standard.</li> </ul>
	Punishment.	<ul style="list-style-type: none"> <li>• If I neglect myself, or feel I haven't worked on myself in a while =. Punish myself.</li> <li>• Mobilise immediately towards an extreme goal (e.g. running three times per day). <ul style="list-style-type: none"> <li>○ Coupled with intense unhealthy drive.</li> </ul> </li> <li>• Instant gratification (instant improvement of how I view my own worth).</li> </ul>
<b>5. Pathological Drive</b>		
Motivation.	Improve myself and my self-worth.	<ul style="list-style-type: none"> <li>• Pursue goals at all costs.</li> <li>• Reflection of self and self-control.</li> <li>• Achieving will make me a better person and increase my self-worth.</li> </ul>
	Self-abuse/punishment or abuse/criticism from others.	<ul style="list-style-type: none"> <li>• Punishment =&gt; Mechanism to improve myself.</li> <li>• Motivate myself.</li> </ul>
	Exert control.	<ul style="list-style-type: none"> <li>• Feel strong and confident.</li> <li>• Cannot control the world, but only myself.</li> </ul>

		<ul style="list-style-type: none"> <li>• Helps me deal with anxiety.</li> </ul>
Discipline.	Strict structures and rules	<ul style="list-style-type: none"> <li>• Dieting principles.</li> <li>• Disciplined principles of living.</li> <li>• Must be done in a set specific way, to a high/perfect standard. <ul style="list-style-type: none"> <li>◦ Otherwise =&gt; punishment or self-abuse.</li> </ul> </li> <li>• Must always invest extreme effort.</li> <li>• I want structures, discipline and high standards to become habits (permanent part of my life).</li> </ul>
	Being very hard on myself.	<ul style="list-style-type: none"> <li>• Mobilises me to achieve.</li> <li>• I must change because I am not good enough.</li> <li>• Invest extreme effort. <ul style="list-style-type: none"> <li>◦ Achieve quickly.</li> <li>◦ Instant gratification to feel better about myself.</li> </ul> </li> <li>• Constant and long-term (I always do it).</li> </ul>
	Exercising.	<ul style="list-style-type: none"> <li>• I miss it when I can't exercise. <ul style="list-style-type: none"> <li>◦ What will happen to me if I can't achieve anymore?</li> </ul> </li> </ul>
Normal wants and needs.	Normal hunger.	<ul style="list-style-type: none"> <li>• Indicative of lack of self-discipline.</li> <li>• Indicative of lack of self-control.</li> </ul>

## 6. Recovery

Culture of healing.	Self-acceptance.	<ul style="list-style-type: none"> <li>• Self-hate and negativity dissipate.</li> <li>• I can recognise my own beauty more (and the beauty in others).</li> <li>• Love myself more.</li> <li>• Get to know myself and my own inherent worth.</li> <li>• Find surety in who I am.</li> <li>• Appreciate myself.</li> <li>• Negativity =&gt; become better at dealing with Food/Weight/Body/Shape and other triggers and more realistic with fluctuations in these.</li> </ul>
	Judgement.	<ul style="list-style-type: none"> <li>• Not be so critical of myself.</li> <li>• Face those aspects of me which I do not like and start embracing them (i.e. make it part of who I am and love them).</li> <li>• Deal with criticism constructively (still be able to see my own worth even in criticism).</li> </ul>
	Perfection.	<ul style="list-style-type: none"> <li>• Acceptance of myself and my own flaws.</li> <li>• Accept that people are not perfect beings.</li> </ul>
Ceasing perfectionism.	Achievement.	<ul style="list-style-type: none"> <li>• Let go of perfection I constantly strive for.</li> <li>• Perfection should not exist in my goals.</li> <li>• Do not aim for high or perfect goals (i.e. goals that <i>improve</i> me).</li> </ul>
Finding balance.	Pathological drive.	<ul style="list-style-type: none"> <li>• Don't be so hard on myself.</li> <li>• Be kind to myself.</li> <li>• Allow myself to just <i>be</i> (thus, no need to <i>change myself</i>).</li> </ul>

		<ul style="list-style-type: none"> <li>• No unhealthy pressure to perform.</li> <li>• Take my feelings and needs into account when investing into a goal.</li> <li>• Let go of unhealthy inner drive.</li> <li>• Cease seeking extreme low weight.</li> <li>• Cease striving for beauty as the only important aspect to life.</li> </ul>
	Perception.	<ul style="list-style-type: none"> <li>• See myself as others see or recognise me.</li> <li>• Better overall perspective and perception of me.</li> </ul>
	Reset the proper healthy routines and structures.	<ul style="list-style-type: none"> <li>• Eat healthily and balanced.</li> <li>• Exercise within <i>normal healthy levels</i>.</li> <li>• Do not engage in unhealthy drive and high achievement.</li> <li>• Grow/develop other areas of my life (thus, beauty does not remain all-important).</li> <li>• Rigid thoughts and beliefs become more flexible.</li> <li>• Vague guidelines (not strict rules and structures) in my life. <ul style="list-style-type: none"> <li>○ Let go of fixed rules and structures more and more.</li> </ul> </li> </ul>
Recovery.	Difficult to achieve.	<ul style="list-style-type: none"> <li>• Even if I break away from achievement for only two days, I may think I am recovered.</li> </ul>
	Mindset.	<ul style="list-style-type: none"> <li>• Develop a new mindset and not fall back into the old mindset.</li> <li>• Very easy to fall back into the old mindset (especially through focusing on aspects of Food/Weight/Body/Shape).</li> </ul>

After having conducted the GT analysis, the above core themes, categories, subcategories and sub-subcategories were identified from the analysed narratives, interviews and notes. From this analysis, a GT of perfectionism in treatment resistant ED clients emerged, which will now be presented in more detail.

## 6.2. Grounded theory of perfectionism within treatment resistant eating disorder clients

### 6.2.1 The Perfectionistic Eating Disorder Self-Schema (PEDSS)

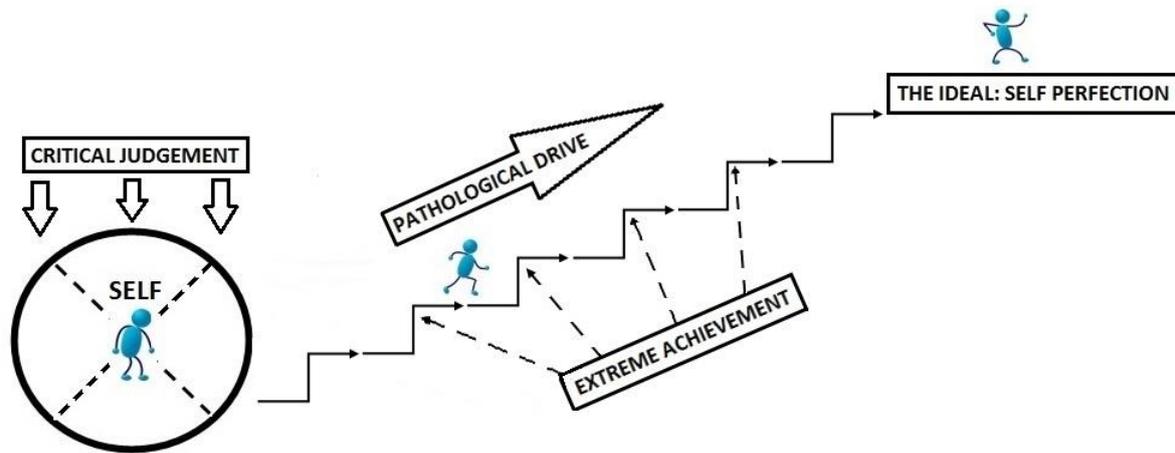


Figure 6.1: The Perfectionistic Eating Disorder Self-Schema (PEDSS)

In forming a theory on perfectionism within the respondents' treatment resistant eating disorders, the following six theoretical core concepts emerged: The Self; Critical Judgement; The Ideal: Self-Perfection; Extreme Achievement; Pathological Drive; Recovery; which will now be explicated.

#### 1. The Self

*The Self* refers to the participant's own being: Their own mental representation of themselves. It refers to all aspects of their own definition of themselves, whether on the physical-, emotional-, or metaphysical level. It is what they would recognise about themselves holistically, when thinking about themselves.

#### 2. Critical Judgement

*Critical Judgement* is defined as the harsh judgement they heap upon themselves and others. This is adhered to when comparing themselves to others, when viewing pictures and photos of themselves, and how they feel others judge them severely. *Critical Judgement* is mostly based upon a person's achievements and

attributes. It attempts to classify a person as per their inherent *worth*, and is based predominantly on how they look and what they have achieved in life. This judgement can, at times, be very self-abusive.

### 3. The Ideal: Self-Perfection

*The Ideal: Self-Perfection* refers to their specific mental representation of *the ideal person who needs to be perfect*. This *ideal* is representative of what that individual believes is the most desirable and coveted characteristics to strive for, as dictated by society's standards and/or their own strongly held personal beliefs.

### 4. Extreme Achievement

Achievement on any level usually brings about positive feelings within an individual. However, regarding the respondents' perfection in treatment resistant eating disorders, *Extreme Achievement* portrays a desire of achievement that is considered pathological. These achievements are extreme because they are potentially unhealthy/harmful, and are usually pursued to the neglect of other important areas of their lives. The intense need for such an extremely high level of achievement is matched only by the *Pathological Drive* that accompanies it.

### 5. Pathological Drive

Perfectionism within treatment resistant ED clients encourages a *Pathological Drive* in the pursuit of *Extreme Achievement*. This intense inner drive encourages them to invest their efforts into goals and achievements that are abnormally high. This drive is abnormal in the sense that the degree of intensity is unhealthy. They still invest intense efforts into their goals even if it comes at great cost (or health risk), or is pursued to the neglect of other important areas of their life. The respondents' *Pathological Drive* is experienced daily. For instance, in a need to achieve an extreme low weight (i.e. *Extreme Achievement*) they are driven to engage in severely restricting their food intake at every opportunity, even if their health is negatively affected.

## 6. Recovery

*Recovery* is the process and state achieved where the person ends the war with the self (described below), and ultimately finds inner peace and holistic acceptance for the self. *Recovery* occurs on each level of the identified core themes: Ending *Critical Judgement*, not pursuing *The Ideal: Self-Perfection*, ending the need for *Extreme Achievement*, adjusting their *Pathological Drive* to within normal levels, as well as developing unconditional acceptance of *Self*.

A schema is defined as a mental structure that consists of a stored domain of knowledge, which interacts with the processing of new information (Williams, Watts, MacLeod, & Mathews, 1997). It is a *mental filter*, which is shaped by previous experiences and which colours subsequent interpretations of new experiences. A schema carries meaning, with its physical, emotional, verbal, visual, acoustic, kinetic, olfactory, tactile and kinaesthetic features, and represents much more than a single belief. It contains information about the self, others and the surrounding world and directs our perception, interpretation and memory. Daily experiences activate schemata, which elicit corresponding feelings and behaviours. While behaviour is observable, cognition is the quality of knowing, which includes perceiving, judging, sensing, reasoning and imaging (Weisenberg, 1994).

The emerging theory from the GT analysis portrays a Self-Schema for the ED clients that is extremely harsh, overly critical and focused on specific elements of achievement. It can also be described as a *war with their selves*. I have named this Self-Schema the Perfectionistic Eating Disorders Self-Schema (PEDSS). The comprising sections that constitute the emerged PEDSS theory include:

1. Perfectionism: The war with the Self
2. Perfectionism: My problem
3. Perfectionism: My solution - Pursuing an Ideal
4. Perfectionism: My plan to become ideal
5. Perfectionism: Pathological drive to achieve an ideal
6. Perfectionism: My result - How my perfectionism and my eating disorder interact
7. Perfectionism: My recovery - Learning to celebrate my Self

Each of these sections will now be discussed regarding each of the core categories identified. This discussion begins with *Perfectionism: The war with the Self*, depicted in Figure 6.2.

### 6.2.2 Perfectionism: The war with the Self

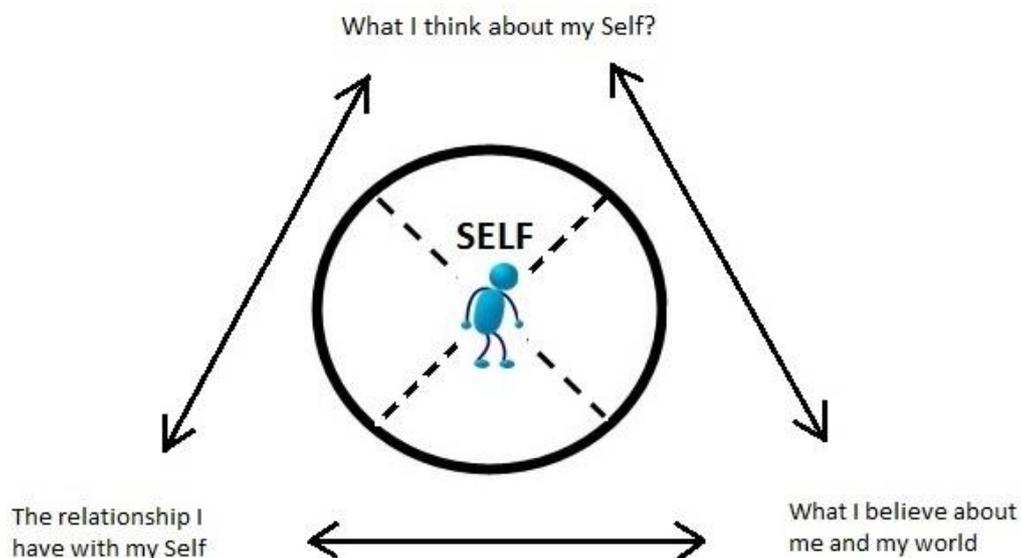


Figure 6.2: Perfectionism: The war with the Self

The GT analysis indicates that perfectionism develops from the individual having an intense negative relationship with the *Self* that can be described as them being at

war with themselves. The relationship the individual has with their self is poorly developed, abusive and irrational. They constantly break down their own self-esteem. Thoughts and beliefs about themselves and their world are very harsh and overly critical. There is a continual interplay between their low self-esteem, judgemental thoughts about themselves, and negative beliefs about their world.

At the core of their thinking lies a low self-esteem. In essence, they think that they are worthless or *not good enough* in their own eyes. *Self-hate* may be prominent and the *Self* is easily criticised or even mentally abused. When referring to their *Self*, nothing ever seems good enough in their own eyes, due to their extremely critical self-judgement.

Perfectionism does not encourage one to focus on oneself in a positive way, or develop a good relationship with one's *Self*. The relationship one has with the *Self* is based mostly on *Negativity* or *Self-hate*. On an almost daily basis, the relationship with the *Self* is experienced more like a battlefield or a war. *Self-hate* is the never-ending conflict with the *Self* and is an emotionally draining process. This *Self-hate* prevents one from accepting one's own *Self* on many levels, or even being able to form deep appreciation and love for the *Self*. For most of the time participants looked down on their *Self*, focusing more on mistakes or perceived imperfections in the *Self*.

*Negativity* describes how intensely one can come to hate one's *Self* for mistakes made, or fluctuations that are noticed in one's weight, unwanted body shape, or poor eating patterns. When *Negativity* is part of one's thinking, it is difficult to become motivated about oneself or the world in a positive manner.

Perfectionists' beliefs about the *Self* and the world are rigid and inflexible. These beliefs set clear expectations on how they think things should happen in certain specific ways, and to what level achievements should be obtained. Mistakes are not tolerated at all, and are seen as a reflection of a bad *Self*. Mistakes encourage *Feeling Like A Failure*, and they are easily recalled from memory. Actual achievements are minimised, while perceived mistakes and perceived flaws are magnified and over-exaggerated.

Perfectionism within treatment resistant ED clients creates strong beliefs about what makes a person happy and how happiness can be obtained. One core belief is that physical beauty equates to happiness: Being of low weight means that one is admirable and acceptable to others and thus one *becomes good enough*. When low weight is achieved, one is beautiful, which implies true and lasting happiness according to one's perfectionistic beliefs. In this regard, being beautiful is the only priority in life, and achievable through hard work and extreme dieting.

The evaluation of the *Self* is strongly influenced by aspects of food, weight, body, and shape. All four aspects remain sensitive topics as they present strong links to perfectionism. Perfectionism within treatment resistant ED clients contributes to having extreme rigid and specific expectations and ideals about how one should look, what one should weigh, and what one should eat. Daily mundane activities like getting dressed, or noticing the ageing process in one's body; can trigger strong negativity because of the emotional connection with food, weight, body, and shape. Unexpected focus by others on either their food, weight, their body or shape can therefore elicit extreme negativity towards their *Self*.

### 6.2.3 Perfectionism: My problem

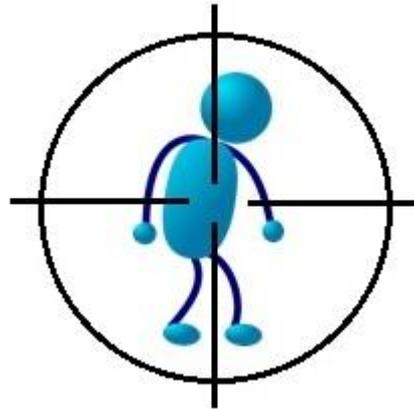


Figure 6.3: Perfectionism: My Problem

Perfectionism within treatment resistant ED clients focuses mostly on trying to establish someone's worth through their achievements, which focusses on aspects of food, weight, body, and shape (people who present with attributes like a small or fit body, or are viewed as disciplined in their habits and food choices, etc.). These are elements used to judge a person's inherent *worth*. Perfectionistic thinking also creates the belief that these aspects are the same merits by which others judge oneself. Perfectionistic ED clients invest constant and intense effort in trying to understand how others judge them. Images like photos, or seeing themselves in the mirror, are utilised in trying to ascertain how they are perceived and viewed by others.

The nature of the judgement towards their *Self* is therefore overly self-critical and harsh. These critical judgements can take the form of mental self-abuses. When comparing themselves to others, perfectionism dictates feelings of low self-worth as they continually try to prove themselves to themselves and others.

*Critical Judgement* is also directed at severely over-exaggerated aspects of food, weight, body, and shape within the *Self*. Food, weight, body, and shape are used to make comparisons to others, which usually *ranks* the perfectionistic person at the lower end of the continuum. When using this perfectionistic thinking, they conclude that they are not good enough, thus the need exists to improve themselves because of the critical low view of *Self*. Using *Critical Judgements*, they force themselves to mobilise into *action* through negative motivation (i.e. *Punishment*). By criticising harshly, they force themselves to start *fixing* the problem through the pursuit of *Extreme Achievements*.

*Critical Judgement* has significant implications for trying to be perfect for treatment resistant ED clients. Their perception of *Self* is distorted. Whether this distortion is part of the ED, or originates from the pursuit of an ideal is not clear. However, the result is similar. They downplay their own achievements and personal traits, and over-inflate their perceived personal imperfections. It is from the basis of a distorted image of the *Self* that they are convinced they need to strive to achieve perfection by pursuing an ideal.

#### 6.2.4 Perfectionism: My solution - Pursuing an ideal

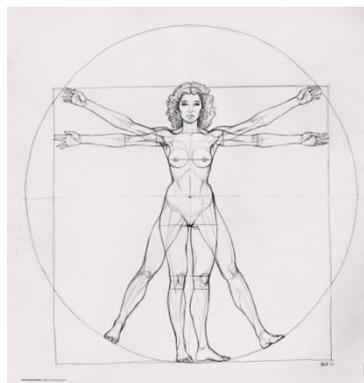


Figure 6.4: The Vitruvian Woman, (Taunton, n.d.)

Pursuing an ideal is driven by the intense desire to be perceived as competent, confident, admirable, desirable, acceptable and lovable to others. It is based upon the logic that one *must be worthy* of the attention and acceptance from others. Eating disorder clients believe that by *moving closer to the ideal* they become more perfect, and thus become more worthy, and others will like them more.

Pursuit of an ideal does not allow one to reveal weakness to others. One must be viewed by others as confident and competent, being able to resolve one's own problems without their help. Also, one cannot ever be perceived to be selfish, or to be boasting about one's own achievements. This is taboo, as one must position oneself as the *least worthy* in any social situation when compared to others.

Even though ED individuals might be aware that they focus excessively on how they are perceived by others, they still develop a metaphorical *mask of perfection* to be worn in front of others. They do this even at the expense of struggling emotionally, because of the self-hatred they have towards their *Self*.

### 6.2.5 Perfectionism: My plan to become ideal

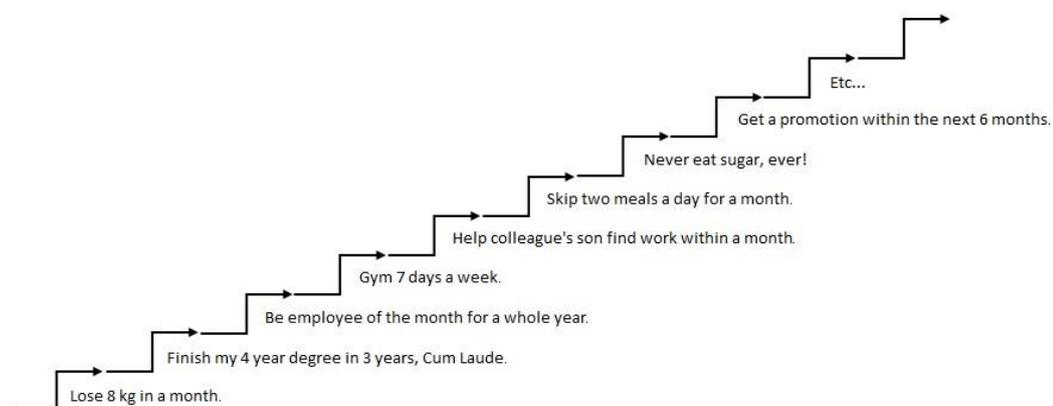


Figure 6.5: Perfectionism: My plan to become ideal

Perfectionism in clients with treatment resistant eating disorders leads to the fallacy that beauty equates to happiness. However, because there is an inherent belief that one is not beautiful and not good enough for oneself or others, an intense need to improve oneself develops to become a better version of oneself.

*Extreme Achievement* focuses on achieving a better version of the *Self*. This is accomplished through reaching extreme goals and constantly maintaining high standards of living, so that one may become worthy. It is only through continually achieving extreme goals that the *Self* improves in worth, and becomes a better version of *Self*.

In choosing which goals to strive for, the tougher the goal, the more the positive impact on the *Self* and one's judgement of self-worth. Perfectionistic ED clients are only satisfied when the goals they aimed for are difficult, completed in a set specific way, according to stringent high standards.

Achieving *Extreme Achievements* instantly gratifies the need to feel better about the *Self*. When these high goals are obtained, the positive feeling that results is almost addictive. In situations where these goals and achievements are unobtainable (e.g. during pregnancy or illness), frustration results because the lack of achievement in life. It does not take long for the yearning to achieve, be productive and improve the *Self* to develop.

Achieving and achievement is also linked to exerting control - one feels powerful and in control of one's surroundings as one portrays mastery of the ability to achieve,

where others usually fail or give up. The opposite is also true for failures. When one fails to achieve extreme goals, the *Self* interprets this as a reflection of the poor, inadequate *Self* which needs to be severely criticised for its failed attempts. This self-abuse is usually coupled with negativity and punishment, which forces one to try harder at achieving that same goal. Quitting is not an option as this means weakness. In turn, this means one is not worthy in one's own eyes and in the eyes of others.

### 6.2.6 Perfectionism: Pathological drive to achieve an ideal

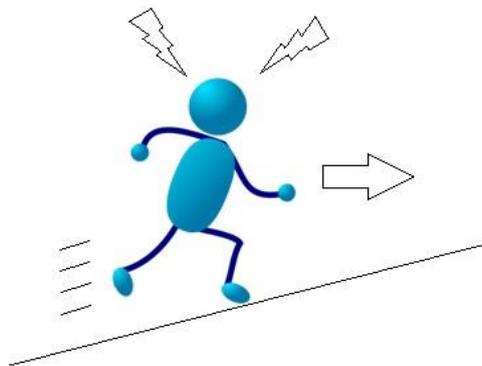


Figure 6.6: Perfectionism: Pathological Drive to achieve an ideal

Achieving *Extreme Achievements* is dependent on a *Pathological Drive* to reach unrealistic goals. The rationale to use a *Pathological Drive* with a perfectionistic attitude (as opposed to a *healthy drive* for achieving *realistic goals*), is that it assists ED clients pursue *Extreme Achievements* effectively. As perfectionists prioritise achieving idealistic goals and maintaining stringent standards of living, where others would give up, they invest unrealistic amounts of effort, by adhering to an extreme regime of discipline, strict structures and rules for living their daily life. The perfectionist believes the more they can adhere to this strict regime for longer periods (despite the negative impact on their lives), the more likely they are to

achieve their difficult goals, and move closer to reaching their perfect ideal - which is the ultimate goal for perfectionists.

*Pathological Drive* is harsh and excessive in nature and drains one extensively of energy. It is not part of sustainable living, although the respondents all showed immense resilience in maintaining these efforts for extended periods. The strict structures and rules were noticeable in their dieting principles and stringent standards of living.

These strict structures impose specific set ways in which decisions, actions, behaviours and habits need to be executed. Whether it is how food should be prepared, or to what degree exercise should be done - *Pathological Drive* forces one to continue engaging with these strict structures and rules effectively even when one does not want to, or when it comes at a cost to one's health and relationships. Disciplined living is viewed as adhering obsessively to strict structures and rules, being very hard on oneself, and regularly achieving extreme goals.

*Punishment* for making mistakes or being criticised by others serves as a catalyst to re-engage in *Pathological Drive*, to achieve one's goals. In mentally abusing and criticising the *Self* with an attitude of *Critical Judgement*, one constantly forces oneself to keep pushing oneself harder and longer on the path towards *Extreme Achievement*, and ultimately *The Ideal: Self-Perfection*. Normal human needs and wants like hunger and relaxation are not tolerated, and they are mostly ignored. *Critical Judgement* regarding normal human needs can be likened to mental self-

abuse, which culminates in starting the process of a *Pathological Drive* in the pursuit of *Extreme Achievement* all over again.

### **6.2.7 Perfectionism: My result - How my perfectionism and my eating disorder interact**

Because perfectionism encourages one to develop and engage in a *Pathological Drive* to reach *Extreme Achievements*, the evaluation of the *Self* becomes very dependent upon achieving. The importance of achieving and achievement become so pronounced to the perfectionist, that they lose perspective of other important areas in their life, and their overall health. This causes two distinct consequences:

1. The individual struggles to form a complex emotional relationship with their *Self*. The deep emotions they feel are usually avoided, or criticised harshly and neglected. The *Self* is constantly *mentally abused*, which alienates them from knowing themselves well, or understanding their own intricacies and interactions of their emotions and behaviours.
2. Aspects of food, weight, body, and shape can become pronounced focus areas of achievement in the perfectionist's life, which may then contribute to the development and maintenance of an ED. It is then within the constant interaction of perfectionistic achievement and disordered eating behaviours of weight- and food manipulation, that both problems maintain each other, and can thus manifest for long periods.

Daily, ED clients must make choices about food and what they eat. What types of foods are consumed, and how they choose to prepare it, are the basic building blocks of their daily habits. They constantly interact with their bodies - when getting dressed, when looking at themselves in the mirror, and when noticing the shape of certain parts of their bodies. There are others around them who comment on their

bodies, or on their habits and decision-making regarding food and exercise. Media- and cultural influences can also focus on such aspects. They are aspects of appearances that in the minds of ED clients, are critical to assessing their social status.

Thus, perfectionism and disordered eating thoughts and behaviours seem like a *good fit*. As the aspects described above are so readily available in a person's daily mental activity, it provides for many opportunities to seek out *Extreme Achievement*. Whether it be attempting to lose weight within a prescribed period, or avoiding certain foods, or exercising even during states of physical illness - the *Pathological Drive* to achieve extreme goals feeds well into these aspects as ED clients constantly sacrifice their basic physiological human needs, in the name of self-improvement (i.e. working towards *The Ideal: Self-Perfection*).

On a mental level, an ED also encourages ED clients to construct a faulty mental representation of their body and self-concept with a distorted body image. This feeds well into the mental self-abuse by the way of *Critical Judgement*, which encourages a low self-esteem - a core concept in the forming and maintenance of an ED. The mental image of an ideal in the form of a specific body, shape, and weight, provides a pathological goal to work towards through the ED.

Perfectionism creates the illusion that when the state of perfection is reached, then happiness and acceptance of the *Self* will be obtained. It is this *fallacy* that encourages the individual to strive for destructive manipulation of food and weight through disordered mechanisms when an ED is prevalent.

## 6.2.8 Perfectionism: My recovery - Learning to celebrate my Self



Figure 6.7: Perfectionism: My recovery – Learning to celebrate my Self

*Recovery* is the process and state achieved whereby a person with an ED ends the *war with the Self*, and ultimately finds inner peace and holistic acceptance of the *Self*. Changing the destructive mindset towards a *Culture of Healing*, revolutionises a client's position towards the *Self* whereby self-acceptance can be fostered, without *Critical Judgement* nor striving for an ideal within perfection. This is a process which takes time and is difficult to achieve, but ultimately results in being able to start accepting the *Self* without set conditions or defining statements. Thus, the *Ideal: Self-Perfection* ceases to remain along with the reduction of the need for *Extreme Achievement* via *Pathological Drive*. Although the drive to achieve will always be part of a person's life, these concepts will exist within a different mindset which does not encourage *Critical Judgement* when the *Pathological Drive* fails in reaching *Extreme Achievements*.

The *Culture of Healing* **includes** the following:

- Ending destructive disordered eating behaviours.

- Destructive behaviours (bingeing-and-purging, restriction of food intake, etc.) keep the ED client in a cycle where they hurt themselves and blame themselves for their own hurt. It keeps them imprisoned in their own disorder and maintains their own negative beliefs (which are essentially incorrect).
- Whilst engaging with destructive behaviours ED clients still feed *Critical Judgement*, which encourages a *war with the Self*. Ending destructive behaviours is essential, and provides the opportunity to start intervening and healing the complex emotional issues of *Self*.
- Developing better mechanisms to deal with complex emotions, and beginning to build the subjective relationship with the *Self*.
- Emotional healing from historical contributory (e.g. severe trauma) that encouraged one to develop a low self-worth in the first place.

The *Culture of Healing* **excludes** the following:

- Achieving an improved version of oneself by pathologically driving oneself to reach extreme achievements.
  - For example: *“If I lose weight as quickly as possible, then I will reach a point where I can heal and be at peace.”*
- *Fixing* errors and past mistakes by wanting to achieve perfection or an improved version of oneself.
- Believing that life’s difficulties will end once the ideal *Self* has been achieved. Personal growth is a never-ending process. However, perfectionistic beliefs dictate that when one can achieve a state of perfection, this will result in never having to face new problems and challenges in life again which may cause harm to one’s mental well-being. Per this belief, life’s difficulties will thus cease after obtaining the ideal *Self*, since one will never have to grow or develop further, as you have already obtained perfection.

The recovery process focuses on each of the identified core elements of perfectionism, and how these elements would be experienced when perfectionism subsides:

- The Self
  - The war with the *Self* ends. The mental self-abuses that happens constantly, day by day, for so long, ends. The need to constantly improve the *Self*, diminishes.
  - Less stress and anxiety about the *Self*. Ending the belief of not being worthy enough for oneself or others, but rather being able to recognise one's inherent self-worth.
  - Inner-peace and happiness develop from merely being oneself. Acceptance of *Self* is not dependent on meeting certain set conditions, or achieving set goals or standards. It means that one can recognise other areas of life that makes one unique and special as a person. One also becomes more positive about the *Self*, can recognise beauty within one, come to recognise personal flaws and be at peace with them, as well as recognise that people have flaws and will never be perfect beings.
- Critical Judgement
  - Excessively harsh self-criticism ends. Instead of criticising those aspects which one feels the need to change for the better, acceptance for who one is prevails (including physical attributes and mistakes in life). This allows for proper self-analysis when making mistakes, to put feelings into perspective and attribute blame accurately.
  - Rigid thinking patterns regarding one's history and one's perceived mistakes lessens. Perceived mistakes are not over-inflated, and one can deal with criticism more constructively.

- The Ideal: Self-Perfection
  - Better personal perspective: Appreciating who one is, instead of noticing personal shortfalls of perfection.
  - The excessive need to become a better version of oneself subsides as self-acceptance encourages one to appreciate who one inherently *is*. Instead of wanting to *become someone better* through reaching extreme achievements, one learns to appreciate who one is under the current circumstances as an imperfect, flawed human being.
- Extreme Achievement
  - *Extreme Achievement* ends, and is replaced with more realistic and healthy goals.
  - One becomes less obsessive about constant achievement and achieving excessively.
  - Not being obsessively focused on one's personal appearance, but developing perspective on all areas of life and *Self*.
  - Achievements or mistakes do not trigger the mindset of perfectionism anymore, as both have the potential to do so.
- Pathological Drive
  - *Pathological Drive* diminishes to a level where inner drive is healthy and within realistic means and a realistic intensity.
  - No rules, structures or disciplines are imposed and pursued to an unhealthy degree. The drive to succeed is not harmful, and goals are not pursued to such a degree where other important areas of life are neglected or sacrificed.
  - 'Letting go' of extreme rules and strict structures of disciplined living: The connection between the *Self* and *Extreme Achievements* is broken, and *Pathological Drive* normalises.
  - Some guidelines for behaviours, habits, and decision-making remain, but none of the pathological rules and rigid structures.

- The ability to judge what is acceptable, good, positive and healing is achieved.

Thus, *Recovery* will create a new Self-Schema that is different from the mindset of perfectionism. This mindset will change from the Perfectionistic Eating Disorders Self-Schema, to one where acceptance of *Self* and inner peace is evident.

As perfectionism may have manifested for a long period, change may be very difficult for the perfectionist. *Recovery* is a complex negotiation with the *Self* which confronts one with issues of perfectionism and one's ED. The mindset must change, and losing focus of this could result in falling back into old ways of thinking. Thus, achieving and striving for goals must always be done in a healthy culture, where the *Self* remains respected always.

Perfectionism can be very imprisoning, but when engaged fully with recovery, it can be *freeing* as one allows oneself to just *be*. Learning to embrace and become passionate about recovery goals, just as one was passionate about investing energy into the *Pathological Drive* to achieve *Extreme Achievements*, can assist in this regard.

### **6.2.9 Perfectionism: Conclusion**

The connection between perfectionism and eating disorders is easily noticeable yet complicated to unravel. The vulnerabilities, needs and wants of both perfectionism and eating disorders seem to *feed* into each other. By meeting the needs of one, the other is maintained, and vice versa. This creates difficulties for treatment professionals who wish to assist those struggling with treatment resistant eating

disorders. They could easily fall into the trap of focusing only on symptom reduction (i.e. the pathological behaviours and problems with food, weight, body and shape), whilst neglecting contributing elements at the personality level in the form of the Perfectionistic Eating Disorders Self-Schema.

It is at this level that perfectionism becomes an important focus. Symptom reduction struggles to bring about full recovery, as self-esteem issues depicted in this pathological Self-Schema may contribute to relapse later. Development of the *Self*, which includes addressing issues of *Critical Judgement*, a *Pathological Drive*, *Extreme Achievement*, and *The Ideal: Self-Perfection*, seem pertinent to full recovery, as well as relapse prevention within treatment resistant cases of eating disorders.

In the next chapter, the integrated findings of the phenomenological analysis and the GT analysis will be discussed.

## CHAPTER 7

### DISCUSSION OF THE RESEARCH FINDINGS

*“In every bit of honest writing in the world, there is a base theme. Try to understand men, if you understand each other you will be kind to each other. Knowing a man well never leads to hate and nearly always leads to love.”*

John Steinbeck

(Quotations Page, n.d.)

#### **7.1 Legitimising this study’s claims toward valid knowledge through current research**

As discussed in Chapter 4, when phenomenological- and GT research methods are used, researchers cannot generalise their results due to the focus on the individual, rather than on the masses. The qualitative research design used in this study focused more on producing expansive and deep reflective accounts of the participants involved, rather than attempting to project the results to the population group for all ED sufferers. I also reflected on the difficulties of qualitative research’s validity and reliability, which is based mostly on the instability and inconsistency of responses from participants being studied over time, and the creative characteristics of qualitative methods, as well as the diversity of methodologies.

However, research validity is not the only criterion by which ideas are judged. New ideas are always judged within the context of existing ideas. If new ideas are close

enough to existing ideas, they will at least be understood. Whether they are accepted, rejected, or ignored is another matter (Hergenhahn, 2009). Hence the need exists to compare the results of the phenomenological- and grounded theory analysis with existing knowledge and research, in order to boost its claim for *legitimate knowledge which is accurate and genuinely reflective of the phenomenon under study*. This comparison will not only attempt to identify where the results agree with the current research, but also where they differ.

## **7.2 Discussion of the phenomenological findings**

Chapter 5 presented the phenomenological findings of the individual participants' experiences, to access the essence of the general experience of perfectionism within treatment resistant eating disorder clients.

In this section a comparative analysis of the nine common group aspects that emerged from the individual protocols is made. These findings are discussed in relation to the research that was presented in the literature review, as well as other literature that may be relevant to the phenomenological findings.

### **7.2.1 Emotions**

The phenomenological findings suggest that three respondents experience a link between their perfectionistic thinking and their emotions - mostly anxiety and anger.

For Cathy and Rochelle, anxiety is an intense part of the experience of an eating disorder. Their anxiety centres around how others perceive them, or not being able to deal with the pressures of life. They fear not being able to achieve what's expected from them by themselves or others in life. The respondents' descriptions

depict how perfectionism serves as a maladaptive coping mechanisms to help overcome anxiety. Having a subjective experience of 'control' helps to dissipate the anxiety. As Hamachek (1978) and Maslow (1970) highlight, when perfectionism becomes neurotic and maladaptive, it hinders healthy development by setting unattainable goals and perpetuating a dread of failure. Becoming excessively focussed on the judgement from others, as well as leaving the individual feeling unsatisfied, or never feeling *good enough* for themselves, are also part of maladaptive perfectionism. Their self-esteem is more fragile, and the concept of failure is more threatening to them (Kim, 2011).

In Jane, perfectionistic thinking serves to create anger towards herself. This anger is in response to things that happen during the eating disorder, or during her daily life when she transgresses her self-imposed strict structures and rules. This is in line with how Arnold and Walsh (2007) describe the problem with maladaptive perfectionism in eating disorders. It sets such high standards, that little is ever good enough, or *perfect enough*. Maintaining such high standards for long is impossible. This may trap the person in a cycle of dissatisfaction and self-hatred when making mistakes, as may be seen in Jane's case in the interaction of her perfectionism and eating disorder.

Szymanski (2011) also touches on aspects of anxiety and anger in perfectionism. He describes that unhealthy perfectionists may experience chronic feelings of anxiety and stress, as well as feelings of anger and frustration at their selves or others. Their behaviour, choices and strategies are driven by factors such as a fear of failure, chronic concerns about making mistakes, constant self-doubting, attempts to live up

to others' expectations of them, anxiety about always falling short of self-made goals, as well as whether the costs outweigh the benefits. Thus, anxiety and anger can be constant companions in the maladaptive perfectionist's life, as portrayed in many of the respondents' experiential descriptions.

### **7.2.2 Goals and decisions**

In most of the respondents, the phenomenological results portray the influence perfectionism has in the goals they choose to aim for in life, and to which degree they hope to achieve them. Four respondents describe how they attempt to achieve goals to a perfect degree. The results reveal that the predominant force behind this self-imposed excessive drive to achieve perfectly, is the conflict with the *self*. These results are in line with a sub-type of perfectionism Flett and Hewitt (2002) identify. Their 'Self-oriented perfectionism' is an achievement-based dimension, which encourages the individual to set unrealistically high self-imposed standards. These standards are usually associated with self-criticism and an inability to accept one's own mistakes and faults, as can be seen in the respondents' phenomenological descriptions. Putting themselves down and self-abuses seem to be mechanisms by which four of the respondents attempt and achieve goals in life. A combination of harsh, negative self-criticism and wanting to do things perfectly, serve as main motivations to set immensely high standards and achieve goals, or to punish themselves for not keeping to their own stringent high standards.

The dissatisfaction with the *self*, and its influence in determining goals has been highlighted in previous research. Bruch (1973) focused on the excessive efforts to live up to a perfectionist's standards of achievement, which he viewed as a main

contributory in AN. Sutandar-Pinnock (2001) also emphasises that dissatisfaction with the *self*, restricting food intake to control body weight, and the desire to be perfect, culminates in a need to establish order and exert control over one's life and body. The respondents exert this control in the goals they aim for, and the decisions they make. Lundh (2004) hypothesised that perfectionism becomes unhealthy at the point when striving for high standards becomes a demand and individuals demonstrate an inability to accept things as they are. In this regard, the respondents portray an unhealthy perfectionism.

Kim (2011) has highlighted how anorexic clients show markedly increased concerns about making mistakes, doubts about their actions and personal standards. There is a difference between high achievers, who are mostly driven by goals to achieve, and unhealthy perfectionists who are driven by fears of failure. The negative reactions to mistakes, as well as the tendency to view mistakes as reflections of personal failures, are judged as one of the most significant contributing factors to the development of an eating disorder (*Perfectionism linked to eating disorders*, 2003). The experiential descriptions of the participants in this study portrayed their fears of failure with respect to their achieving high standards. Not being able to achieve difficult goals was experienced as a reflection of poor *self*, and resulted in negativity towards their *self*. This is in accordance with Kim's (2011) research, where perfectionists are viewed as being driven by failure and not by the goals they want to achieve, and are more likely to have negative reactions to their own mistakes, or to view their mistakes as failures.

The results show how Jane uses weight fluctuations as indicators for whether she has successfully adhered to the strict rules and achieved the goals set by the eating disorder. In terms of weight, Kim (2011) highlights that conditional self-acceptance seems to be obtained through attaining a certain weight. Likewise, when considering performance or competence, conditional self-acceptance seems obtainable through attaining self-perceived perfection or exceptionally high achievement. Jane's belief system is such that either one does something perfectly, or it proves one has no self-control at all.

### **7.2.3 Thought processes and beliefs**

The phenomenological results portray how strivings for perfectionism not only happen on the physical level, but encapsulates all aspects of the respondents' life, to the core of their being. Fairburn (2008) echoes this sentiment. Although, for him, perfectionism is particularly obvious in the dietary- and weight goals that eating disordered individuals set for themselves.

The respondents' results indicated how self-imposed pressure and negative self-ridicule is intense and constant, and brings negativity into their daily existence, continuously influencing thoughts and feelings. Rice et al. (1998) report how maladaptive perfectionists experience excessive concern about making mistakes, doubt their actions, and feel tense and anxious. The respondents' experiences were in line with such subjective descriptions. In terms of the relationship between perfectionism and eating, Schmidt and Treasure (2006) highlight that individuals with these traits value perfection and fear making mistakes. They are excessively conscientious and cognitively rigid. Being rule-bound and striving for perfection can

facilitate persistent dietary restriction and the control of appetite. Their cognitive focus on details make this type of behaviour satisfying and may lead to subjective feelings of being in control, like the respondents' experiences.

The phenomenological results portray how perfectionism interacts with the ED, and strong beliefs about the body's shape and weight guide thinking and decision-making processes. Weight loss is a constant goal, and the drive to achieve this goal intense. Most of the respondents' experiential descriptions depict weight loss, and achieving a thin-ideal weight, as the main mechanism to bring about self-worth, self-acceptance, competence, confidence and happiness. Anthony and Swinson (2009), Culbert et al., (2015), Levine (2000) and Nielsen's (2000) research all highlight how Western standards have increasingly focussed on woman's thinness through media exposure and social learning, which encourages a perfectionistic outlook on life, increasing the chances of harmful means of attainment of the thin-ideal. The internalisation of the thin-ideal and thinness expectancies have previously been shown to prospectively predict increased levels of disordered eating, thinking and behaviours (Culbert et al., 2015). The opposite is true for weight gain - if the respondents perceived themselves as overweight, it resulted in emotional distress and self-blame. Pinto-Gouveia, Ferreira and Duarte (2014) suggests that central features of eating psychopathology - body image dissatisfaction and drive for thinness - emerge in the context of a critical relationship with oneself, feelings of inadequacy and inferiority, and fears of being disapproved of, or looked down upon by others. These experiences were also present in the phenomenological descriptions of the respondents' experiences, and clearly influenced their self-judgement.

#### **7.2.4 Judgement**

The phenomenological descriptions of the respondents' experiences show how their self-judgement is harsh and critical. This self-judgement is based on subjective interpretation of looks and behaviours, and how they judge their own performance in life. Especially when they perceive mistakes, the self-judgement is excessive. This concurs with Kim's (2011) view that perfectionists are more likely to have negative reactions to their own mistakes, or to view their mistakes as failures. The respondents' self-ridicule and harsh self-judgement contributes to becoming more disengaged from their selves, avoiding their feelings and thoughts about themselves. Research has previously highlighted the important role of self-criticism in eating related symptoms. In particular, self-criticism has been considered a potent maladaptive emotional regulation process that, by fueling a sense of being an inferior or flawed self in comparison to others, predicts increased drive for thinness (Pinto-Gouveia et al., 2014).

Rochelle, Tracy and Lara struggle to judge their own performance and recognise personal good achievement. It does not come naturally to them. More generally, the respondents view their own performance as quite average, not exceptional. As Burns (1980; 1983) highlights, unhealthy perfectionists disqualify the positives in their lives (i.e. good performance), and easily magnify the importance of errors made.

Most of the respondents' self-judgement is in line with what Dunkley et al. (2003) describe as self-critical perfectionism (SC), which involves constant and harsh self-scrutiny, overly critical evaluations of one's own behaviour, an inability to derive satisfaction from successful performance, and chronic concerns about others'

criticism and expectations. The phenomenological results show how the respondents judge themselves harshly and interpret any perceived flaws in their bodies very negatively. This encourages self-hatred as they feel only looking perfect is good enough. Dealing with stressors is made cumbersome by perfectionist tendencies, as personal high expectations may be unobtainable, resulting in feeling like a failure. The pressure experienced from perfectionism is self-inflicted and does not aid in dealing with stress more efficiently. Dunkley et al.'s (2003) research highlights how self-critical perfectionists quickly blame and condemn their abilities and personal qualities, which they view as fixed and deep-seated. They become preoccupied with their deficiencies and their inability to handle a stressful situation, engaging instead in avoidance of threatening stimuli. Self-blame and denigration also explain their perceptions of low efficacy and expectations of criticism from others in their dealing with the stressful situations, which also contributes to their use of avoidant coping styles.

The tendency to engage in avoidant coping styles might serve both to impede adaptive coping, and to increase the severity of the stressors that self-critical perfectionists experience. In addition, it is hypothesised that SC perfectionists believe they have less social support available to them in times of stress (Dunkley et al., 2003), which was also portrayed in the research participants' descriptions. They believe that they must deal with their problems on their own, without reaching out to others around them for support. Thus, the respondents lack an important resource to encourage more adaptive coping strategies and to make stressful situations seem less overwhelming.

### 7.2.5 The Self

The phenomenological results portray that for most of the respondents, perfectionism is linked to their low self-esteem and low self-worth. Their struggle to accept their self results in an inner discomfort which is persistent. In trying to resolve this, constant attempts are made to try achieving goals, to prove to themselves (and others), that they are good enough. Self-acceptance is thus something to be *worked for* via achievements. Their belief is that self-acceptance must be *earned* by proving to oneself that one is acceptable. Slade (1982) pointed to neurotic perfectionism as one of the major predisposing factors contributing to the emergence and maintenance of an ED. He argued that dissatisfaction with the *self*, restricting food intake to control body weight, and the desire to be perfect, culminates in a need to establish order and exert control over one's life and body. These elements were evident in the respondents' experiences.

The dissatisfaction with the *self* in the respondents' experiences is in line with Hewitt et al.'s (1995) research, which suggests perfectionists have a strong need to present to others an image of perfection, or avoid revealing imperfection in the self; and are significantly related to both AN and BN tendencies. Hewitt et al. (1995) described that perfectionistic striving seen in eating disordered behaviour is motivated by strong needs to conform to a model or ideal of perfection that is perceived as demanded by the self or others. What seems to be a key determinant of this motivation is the central belief that one must be acceptable to others by meeting their perceived perfectionistic requirements (Hewitt et al., 1995). This belief is evident in the respondents' experience of their perfectionism and eating disorders. The respondents describe their own disapproval of their self, and the need to improve

their self constantly to meet the requirements of society's standards, as well as their own self-imposed standards of living. The respondents' striving to appear flawless is an attempt to compensate for low self-esteem.

Bruch (1978) already noticed then that clients with eating disorders demonstrated 'superperfection', and argued that body weight may serve as a viable source of self-definition, as a means of compensating for the lack of a clear identity, and for associated feelings of powerlessness and incompetence. Most of the respondents' experiences agree with these sentiments, portraying a clear link between perfectionism and self-esteem by focussing excessively on their body weight and shape. Egan et al. (2014) also highlight how the individual with low self-esteem and perfectionistic tendencies may feel a need to completely control, or attain success in some aspect of life. In the case of the development of an ED, the aspect of life chosen is dieting and weight loss (Egan et al., 2014).

The phenomenological results indicate that for most of the respondents, their perfectionistic thinking focusses more on what they *lack*, instead of recognising who they already *are* as individuals. They personify their problems, blaming themselves why things in life are not good enough, or that their bodies are not good enough. Focus is more towards the external world and how one presents to it. Intense and steady effort is invested in constantly pleasing others, or meeting their expectations and needs first. As mentioned earlier, Arnold and Walsh's (2007) research describe the problem with maladaptive perfectionism in eating disorders. By setting such high standards, little is ever good enough, or *perfect enough*. This may trap the person in a cycle of dissatisfaction and self-hatred, as evident in the respondents' experiences

of their perfectionism and self-esteem. They can foster their own mental abuse towards the self for a long period, which hinders inner peace and self-acceptance. Despite achieving throughout life, or being surrounded by positive things, self-evaluation and self-worth remains deficient. As Fairburn (1995) highlights, these self-perceived repeated *failures* can be undermining, especially if self-esteem is already low.

### **7.2.6 Relationships**

The phenomenological results portray the negative impact their perfectionism has on their relationships. Others' approval of them is a priority, and they avoid being fully transparent with those around them about their feelings and thoughts. Others' feelings such as happiness, pain and sorrow are very important - more so than their own. They attend to others' problems, as they constantly attend to pleasing others. This is in line with Rimes and Chalder's (2010) description of unhealthy perfectionism. It encourages the belief that experiencing or expressing negative thoughts and emotions to others is unacceptable, as this will lead to negative evaluation by others.

Such beliefs are associated with attempts to suppress distressing emotions (Spokas, Luterek & Heimberg, 2009), which may result in an unintended increase in distress (Trinder & Salkovskis, 1994). However, no previous studies have investigated whether beliefs about the unacceptability of negative emotions may mediate the relationship between unhealthy perfectionism and distress.

Jane, Pamela, and Lara experience attention received from others as only warranted when maintaining a high standard of living through achievements and perfection. These results are in line with a sub-type of perfectionism Flett and Hewitt (2002) identify. Their 'Socially prescribed perfectionism' is an interpersonal dimension that involves the belief that others expect perfection from them. There is a tendency to assume that others have high expectations of them, and to obtain others' approval, they must meet these high standards. These expectations were evident in the respondents' experiences of their relationships.

### **7.2.7 Behaviours and habits**

The phenomenological results highlight how self-disciplined behaviours and habits are part of the participants' experience of perfectionism in eating disorders. Ferreira, Pinto-Gouveia and Duarte (2014) emphasise that the search for perfection, keeping in mind that ED sufferers present with a distorted body image and the need to aspire to the thin-ideal, as well as a dire need for behavioural and cognitive self-control, justifies the persistence of body dissatisfaction, dietary restraint and purging behaviours over time. In the respondents' experiences, maintaining habits of healthy living to an excessive degree serve to reflect self-worth and competence. Keeping to strict rules of diet and food intake is of the utmost importance, and adhered to at all costs in their search for perfection.

Egan et al. (2014) highlights how people with perfectionistic tendencies tend to turn to a domain of life that offers them some degree of attainment of control. In particular, weight loss is highly valued by Western society and usually met with positive affirmations and admirations from others. This can lead to increased

acceptance and popularity, bolstering the perfectionist's self-esteem. These aspects were evident in the respondents' experiences, in their search for recognition of worth from themselves and others.

### **7.2.8 Social and environmental influences**

The phenomenological results indicate that the respondents experience acceptance from others to be based strongly on how they look. They perceive intense pressure from external influences to obtain a level of physical beauty, otherwise people will reject them. Slim people are idealised and their desire to look slim is strong. These sentiments are in line with Mas et al.'s (2011) descriptions of ED sufferers' self-esteem, which is dependent on the importance others attribute to body image, that is, it is dependent on the social importance of their bodies.

External environments can influence one to become more focused on one's appearance. Cathy and Rochelle experience society at large as being very harsh on women in general. Society sets specific standards which they need to achieve, otherwise they are viewed as 'not good enough'. Society judges them on how they look and how successful they are perceived to be - that's all that's important. The importance of their body's shape and being sexy and desirable is more important than all other qualities in life. More than two decades ago, Stice, Schupk-Neuberg, Shaw and Stein (1994) already suggested that people with low self-esteem try to make themselves fit the sociocultural cannon to gain acceptance from those around them. The respondents' descriptions depict their efforts to adhere to the norm that society dictates, as their low self-esteem prioritises the acceptance from others.

### 7.2.9 Recovery

The phenomenological results indicate that in most of the respondents' experiences, perfectionism contributes to the maintenance of an ED and hinders recovery thereof. The results also indicate that ending the striving for perfection results in an overall improvement in subjective feelings towards the self, as well as destructive habits. Various researchers have highlighted positive implications for targeting perfectionism as an underlying personality construct to recovery in eating disorders (Egan et al., 2011; Egan et al., 2014; Macedo, Marques & Pereira, 2014). Bardone-Cone, Sturm, Lawson, Robinson and Smith (2010) suggest that interventions that help decrease perfectionism may be key to making a full recovery from an ED attainable.

The respondents' results depict that when perfectionistic thinking diminishes, superiority is given to who one *is*, instead of one's perceived shortcomings which need to be compensated for. This is in line with Fairburn et al.'s (2003) sentiments, asserting that if *clinical perfectionism* were to be ameliorated then "...a potent additional network of maintaining mechanisms would be removed thereby facilitating change" (p. 511) in the mechanisms that maintain ED pathology.

Increased self-awareness into self-imposed strict standards of living is an integral part of starting to address and challenge an eating disorder. When the respondents managed to free themselves from this harsh criticism (even just temporarily), they experienced freedom to apply self-analysis. In doing so, they ultimately released themselves from some of the emotional pressures they constantly placed upon themselves. When one can remove the excessive focus on food, and appreciate all the other areas of life, one gains a better perspective of oneself. This perspective

also helps one to self-criticise or self-ridicule less. These descriptions are in line with previous research, where self-compassion has been associated with lower levels of psychological distress, and that high levels of self-compassion encourage lower levels of perfectionism (Neff, 2003). Also, James, Verplanken and Rimes (2015) suggest that interventions supporting perfectionists to reduce repetitive, self-judgemental thinking may help reduce psychological distress. Their research supports the use of interventions that target an increase in self-compassion, nonjudgement, and awareness of the present moment, rather than becoming distracted by one's thoughts.

### **7.3 Second phase literature review**

#### **7.3.1 The issue a literature review within grounded theory research**

When conducting GT research, the area of literature reviews and its uses are contested between traditional and evolved grounded theorists. Traditional GT advocates that “there is a need not to review any of the literature in the substantive area under study” (Glaser, 1992, p.31) for fear of contaminating, constraining, inhibiting, stifling, or impeding the researcher's analysis of codes emergent from the data (Glaser, 1992). Classic GT suggests that researchers should not commence efforts by in-depth literature searching on the topic in question. Glaser (1992) advocates entering the field with a completely open mind, which equates to *not* searching literature or having predetermined research questions at the start of a study. He argues that data collection and analysis should be entered with as few preconceived ideas as possible, ensuring that the theory emerges from the data only.

However, there are those who argue against Glaser's perspective (Dunne 2011; Smith & Biley, 1997; Strauss & Corbin 1990), suggesting that it is important, at the very least, to broadly review the literature before collecting data (Markey, Tilki & Taylor, 2014). Strauss and Corbin (1998) believe engaging proactively with the literature from the beginning of the research process, serves as a contributor to the researcher's theoretical reconstruction as he/she interweaves the literature into their theory construction. They view the use of the literature as being able to provide examples of similar phenomena that can "stimulate our thinking about properties or dimensions that we can then use to examine the data in front of us" (Strauss & Corbin, 1998, p.45).

In considering my personal context, I was already quite versed in eating disorders and its treatment when commencing this study. I did not want the emerging theory to be influenced by historical knowledge, or possible bias on my part. Practically speaking, as part of preparing a proposal for this PhD study for my institution of study, it was required that I complete a standard research proposal. This necessitated a review of literature to familiarise myself with the current body of knowledge concerning the research topic. Thus, in my attempts to balance these opposing aspects, my strategy in this thesis was to conduct a broad overview of literature on eating disorders and perfectionism to contextualise the study (i.e. Chapter 2 and Chapter 3), but not to the extent that it would negatively influence theory generation from the GT analysis. The emerging theory would later then be thoroughly compared to current literature on the topic.

The information in Chapter 2 and Chapter 3 only served to provide me with a basic foundation of the research topic in question. Strauss and Corbin (1998) describe this literature as merely being a prelude, giving the researcher and reader a simplified backdrop of the research topic. It merely familiarises one to the underpinning of the phenomenon under study. Therefore, the intention of studying that literature is to augment the final research information, rather than provide data for analysis and comparison. In this study, a more detailed literature review and comparison that related to perfectionism within treatment resistant eating disorders was only conducted *after* the GT was generated, which is what Strauss and Corbin (1998) refer to as the second phase of the literature review (Markey et al., 2014). This section is dedicated to that second phase of the literature review. It considers perfectionism as a construct, as well as its influence in eating disorders, followed by the different conceptualisations thereof.

### **7.3.2 Perfectionism defined**

Chapter 3 identified multiple definitions of perfectionism. However, as Williams (2015) emphasises, one of the difficulties associated with conducting research on perfectionism is that despite an increase in research interest in this area over the past few decades, there is still no universally accepted definition of perfectionism. A variety of ways of conceptualising the construct have been developed, with the majority of these acknowledging that perfectionism consists of both positive/adaptive qualities, as well as negative/maladaptive features. Lee, Roberts-Collins, Coughtrey, Phillips and Shafran (2011, p. 415) highlight the problem with literature on perfectionism research in their statement:

*Despite the importance of dysfunctional perfectionism across mental health problems and an extensive literature on the construct and its measurement (e.g. Shafran and Mansell, 2001), relatively little is known about the phenomenon. In addition, studies that have highlighted the association between perfectionism and psychopathology are not always explicit in terms of the nature of the perfectionism that they assess.*

Most definitions of perfectionism share the assumption that perfectionists hold elevated standards. However, definitions can differ in important ways. Some definitions focus on problematic forms of perfectionism, in which self-worth is contingent on meeting one's high standards and in which perfectionism has negative consequences for the individual. These definitions imply *rigid* perfectionistic standards that are pathological. In contrast, other definitions of perfectionism focus on how perfectionism assists in achieving and maintaining high levels of excellence in performance of some kind (Egan et al., 2014). The drawback of having multiple definitions and multiple assessment methods for perfectionism, implies problems when researching this construct as there is no accepted gold standard or single definition of it. In this sense, it also creates issues with diagnosing and treating individuals struggling with perfectionism.

Ghent (2005, p. 60) specifically refers to perfectionism as individuals portraying the following:

- Selective attention to, and over-generalisation, of failure.
- Stringent self-evaluations.
- A tendency to engage in 'all-or-none' thinking, whereby total success or total failure exist as outcomes (Hewitt & Flett, 1991a).

- Cognitive rumination over mistakes and imperfections.
- Frequent automatic thoughts about attaining perfection (Hewitt, Flett, Besser, Sherry, & McGee, 2003).

The debate regarding the definition, boundaries and dimensionality of perfectionism is far from over and has been the source of confusion and disagreement in the literature (Egan et al., 2014). Although perfectionism has been previously identified as a personality trait, most of the research considered here focused on describing its various elements and the different types of perfectionism that were identified. Burns (1983), Flett and Hewitt (2002), Stoeber and Otto (2006), Randy Frost and his colleagues (Anthony & Swinson, 2009), as well as Szymanski (2011) all proposed different types/dimensions of perfectionism. Perfectionism has also been categorised as positive or negative, or rather, *normal* and *neurotic* perfectionism (Hamachek, 1978).

Shafran et al. (2002) argue that it is unhelpful and confusing to use the term *perfectionism* to refer to both the healthy pursuit of excellence as well as the dysfunctional high standards seen in clinical examples. In response to this, they coin the term *clinical perfectionism* which they define as “the overdependence of self-evaluation on the determined pursuit of personally demanding, self-imposed standards, in at least one highly salient domain, despite adverse consequences” (Shafran et al., 2002 p.778). According to these authors, the adverse consequences may be emotional (e.g. anxiety), social (e.g. lack of social support), physical (e.g. poor nutrition from excessive dieting), cognitive (e.g. poor concentration) or behavioural (e.g. procrastination) (Egan et al., 2014).

Despite the debate concerning the exact definition of perfectionism, findings have consistently demonstrated the existence of two distinct, albeit related, dimensions of perfectionism (e.g., Bieling, Israeli, & Anthony, 2004; Blankstein & Dunkley, 2002). The first reflects the setting and striving for high personal standards and the second reflects a tendency towards self-criticism (Dunkley, Blankstein, Masheb, & Grilo, 2006).

In conducting the literature review, I found that the two most utilised definitions receiving the most interest within the perfectionism literature, are those defined by Hewitt & Flett (1991a, 1991b), and Frost, Marten, Lahart and Rodenblate (1990). Flett and Hewitt (2002) define perfectionism as a multidimensional concept, consisting of several different components. They identify three types of perfectionism (Flett & Hewitt, 2002):

1. Self-oriented perfectionism.

An achievement-based dimension that involves the need for one's own perfection while setting unrealistically high self-imposed standards which are impossible to obtain. These standards are usually associated with self-criticism and an inability to accept one's own mistakes and faults. Negative life events or perceived failures may lead to difficulties with depression. Expectations are self-imposed.

2. Other-oriented perfectionism.

An interpersonal dimension that involves the need for others to be perfect: A tendency to demand for others to meet your unrealistically high standards. These are high expectations which are imposed upon others.

### 3. Socially prescribed perfectionism.

This is an interpersonal dimension that involves the belief that others expect perfection from oneself. There is a tendency to assume that others have expectations of you that are impossible to meet. Socially prescribed perfectionists usually believe that to obtain others' approval, they must meet these high standards. Unlike self-imposed perfectionism, the high standards are not self-imposed but are rather believed to be imposed by others around you. This perception is held within the individual that expectations of perfection are imposed upon them.

Psychologist Randy Frost and his colleagues proposed six different dimensions of perfectionism, including (Frost et al., 1990):

- Concern over mistakes (tendencies to be overly concerned about making mistakes).
- Personal standards (to have overly high personal standards).
- Doubts about actions (to doubt whether one has done things correctly).
- Organisation (to have an extreme need for organisation).
- Parental expectations (to have parents with unreasonably high expectations).
- Parental criticism (to have parents who are overly critical).

Whichever definition one refers to, this study aims at understanding *dysfunctional perfectionism* within treatment resistant eating disorders.

### **7.3.3 Perfectionism and its influence in psychopathology: Perfectionism as a transdiagnostic process**

Generally, it is assumed that perfectionism is a dimensional construct that varies in intensity from low to high. In other words, perfectionism is not something which people either *have* or *do not have*. Rather, everyone experiences degrees of perfectionism in one or more areas in their lives (Egan et al., 2014).

Chapter 3 has already highlighted the link between perfectionism and psychopathology. Studies have shown that perfectionism is not only correlated with, but predictive of disorders like anxiety, depression, suicidal ideation and eating disorders. The co-existence of perfectionism with various psychiatric disorders such as eating disorders, depression and obsessive-compulsive personality disorder have also been identified within the Cognitive-behavioural Model of Clinical Perfectionism (Shafran et al, 2002; Shafran, Cooper & Fairburn, 2003). Such evidence suggests perfectionism to be a transdiagnostic maintenance mechanism in models of social phobia (Heimberg, Juster, Hope & Mattia, 1995) and OCD (Obsessive Compulsive Cognitions Working Group, 1997), as well as eating disorders (Fairburn, 2008; Shafran et al, 2002). This infers that perfectionism is being described as a *transdiagnostic process* which indicates how it cuts across many disorders, either as a risk or maintenance factor (Egan et al., 2011). In viewing perfectionism as a transdiagnostic process, Egan et al. (2014) highlights the following elements of perfectionism:

- Perfectionism is proven to be elevated across a variety of disorders.
- Perfectionism is a risk- and maintenance factor across a variety of disorders.

- Perfectionism treatment has been associated with positive treatment outcome across a variety of disorders.
- Treatment of perfectionism decreases symptoms across multiple disorders.

In research on perfectionism as a transdiagnostic factor, Bieling, Summerfeldt, Israeli and Antony (2004) conclude that "...perfectionism is not associated with a single disorder or type of disorder, but may be an underlying factor across several disorders and categories of psychopathology" (p.194). In this regard, Egan and colleagues (2011) believe it useful to consider targeting perfectionism to ameliorate a range of symptoms or various disorders. It can therefore be said that specifically targeting perfectionism during treatment may be more beneficial in individuals with co-morbid disorders than traditional single-disorder based approaches, which only target maintaining factors of each disorder sequentially (Bieling et al., 2004). Macedo et al. (2014) concur with this statement, confirming that considering perfectionism as a transdiagnostic process has positive implications for those individuals who suffer from maladaptive perfectionism. This means that the consequence of treating one area of dysfunction is likely to have a significant effect in relieving symptoms in other multiple areas of their lives. Thus, a treatment approach that embodies multiple domains, rather than merely focusing on a single disorder, is a promising avenue in the treatment of complex cases (Egan, Shafran & Wade, 2010).

#### **7.3.4 Perfectionism and its influence in eating disorders**

As mentioned in Chapter 3, perfectionism is a construct that has been conceptualised in many ways, often associated with psychopathology (Anthony & Swinson, 2009), and its link to eating disorders is clear (Bruch, 1973; Fairburn et al.,

2003; Lasegue, 1873 & Slade, 1982). Bruch (1978) already noticed then that clients with eating disorders demonstrated 'superperfection' and argued that an adolescent turns to body weight as a viable source of self-definition, and as a means of compensating for the lack of a clear identity and for associated feelings of powerlessness and incompetence. The adolescent with low self-esteem and perfectionistic tendencies would feel a need to completely control, or attain success in some aspect of life. In the case of the development of an ED, the aspect of life chosen is dieting and weight loss (Egan et al., 2014).

Research consistently shows perfectionism to be elevated in people with eating disorders and people recovering from eating disorders (Bardone-Cone et al., 2010). Research addressing itself to both premorbid and hereditary patterns of perfectionism in relation to both AN and BN (e.g. Fairburn, Cooper, Doll & Welch, 1999; Lilenfeld, Stein, Bulik, et al., 2000) indicate elevated levels of perfectionism. For AN sufferers, there is evidence that elevated pre-treatment perfectionism levels have been associated with a poorer prognosis at long term follow up (Bizeul, Sadowsky & Rigaud, 2001), as well as higher drop-out rates before completing treatment (Sutander-Pinnock et al., 2003). Evidence also indicates that perfectionism levels remain elevated in ED sufferers' post-treatment (e.g. Bastiani, Rao, Weltzin & Kaye, 1995; Kaye, Strober & Jimerson, 2004; Srinivasagan, Kaye, Plotnicov, et al., 1995). Bardone-Cone et al. (2010) suggest that interventions that help decrease perfectionism may be key to making a full recovery from an ED attainable.

In terms of the relationship between perfectionism and eating, Schmidt and Treasure (2006) assert that:

*Individuals with these traits value perfection and fear making mistakes. They are excessively conscientious and cognitively rigid. ...The traits (being rigidly rule-bound, striving for perfection) can facilitate persistent dietary restriction and the control of appetite. A wish for simplicity and focus on details make this type of behaviour satisfying and may lead to the... belief of 'anorexia nervosa makes me feel in control' (p. 349).*

People with perfectionistic tendencies tend to turn to a domain of life that offers them some degree of attainment of control. Weight loss, in particular, is highly valued by Western society. Initially, weight loss is usually met with positive affirmations and admirations from others possibly leading to increased acceptance and popularity, bolstering self-esteem. However, long-term losses may become destructive in terms of loss of self-esteem and encouraging social isolation and narrowing of life through sacrificing hopes and goals. Most theories describing the maintenance of disordered eating associated with AN and BN include aspects of perfectionism (Egan et al., 2014).

### **7.3.5 Conceptualisations of perfectionism**

In considering the literature on the different conceptualisations of perfectionism, the models differ in relation to explaining either the aetiology or maintenance of perfectionism.

Maloney et al. (2014) state that almost no models have been developed pertaining specifically to perfectionism's aetiology. Flett, Hewitt, Oliver and MacDonald (2002) developed the only aetiological model of perfectionism to date to explain the onset of self-oriented perfectionism (i.e. expecting perfection of oneself), socially-prescribed

perfectionism (i.e. others expecting perfection of the individual) and other-oriented perfectionism (i.e. expecting others to be perfect). These authors proposed that perfectionism develops due to an interaction of parental, temperamental and environmental factors. Except for Flett and colleagues (Flett et al., 2002), the work of Maloney et al. (2014) is the only other conceptualisation as to perfectionism's aetiology. Maloney et al.'s (2014) research focused on salient factors that had been consistently shown to have association with perfectionism and then configured them in an aetiological model.

This study however focuses more on understanding the *current state* of perfectionism within treatment resistant ED clients, not its aetiological roots. Hence, only a consideration for maintenance models of perfectionism was made in this literature review. In addition to this, even though multiple conceptualisations exist to explain eating disorders (e.g. Schmidt & Treasure, 2006), only those models specifically including the aspect of perfectionism were considered. A review of the literature identifies the following four prominent models of perfectionism that have gained popularity in recent years, as evidenced by their extensive usage in research:

1. Positive conceptions of perfectionism: Perfectionistic Strivings and Perfectionistic Concerns
2. The 2 x 2 Model of Dispositional Perfectionism.
3. The original Cognitive-behavioural model of Clinical Perfectionism.
4. The revised Cognitive-behavioural model of Clinical Perfectionism.

These four models will now be described, discussed and compared with my emerged PEDSS model.

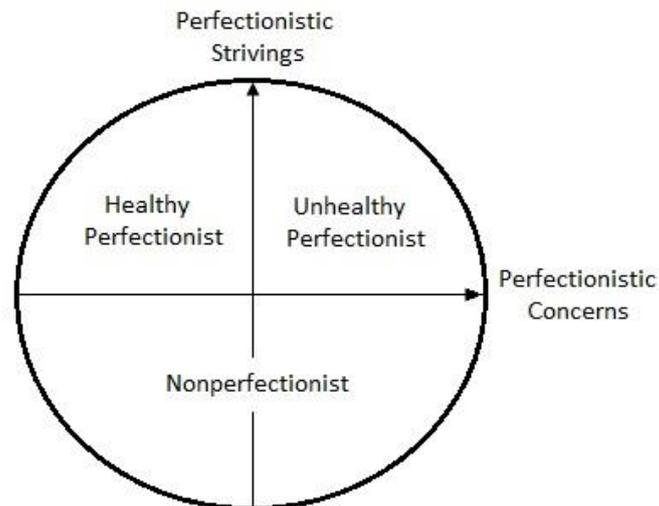
### **7.3.5.1 Positive conceptions of perfectionism: Dimensional- and Group-based approaches**

Stroeber and Otto (2006) emphasise that perfectionism as a personality construct can influence an individual's strivings in all areas of life. In essence, their research argues against the general idea that perfectionism represents a negative, dysfunctional or pathological characteristic. Instead, they suggest that self-oriented perfectionistic strivings can be positive, if perfectionists are not overly concerned about mistakes and negative evaluations by others.

In an extensive review of 35 empirical studies focussing on perfectionism, Stroeber and Otto (2006) present an overview of the different conceptions of perfectionism. They suggest the core facets of perfectionism to be the following: Personal standards, self-oriented perfectionism, high standards, striving for excellence, perfectionistic tendencies, concern over mistakes, doubts about actions, socially prescribed perfectionism, discrepancies (between actual achievements and high expectations), and negative consequences of perfectionism.

Stroeber and Otto (2006) present a common framework for the two basic approaches identified in conceptualising perfectionism: The dimensional approach and the group-based approach. They use these two approaches to differentiate the positive and negative forms of perfectionism. The conceptual framework is presented in Figure 7.1.

**Figure 7.1: Common conceptual framework combining both dimensional and group-based conceptions of the two basic forms of perfectionism (Stroeber & Otto, 2006, p. 21):**



In the dimensional approach to perfectionism, the facets of perfectionism are combined to form two independent dimensions of perfectionism (*Perfectionistic Strivings* and *Perfectionistic Concerns*). In the group-based approach to perfectionism, the facets of perfectionism are combined to differentiate two groups of perfectionists (*Healthy Perfectionists* and *Unhealthy Perfectionists*), which differ with respect to the *perfectionistic concerns* they present. This differentiation between healthy and unhealthy perfectionists corresponds to Hamachek's (1978) definitions of 'normal perfectionists' and 'neurotic perfectionists'. Each of these terms are defined below:

- *Perfectionistic strivings* are associated with positive characteristics. It is unrelated to the negative characteristics traditionally associated with perfectionism, and has become associated with Flett and Hewitt's 'self-orientated perfectionism' (Stoeber & Corr, 2016). The core facets defining the perfectionistic strivings dimension include high personal standards and self-oriented perfectionism. This dimension

is related to higher levels of conscientiousness, extraversion, endurance, positive affect, satisfaction with life, active coping styles, and achievement; and to lower levels of external control and suicidal ideation. They are also related to higher levels of perceived social support and lower levels of depression, self-blame, and perceived hassles.

- *Perfectionistic concerns* are associated with negative characteristics. It is associated with all the negative features that traditional views have associated with perfectionism, and has become associated with Flett and Hewitt's 'socially prescribed perfectionism' (Stoeber & Corr, 2016). The core facets defining the perfectionistic concerns dimension include concerns over mistakes, doubts about actions, socially prescribed perfectionism, and perceived discrepancy between actual achievements and high expectations. Perfectionistic concerns may be the factor that distinguishes clinical forms of perfectionism from a healthy pursuit of excellence.
- *Healthy perfectionists* are associated with positive characteristics. Healthy perfectionists can be conceived of as individuals with **high levels** of perfectionistic strivings and **low levels** of perfectionistic concerns, and have better levels of subjective well-being (enjoyment, satisfaction). They present with higher self-esteem, agreeableness, social integration (e.g. greater social interest, greater willingness to go along with others), and academic adaptation (e.g., higher grade point average, greater academic satisfaction), and lower levels of anxiety, depression, procrastination, defensiveness, maladaptive coping styles, and interpersonal problems; and report fewer somatic complaints and psychological symptoms.
- *Unhealthy perfectionists* are associated with negative characteristics. Unhealthy perfectionists can be conceived as individuals with **high levels** of perfectionistic strivings and **high levels** of perfectionistic concerns. They are overly distressed by the issues that are combined in the dimension of perfectionistic concerns,

namely concerns over mistakes, doubts about actions, feelings of discrepancy between actual achievements and high expectations, self-criticism, and the fear of failure to live up to one's own standards and to the high expectations of others.

- *Nonperfectionists* are conceived as individuals with low levels of perfectionistic strivings.

Stroeber and Otto (2006) view *normal perfectionists* as individuals who show high levels of perfectionistic strivings, but are not overly distressed by the issues that are combined in the dimension of perfectionistic concerns. In contrast, they view neurotic perfectionists as individuals who show high levels of perfectionistic strivings, and are overly distressed by the issues combined in the dimension of perfectionistic concerns. It is within this group of neurotic perfectionists that I would consider perfectionism within treatment resistant ED clients. All the facets described on the dimension of perfectionistic concerns are also attributable to the PEDSS model - specifically within the aspects of *Critical Judgement* and *Self*. It is in the way the PEDSS schema encourages one to focus on perceived deficiencies of *Self*, and continually attack the *Self* through *Critical Judgement*, that perfectionistic concerns remain debilitating in the sufferer's life.

Stroeber and Otto (2006) conclude that perfectionistic concerns may be the factor that distinguishes clinical forms of perfectionism from a healthy pursuit of excellence. They argue that perfectionistic strivings in themselves are not only normal, but may be positive in life: If only perfectionists could focus on doing their best, rather than worrying about mistakes - enjoy striving for perfection rather than being afraid of falling short of it. They emphasise that perfectionists should concentrate on what has been achieved, rather than pondering the discrepancy between what has been

achieved and what might have been achieved if everything had worked out perfectly. Then, they conclude, perfectionism would be a perfectly positive disposition (Stroeber & Otto, 2006).

Stroeber and Otto's (2006) conceptions of perfectionism (including dimensional- and group-based approaches) acknowledge that perfectionism does not necessarily represent a negative, dysfunctional or even pathological characteristic. Instead, perfectionism is viewed as a multidimensional phenomenon with positive and negative facets - that combine to two basic dimensions of perfectionism. Perfectionistic strivings and perfectionistic concerns, which differentiate between healthy and unhealthy perfectionists represent a useful framework through which to understand and explain the differences noted between healthy- and unhealthy perfectionists. The PEDSS model is specific to the negative influence of perfectionism in a person's life. In this way, the models' focus differs. Stroeber and Otto (2006) view perfectionism as something that can be something of value in the person's life, if they could change their orientation towards it. The PEDSS schema focusses more on changing the excessive focus on perfectionistic striving for *The Ideal: Self-Perfection*, and rather developing a better relationship with the *Self*.

However, Stroeber and Otto's (2006) conception holds value in how it could possibly differentiate why an individual's striving for perfection becomes unhealthy, and in what manner these strivings need to be corrected for healthy development to occur.

### 7.3.5.2 The 2 x 2 model of Dispositional Perfectionism

Gaudreau and Thompson (2010) believed previous approaches to forming a model on perfectionism focused solely on the associated outcomes of the core facets of perfectionism, rather than on how the dimensions were structured, and how these two dimensions might be integrated within each individual. To address this shortfall, Gaudreau and Thompson formulated a model that focused on the potential integration of the core dimensions of perfectionism. Their theory recognised and supported a need to address the interactive effects of the two dimensions of perfectionism (adaptive and maladaptive). Within their theory, the following two dimensions were identified:

1. Evaluative Concerns Perfectionism (ECP)

*“...a socially prescribed tendency to perceive that others are exerting pressure to be perfect, combined with a propensity to evaluate oneself harshly and to doubt one’s capacity to progress towards elevated standards” (Gaudreau & Thompson, 2010, p.532).*

2. Personal Standards Perfectionism (PSP)

*“...the self-oriented tendency to set highly demanding standards and to consciously strive for their attainment” (Gaudreau & Thompson, 2010, p.532).*

**Figure 7.2: The 2 x 2 model of Dispositional Perfectionism (Gaudreau & Thompson, 2010, p. 535)**

		EVALUATIVE CONCERNS PERFECTIONISM (ECP)**	
		LOW	HIGH
PERSONAL STANDARDS (PSP)*	HIGH	PURE PERSONAL STANDARDS PERFECTIONISM	MIXED PERFECTIONISM
	LOW	NON-PERFECTIONISM	PURE EVALUATIVE CONCERNS PERFECTIONISM

\*Personal Standards Perfectionism – encompasses more of the adaptive traits of perfectionism  
 \*\*Evaluative Concerns Perfectionism – encompasses more of the maladaptive traits of perfectionism

Gaudreau and Thompson’s (2010) model proposes the following four subtypes of dispositional perfectionism:

1. Non-perfectionism

This subtype identifies individuals who possess low levels of both personal standards perfectionism and evaluative concerns perfectionism. Such individuals have been described as not being directed by perfectionistic strivings, and do not feel that significant others expect them to meet high standards.

2. Pure personal standards perfectionism

An internally regulated subtype of perfectionism which, per Gaudreau and Thompson (2010), is the category “at the heart of the debate about the healthy or

unhealthy nature of perfectionism” (p.533). Here individuals possess high levels of personal standards perfectionism, but low levels of evaluative concerns perfectionism.

### 3. Pure evaluative concerns perfectionism

Individuals within this subtype are driven by external perfectionism, whereby they are primarily influenced by pressures inherent in the social environment. They portray low personal standards perfectionism and high evaluative concerns perfectionism.

### 4. Mixed perfectionism

This subtype is the partially internally regulated category of perfectionism. Here, individuals have high levels of both evaluative concerns perfectionism and personal standards perfectionism. They are influenced jointly by the perceived pressure from others, as well as the need to strive and achieve for themselves.

Gaudreau and Thompson’s (2010) research indicates that the subtype *pure evaluative concerns perfectionism* is associated with lower general positive affect, lower academic self-determination, lower academic goal progress, lower academic satisfaction and higher negative affect when compared to the subtype of non-perfectionism. *Pure evaluative concerns perfectionism* produced the most negative outcomes when compared to all the other subtypes of perfectionism. Furthermore, they found that the subtype *pure personal standards perfectionism* is associated with the most favourable outcomes (when compared with non-perfectionists), which includes higher levels of self-determination, academic satisfaction, academic goal progress and general positive affect.

The 2 x 2 model of Dispositional Perfectionism focuses on both the adaptive and maladaptive domains of the perfectionism construct, and represents a useful framework through which to understand and explain the interactive effects of the different components of perfectionism. It is also an easy to grasp model whereby perfectionism is portrayed by the two dimensions of Evaluative Concern Perfectionism (ECP) and Personal Standards Perfectionism (PSP). Although it is straightforwardly utilised to try and classify individuals according to the type of perfectionism they may exhibit, it does not really provide much in-depth detail as to the interaction of the psychological thought processes within perfectionism. By merely highlighting which subtype of perfectionism is associated with which types of general behaviours, it does not offer a deep understanding for perfectionism's interaction with specific pathologies (like an ED). Also, it provides no real explication or description of how perfectionism specifically affects the person's psychological functioning.

The two dimensions of ECP and PSP focus on socially prescribed tendencies and self-oriented tendencies respectively. When considering perfectionism within treatment resistant ED clients, I believe the 2 x 2 model of Dispositional Perfectionism describes those individuals who would most probably fall under the mixed perfectionism subtype of Gaudreau and Thompson's (2010) model; jointly influenced by the perceived pressure from others, as well as the need to strive and achieve for themselves. As described in my emerged PEDSS model, individuals struggling with perfectionism set high and demanding personal standards (i.e. *Extreme Achievement*), which can be influenced by their own beliefs on what is

acceptable, as well as influenced by the standards dictated by those around them within certain social circumstances.

The differences in the two models are expressed in each model's specific focus. The 2 x 2 model of Dispositional Perfectionism focuses on the different dimensions of perfectionism and how these two dimensions are portrayed and then integrated within each individual. On the other hand, the PEDSS model attempts to describe more the subjective process of perfectionism within the individual, describing the different facets of perfectionism and how it relates specifically to the maintenance of their eating disorders. Although they can complement each other's findings on some level, they seem very different in terms of their approach and application as per their focus within perfectionism.

### **7.3.5.3 The Cognitive-behavioural model of Clinical Perfectionism**

This model arose when clinicians observed that perfectionism was a salient factor in eating disorders, and thus needed to be studied more in-depth. At the time, the multidimensional models of Frost et al. (1990) and Hewitt and Flett (1991a, 1991b) dominated the literature, with no cognitive-behavioural conceptions of the factors that maintained perfectionism. These multidimensional models provided little information about what to do in treatment, whilst the transdiagnostic model offered an account for perfectionism across many presenting problems (Egan et al., 2014). Shafran and colleagues (Shafran et al., 2002) devised the Transdiagnostic model of Clinical Perfectionism illustrating how clinical perfectionism might maintain a variety of psychopathologies. The conceptualisation was based on a cognitive-behavioural

framework, and utilised what they termed *Clinical Perfectionism*, which encompasses:

“...the overdependence of self-evaluation on the determined pursuit of personally demanding, self-imposed, standards in at least one highly salient domain, despite adverse consequences.” (Shafran et al., 2002, p.778).

According to this model, the term *clinical perfectionism* describes the distorted way in which individuals evaluate their personal standards and associated performance. They described a process where, if an individual's self-imposed standards are not achieved, it is interpreted as a personal failure and harsh self-criticism is likely to follow. If, on the other hand, standards are achieved, the individual is likely to re-evaluate them as not being demanding enough in the first place (Shafran et al., 2002). Their view is that individuals struggling with *clinical perfectionism* spend a disproportionate amount of time attending to their failures, and not noticing or crediting themselves when they have done a good job, or successfully achieved their goals (Shafran et al., 2002).

According to Shafran and colleagues (2002), the dysfunctional consequences of *clinical perfectionism* are endured because “the person's self-evaluation is contingent on the pursuit of attainment of their goals” (p.778). This implies that an individual's self-belief and self-worth are strongly linked to their achievement of goals. The unpleasant consequences are tolerated because they provide feedback and confirmation to the perfectionist that they are continually pushing themselves to attaining even higher goals (Shafran et al., 2002).

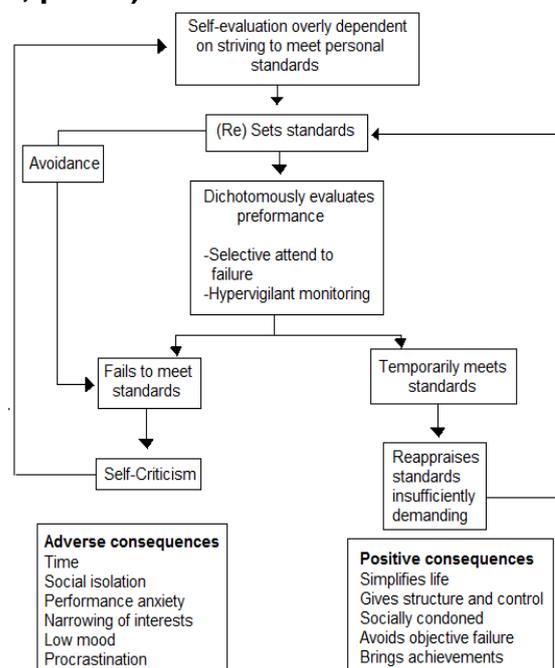
Shafran and colleagues proposed their original model of perfectionism in 2002, with a revised model proposed in 2010. Following next, I provide a report on both models.

### 7.3.5.3.1 The Original Cognitive-behavioural model of Clinical Perfectionism

The original model of Shafran et al. (2002) is based on their definition of *clinical perfectionism*. Fundamental to the definition of *clinical perfectionism* is that self-esteem is based upon how well a person thinks they are doing at meeting important standards.

During the development of their model, Shafran et al. (2002) focused on several cognitive processes that they consider to contribute to the maintenance of perfectionism. They noted the role of perfectionism in the aetiology, continuation and development of certain psychopathological states such as AN and BN (Fairburn et al., 1999; Lilenfeld, et al., 2000).

**Figure 7.3: The Original Cognitive-behavioural model of Clinical Perfectionism (Shafran et al. 2002, p. 780)**



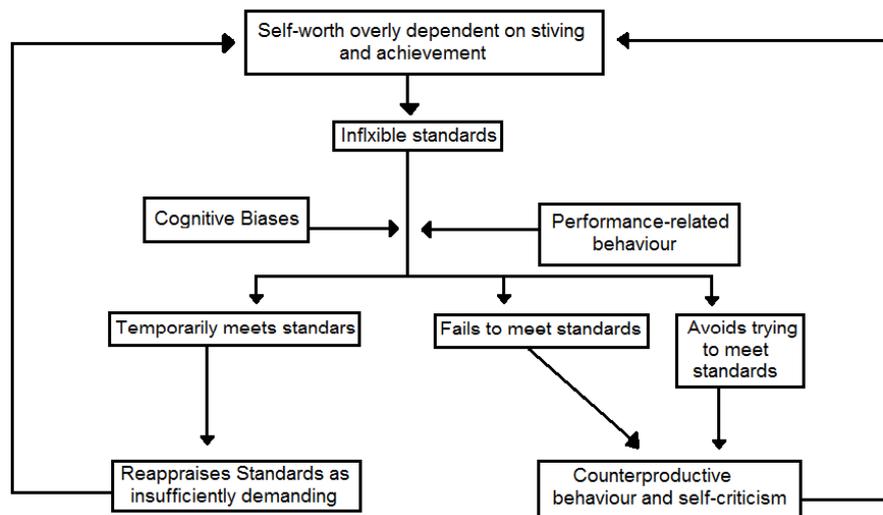
The model included several core maintaining factors, including rigid standard setting, dichotomous evaluation of standards, cognitive biases, self-criticism, avoidance and resetting higher standards when the person thinks a standard has been met. An implicit component to the model is 'performance-checking behaviour' (Shafran et al., 2002). The model was then revised in 2010 by Shafran, Egan and Wade to explicitly include these behavioural components, as well as expanding on the emotional components of perfectionism.

#### **7.3.5.3.2 The Revised Cognitive-behavioural model of Clinical Perfectionism**

In response to the criticisms of the Original Cognitive-Behavioural Model of Clinical Perfectionism, Shafran, Egan and Wade (2010) proposed their revised version, which considered the role of performance related behaviours and their function in the maintenance cycle of clinical perfectionism. These behaviours include procrastination, avoidance and excessive checking of performance.

In the revised model, Shafran et al. (2010) explicitly emphasise the role that performance related behaviour, including performance checking (e.g. constantly comparing performance to others), avoidance, procrastination and counterproductive behaviours (e.g. being over-thorough and checking) have in maintaining the cycle of clinical perfectionism (See Figure 7.4).

**Figure 7.4: The Revised Cognitive-behavioural model of Clinical Perfectionism**  
(Shafran et al., 2010, p. 32)



The revised model of clinical perfectionism (Shafran et al., 2010) identified the following maintenance factors to *clinical perfectionism* (Egan et al., 2014):

- Self-evaluation is overly dependent on striving and achievement
  - Shafran et al. (2002) defined this as the core problem in the original model which drives all other factors that maintain clinical perfectionism.
  - Self-evaluation is dependent on achieving which leads the individual to set inflexible standards for performance.
- Inflexible standards
  - Self-imposed rigid rules about how they should perform.
- Cognitive biases
  - Dichotomous thinking ('All-or-nothing'/'Black-or-White' thinking)
    - Meeting their rules in a dichotomous manner.
  - "Shoulds" and "Musts"
    - Self-statements used to push themselves to meet their standards and berate themselves if they feel they have not met a standard.

- Selective attention ('Noticing the Negative' and 'Discontinuing the Positive')
  - Focusing on every mistake no matter how small.
  - Ignoring the positive aspects of their performance.
- Overgeneralisation
  - One instance indicates something about him- or herself overall.
- Double Standards
  - Holding a different set of standards for oneself as compared to others.
- Evaluation of standards
  - Constantly trying to judge whether their standards have or have not been met.
    - Failure to meet standards
      - Feeling they have not met their own personal standards resulting in intense self-critical thinking. This reinforces the notion that self-worth is dependent on striving.
    - Temporarily meeting standards
      - When achieving their standards, they discount their successes and see them as 'no big deal', or that anyone could have achieved it.
      - Often results in resetting the standard and trying to achieve even higher standards.
      - Even when meeting their standards, they do not feel satisfied and their self-evaluation, which is based on striving and achievement, is again reinforced.

- Avoidance of meeting standards
  - Avoiding meeting one's inflexible standards and rules because of intense worry and anxiety of whether they can be met. Procrastination can also be seen as avoidance behaviours.
- Performance-related behaviour
  - Methods to check how well they are meeting their standards or to help them achieve their goals:
    - Goal achievement behaviours
      - Engaging in performance-related behaviours to meet their goals.
    - Testing performance
      - Testing how well one thinks you are doing at a task.
    - Comparisons
      - Measuring one's performance against others.
      - Clinical perfectionism encourages 'upward social comparison', defined as comparing oneself against others who are perceived to be much better.
    - Reassurance seeking
      - Trying to ascertain how well one is meeting standards by asking others for their impressions.
      - Excessive reassurance seeking creates fleeting moments of reassurance and maintains anxiety about performance.

- Counterproductive behaviours and self-criticism
  - Behaviours displayed to reduce concerns about performance, or to feel more at ease about their performance.

The authors conducted an extensive review on the literature on perfectionism and how perfectionism had repeatedly been associated with the cause, maintenance, and progression of various psychopathologies such as anxiety, depression and eating disorders (e.g. Antony, Purdon, Huta & Swinson, 1998; Flett, Besser, Davis & Hewitt, 2003; Shafran et al, 2002; Sutander-Pinnock et al., 2003). Their revised model paved the way for a better understanding of perfectionism from a transdiagnostic perspective. Their formulation moved beyond the basic definition of a transdiagnostic process, to also incorporate risk and maintenance factors. In their view, the problem with perfectionism is not the actual goals and standards that are a problem, but the evaluation of self, based upon meeting one's standards (Egan et al., 2014).

An advantage of considering the transdiagnostic approach is the de-emphasis of diagnostic categories. Attention is rather focussed on addressing the critical constructs maintaining an ED, regardless of the diagnostic status (i.e. AN or BN). Also, a range of transdiagnostic treatments have been found to be effective. Transdiagnostic approaches emphasise that targeting key, critical processes that maintain a range of disorders is likely to be more effective and efficient in dealing with comorbidity, rather than multiple disorder-specific interventions. Providing a

treatment that is transdiagnostic, with one set of principles is easier and more efficient and will help evidence-based therapies (Egan et al., 2014).

When considering The Revised Cognitive-behavioural model of Clinical Perfectionism, it represents a useful framework through which to understand and explain the interactive effects of the different components of perfectionism. It provides more in-depth detail as to understanding how people engage with their perfectionism than the 2x2 Model of Dispositional Perfectionism. It also offers a better understanding about perfectionism's interaction with specific pathologies (like an ED), and illustrates the potential negative effects on the perfectionist's psychological functioning.

When considering my emerged PEDSS model in relation to Shafran et al.'s (2010) Revised Cognitive-behavioural Model of Clinical Perfectionism, both models attempt to describe and depict the interaction of thought processes of perfectionism. The main difference is noted where Shafran et al.'s (2010) model describes the problem of low self-worth as being overly dependent on striving and achievement: They explain a process whereby the low self-worth is continually maintained through either achieving or failing to maintain strict standards, followed by undue criticism or appraising them as insufficiently demanding. My emerged PEDSS model is more descriptive in its interpretation of the inherent low self-worth experienced, depicting it as a *war with the self*. To *become a better version of oneself*, there is engagement with demanding standards and achievement. Shafran et al.'s (2010) model seems to delineate recovery in terms of merely discontinuing the dysfunctional cycle of thoughts and behaviours, and does not really unpack how the recovery process

would affect the individual. In my emerged PEDSS model, recovery is described in more qualitative detail in the development of an improved relationship with the *Self* and the discontinued process of striving for *The Ideal: Self-Perfection*.

#### **7.4 Discussion of the grounded theory findings:**

##### **Placing the emergent PEDSS theory within the context of existing literature on perfectionism**

The results of the GT analysis produced an emerging theory: The Perfectionistic Eating Disorder Self-Schema (PEDSS), which is new in the realm of treatment resistant cases of eating disorders. The following section discusses the findings of the grounded theory analysis, and considers the PEDSS theory within the context of literature on perfectionism by comparing it to existing research and commentary.

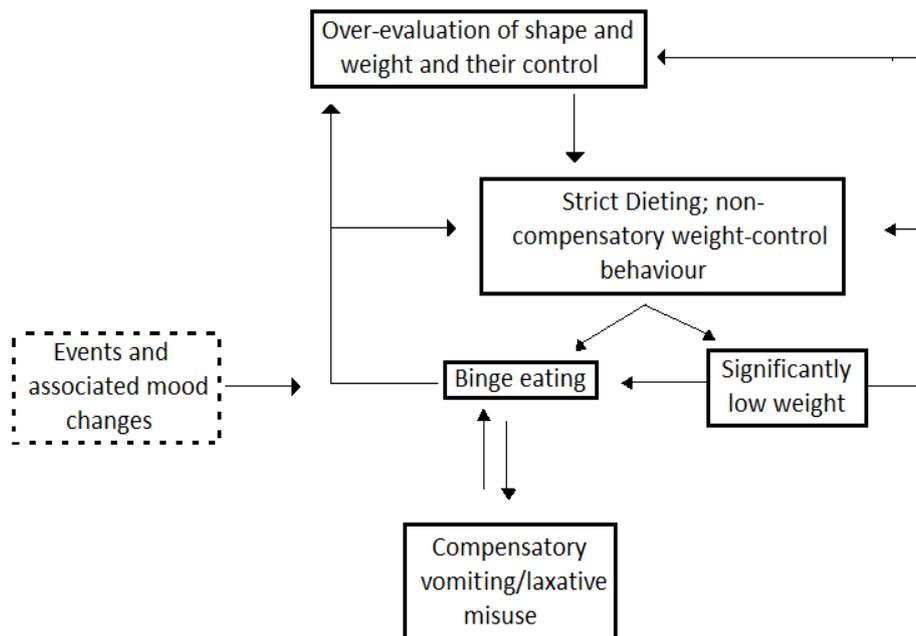
As this study focuses on understanding perfectionism within treatment resistant eating disorders, any theory that would be generated from the data analysis needs to be compared with existing theories that focus on the topic in question as closely as possible. In considering the available literature that combines theories of perfectionism and eating disorders into one, Fairburn's (2008) Transdiagnostic model of Eating Disorders was selected. His model focuses on understanding the processes of eating disorders and includes clinical perfectionism as part of its conceptualisation in difficult cases. In this regard, it seems to provide the best basis for understanding the relevance and applicability of my emerged PEDSS model through integration and comparison.

#### **7.4.1 The Transdiagnostic model of Eating Disorders (Fairburn, 2008)**

Dr. Cristopher Fairburn is a Professor of Psychiatry at the University of Oxford (England, United Kingdom), and a well-known international authority on eating disorders and its treatment. He is credited as the author of CBT-E (Cognitive-behaviour Therapy – Enhanced), a leading treatment intervention for sufferers of AN and BN (Fairburn, 2008). It has been shown to be effective in the treatment of eating disorders (Fairburn et al., 2009).

In keeping with previous cognitive-behavioural conceptions of eating disorders, Fairburn's view is that an eating disorder's *core psychopathology* revolves around the over-evaluation of shape and weight and the control of these aspects. This infers that the judging of self-worth is largely, or even exclusively, in terms of shape and weight and the person's ability to control it. This view is similar for both AN and BN. His model of eating disorders is termed 'The Transdiagnostic Cognitive-behavioural Theory', with the view that both AN and BN share the essential core psychopathology, which is then expressed in similar attitudes and behaviours. For him the difference between AN and BN lies in the relative balance of the undereating and overeating, and its effect on body weight. The core psychopathology has the consequence of behaviours which either serves to manipulate aspects of food or weight or concludes itself in a cyclic repetitive pattern (Fairburn, 2008). He offers the following figure to illustrate the composite transdiagnostic cognitive behavioural theory, as experienced in the repetitive cycle of behaviours within eating disorders (Fairburn, 2008, p.21):

**Figure 7.5: The Transdiagnostic Cognitive-behavioural theory of Eating Disorders (Fairburn, 2008, p. 21)**



Fairburn’s (2008) illustration depicts a maladaptive repetitive cycle with key steps that the individual engages in during the manipulation of food intake and weight. The core psychopathology at the top of the model identifies the over-evaluation of shape and weight dominating the individual’s thoughts. From there the individual engages in eating disordered behaviours which, instead of assisting to dissipate the anxiety about shape and weight, increases it and maintains the cycle. According to Fairburn (2008), the core psychopathology of over-evaluation occupies the central element in the person’s eating disorder problem, which must be addressed in order to prevent relapse. Coming to understand the ED sufferer’s schema of self-evaluation is vital, which includes identifying the specific areas of life that are important to their self-evaluation, as well as exploring each area’s relative importance towards the self-evaluation process.

Although Fairburn usually advocates using a '*focused*' form of his CBT-E program (i.e. 20 contact sessions between therapist and the client) as the standard for most individuals undergoing eating disorder treatment, there is also a '*broad*' form (i.e. 40 contact sessions between therapist and client). The broad version of the treatment is designed for clients for "whom certain mechanisms external to the eating disorder psychopathology maintain this psychopathology and thereby obstruct change" (Fairburn, 2008, p.197). These mechanisms deter a client from being able to successfully change their core problem of over-evaluation. These external mechanisms include Clinical Perfectionism, Core Low Self-esteem and Interpersonal Problems. For the purposes of comparing Fairburn's CBT-E to my emerged PEDSS model, I will focus on two of Fairburn's (2008) three aspects: Clinical Perfectionism and Core Low Self-esteem.

#### **7.4.1.1 The Transdiagnostic model of Eating Disorders:**

##### **Clinical Perfectionism**

According to Fairburn (2008), perfectionism is common among most people with eating disorders and often evident before the onset of an ED. At the extreme end of this trait is what Shafran et al. (2002) identify as 'clinical perfectionism':

*...a state in which this trait is so pronounced that the person's life is significantly impaired. It is our strong impression that clinical perfectionism interferes with treatment response. The psychopathology of clinical perfectionism is similar in form to that of an eating disorder. At its heart is the over-evaluation of achieving and achievement. People with clinical perfectionism judge themselves exclusively, in terms of working hard, and meeting, personally demanding standards in areas of life that are important to them. If they have a co-existing eating disorder, they also apply their extreme standards to their eating, weight*

*and shape and their control, and so they diet especially intensely and similarly rigorously in their exercising, body checking, etc. Thus the psychopathology of perfectionism intensifies aspects of the eating disorder and makes it harder to treat (p.199).*

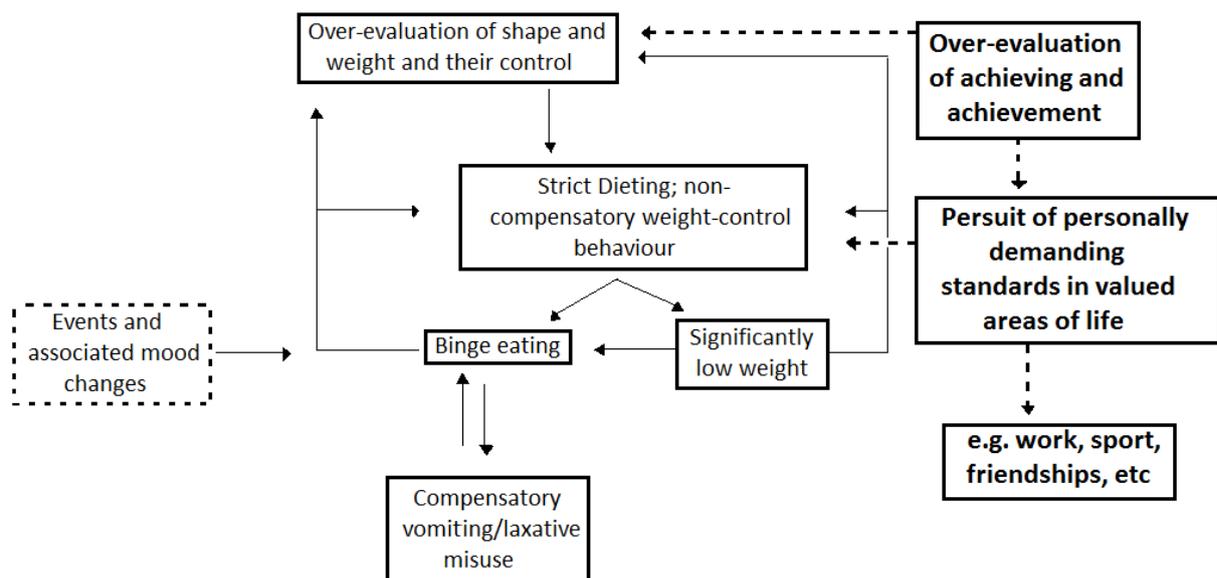
Fairburn (2008, p. 200) lists the following main features of *clinical perfectionism*:

- Over-evaluation of achieving and achievement in valued domains of life (expressed in areas such as work, performance at sports or music, etc., and in the eating disorder itself).
- Marginalisation of other aspects of life.
- Rigorous pursuit of personally demanding standards despite this having adverse effects on actual performance and causing impairment in other aspects of life.
- Discounting successes and resetting standards if goals are met (e.g. if your goal is met, it is immediately replaced by a new, even more demanding one).
- Repeated performance-checking (i.e. checking that one's performance meets one's personal standards and comparing it with that of others).
- Fear of failing to meet personal standards.
- Avoiding crucial tests of performance (e.g. not submitting work) for fear that one's performance will not be good enough.
- Preoccupation with thoughts about performance.

According to the findings of this research study, it is my opinion that all of the above aspects were present to varying degrees in the research participants, which qualifies the information obtained as accurate to the extent that those providing it were struggling with *clinical perfectionism*.

When Fairburn considers *clinical perfectionism* within the transdiagnostic formulation of eating disorders, he offers the following figure to recognise the influence of *clinical perfectionism* in the classic CBT-E conceptualisation (Fairburn, 2008, p.201):

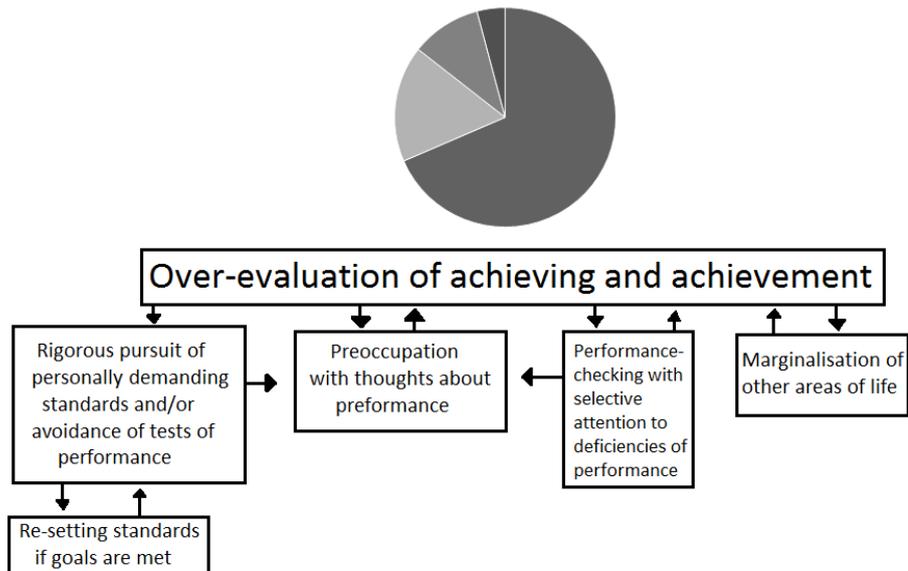
**Figure 7.6: Fairburn’s Transdiagnostic formulation with Clinical Perfectionism added (Fairburn, 2008, p. 201)**



Cognitive-behavioural treatments for eating disorders usually encourage patients to decrease negative attitudinal and behavioural restraints upon eating behaviour (Ghent, 2005). Fairburn’s (2008) treatment strategy advocated in CBT-E for clinical perfectionism is similar to the program’s efforts in addressing the over-evaluation of shape and weight. Within Fairburn’s (2008) revised model (i.e. the ‘*broad form*’), he views the individual’s Self-Schema for over-evaluation as being dominated by their over-evaluation of achieving and achievement. The over-evaluation of achieving and achievement pertains to their eating disorders and weight manipulation, as well as achievement in other areas of life they deem important. It has the consequence of marginalising other areas of life (see Figure 7.6), with the treatment model dictating

that the therapist teaches the client the importance of other domains of self-evaluation (Fairburn, 2008).

**Figure 7.7: The over-evaluation of achieving and achievement (Fairburn, 2008, p. 203)**



Fairburn’s (2008) therapeutic work with these clients regarding their *clinical perfectionism* commences with identifying the over-evaluation of achieving and its consequences, and then attempts to enhance the importance of other areas of life. Goals and striving for goals are addressed, as well as performance checking and aspects of avoidance, which is driven by the fear of failure or not being good enough (i.e. avoidance of their own assessment of performance, or objective measures of performance). Exploration of the origins of over-evaluation of achievement is considered and work is done with the client to teach them to manipulate the perfectionist mindset as they move towards minimising the risk of relapse.

Fairburn (2008) encourages these clients to partake in activities for the sake of pure enjoyment, although he acknowledges that it is difficult for them to do so. He suggests involving significant others and focusing on activities that cannot be *measured with regard to performance* (e.g. reading a book, listening to music). He comments on performance checking and the need to address it, as this tends to be a potent mechanism in maintaining over-evaluation. This needs to be done generally, as well as in relation to weight (weight and weight checking) and shape (shape checking). According to Fairburn (2008) spontaneity and unpredictability can also assist with over-evaluation of achieving, although these are difficult to tolerate. By educating them on more appropriate work habits (as they work exceptionally hard), they might be able to develop marginalised domains of self-evaluation. Making them accept lower levels of performance may also be necessary, which is rationalised by explaining that they will essentially become 'more effective' in life (Fairburn 2008).

#### **7.4.1.2 The Transdiagnostic model of Eating Disorders:**

##### **Core Low Self-Esteem**

Although my emerged PEDSS model agrees with Fairburn's (2008) Transdiagnostic model of Eating Disorders with added Clinical Perfectionism, it (i.e. *clinical perfectionism*) does not provide much detail as to the destructive element of critical judgement and how these individuals struggle with their extreme low self-esteem (i.e. the '*War with the self*'). To this end, Fairburn offers another external mechanism which he identifies in deterring an eating disordered client from changing: Core Low Self-Esteem. This extreme *core low self-esteem* in populations of ED clients presents itself in two main processes (Fairburn, 2008, p.208):

1. The intensity of the low self-esteem leads them to strive extremely hard to control the eating, shape and weight to gain some sense of self-worth. This makes it very difficult for them to moderate their dieting, exercising, body checking, etc. Thus, this mechanism drives the eating disorder.
2. The pervasive nature of these clients' negative view of themselves results in them seeing little or no prospect of recovery. Essentially, these patients write themselves off from the beginning and do therefore not fully engage in treatment.

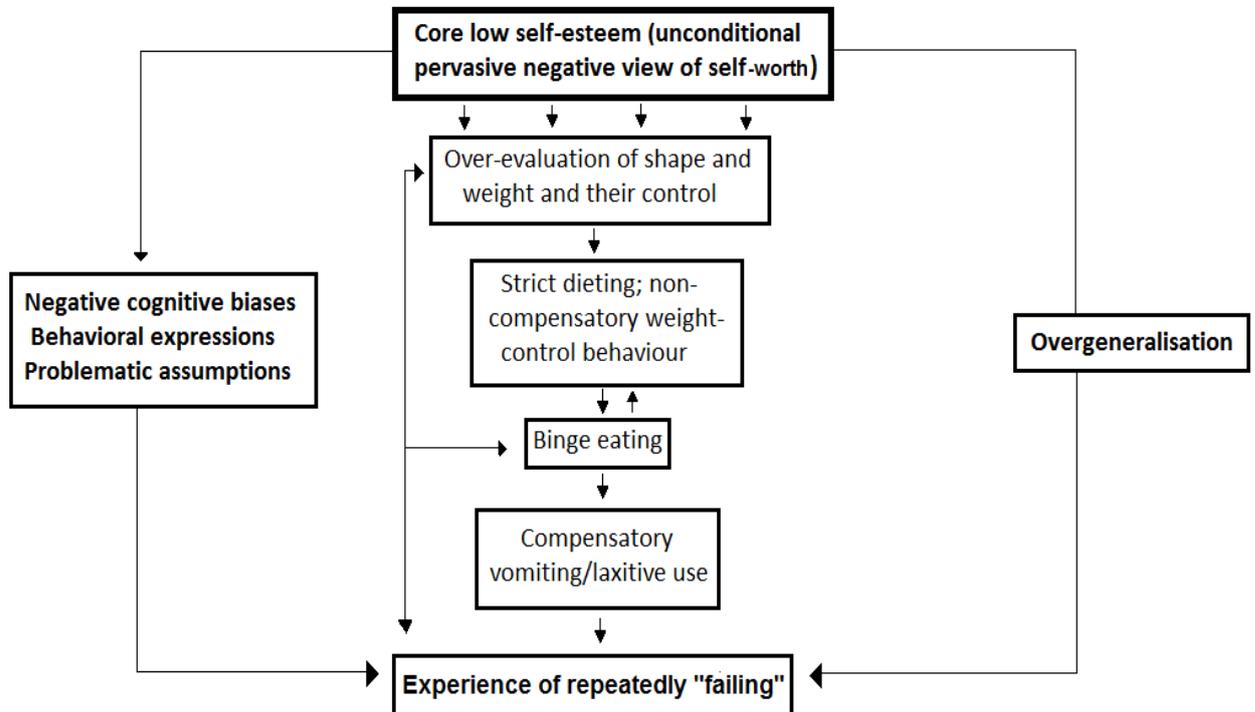
Fairburn lists the following main features of *core low self-esteem* (Fairburn, 2008, p.209):

- A pervasive negative view of self-worth that is long-standing and not explained by the presence of clinical depression. They believe that they have little or no value as people and they describe themselves using terms such as 'worthless', 'useless', 'stupid', 'unlovable', or a 'failure'.
- Negative view of the future and the possibility of change.
- Pronounced negative cognitive processing biases.

According to the findings in this study, all of the above aspects were present to varying degrees in the participant population, which qualifies the information obtained as accurate to the extent that those providing it were struggling with *core low self-esteem*.

Fairburn offers the following figure to explain the interchange between *core low self-esteem* and an ED, within the transdiagnostic formulation (Fairburn, 2008, p. 210):

**Figure 7.8: Fairburn’s Transdiagnostic formulation with Core Low Self-esteem added (Fairburn, 2008, p. 210)**



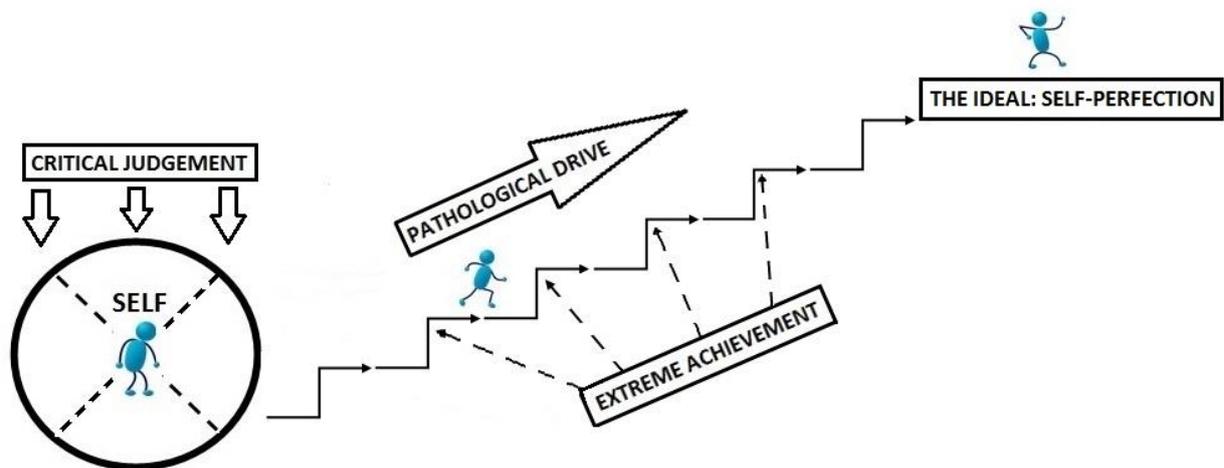
The therapeutic work with clients in Fairburn’s CBT-E on *core low self-esteem* starts with personalised education regarding the processes that maintain their low self-esteem. This is followed by a sustained focus on helping them recognise and correct, in real-time, those cognitive processes that maintain their negative self-evaluation. A ‘historical review’ is conducted to help explore how they acquired this negative view of themselves after which the client is then assisted to identify and start engaging in new and rewarding aspects of life. This helps them to formulate and accept and have a more balanced appraisal of the self-worth (Fairburn, 2008).

#### 7.4.2 Theory integration:

### The Perfectionistic Eating Disorder Self-Schema (PEDSS) VS The Transdiagnostic model of Eating Disorders

To place my emerged PEDSS model within current literature, a theoretical integration and comparison will be made with Fairburn's (2008) Transdiagnostic CBT model of Eating Disorders, including the aspects of *clinical perfectionism* and *core low self-esteem*. Such an integration and comparison may serve as validation that the PEDSS model compares to current scientific literature, but may also indicate where the PEDSS model moves above-and-beyond Fairburn's (2008) work. To this end, Figure 7.9 is utilised to illustrate the step-by-step integration and comparison process.

**Figure 7.9: The Perfectionistic Eating Disorder Self-Schema (PEDSS)**



To integrate Fairburn's (2008) original Transdiagnostic CBT model (Figure 7.5) with the PEDSS model, each individual aspect of his model was analysed in depth, trying to understand the core idea of what each aspect conveys in relation to his overall theory. With this information, the different constructs of both theories were related to

each other based upon their inherent meaning and what they explain. This process is illustrated in Table 7.1 below, which includes a motivating statement as to how Fairburn’s (2008) constructs relate to the identified constructs within the PEDSS model:

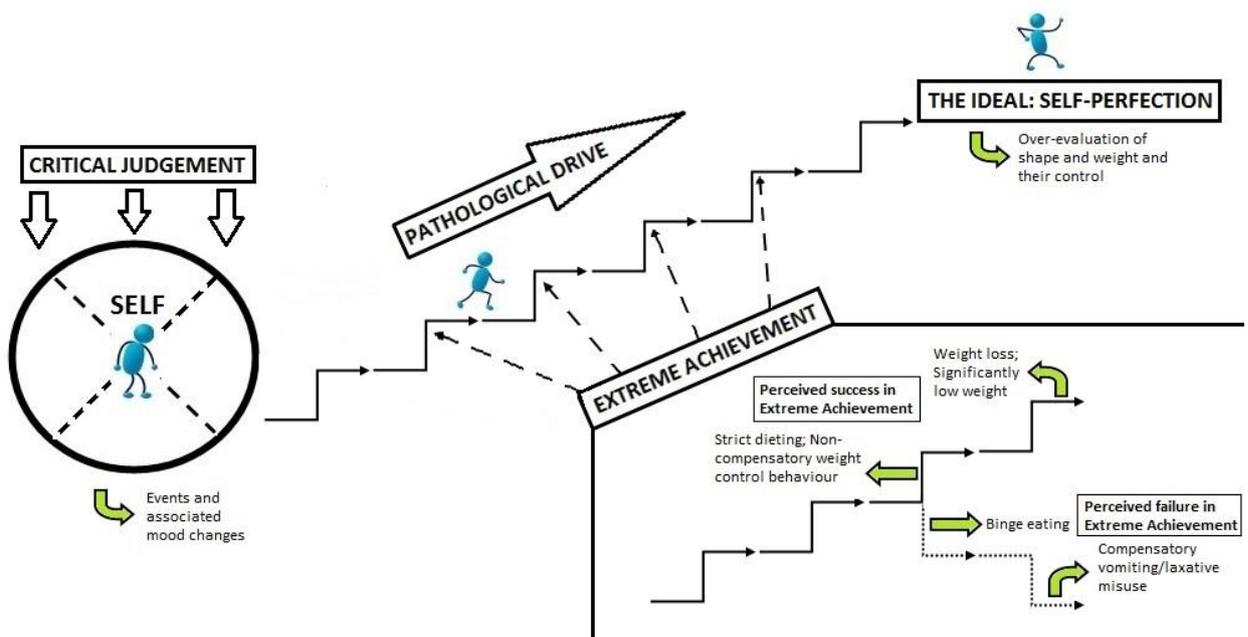
**Table 7.1: Comparing and relating Fairburn’s (2008) Transdiagnostic CBT model of Eating Disorders with my emerged Perfectionistic Eating Disorder Self-Schema**

<u>Fairburn’s (2008) individual constructs of the Transdiagnostic CBT model of Eating Disorders</u>	Compares and relates to...	<u>The individual constructs of the Perfectionistic Eating Disorder Self-Schema (PEDSS)</u>	<u>Motivating statement as to how the two constructs relate to each other</u>
Over-evaluation of shape and weight and their control.	↔	The Ideal: Self-Perfection.	The individual’s wish to achieve a specific shape and weight is present to an unhealthy degree. They over-evaluate its importance, as this forms part of the ideal that the individual wants to realise.
Strict dieting; Non-compensatory weight-control behaviours.	↔	Extreme Achievement (behaviours in the pursuit of the experience of success).	Efforts/behaviours invested with the aim of moving closer to their goal of the ideal (i.e. Extreme Achievement in the ‘upward’ direction).
Weight loss; Significant low weight.	↔	Extreme achievement (experience of success).	Results of strict dieting and weight control behaviours, resulting in an experience of succeeding to move closer to the ideal.
Binge eating.	↔	Extreme Achievement (behaviours in the experience of failure).	Behaviours which result in making the individual perceive that they are moving further away from the goal of the ideal (i.e. Extreme Achievement in the ‘downward’ direction).

Compensatory vomiting/laxatives misuse.	↔	Extreme Achievement (experience of failing).	Behaviours that serve to compensate for perceived failure of not being able to keep to strict dieting and weight control behaviours.
Events and associated mood changes.	↔	Self.	Thoughts and emotions about life events that the individual is conscious of.

Figure 7.10 illustrates how the PEDSS model incorporates Fairburn’s (2008) Transdiagnostic CBT model’s aspects (marked with green arrows). It is an adaption of Figure 7.9, and incorporates the analysis and integration conducted in Table 7.1. The PEDSS concept of *Extreme Achievement* is dissected further to include Fairburn’s (2008) behavioural concepts exhibited by the individual during the ED process:

**Figure 7.10: The Perfectionistic Eating Disorders Self-Schema combined with Fairburn’s (2008) Transdiagnostic Cognitive-behavioural model of Eating Disorders**



Fairburn's (2008) ideas on *core low self-esteem* and how it relates to experiences of failure, as well as the individual's continued pursuit of *success* (through weight control behaviours), assisted in dividing the concept of *Extreme Achievement* in the PEDSS model into two possible subsections: '*Perceived success in Extreme Achievement*' and '*Perceived failure in Extreme Achievement*'. These subsections relate to the perception and subjective experience of the individual during the *Extreme Achievement* process, which is depicted in 'upward' or 'downward' steps. In *Extreme Achievement* in the PEDSS model, an upward trend/line is delineated when the individual engages in *Strict dieting; Non-compensatory weight control behaviour*, which results in successfully achieving *Weight loss; Significantly low weight* at the corresponding horizontal step. This upward progression results in *Perceived success in Extreme Achievement*. In contrast, a downward trend/line is delineated to when the individual engages in *Binge eating*, which may result in *Compensatory vomiting/laxative misuse* being employed at the corresponding horizontal step. This downward progression results in *Perceived failure in Extreme Achievement*.

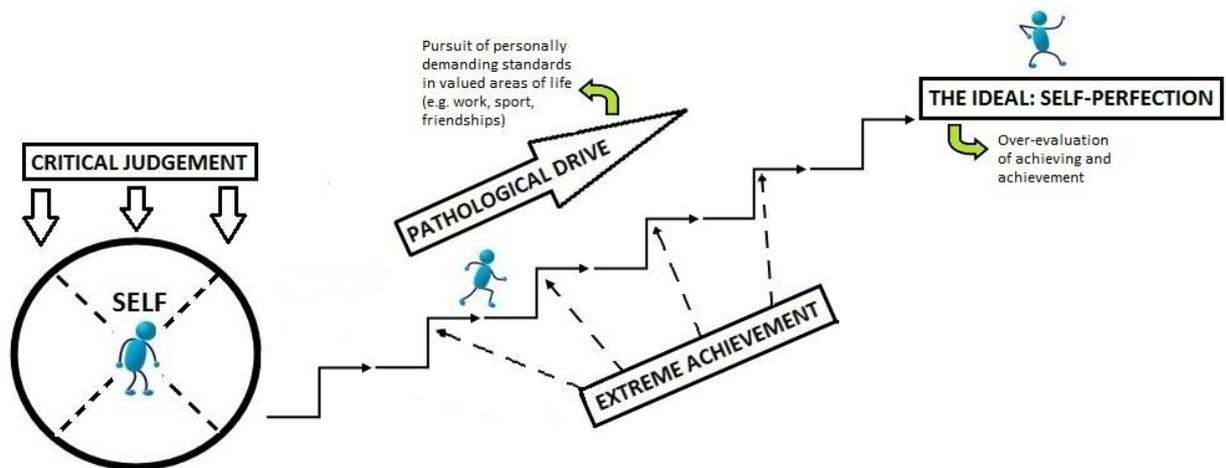
When considering Fairburn's (2008) Transdiagnostic formulation with Clinical Perfectionism added, the process of relating the different constructs of both theories was repeated, based upon their inherent meaning and what they explain. This process is illustrated in Table 7.2 below, which includes a motivating statement as to how Fairburn's (2008) constructs relate to the identified constructs within the PEDSS model:

**Table 7.2: Comparing and relating Fairburn’s (2008) Transdiagnostic CBT model of Eating Disorders with Clinical Perfectionism added, with my emerged Perfectionistic Eating Disorder Self-Schema**

<u>Fairburn’s (2008) individual constructs of the Transdiagnostic CBT model of Eating Disorders with Clinical Perfectionism added</u>	Compares and relates to...	<u>The individual constructs of the Perfectionistic Eating Disorder Self-Schema (PEDSS)</u>	<u>Motivating statement as to how the two constructs relate to each other</u>
Over-evaluation of achieving and achievement.	↔	The Ideal: Self-Perfection.	Achievement, and the importance thereof, is due to the individual’s strong desire to obtain perfection, which comes at a cost of most other areas of their lives and to the detriment of the Self.
Pursuit of personally demanding standards in valued areas of life (e.g. work, sport, friendships).	↔	Pathological Drive	Unhealthy drive is invested in areas that the individual judges to be extremely important. The amount of commitment invested into these achievement is unhealthy, and to the detriment of other areas of life.

Figure 7.11 is the PEDSS model, which includes Fairburn’s (2008) Transdiagnostic model with Clinical Perfectionism aspects added (marked with green arrows). It is a further adaption of Figure 7.9, and incorporates the analysis and integration conducted in Table 7.2.

**Figure 7.11: The Perfectionistic Eating Disorders Self-Schema combined with Fairburn’s (2008) aspect of over-evaluation of achieving and achievement**



Considering Fairburn’s (2008) Transdiagnostic formulation with Core Low Self-esteem added, again the process of relating the different constructs of both theories was repeated, based upon their inherent meaning and what they explain. This process is illustrated in Table 7.3 below, which includes a motivating statement as to how Fairburn’s (2008) constructs relate to the identified constructs within the PEDSS model:

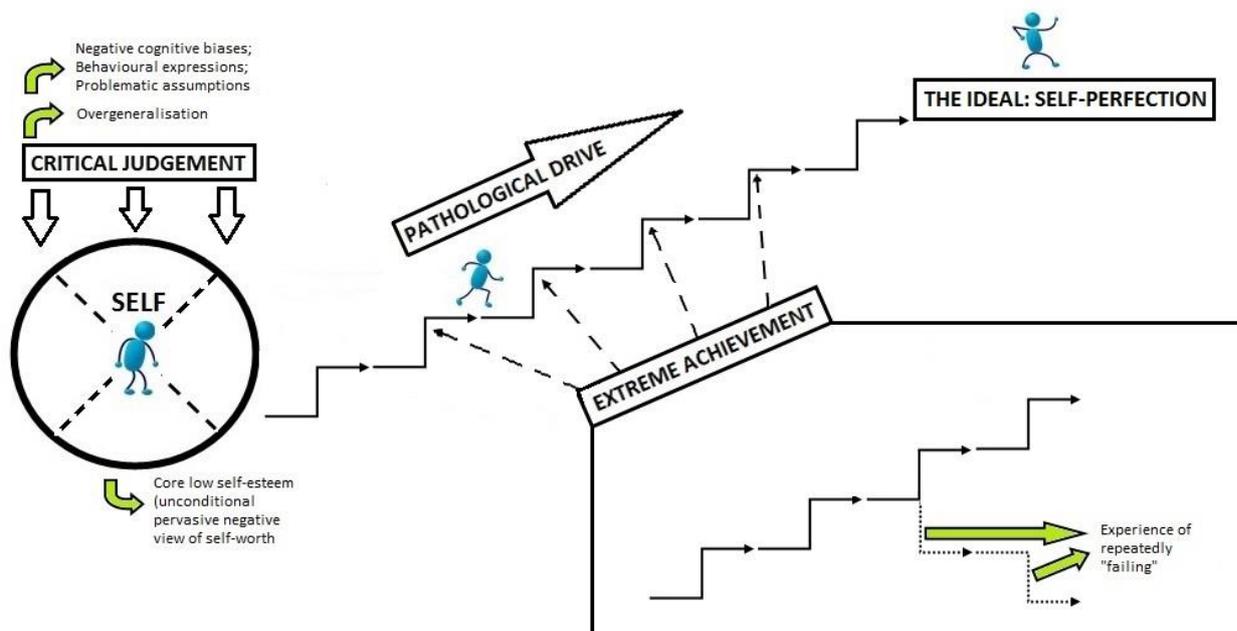
**Table 7.3: Comparing and relating Fairburn’s (2008) Transdiagnostic CBT model of Eating Disorders with Core Low Self-esteem added, with the Perfectionistic Eating Disorder Self-Schema**

<u>Fairburn’s (2008) individual constructs of the Transdiagnostic CBT model of Eating Disorders with Core Low Self-esteem added</u>	<u>Compares and relates to...</u>	<u>The individual constructs of the Perfectionistic Eating Disorder Self-Schema (PEDSS)</u>	<u>Motivating statement as to how the two constructs relate to each other</u>
Core low self-esteem (unconditional pervasive view of self-worth)	↔	Self	Thoughts and emotions about life events that the individual is conscious of.

Negative cognitive biases; Behavioural expressions; Problematic assumptions	↔	Critical Judgement	The individual's thoughts, beliefs, and judgements are overly critical. They focus on the negative and serve to put the person down.
Overgeneralisation	↔	Critical Judgement	Judgements of failure are over-exaggerated and their judgements of themselves become more negative,
Experience of repeatedly "failing"	↔	Extreme Achievement (experience of failing).	Perception of failing because they are not able to achieve or maintain demanding standards of achievement.

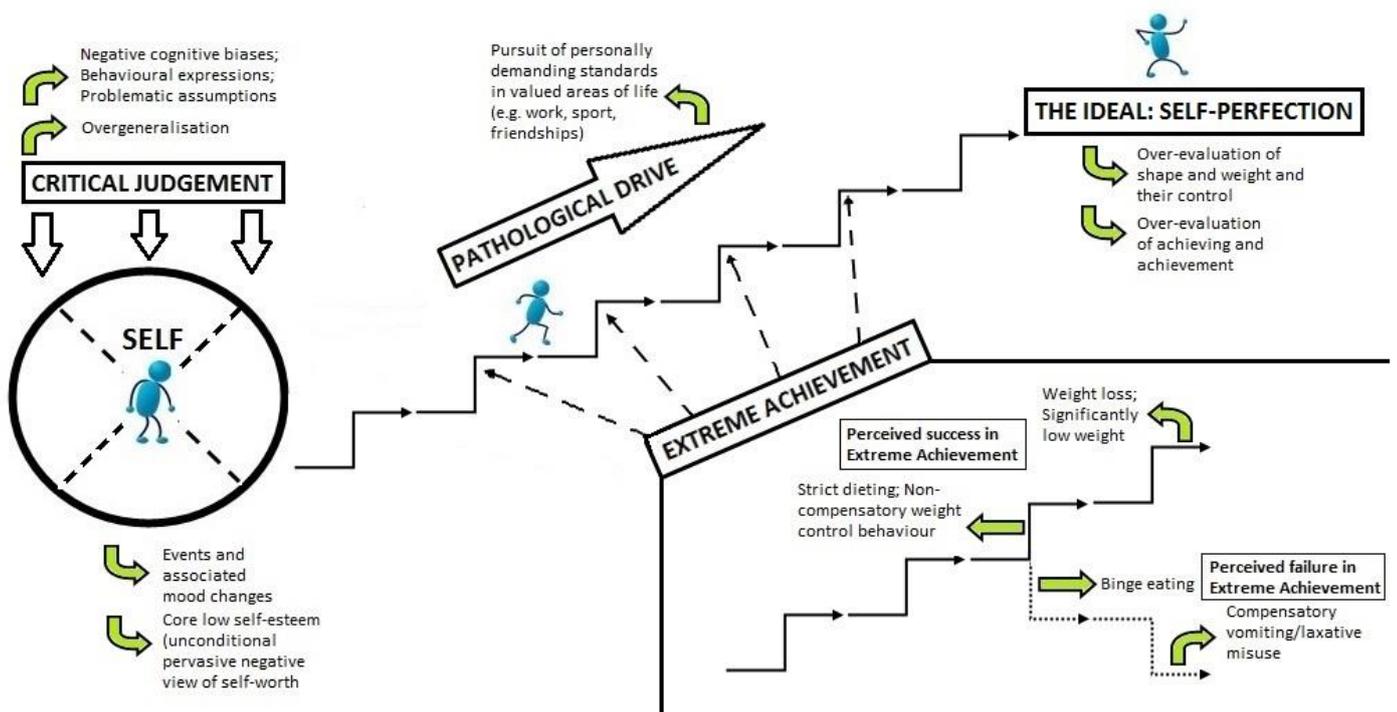
Figure 7.12 depicts the PEDSS model, which includes Fairburn's (2008) Transdiagnostic model with Core Low Self-esteem aspects added (marked with green arrows). It is the next level adaption of Figure 7.9, and incorporates the analysis and integration conducted in Table 7.3.

**Figure 7.12: The Perfectionistic Eating Disorders Self-Schema combined with Fairburn's (2008) aspect of Core Low Self-esteem**



Thus, in comparing and relating Fairburn's (2008) Transdiagnostic CBT model (including aspects of *clinical perfectionism* and *core low self-esteem*), the PEDSS model can account for all the aspects identified. Figure 7.13 depicts the PEDSS model, which includes Fairburn's (2008) Transdiagnostic model of Eating Disorders, including aspects of Clinical Perfectionism and Core Low Self-esteem (marked with green arrows). It is the completed adaption of Figure 7.9, and incorporates all the analyses and integrations conducted in Table 7.1., Table 7.2., and Table 7.3.

**Figure 7.13: The Perfectionistic Eating Disorders Self-Schema combined with Fairburn's (2008) Transdiagnostic model of Eating Disorders, including aspects of Clinical Perfectionism and Core Low Self-esteem**



### 7.4.3 Theory comparison:

#### The Perfectionistic Eating Disorder Self-Schema (PEDSS) VS

#### The Transdiagnostic model of Eating Disorders

A fundamental difference in underlying suppositions in treatment is evident between the PEDSS model and Fairburn's Transdiagnostic CBT-E model. Although Fairburn calls for a historical review of the individual's history in the CBT-E treatment process, some difficulty may arise in engaging with such a review when viewed from the perspective of the PEDSS model.

Firstly, in the event of attempting to understand one's perfectionism, it may essentially reveal where individuals have *gone wrong* in their lives regarding their own thinking processes. This personal reflection may itself be something that they would rather want to avoid, as it essentially may reveal imperfections in their own person. Secondly, in the cases of Cathy, Rochelle, Lara, Jane, Tracey and Pamela, who participated in this study, there was not even an awareness of their own tendency to strive for perfectionism. These research participants were so used to their way of thinking, that when they were enlightened of its possible influence, they merely claimed to be ignorant and could not provide much detail pertaining to its historical roots or current existence. Lastly, self-reflection is not a process which perfectionists easily engage in. They would rather focus on trying to understand what perfection, or their *Ideal: Self-Perfection*, should look like and actively work towards that, rather than try to understand the person they are, for whom they have significant discontent.

In this regard, the PEDSS theory suggests a different approach. By providing a framework in treatment for understanding perfectionism per se' and how it relates to the *Self*, ED clients may be assisted in dissecting their thought processes more constructively. By splitting the *Self* and *The Ideal: Self-Perfection*, the individual could possibly start to attribute which thoughts pertain to themselves, and which pertain to the situation around them (or their destructive thoughts). Which, from their perspective, means to understand who I inherently *am*, as opposed to understanding who I *want to become*? This is important, as during their struggle most of their mental- and physical efforts are towards their *Ideal: Self-Perfection*. There is a clear need to change these efforts to gaining more insight and understanding into their real *Self*, rather than delving further into *The Ideal: Self-Perfection* through *Extreme Achievement* via *Pathological Drive*. This process is also complicated as they actively avoid exploring their *Self*, as *Critical Judgement* makes them inherently hate their *Self*.

Fairburn's (2008) model is essentially more cyclic in its form, focusing more on repetitive cognitive- and behavioural processes in the maintenance of the ED. In Fairburn's model, perfectionism is merely seen as another hindrance in the ED problem. His model focuses more on the ED processes, with perfectionism being subordinate to it - simply a significant hindrance in the way of change within the healing process.

When comparing both theories/models, even though the aspect of 'over-evaluation of achievement' Fairburn identifies is strongly related to perfectionism, the process of perfectionism itself is not thoroughly explained. However, it is important to note that

Fairburn's models' primary focus falls upon eating disorders, not perfectionism. Compared to Fairburn's (2008) model, the emerging PEDSS theory clearly focuses mainly on the construct of perfectionism and attempts to understand how it contributes to developing eating disordered behaviours and thoughts. In the PEDSS model, perfectionism is something individuals *live* with and is much more enduring in their overall thoughts and emotions. The PEDSS model is more *linear* in form, describing a process of how the individual continually strives to reach the *Ideal: Self-Perfection* (i.e. perfection), and the functional value each step has (i.e. *Critical Judgement, Pathological Drive* and *Extreme Achievement*) in becoming an improved version of *Self*.

As with most cognitive-behavioural perspectives, understanding deeper rooted problems are approached from a logical step-by-step basis. Fairburn's (2008) model focuses more on describing the processes of dysfunctional behavioural and mental elements of an ED, and how perfectionism might increase such dysfunctionality. Although the link between achievement and its over-evaluation in ED clients is established, it does not provide an in-depth understanding of the construct and its functional value for the perfectionist and their thoughts and emotions (except that achievement is over-evaluated and that other areas of life are marginalised). Many ED clients would want to understand the nature of their over-achievement, understand its process, and how it affects their overall thinking processes. In this regard, my emerged PEDSS theory may assist them.

#### 7.4.4 Discussion of the individual PEDSS concepts

In the following section, each of the individual concepts of the emerged PEDSS theory will be discussed in relation to existing literature.

##### 7.4.4.1 The Self (i.e. 'The war with the Self')

St. Catherine of Siena (1347 – 1380), often being cited as one of the earliest case studies of AN, exemplifies *the war with the Self* in the face of the quote below. She practised what later came to be known as *holy self-hatred*, eating less and less until her death at age 33 (Egan et al., 2014):

*“Make a supreme effort to root out self-love from your heart and to plant in its place this holy self-hatred. This is the royal road by which we turn our back on mediocrity, and which leads us without fail to the summit of perfection” (p. 31).*

My emerged PEDSS theory describes a clear problem with perfectionism at the level of the *Self* with regard to treatment resistant ED clients. This problem is characterised by an *internal warfare* in which the person continually *attacks* him/her self by critically judging everything they do. In terms of their self-esteem and personal regard for their *Self*, it is extremely negative and self-demoting in nature. These individuals easily classify others above themselves, regarding others' opinions of them as more important and with higher regard, than their own opinions about themselves. Within their thinking, their own thoughts and emotions about the *Self* are not as important as what others think and feel about them and how they present to others around them seems crucially important to them.

*The war with the Self* in the face of perfectionism in treatment resistant ED clients is not purely a short-lived experience. Previous research has identified that perfectionistic thoughts and other cognitive distortions/biases may alter the personal experience of illness for an individual (e.g. Flett et al., 2011). Cognitive distortions, accompanied by having highly perfectionistic tendencies, are likely to exacerbate an already difficult and stressful situation (Hewitt & Flett, 1991b). In describing the potentially debilitating role of perfectionist thoughts in this process, Flett et al. (2011) suggest:

*“Chronic awareness of not being perfect while still feeling compelled and needing to achieve this essential personal goal should be a chronic source of stress and distress for certain perfectionists...” (p. 566).*

This means that the constant awareness of *being imperfect*, whilst being excessively focused on *wanting to be perfect*, becomes a constant enduring hindrance in developing a positive self-esteem. This then implies a chronic internal negative struggle within the person at the foundational level of their *Self* and blocks them from developing a positive relationship with themselves. It is within this culture of a negative view of *Self* (i.e. *‘The war with the Self’*) that the chances of development of an eating disorder thrives. This general negative Self-Schema, a core cognitive characteristic of an ED, has previously been described as ‘long-standing negative self-evaluation’ (Vitousek & Hollon, 1990). Ghent’s (2005) comments highlight that eating disorders could be described as disorders of the sense of self-esteem and self-worth which are without remedy, pervasively negative. Achieving self-control is the goal of ED individuals, who fear that they are not sufficiently worthy (Bruch, 1973; Katzman & Lee, 1997).

In this regard, perfectionism and eating disorders match each other in terms of the negative view of *Self*, and both provide aligned solutions to deal with this problem. Through constantly pursuing *The Ideal: Self-Perfection through Extreme Achievement* via a *Pathological Drive*, both perfectionism and eating disorders guide the individual's behaviours through maladaptive mechanisms. Essentially, the solution to improve this negative Self-Schema is found in earning self-worth through achievements (such as, among others, achieving an ideal body weight and shape, exerting control over various aspects of life, maintaining strict disciplined living standards, obtaining high levels of achievement, etc.).

#### **7.4.4.2 Critical Judgement**

Sutandar-Pinnock (2001) emphasises that the driving force behind perfectionists' unending efforts is continual self-belittlement which is motivated by the fear of failure. These individuals constantly worry about their perceived deficiencies (i.e. the *Self*) and how to avoid making mistakes (i.e. how this would portray them to others). Making mistakes is endured with extreme discomfort.

The aspect of *Critical Judgement* in my emerged PEDSS theory accounts for these aspects described by Sutandar-Pinnock (2001), in the individual's cognitive attempts to attack the *Self* through excessive critique and harsh negative self-talk. The model indicates the influence of maintaining high personal standards of eating psychopathology, as mediated by self-criticism. *Critical Judgement* is the main mechanism used to mobilise the perfectionist towards *Extreme Achievement* through *Pathological Drive*, which is in line with Sutandar-Pinnock's (2001) view.

Historically, cognitive processes have been implicated in the maintenance of perfectionism. For example, Hollander (1965) observed that perfectionists were prone to selectively attend to certain features of their surroundings. He stated that the individual is:

*“... constantly on the alert for what is wrong and seldom focuses on what is right. He looks so intently for defects or flaws that he lives his life as though he were an inspector at the end of a production line” (p.95).*

Slade (1982) states that individuals who develop eating disorders “tend to see events and their own achievements in black-and-white terms, such that anything else less than idealised, perfect success or attainment represents failure and lack of success” (p. 171). When considering early definitions of perfectionism, they often focused on the dysfunctional cognitive style that presented itself in the dialogue of many highly perfectionistic individuals. Horney (1950) described the perfectionists’ inner drive and narrative which dictated what they *should* and *should not* do in a given situation. The harsh self-talk was alleged to lead perfectionists to impose upon themselves unrealistic and impossible standards, without considering the internal or external factors that may influence their achievement of such goals (Horney, 1950).

These statements concur with my emerged PEDSS theory about ED clients who are engaged in a constant *war with the Self*. *Critical Judgement* serves as the method to belittle the *Self* through most of the cognitive errors. This idea is consistent with Dunkley et al.’s (2006) finding that self-criticism substantially accounts for the relationship between perfectionism and depressive, anxious, and eating disorder symptoms, and adds further support to the emerging PEDSS theory’s framework

delineating negative self-criticism (i.e. *Critical Judgement*) as a core indicator of dysfunctional perfectionism (Taranis, 2010).

Lorin Taranis (2010) suggests that treatment efficacy may be enhanced if therapists are aware of the specific cognitive content and functional utility of the self-critical tendencies associated with eating psychopathology. She states that while self-criticism is clearly an important component in the context of eating disorders, the specific *form* these self-critical tendencies take (i.e., the typical style of thinking about themselves when faced with failure) and the *functional utility* of these cognitions for the individual, remain unknown. Thompson and Zuroff (2004) proposed a model of self-criticism. Their model identifies two different forms of self-criticism:

1. Comparative Self-criticism (negative comparisons with others).
2. Internalised Self-criticism (self-directed criticism over failing to meet internal, personal standards).

Considering that the key aspect of Shafran et al.'s (2002) Clinical Perfectionism Model is that self-criticism occurs in response to a perceived failure to meet personal standards that are self-imposed and internalised, it follows that internalised self-criticism should be a stronger predictor of eating psychopathology than comparative self-criticism. In addition, Gilbert, Clark, Hempel, Miles and Irons (2004) found that the specific form self-criticism takes, serves one of two functional utilities (i.e. the reason for the criticism) by differing on three dimensions (Taranis, 2010):

- Maladaptive/dysfunctional self-criticism for persecution of self
  - Inadequate Self (specific self-criticisms that focus on disappointment, inferiority and feelings of inadequacy).
  - Hated Self (specific self-criticisms that focus on self-disgust and self-hatred).

- Adaptive self-criticisms for improvement of self
  - Self-reassurance (focus on reassuring the self through self-correction).

Lorin Taranis' (2010) research findings are compatible with my emerged PEDSS theory, in which the influence of high personal standards of ED clients is mediated via self-criticism (i.e. *Critical Judgement*). Her findings demonstrate that the specific form of self-criticism associated with eating psychopathology is characterised by self-criticisms that focus on a failure to live up to internal, personal standards that are high and constantly receding. This supports the view that *clinical perfectionism* in the context of eating disorders can be considered uni-dimensional (Shafran et al., 2002). Whilst both *normal* (i.e. adaptive) and *clinical* (i.e. maladaptive) dimensions of perfectionism are characterised by high personal standards, *clinical perfectionism* is uniquely characterised by high standards that are constantly receding, and when unmet they are reacted to with punitive self-criticism (i.e. *Critical Judgement*) (Shafran et al., 2002).

Thus, the emerging PEDSS theory's description of *Critical Judgement* substantially accounts for a clear distinct relationship between perfectionistic high standards and eating psychopathology. This is consistent with Dunkley et al.'s (2006) findings which delineates negative self-criticism as a primary indicator of dysfunctional perfectionism in eating disorders. In addition, the emerging theory also extends its findings on *Critical Judgement* by detailing the form and function of the self-criticism in its relation to treatment resistant eating psychopathology in the pursuit of *The Ideal: Self-Perfection*.

#### 7.4.4.3 The Ideal: Self-Perfection

My emerged PEDSS theory describes a constant pursuit of *The Ideal: Self-Perfection*. As previously mentioned, perfectionism has been described as the consequence of certain external influences: Western cultural influences (Brown, 1993; Nielson, 2000; Selvini-Palazolli, 1985), mass media contributories (Anthony & Swinson, 2009; Dietz, 1990; Harrison & Cantor, 1997) as well as social learning influences (Anthony & Swinson, 2009; Harrison & Cantor, 1997; Levine, 2000). These findings account for influences from the external environment that could influence the perfectionist's definition of the ideal self, as well as its importance in becoming that ideal. Ellis (2002) provides a good portrayal of the all-encompassing and biased cognitions present in the inner dialogue of the perfectionist:

*“A person should be thoroughly competent, adequate and intelligent in all possible respects; the main goal and purpose of life is achievement and success; incompetence in anything whatsoever is an indication that a person is inadequate or valueless” (Ellis, 1962).*

The perfectionist's conviction and belief in *The Ideal: Self-Perfection* as something positive and of worth, is extreme. Anthony and Swinson (2009) stress the importance of understanding to what extent one's beliefs are inflexible: The more inflexible one's beliefs and the more situations in which one has inflexible opinions, the more likely one is to struggle with perfectionistic thinking. Flett et al. (2011) emphasises that one of the main difficulties for the perfectionist appears to be an inability to disengage cognitively from the need to keep pushing towards the achievement of perfection. Constantly noting their own discrepancy between the *Self* and *The Ideal: Self-Perfection*, only seems to reinforce their conviction to pursue *Extreme Achievements* as a mechanism to becoming *The Ideal: Self-Perfection*.

*The Ideal: Self-Perfection* also relates to their conception of the perfect body shape and weight, the perfect diet and exercise program, the perfect behaviour, the perfect relationships, etc. This accounts for the interplay between perfectionism and treatment resistant eating disorders in the pursuit of perfection and *The Ideal: Self-Perfection*. The self-presentational nature of perfectionism has previously been described by Hewitt et al. (2003) and is considered an integral component of the maladaptive perfectionism within my emerged PEDSS theory. Self-presentation has been described as a method employed by individuals in their attempts to control other peoples' impressions and opinions of them, implying that these individuals will do whatever they can to try and create the best possible impression to others in any given situation. To achieve this, they only present information that portrays them in a favourable light, whilst concealing information that could jeopardise the desired ideal image they wish to portray (Williams, 2015). Hewitt et al. (2003) view the self-presentational aspect of perfectionism as a dual drive towards wanting to appear perfect always (i.e. an image of flawlessness), encompassing two specific motivational components:

1. The desire to demonstrate one's perfection to the world (self-promotion).
2. The desire to conceal one's imperfections from others (self-concealment).

Hewitt et al.'s (2003) proposed self-presentational aspects of perfectionism seem to be related specifically to masking the extent of both psychological and physical 'defects', creating problems when having to deal with these issues, affecting the likelihood that perfectionists will seek help or support for themselves. Self-presentation provides insight into how perfectionists make decisions concerning their health and wellbeing as opposed to how they look.

#### 7.4.4.4 Extreme Achievement

My emerged PEDSS theory highlights the importance of *Extreme Achievement* as the mechanism to become *The Ideal: Self-Perfection*. Liz Jones (as cited in Egan et al., 2014) highlights the concept of *Extreme Achievement* in the following personal comment:

*It makes no sense, but I'd rather be thin than happy and healthy. ...It's so pathetic to admit that a grown woman, and a fairly acceptable one, has her world ruled by how many calories she ingests...and that the only pleasures in life are to see how concave you can make your stomach, how many ribs you can count, how normal it is to feel faints, to see stars, to be so weak you can some days hardly stand (p.33).*

Egan et al. (2014) state that eating disorders are often associated with both the desire to be perfect and low self-esteem or self-efficacy. Hence, it produces a destructive combination, highly valuing achievement but feeling intrinsically unable to attain it, and downplaying any achievements as being insufficient. The main domain of achievement in eating disorders becomes destructive, wreaking havoc on both physical and psychological health, such that it interferes with, or prevents achievement in other domains. Thus, the only domain that remains and is valued is the domain of eating.

When self-worth is judged mainly in terms of the degree to which one can achieve demanding or rigid standards, it is difficult to move away from the influence of *clinical perfectionism* (Egan et al., 2014). Flett et al. (2011) describe how perfectionists appear to have specific difficulties in dealing with health problems when they interfere with the achievement of their goals. This highlights how much importance

perfectionists place on achievement of extreme personal standards, expectations and goals. If no *Extreme Achievement* can be obtained, the individual remains within the cycle of discontent of the *Self* via *Critical Judgement*. Also, as Fairburn (2008) highlights, the degree of achievement must also be of a high enough calibre, otherwise the achievement itself is belittled and no positive consequences towards the *Self* are experienced.

Williams (2015) highlights that it may be particularly stressful for perfectionists when treatment interferes with the achievement of goals and standards. Even in the light of understanding that the pursuit of unrealistically high standards may be detrimental to their health, perfectionistic individuals may still find it hard to let go of them. Williams (2015) poses the following possible reasons for this:

- Individuals may perceive that their high standards have, for the most part, served them well (e.g. achieving high standards in the work place that resulted in achieving a promotion).
- Perfectionistic beliefs have often had their origins in childhood and therefore such ingrained personality traits are difficult to change.
- Greenspon (as cited in Williams, 2015) highlights that we live in a society where perfectionistic traits are necessary to deal with the fierce competition that exists in the workplace. Western society rewards you to push yourself to reach high standards. Such traits are often praised which makes it almost inconceivable for some perfectionists to consider adjusting their standards.

If the perfectionist is hindered in their pursuit of *Extreme Achievement* to the extent that failures result (or are not achieved to the expected standard), they experience increased amounts of stress (Hewitt & Flett, 2002). This is the result of the combined

negative effect of both the poor opinion of *Self*, as well as the *Critical Judgement* the individual imposes on the *Self*. Failures in this regard can account for the significant negative emotions that the ED clients experienced in this research.

#### **7.4.4.5 Pathological Drive**

My emerged PEDSS theory identifies *Pathological Drive* and how it assists the perfectionist in obtaining *Extreme Achievement* in the pursuit of *The Ideal: Self-Perfection*.

Williams (2015) highlights that there may be clear differences in the coping mechanisms utilised by perfectionists, specifically regarding their coping style. Perfectionistic individuals appear to rely more on avoidant- or emotion-focused coping in response to stressful situations (Flett et al., 2011). Such strategies, although providing short-term relief, may not be beneficial in the long-term as they do not address the source of the stress.

To explain this, I posit the following process:

By being pathologically driven (i.e. *Pathological Drive*), the perfectionist diverts his/her attention to the pursuit of attaining *Extreme Achievements*. When this is done successfully (i.e. *Perceived success in Extreme Achievement*), they experience feelings of control over their environment and their own inner state. A feeling of control is thus experienced as they exert extreme amounts of energy to the level of becoming pathologically driven. This provides them with comfort and a renewed sense of purpose at that moment – despite having a significant problem in their life. My assumption is, that they are not focused on their immediate problem, but rather just invest energy in being pathologically driven, which they

feel is an appropriate action as this would lead them closer to becoming *The Ideal: Self-Perfection* – which is a better version of *Self*, and, thus, a good thing. This denotes that there is no need to deal with the problem, as an improved version of *Self* is more important than the problem experienced.

My emerged theory describes how a *Pathological Drive* is associated with *Critical Judgement*, which supports previous descriptions of compulsive behaviours in eating disorder patients (e.g. Beumont, Arthur, Russell & Touyz, 1994). Hollander (1978) noted the confusion among psychotherapists between compulsiveness and perfectionism: Compulsiveness refers to "a pattern of behaviour that serves to fend off unacceptable feelings or impulses. Perfectionism refers to acts of performance designed to evoke commendation" (Hollander, 1978, p. 384). Perfectionism reaches for approval, while compulsiveness protects against disapproval. Compulsive individuals engage in ritualistic or highly stylised behaviour, while the perfectionist is goal-oriented and may carry an appropriate behaviour to the extreme (Hollander, 1978). Broday (1988) listed the differences between compulsive- and perfectionistic individuals:

- Compulsives adhere to rules, while perfectionists tend to resist rules.
- Compulsives are often dependable workers, whereas perfectionists are inefficient procrastinators.
- Compulsives are emotionally restrained, whereas perfectionists tend to be hostile and negative.

The severe drive for thinness in ED clients is viewed as an example of a *Pathological Drive*. Concurring with my emerged PEDSS theory's placing of a *Pathological Drive* in its relation to perfection and eating disorders, Ghent's (2005) findings state that a

low drive for thinness (i.e. low *Pathological Drive*) among AN patients is associated with less eating-related pathology (i.e. less restrained eating) and less severe psychopathology (Ghent, 2005). Consequently, a lower *Pathological Drive* implies a less intense pursuit of *Extreme Achievements* (i.e. severe food restriction), which ultimately results in less striving towards *The Ideal: Self-Perfection*, and more energy and time to focus on developing other aspects of life.

#### **7.4.4.6 Recovery**

My emerged PEDSS theory identifies the concept of *Recovery* where the individual ceases the *war with the Self*. This is manifest in the discontinued pursuit of *The Ideal: Self-Perfection* via mechanisms of *Extreme Achievement* and *Pathological Drive*, as an unhealthy response to *Critical Judgement* in the goal of improving the *Self*.

When considering their adherence to treatment plans and medication regimens research by Flett, Blankstein and Martin (1995) has highlighted that perfectionists generally have an elevated need for control and that adherence to treatment plans is likely to interfere with their need for personal regulation. Sutandar-Pinnock (2001) concurs and highlights that it may be difficult for individuals who are highly perfectionistic to engage in treatment programs where they are expected to share their problems and therefore reveal themselves to be *imperfect*. During the recovery process, Sutandar-Pinnock (2001) states that highly perfectionistic clients may be more easily discouraged by the *less than perfect path* to recovery. The client may be tempted to regress back into their eating disorder, which was a process they may feel competent in, rather than progressing towards unknown territory with multiple

possibilities for failure. When considering the length of treatment, some have argued that only long-term therapeutic interventions are likely to be beneficial due to the deep-rooted nature of many perfectionistic traits (e.g. Blatt, Quinlan, Pilkonis & Shea, 1995). It is argued that short term therapies may simply not be enough to address the core beliefs associated with the perfectionism construct. Furthermore, perfectionists are reluctant to let go of their unrealistically high standards during the treatment process (Williams, 2015).

The maintenance models of perfectionism of Shafran et al. (2002; 2010) and Fairburn's Transdiagnostic Model of Eating Disorders (2008) seem to focus more on symptom reduction in the pursuit of discontinuing the destructive cycle of pathological thoughts and behaviours. However, even though I believe these goals are necessary for successful treatment of an ED, my emerged PEDSS theory highlights that there should be treatment consideration beyond mere symptom reduction when considering recovery in treatment resistant eating disorders.

When considering the aspect of *Recovery*, my emerged PEDSS model encourages a new type of relationship to be developed with the *Self*, meaning that there will be some sort of experience of growth in the individual. This also positively affects relapse rates, as the individual discontinues to use the Perfectionistic Eating Disorder Self-Schema and bases their relationship with the *Self* on more meaningful and balanced criteria. This stage is depicted in Sarah's final remarks in her autobiography of her journey with bulimia nervosa (Jowell, 2011):

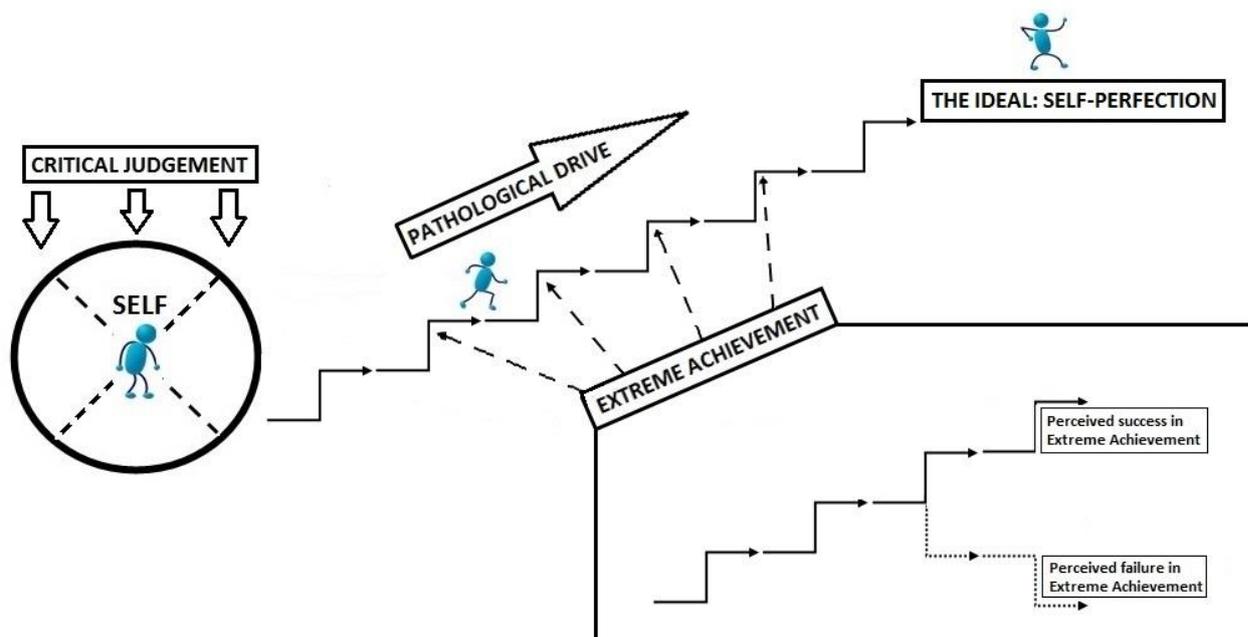
*I do think I look better these days. I'm starting to believe that the bony kind of structure isn't attractive at all. It's weird because I don't even know when I made that decision. I've spent so long being self-indulgent and self focused yet I*

*haven't looked after myself at all... And the more you value yourself, the less you want to fuck up yourself. You don't want to throw up all your food, and you don't want to cut,... because that's all devaluing you. In the clinics, I learned to do self affirmations and to recognise what I'm grateful for... I think I can safely say, after a long time of not being able to, that I'm starting to enjoy life again (p. 154).*

## 7.5 Discussion of the integrated findings:

**Understanding perfectionism in treatment resistant eating disorder clients through the experiences of the participants and The Perfectionistic Eating Disorder Self-Schema (PEDSS)**

**Figure 7.14: The Perfectionistic Eating Disorder Self-Schema (PEDSS)**



Since I immersed myself in the respondents' stories for such a long period during the process of data collection (more than 2 years), I now offer my own reflection and understanding of the study's findings. Although this is my subjective view, it forms

part of qualitative research where the researcher is viewed as the co-constructor of the new knowledge. I trust that this reflection will assist in providing the reader with the best possible understanding of perfectionism in treatment resistant eating disorder clients.

This study serves to understand perfectionism in treatment resistant ED clients. To understand perfectionism, I have described and then explained it in-depth using qualitative research methods. The focus of both qualitative procedures fell into the realm of the respondents' thoughts and feelings in their attempt to understand perfectionism in treatment resistant ED clients. Per the volume and depth of information obtained from the respondents regarding their personal lives during the data gathering procedure, I vouch that it accurately describes perfectionism in the treatment resistant ED clients that participated in this study.

Cognitive-behavioural therapy for eating disorders reviewed in this chapter seemingly aims to understand the maintenance factors of the problem, by addressing them directly. According to my experience, it is based more on cognitive logic and giving the client mechanisms to improve their behaviours, which may result in symptom reduction and improved overall functioning. Even though it is an effective therapeutic intervention for addressing eating disorders and the pathological behaviours clients portray, the resistance to change for treatment resistant clients is not so easily addressed. In treating resistant clients (as defined by this study), it seems their problem has more to do with the intense degree to how much the PEDSS schema has become fixed.

After having conducted the research, the study's findings have brought to light that perfectionism is a complex phenomenon involving a destructive Self-Schema which imposes debilitating structures on the sufferer's life, and positively influences the possible development and maintenance of an eating disordered lifestyle. These individuals function at the level of perfection: Their thoughts being directed to demote themselves on some level, to keep motivating themselves through the constant need to improve via achievement, in the search of an improved version of themselves. They portray a constant need to become a better version of *Self*, as they believe that they are of low self-worth. This strong belief hinders them to accept who they are, or develop a positive self-esteem.

The phenomenological analysis highlighted how perfectionism negatively impacts the sufferer on nine important aspects of their life (i.e. Emotions, Goals and decisions, Thought processes and beliefs, Judgement, The Self, Relationships, Behaviours and habits, Social and environmental influences, and Recovery). Together they describe the general experience of perfectionism within treatment resistant eating disorder clients. The respondents' inner worlds were portrayed through their descriptions of how they struggle to accept their *Self*, and how achieving perfection provides some dysfunctional relief. Even when hurting themselves seriously through adverse medical consequences for their choices and behaviours, convincing them that their strivings for perfection is futile, or inappropriate, remains a difficult challenge as they battle with the perfectionistic mentality.

The emerging PEDSS theory ties together five components of perfectionism, whilst the sixth component, *Recovery*, is more geared towards healing from perfectionism and an ED. The emerging theory posits each component's functional value and highlights how and where each one fits together with treatment resistant eating disorder clients' level of thoughts, emotions and behaviours. The emerging PEDSS theory is thus a model grounded in data, and its components have been shown to be identifiable within the current literature. In addition, in terms of eating pathology, the emerging theory provides a solid framework for the understanding of perfectionism in treatment resistant ED clients, which could positively influence therapeutic efficacy by enhancing the therapist's awareness of the structures, processes and utilities involved in dealing with such clients.

Ghent (2005) highlights that perfectionism and low self-esteem reflect a specific way of information processing, which may make individuals vulnerable to develop an ED. The PEDSS theory lays emphasis on the *Self*, and understanding the perfectionistic relationship the individual has with their own *Self*. In treatment resistant ED clients, the respondents' relationship with the *Self* was very unsympathetic and under-developed. The relationship was primarily focused on the vicious discontent the respondents had with their own *Self* and traced their attempts to resolve this discontent by striving for perfection and an Ideal Self. Taken together, the emerging PEDSS theory describes how *Extreme Achievement* and a *Pathological Drive* are constantly mediated using *Critical Judgement* in the pursuit of *The Ideal: Self-Perfection*. Thus, they never yearned to develop a relationship with themselves, to truly understand who they *are*. The way they are trying to develop a relationship with

themselves is to *become acceptable by becoming perfect* always trying to become someone they thought to be better than themselves.

In understanding the processes involved, all five components of perfectionism within the PEDSS model are in relationship with each other always. One can connect and relate any one of the elements to each other at any given time. The only element that is separate from the main theory is the concept of *Recovery*. *Recovery* stands on its own, providing a clear definition (or a process of transformation) to work towards during treatment for each of the other five components. However, the main process of *Recovery* leans specifically towards the *Self*. It is within the change in the way the relationship is fostered towards the *Self* that most of the other elements will either weaken or disappear automatically.

Living a lifestyle with a perfectionistic mindset is not sustainable. Whether the person gives in to their own mental exhaustion or whether their body gives in because of physical exhaustion through organ failure or illness, it is a battle to maintain their system of thinking (i.e. The Perfectionistic Eating Disorder Self-Schema) as they pursue what they believe to be good, right, and necessary. Some do manage to realise the error of their ways and decide to accept the self, which brings about maturity and personal growth. Unfortunately, others keep refusing to give up, as they probably view this as further *proof* of their own failure.

The development of eating disorders is chronic and closely linked to strong patterns of maladjusted thinking and emotional regulatory mechanisms. My experiences during this study showed that the reason for its slow, chronic development and

course, is attributed to the slow development of schemas. Pathological behaviours are *tried and tested* over the course of weeks and months, which then start to confirm self-fulfilling prophecies and set the constructs of the PEDSS schema firmly in place. People in vulnerable emotional states, who are currently in a difficult developmental phase (such as adolescence), are susceptible to creating, forming and following pathological belief systems, schemas and thought patterns that impose on their ability to make decisions and cope with life effectively, increasing their ability to engage with an ED.

During *Recovery*, it is posited that the person would develop a more mature relationship with themselves by adopting better coping mechanisms. Perfectionism is a schema of *Self*. Hence it is *not* a diagnosable condition. It is subtle in nature, and colours the individual's perception of the world and the processing of information, which results in destructive decisions, behaviours and habits. One can therefore treat the behaviours resulting thereof, but the PEDSS schema, which is a relational aspect of the *Self*, will continually hinder treatment efforts as the person fails to develop a positive relationship with themselves. In this regard, a positive self-esteem could not ever be developed fully unless this Self-Schema is addressed.

The next chapter concludes the study and considers recommendations for future research.

## CHAPTER 8

### CONCLUSIONS AND RECOMMENDATIONS

*“Not everything that is faced can be changed, but  
nothing can be changed until it is faced.”*

James Baldwin

(Quotations Page, n.d.)

#### 8.1 Perfectionism in treatment resistant eating disorder clients

This study attempted to shed light on perfectionism in treatment resistant eating disorder clients in the South African context. My assumption that there could be a possible link between perfectionism and eating disorders, and that in treatment resistant cases the presence of perfectionism would be more profound, was explored.

This exploration went beyond the current existing body of knowledge on eating disorders and its relation to perfectionism within the South African context. The lives of the six participants were explored regarding perfectionism in the setting of treatment resistant eating disorders, through phenomenology and grounded theory methods to achieve a deeper *understanding* of the phenomenon. The phenomenological approach was employed to *describe* the phenomenon, whilst the grounded theory approach was utilised to *explain* the phenomenon. Both research objectives were successfully achieved.

## **8.2 Results of the phenomenological approach to exploring perfectionism in treatment resistant eating disorder clients**

Analysis of the individual- and group themes provided an accurate reflection of perfectionism, which focussed on nine significant areas in which perfectionism is experienced: *Emotions; Goals and decisions; Thought processes and beliefs; Judgement; The Self; Relationships; Behaviours and habits; Social and environmental influences; and Recovery*. The results provided insight into how participants interpret their perfectionism and how it affects their daily lives on a physical-, emotional-, cognitive- and relational level.

The phenomenological results indicated how perfectionism assists the participants to deal with their anxiety, or how perfectionism can be used by the participants as a mechanism to become angry with themselves in a self-abusive manner. Their perfectionism influenced the goals they choose to *aim* for in life, and to which *degree* they hoped to achieve them. Perfectionism was constant and intense in their thought process, bringing negativity into their daily existence and continuously influencing thoughts and feelings. Their self-judgement remained overly harsh and critical: They struggled to give themselves credit when performing well in life, and easily concluded they aren't good enough when comparing themselves to others, especially on the physical level.

Overall, the link between the participants' perfectionism and their low self-esteem (and low self-worth) is clear. A low self-esteem forms the foundation for their eating disorder. Their struggle to accept their *Self* causes an inner discomfort which is persistent. In attempting to resolve this, constant attempts are made to try achieving

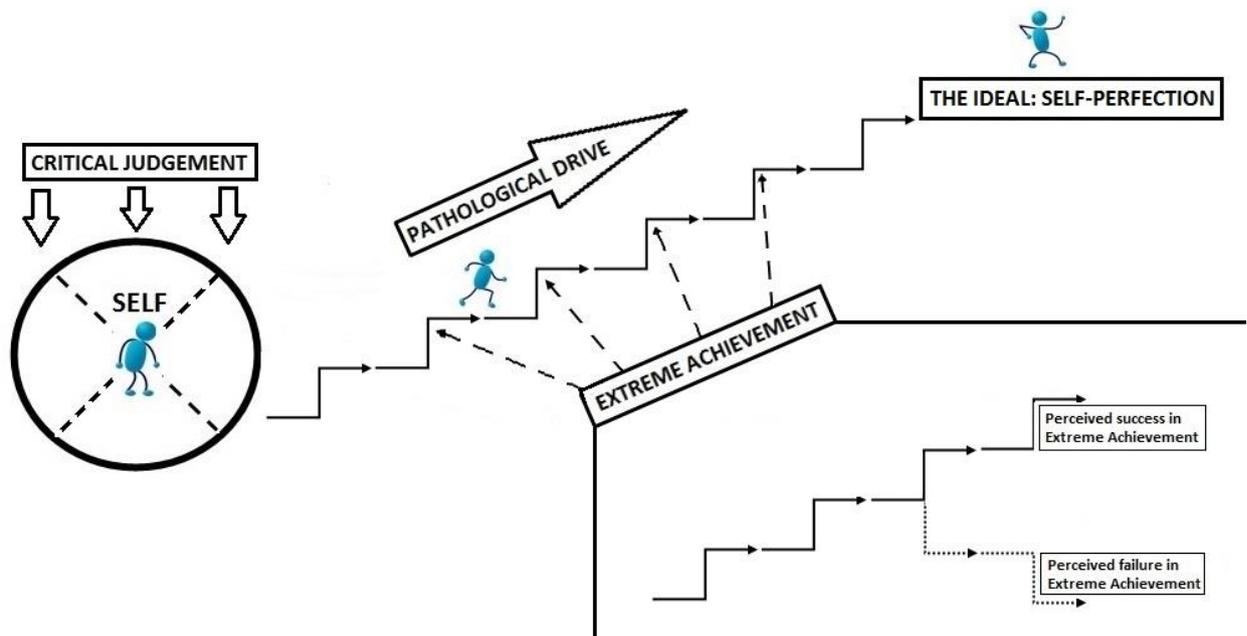
goals to their own illogical ideals. Perfectionistic thinking predominantly focuses on what they *lack*, instead of recognising who they already *are* as individuals. Instead of being appreciative of who they are, they intensely question why they are the way they are. Recognising their own uniqueness is difficult, and an underlying constant urge exists to want to prove to themselves (and others) that they are good enough. Their focus is more towards the external world and how they present to others, as others' approval remain an important element in their lives. Attention received from others is only warranted by maintaining a high standard of living through achievements and perfection.

Perfectionism was also influential in their recovery process. Receiving treatment was experienced as a difficult process, as the intervention process highlighted or confirmed problems that they struggle with, but might not want to acknowledge.

### **8.3 Results of the grounded theory approach to exploring perfectionism in treatment resistant eating disorder clients**

The grounded theory that emerged from the verbatim descriptions of the participants after I conducted a grounded theory analysis, yielded the following six constructs regarding perfectionism: *The Self*; *Critical Judgement*; *The Ideal: Self-Perfection*; *Extreme Achievement*; *Pathological Drive*; and *Recovery*; which together formed the Perfectionistic Eating Disorders Self-Schema (PEDSS) depicted in Figure 8.1.

**Figure 8.1: The Perfectionistic Eating Disorders Self-Schema (PEDSS)**



The PEDSS theory lays emphasis on the *Self*, and understanding the perfectionistic relationship the individual has with their own *Self*. In treatment resistant ED clients, the respondents' relationship with the *Self* is very unsympathetic and under-developed. Acceptance of *Self* remains the core problem, whereby achieving perfection is a solution to this problem: The vicious discontent the respondents have with their own *Self* is resolved by striving for *The Ideal: Self-Perfection*. Although *The Ideal: Self-Perfection* is never truly obtainable and not a sustainable lifestyle, these individuals continually invest in a *Pathological Drive* to achieve *Extreme Achievement*, which is constantly mediated through the use of *Critical Judgement*. They invest their efforts to such an extent that they ignore the threat of severe health consequences, or even death (in worst case scenarios). As the PEDSS schema diminishes, it is posited that the person would develop a more mature relationship with themselves by adopting better coping mechanisms. Perfectionism is thus seen as a schema of *Self*.

By adhering to the procedural boundaries and structures of GT, which included reflecting on my assumptions prior to theory development, refraining from deep literature analysis prior to GT data analysis, as well as comparing the theory extensively to current literature after the emerging theory was constructed, I gained an uncontaminated explanation of how treatment resistant ED clients lived with perfectionistic tendencies.

#### **8.4 Value of the research**

Eating disorders are complex in nature in terms of their aetiology, understanding and treatment. In the South African context, with its diversities within different cultural and social populations, there exist unique elements regarding each eating disorder sufferer's case. In my search for understanding the clients I was treating, the research yielded a general description of the experience of perfection, as well as a theory that attempts to explain perfectionism within treatment resistant eating disorders, thus developing the construct of perfectionism in the South African research base.

The study's findings and results add value to the existing body of knowledge in the following ways:

- Provides a qualitative in-depth look at perfectionism in ED clients which is vivid in its description and explanation of the phenomenon.
- Gives a dramatic portrayal of those struggling with eating disorders in the process of individual therapy. The study presents a qualitative dissecting of their problems and the challenges they face on a mental level.
- Informs and educates the reader (and those professionals who treat eating disorders) on the influence of perfectionism in treatment resistant ED clients.

- Provides important information about the developmental course of the perfectionism-eating disorder link regarding aetiology and maintenance. Within treatment, this information assists in establishing the client's treatment plan, as well as judging the overall prognosis.
- Confirms the psychological construct of perfectionism in South African treatment resistant ED sufferers, as defined by Shafran et al.'s (2002) term *clinical perfectionism*.
- Portrays the healing process, that may be necessary on the level of personality regarding perfectionistic thinking, as some other forms of intervention (for example cognitive-behavioural therapy) focus solely on behavioural symptoms and their reduction.
- Being aware of how perfectionists react to treatment and how perfectionism may interfere with the treatment process may be helpful for health professionals in developing more appropriate treatment programs that can be specifically directed towards helping individuals who suffer from the maladaptive perfectionistic traits. Additionally, knowing whether an individual engages in the Perfectionistic Eating Disorders Self-Schema may help more accurately match individuals to the most effective treatment modalities. Assessing the extent and nature of operations within perfectionism before treatment may help the clinician to understand some of these barriers to recovery. These considerations in the treatment of eating disorders may bring us closer to help patients overcome the disorder.
- The information gained from the study can be utilised when developing interventions and prevention programs for vulnerable groups (such as young teenagers, ballet dancers or gymnasts, etc.) who are at risk of developing eating disorders, as well as broadening our intellectual horizons on a topic which is under-researched in South Africa.

- The findings may contribute to educating the public at large about the psychological and emotional complexities that sufferers of eating disorders experience.

## **8.5 Strengths of the research**

When considering the study design, procedures followed, and research findings obtained, the following strengths to the research are identified:

- Considering the sample group, the participants represented individuals from various backgrounds, races, cultures, ages, and personal experiences. The diverse sample group offered a more accurate all-round reflection of the phenomenon under study.
- When conducting the fieldwork, I endeavoured to achieve that simultaneously structure and freedom existed within the dialogue. The extensive therapy process provided structure as the basis for the conversations and the freedom of unconditional positive regard, and mutual respect fostered the spirit of exploration and discovery into their thoughts and feelings. The combination of structure and freedom successfully encouraged the building of trust that allowed for deep expansive dialogue between me, the researcher, and the six participants. In so doing, the research participants could mobilise into positions of vulnerability, where they could extend themselves and their feelings at length. This position ensured that I obtained rich data and an accurate reflection of their experiences.
- The fieldwork was extensive and conducted over a long period. The investigation stretched over a period of more than two years, with participants engaging in extensive discussions with me as their therapist, with whom they had established deep rapport. This adds legitimacy to the putative relationships observed in the research findings.
- The study utilised a combination of two qualitative methods of enquiry which complimented each other and facilitated the findings that were achieved. The methodology also progresses further than mere studies relying on retrospective,

global self-reports, questionnaires and written exercises, by including transcripts of therapy interviews, field notes and observations.

- My emerged Perfectionistic Eating Disorder Self-Schema, seems to be an easy-to-understand model and provides a solid framework as a basis to understand the destructive interplay between perfectionism and treatment resistant eating disorders. This theory was also compared to the existing literature to legitimise its claim as valid knowledge.

## **8.6 Limitations of the research**

When considering the study design, procedures followed, and research findings obtained, the limitations to the research are highlighted:

- The participant sample group consisted only of females. This was partly because eating disorders occur predominantly among women and that no male participants could be located in the sampling procedure. This feature raises a concern about whether the findings would generalise to male samples.
- The participant sample group consisted predominantly of Caucasian adult females. Only one Coloured female and one Black female were included in the sample group. This was due to not being able to locate any more research participants within those ethnic groups at the time of sampling procedures. Including more participants from those ethnic groups would be more representative of South Africa's population demographics.
- The research was conducted with adult women and may not be generalisable to adolescents, the demographic group at which prevention efforts for eating disorders are typically targeted.
- Qualitative research focuses on the individual, rather than on the masses. Rather than seeking to describe the mean and standard deviation of a group as it relates to a phenomenon, this study's focus was more towards the inherent *nature* of

perfectionism, as this was an exploratory study using a methodology that was limited to only a few participants. Even though the validity of the research is not questionable (i.e. procedurally sound), I acknowledge that the findings are only applicable to the participants at the time of interviewing. With this statement, the study's limitations to reliability, as well as generalising its results to other populations, are highlighted.

- When analysing transcripts in qualitative research, a constant danger exists in that the fieldworker remains the victim of his own preconceived assumptions which may have a bearing or negative impact on his results. Although I attempted to sustain an adequate awareness of my own presuppositions, the analysis of the transcripts was nevertheless influenced by my own perspectives, values and principles. The possibility therefore exists that another researcher re-analysing the transcripts may derive more themes from the data.
- The research endeavour depended on self-report data during a qualitative interview process within therapy. The data gathered might have been influenced by personal variables unbeknown to me, as well as by a socially desirable bias within the participants to be seen in a favourable light.
- The research data elicited is of a unique nature. Although I made concerted efforts to protect participants by omitting transcriptions of the interviews, as well as personal identifiable information, there remains a small risk that reading the presentations of their personal experiences may result in being identified by another reader.
- Extensive consideration for external and personal variables such as age, race and culture of the participants were not considered in the research. I recognise the importance of identifying these personal variables and attempt to understand what influence they may have in their perfectionism and eating disorder.
- The study did not consider the influence of dual-diagnoses. In cases where traumatic life events had been experienced or if a participant was under the influence of substance abuse, or a possible mood disorder was prevalent - focussing on the

influence of these personal variables would have provided stronger evidence of the relative contributions of these dimensions within perfectionism.

- Adding quantitative measures of perfectionism would have added to the strength of these findings. Measuring levels of perfectionism prior to, and after the respondents' therapy process would give insight into whether their perfectionism had changed and attempt to extract information regarding the process of how this happens.

## **8.7 Recommendations for future research**

The following recommendations are offered in consideration for future research endeavours:

- Utilising a larger sample size to ensure greater validity, reliability and generalisability of the results obtained. Future studies could also attempt to incorporate a quantitative research design, thus yielding more objective results.
- Further studies should investigate whether similar results are obtainable in the other eight provinces of South Africa, as well as utilising more participants from Indian/Coloured and Black ethnic backgrounds. This would expand our knowledge on the experiences of those struggling with perfectionism in treatment resistant eating disorders within our country. Comparative analyses of these alternative research contexts may yield global variables of importance within our population.
- Comparative analysis of findings to studies conducted in other countries (e.g. first world countries and countries with non-western dominant cultures) could also yield important new revelations and links within the population of eating disorder sufferers.
- Establishing the origins of perfectionism or the developmental course would assist in establishing the relative importance of perfectionism in predicting psychological outcomes in different settings and under a variety of circumstances.
- The development of appropriate intervention strategies and programmes to prevent and remediate perfectionist ED attitudes and thought processes.

- Some of the respondents felt as if they were misunderstood by society at large. They experience little empathy and understanding for their disorder and are anxious that others will misconstrue it for attention-seeking behaviour, or that they will be judged for it. In this regard, investigation into more effective mechanisms of supplying accurate information to the public regarding the intricacies of eating disorders should be attempted.
- The theory that emerged in this research study (i.e. The Perfectionistic Eating Disorder Self-Schema) needs to be compared to a larger number of participants and to other contexts and age groups to see whether it maintains its legitimacy, and/or where it needs to be developed further.
- Investigate to what extent the decrease in concern over perfectionism results in reductions in the individual aspects of ED psychopathology (such as body dissatisfaction, obsessive thinking patterns, etc.).

## **8.8 Final conclusions of the research**

In a final personal reflection on the research, I conclude that this study has provided valuable information regarding the thoughts and feelings of those struggling with perfectionism within treatment resistant eating disorders. The study has offered a *description* of their experiences, as well as postulating a theory to *explain* their perfectionism within their ED in the form of the Perfectionistic Eating Disorders Self-Schema (PEDSS). The qualitative focus of the study was achieved, namely to gain better *understanding* of perfectionism and how this possibly affects the respondents' eating disorders. The unique experiences of the participants and the complicated nature of their perfectionism within an eating disorder, has been successfully demonstrated through the meticulous analyses of the interviews.

The research has provided me, the researcher, with deeper insight and understanding into the lives of those struggling with treatment resistant eating disorders. Significant aspects pertaining to the individual ED participants and the group were identified and analysed phenomenologically. The grounded theory analysis of the individual participants' experiences of this phenomenon yielded an emerged theory of perfectionism in treatment resistant ED clients. The qualitative research methods of phenomenology and grounded theory proved to be of great value in acquiring, analysing and portraying the in-depth information, thus obtaining the research objectives successfully.

Perfectionism within treatment resistant eating disorders is unique and complex. Understanding those who struggle with this phenomenon can at times be difficult because of the interaction of intricate variables. However, the PEDSS theory provides a window into the psychological world of those living with this problem. Rather than following the classic aetiological model of eating disorders (biological/genetic predisposition, psychological factors of early experiences and interpersonal relationships, as well as social climate including social influences); the emerging theory has provided researchers, therapists and the public a way to *understand* in-depth the psychological phenomenon of perfectionism within complex cases of eating disorders in South Africa.

The participants displayed profound resilience in their struggle with their eating disorders and maintaining perfectionist standards of living for extended periods in their lives. This struggle is characterised by unique and destructive thinking and

emotional patterns, which needs to be understood properly to fully grasp the link between perfectionism and treatment resistant eating disorders.

In closing, I offer Max Ehrmann's "Desiderata" as inspiration for those living with perfectionism whilst in the grips of their eating disorder in their efforts towards recovery.

May you succeed in finding peace, and truly accepting your *Self*...

Go placidly amid the noise and the haste, and remember what peace there may be in silence. As far as possible, without surrender, be on good terms with all persons.

Speak your truth quietly and clearly; and listen to others, even to the dull and the ignorant; they too have their story.

Avoid loud and aggressive persons; they are vexatious to the spirit. If you compare yourself with others, you may become vain or bitter, for always there will be greater and lesser persons than yourself.

Enjoy your achievements as well as your plans. Keep interested in your own career, however humble; it is a real possession in the changing fortunes of time.

Exercise caution in your business affairs, for the world is full of trickery. But let this not blind you to what virtue there is; many persons strive for high ideals, and everywhere life is full of heroism.

Be yourself. Especially, do not feign affection. Neither be cynical about love; for in the face of all aridity and disenchantment, it is as perennial as the grass.

Take kindly the counsel of the years, gracefully surrendering the things of youth.

Nurture strength of spirit to shield you in sudden misfortune. But do not distress yourself with dark imaginings. Many fears are born of fatigue and loneliness.

Beyond a wholesome discipline, be gentle with yourself. You are a child of the universe no less than the trees and the stars; you have a right to be here.

And whether or not it is clear to you, no doubt the universe is unfolding as it should. Therefore be at peace with God, whatever you conceive Him to be.

And whatever your labours and aspirations, in the noisy confusion of life, keep peace in your soul. With all its sham, drudgery and broken dreams, it is still a beautiful world. Be cheerful. Strive to be happy.

*Max Ehrmann, "Desiderata"*

## APPENDIX A

### Consent form:

With this form I,

..... consent to participate in the research study approved by the University of South Africa (UNISA) for student Guillaume Walters- du Plooy (4987-944-8).

I acknowledge the following:

- I understand that my participation is purely voluntary, and I reserve the right to withdraw from the research study at any given time without providing any reasons.
- I have been given adequate information regarding the research, its design, and the uses for which the results are to be used.
- The interviews/sessions conducted are to be recorded on audio tape. This information may be added to the research appendix without any of my personal/biographical information.
- I have been given the opportunity to ask any questions regarding the research.
- I understand that the personal information shared will be kept in the strictest confidence and only be used for the purposes necessary for the research to which I have consented to.

Age: .....

Gender: .....

Signed this day, ..... at .....

.....  
Participants signature

.....  
Researcher signature

## REFERENCES

- Aldiabat, K., & Le Navenec, C.L. (2011). Clarification of the Blurred Boundaries between Grounded Theory and Ethnography: Differences and Similarities. *Turkish Online Journal of Qualitative Inquiry*, 2(3). Retrieved from [http://prism.ucalgary.ca/jspui/bitstream/1880/48700/1/LaNavenec\\_TOJQI\\_2011.pdf](http://prism.ucalgary.ca/jspui/bitstream/1880/48700/1/LaNavenec_TOJQI_2011.pdf)
- Allan, G. (2003). A critique of using grounded theory as a research method. *Electronic Journal of Business Research Methods*, 2(1), 1-10.
- Alton, I. (2005). Eating Disorders. In J. Stang & M. Story (Eds.), *Guidelines for Adolescent Nutrition Services* (pp. 137-154.) Retrieved from [http://www.epi.umn.edu/let/pubs/adol\\_book.shtm](http://www.epi.umn.edu/let/pubs/adol_book.shtm)
- American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington, USA: American Psychiatric Publishing.
- American Psychiatric Association. (2006). *Practice guidelines for the treatment of patients with eating disorders* (3rd ed.). Retrieved from [http://www.psychiatryonline.com/pracGuide/PracticePDFs/EatingDisorders3ePG\\_04-28-06.pdf](http://www.psychiatryonline.com/pracGuide/PracticePDFs/EatingDisorders3ePG_04-28-06.pdf)

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5<sup>th</sup> ed.). Washington, USA: American Psychiatric Publishing.

*Anorexia: Overview*. (n.d.). Retrieved May 13, from <http://www.kosmix.com/topic/anorexia/overview/adam20#ixzz1IUW6ktlJ>

Anthony, M.M., & Swinson, R.P. (2009). *Then perfect isn't good enough* (2nd ed.). United States of America: New Harbringer Publications.

Antony, M.M., Purdon, C.L., Huta, V., & Swinson, R.P. (1998). Dimensions of perfectionism across the anxiety disorders. *Behaviour Research and Therapy*, 36, 1143-1154.

Arcelus, J., Mitchell, A.J., Wales, J., & Nielsen, S. (2011). Mortality Rates in Patients with Anorexia Nervosa and Other Eating Disorders. *Archives of General Psychiatry*, 68(7), 724 - 731. Retrieved from <http://archpsyc.jamanetwork.com/article.aspx?articleid=1107207>

Arnold, C., & Walsh, B.T. (2007). *Next to nothing: A firsthand account of one teenager's experience with an eating disorder*. New York, USA: Oxford University Press.

Astrachan-Fletcher, E., & Maslar, M. (2009). *The dialectical behaviour therapy skills workbook for bulimia*. Oakland, CA: New Harbringer Publications.

- Atiye, M., Miettunen, J., & Raevuori, A. (2014). A meta-analysis of temperament in eating disorders. *European Eating Disorders Review*, 23(2), 89 - 99.
- Bardone-Cone, A.M., Wonderlich, S.A., Frost, R.O., Bulik, C.M., Mitchell, J.E., Uppala, S., & Simonich, H. (2007). Perfectionism and eating disorders: Current status and future directions. *Clinical Psychology Review*, 27, 384 - 405. Retrieved from <http://bardonecone.web.unc.edu/files/2014/10/Bardone-Cone-et-al-2007.pdf>
- Bardone-Cone, A.M., Joiner, T.E., Crosby, R.D., Crow, S.J., Klein, M.H., le Grange, D., & Wonderlich, S.A. (2008). Examining a psychosocial interactive model of binge eating and vomiting in women with bulimia nervosa and subthreshold bulimia nervosa. *Behaviour Research and Therapy*, 46, 887–894.
- Bardone-Cone, A.M., Sturm, K., Lawson, M.A., Robinson, D.P., & Smith, R. (2010). Perfectionism Across Stages of Recovery from Eating Disorders. *International Journal of Eating Disorders*, 43(2), 139-148.
- Bastiani, A.M., Rao, R., Weltzin, T., & Kaye, W.H. (1995). Perfectionism in anorexia nervosa. *International Journal of Eating Disorders*, 17, 147-152
- Bauman, S. (2008). Eating Disorders. In N. Danner & A. Briggs (Eds.), *Essential topics for the helping professional* (pp. 59-88). Boston, MA: Person Custom Publishing.

- Bemporad, J.R. (1996). Self-starvation through the ages: Reflections on the pre-history of anorexia nervosa. *International Journal of Eating Disorders*, 19, 217- 237.
- Bennett, D., Sharpe, M., Freeman, C., & Carson, A. (2004). Anorexia Nervosa among female secondary school students in Ghana. *British Journal of Psychiatry*, 185, 312–317.
- Berkman, N.D., Bulik, C.M., Brownley, K.A., Gartlehner, G., Lohr, K.A., Sedway, J.A., & Rooks, A. (2006). Management of Eating Disorders. Retrieved from <http://www.ncbi.nlm.nih.gov/books/NBK38099>
- Beumont, P.J.V., Arthur, B., Russell, J.D., & Touyz, S.W. (1994). Excessive physical activity in dieting disorder patients - proposals for a supervised exercise program. *International Journal of Eating Disorders*, 15, 21-36.
- Bhadrinath, B. (1990). Anorexia nervosa in adolescents of Asian extraction. *British Journal of Psychiatry*, 156, 565-568.
- Bieling, P.J., Israeli, A.L., & Anthony, M.M. (2004). Is perfectionism good, bad, or both? Examining models of the perfectionism construct. *Personality and Individual Differences*, 36, 1373-1385.

- Bieling, P.J., Summerfeldt, L.J., Israeli, A.L., & Antony, M.M. (2004). Perfectionism as an explanatory construct in comorbidity of Axis I disorders. *Journal of Psychopathology and Behavioral Assessment, 26*, 193-201.
- Birks, M. & Mills, J. (2011). *Grounded Theory: A Practical Guide*. London: Sage Publications.
- Bizeul, C., Sadowsky, N., & Rigaud, D. (2001). The prognostic value of initial EDI scores in anorexia nervosa patients: a prospective follow-up study of 5–10 years. *European Psychiatry, 16*, 232–238.
- Blaikie, N. (1993). *Approaches to Social Enquiry*. Cambridge: Polity Press. Retrieved May 15, 2013, from <http://www.waterstones.com/waterstonesweb/products/norman+blaikie/approaches+to+social+enquiry/3701804/>
- Blankstein, K.R., & Dunkley, D.M. (2002). Evaluative concerns, self-critical, and personal standards of perfectionism: A structural equation modeling. In G.L. Flett & P.L. Hewitt (Eds.), *Perfectionism: Theory, research, and treatment* (pp. 285–316). Washington, DC: American Psychological Association.
- Blatt, S.J., Quinlan, D., Pilkonis, P., & Shea, M.T. (1995). Impact of perfectionism and need for approval on the treatment of depression: The National Institute of Mental Health treatment of depression collaborative research program revisited. *Journal of Consulting and Clinical Psychology, 63*, 125–132.

Bogdan, R., & Taylor, S.J. (1975). *Introduction to Qualitative Research Methods*.  
New York: Wiley-Interscience.

Brambilla, F., & Monteleone, P. (2003). Physical complications and physiological aberrations in eating disorders: A review. In M. Maj, K. Halmi, J.J. Lopez-Ibor & N. Sartorius (Eds.), *Eating disorders: Vol. 6. WPA series evidence and experience in Psychiatry* (pp. 139-193). England: Wiley.

Briere, J., & Scott, C. (2007). Assessment of Trauma Symptoms in Eating-Disordered Populations. *Eating Disorders: The Journal of Treatment and Prevention*, 15(4), 347–358. Retrieved from <http://dx.doi.org/10.1080/10640260701454360>

Brodsky, S.F. (1988). Perfectionism and Millon basic personality patterns. *Psychological Reports*, 63, 791-497.

Brown, H. (2006). *One Spoonful at a Time*. Retrieved June 18, 2016, from <http://eatingdisorders.ucsd.edu/OneSpoonfulatTimeHBrown.pdf>

Brown, S.R. (1993). *Perfectionistic thinking and self-efficacy as predictors of college student's psychological development* (Unpublished Doctoral Thesis). University of Georgia, Athens.

Browne, M. (1993). Dying to be thin. *Essence*, 24(2), 86-91.

Bruch, H. (1973). *Eating Disorders: Obesity, Anorexia Nervosa, and the Person Within*. United States of America: Basic Books.

Bruch, H. (1978). *The golden cage*. Cambridge, MA: Harvard University Press.

Buchan, T. & Gregory, L.D. (1984). Anorexia in a Black Zimbabwean. *British Journal of Psychiatry*, 145, 326-330.

Burns, D.D. (1980). The perfectionist's script for self-defeat. *Psychology Today*, 14(6), 34–52.

Burns, D.D. (1983). The spouse who is a perfectionist. *Medical Aspects of Human Sexuality*, 17(1), 219–230.

Burns, N. (1989). Standards for qualitative research. *Nursing Science Quarterly*, 2(1), 44-52.

Caradas, A.A., Lambert, E.V., & Charlton, K.E. (2001). An Ethnic Comparison of Eating Attitudes and Associated Body Image Concerns in Adolescent South African Schoolgirls. *Journal of Human Nutrition and Dietetics*, 14, 111 - 120.

Casey, E.S. (1998). *The Fate of Place: A philosophical history*. Los Angeles: University of California Press.

Charmaz, K. (1983). The grounded theory method: An explication and interpretation. In R.M. Emerson (Ed.), *Contemporary field research* (pp. 109-126). Boston: Little Brown.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London and Thousand Oaks, CA: Sage.

Chen, E.Y., Weissman, J.A., Zeffiro, T.A., Yiu, A., Eneva, K.T., Arlt, J.M. & Swantek, M.J. (2016). Family-Based Therapy for Young Adults with Anorexia Nervosa Restores Weight. *International Journal of Eating Disorders*, 49, 701 - 707.

Clarke, A. (2005). *Situational analysis: Grounded theory after the postmodern turn*. Thousand Oaks, CA: Sage Publications.

Claude-Pierre, P. (1999). *The secret language of eating disorders*. New York, USA: Vantage Press.

Cloonan, T.F. (1971). Experimental and Behavioural Aspects of Decision Making. In Giorgi et al. (Eds.), *Duquesne Studies in Phenomenological Psychology* (pp. 112-131). Pittsburgh: Duquesne University Press.

Cohen, M. (1987). A Historical Overview of the Phenomenological Movement. *The Journal of Nursing Scholarship*. 17(1), 31-34.

Colborn, A.L. (1994). *Investigation into the relationship between disturbed eating patterns and pressure to achieve in female students*. (Master's thesis).

University of Cape Town, Department of Psychology, Cape Town, South Africa.

*Consequences of eating disorders*. (n.d.). Retrieved April 2, 2011, from

[http://aedtest.sherwood-group.com/Consequences\\_of\\_ED.htm](http://aedtest.sherwood-group.com/Consequences_of_ED.htm)

Corbin, J.M., & Strauss, A.L. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (3<sup>rd</sup> ed.). Los Angeles: Sage Publications.

Constain, G.A., Rodriguez-Gazquez, M.L., Ramirez, G.A., Gomez Vasquez, G.M., Mejia Cardona, L., & Cardona Valez, J. (2016). Diagnostic validity and usefulness of the Eating Attitudes Test-26 for the assessment of eating disorders risk in a Colombian male population. *Aten Primaria*, 16, 212.

*Course and Outcomes*. (n.d.). Retrieved February 25, 2013, from

[http://www.aedweb.org/Course\\_and\\_Outcomes.htm](http://www.aedweb.org/Course_and_Outcomes.htm)

Cowley, R., Gibson, D., & Sewell, C. (2008). *History of Eating Disorders in the United States*. Retrieved July 8, 2016, from

<http://historyofeating.umwblogs.org/history-of-eating-disorders/>

Creswell, J.W. (2009). *Research design: Qualitative, quantitative, and mixed method approaches* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Crisafulli, M.A., Von Holle, A., & Bulik, C. (2008). Attitudes towards Anorexia Nervosa: The impact of framing on blame and stigma. *International Journal of Eating Disorders*, 41(4). Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/18186057>

Crisp, A., Gelder, M., Rix, S., Meltzer, H., & Rowlands, O. (2000). Stigmatisation of people with mental illnesses. *The British Journal of Psychiatry*, 177, 4–7.

Crow, S.J., Peterson, C.B., Swanson, S.A., Raymond, N.C., Specker, S., Eckert E.D., & Mitchell, J.E. (2009). Increased mortality in bulimia nervosa and other eating disorders. *The American Journal of Psychiatry*, 166(12), 1342-1346.

Culbert, K.M., Racine, S.E. & Klump, K.L. (2015). Research Review: What we have learned about the causes of eating disorders - a synthesis of sociocultural, psychological, and biological research. *Journal of Child Psychology and Psychiatry*, 56(11), 1141 - 1164.

Czarniawska, B. (2004). *Narratives in Social Science Research: Introducing Qualitative Methods*. London: Sage Publications.

*Death of Karen Carpenter – Death from Anorexia*. (n.d.). Retrieved April 14, 2011, from <http://www.anorexia-reflections.com/death-of-karen-carpenter.html>

Denzin, N.K. (1989). *Interpretive Biography*. United Kingdom: Sage Publications.

Denzin, N.K. & Lincoln, Y.S. (Eds.). (1994). *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage Publications.

Denzin, N.K. & Lincoln, Y.S. (2000). Introduction: The discipline and practice of qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (2<sup>nd</sup> ed., pp. 1-29). California: Sage Publications.

Department of Health, Social Services & Public Safety. (2002). *Eating disorder services: A consultation paper*. Retrieved January 5, 2013, from [http://www.dhsspsni.gov.uk/eating\\_disorders.pdf](http://www.dhsspsni.gov.uk/eating_disorders.pdf)

*Dialectical Behavior Therapy Frequently Asked Questions* (n.d.). Retrieved June 5, 2013, from [http://behavioraltech.org/downloads/dbtFaq\\_Cons.pdf](http://behavioraltech.org/downloads/dbtFaq_Cons.pdf)

Dietz, W.H. (1990). You are what you eat – What you eat is what you are. *Journal of Adolescent Health Care*, 11, 76-81.

Dimeff, L.A., & Koerner, K. (2007). *Dialectical Behaviour Therapy in Clinical Practice*. New York: The Guildford Press.

Dunkley, D.M., Blankstein, K.R., Masheb, R.M., & Grilo, C.M. (2006). Personal standards and evaluative concerns dimensions of “clinical” perfectionism: A reply to Shafran et al. (2002, 2003) and Hewitt et al. (2003). *Behaviour Research and Therapy*, *44*, 63– 84.

Dunkley, D.M., Zuroff, D.C., & Blankstein, K.R. (2003). Self-Critical Perfectionism and Daily Affect: Dispositional and Situational Influences on Stress and Coping. *Journal of Personality and Social Psychology*, *84*(1), 234–252.

Dunne, C. (2011). The place of literature review in grounded theory research. *International Journal of Social Research Methodology*, *14*, 111–124.

Dunne, F.J., Freeney, S., & Schipperheijn, J. (1991). Eating disorders and alcohol misuse: features of an addiction spectrum. *Postgraduate Medical Journal*, *67*, 112- 113.

*Eating disorder diagnosis*. (n.d.). Retrieved February 25, 2013, from [http://www.aedweb.org/Eating\\_Disorder\\_Diagnoses.htm](http://www.aedweb.org/Eating_Disorder_Diagnoses.htm)

*Eating disorder risk factors*. (n.d.). Retrieved February 25, 2013, from [http://www.aedweb.org/Risk\\_Factors.html](http://www.aedweb.org/Risk_Factors.html)

*Eating Disorders*. (n.d.). Retrieved January 20, 2013, from [http://www.trickcyclists.co.uk/pdf/Eating\\_Disorders.pdf](http://www.trickcyclists.co.uk/pdf/Eating_Disorders.pdf)

*Eating disorders and the road to recovery.* (n.d.). Retrieved April 3, 2011, from <http://www.anad.org/forum/viewtopic.php?id=84>

Eating Disorders Coalition. (2009). *Facts About Eating Disorders: What the Research Shows.* Retrieved January 20, 2013, from <http://www.eatingdisorderscoalition.org/documents/TalkingpointsEatingDisordersFactSheetUpdated5-20-09.pdf>

*Eating disorders: Criteria for organizing resources and activities.* (n.d.). Retrieved January 20, 2013, from <http://es.salut.conecta.it/pdf/tca-ea.pdf>

*Eating Disorders in Scotland: Recommendations for Management and Treatment* (2006). Retrieved January 20, 2013, from [http://www.playfieldinstitute.co.uk/information/pdfs/publications/eating\\_disorders/InScotland.pdf](http://www.playfieldinstitute.co.uk/information/pdfs/publications/eating_disorders/InScotland.pdf)

Ebner, D.S., Latner, J.D., & O'Brien, K.S. (2011). Just world beliefs, causal beliefs, and acquaintance: Associations with stigma toward eating disorders and obesity. *Personality and Individual Differences, 2011*(51), 618-622. Retrieved from [http://www2.hawaii.edu/~jlatner/downloads/pubs/Ebner\\_Justworld\\_2011.pdf](http://www2.hawaii.edu/~jlatner/downloads/pubs/Ebner_Justworld_2011.pdf)

Edwards, D. & Moldan, S. (2004). Bulimic pathology in black students in South Africa: Some unexpected findings. *South African Journal of Psychology, 34*(2), 191-205.

- Egan, S.J., Shafran, R., & Wade, T. (2010). *Overcoming perfectionism: A self-help guide using cognitive behavioral techniques*. London, UK: Constable & Robinson.
- Egan, S.J., Wade, T.D., & Shafran, R. (2011). Perfectionism as a transdiagnostic process. *Clinical Psychology Review, 31*, 203-212.
- Egan, S.J., Wade, T.D., Shafran, R., & Antony, M.M. (2014). *Cognitive- Behavioural Treatment of Perfectionism*. London: Guilford Press.
- Ellis, A. (2002). The role of irrational beliefs in perfectionism. In G.L. Flett & P.L. Hewitt (Eds.), *Perfectionism: Theory, research, and treatment* (pp. 217–230). Washington, DC: American Psychological Association.
- Engel, B., Reiss, N.M., & Dombek, M. (2007). *Eating disorders: Historical Understandings*. Retrieved February 25, 2013, from [http://www.mentalhelp.net/poc/view\\_doc.php?type=doc&id=11747&cn=46](http://www.mentalhelp.net/poc/view_doc.php?type=doc&id=11747&cn=46)
- Espie, J. & Eisler, I. (2015). Focus on anorexia nervosa: modern psychological treatment and guidelines for the adolescent patient. *Adolescent Health, Medicine and Therapeutics, 6*, 9–16.
- Facts and findings for eating disorders*. (n.d.). Retrieved February 19, 2011, from <http://www.ceed.org.au/facts-and-findings/w1/i1001246/>

Fairburn, C.G. (1995). *Overcoming Binge Eating*. New York, USA: The Guilford Press.

Fairburn, C.G. (2008). *Cognitive Behavior Therapy and Eating Disorders*. New York: Guilford Press.

Fairburn, C.G., Cooper, Z., Doll, H.A., & Welch, S.L. (1999). Risk-factors for anorexia nervosa: Three integrated case-control comparisons. *Archives of General Psychiatry*, 56, 468-476.

Fairburn, C.G., Cooper, Z., & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: A “transdiagnostic” theory of treatment. *Behaviour Research and Therapy*, 41, 509 – 528.

Fairburn, C.G., Cooper, Z., Doll, H.A., O’Conner, M.E., Bohn, K., Hawker, D.M., Wales, J.A., & Palmer, R.L. (2009). Transdiagnostic cognitive-behavioral therapy for patients with eating disorders: A two-site trial with 60-week follow-up. *The American Journal of Psychiatry*, 66(3), 311-319.

Fankhauser, M.P. (n.d.). *Eating Disorders. PSAP-VII. Woman’s and Men’s Health*.

Retrieved January 20, 2013, from

<http://www.accp.com/docs/bookstore/psap/p7b03.sample03.pdf>

- Fear, J.L., Bulik, C.M., & Sullivan, P.F. (1996). *The prevalence of disordered eating behaviours and attitudes in adolescent girls. New Zealand Journal of Psychology, 25*(1), 7-12.
- Ferreira, C., Pinto-Gouveia, J., & Duarte, C. (2014). Self-criticism, Perfectionism and Eating Disorders: The Effect of Depression and Body Dissatisfaction. *International Journal of Psychology and Psychological Therapy, 14*(3), 409 - 420. Retrieved from <http://www.ijpsy.com/volumen14/num3/396/self-criticism-perfectionism-and-eating-EN.pdf>
- Flett, G.L., Blankstein, K.R., & Martin, T.R. (1995). *Procrastination, negative self-evaluation, and stress in depression and anxiety: A review and preliminary model*. In J.R. Ferrari, J.H. Johnson & W.G. McCown (Eds.), *Procrastination, and task avoidance: Theory, research, and treatment* (pp. 137– 167). New York, NY: Plenum Press.
- Flett, G.L., & Hewitt, P.L. (2002). *Perfectionism: Theory, Research and Treatment*. Washington DC, USA: American Psychological Association.
- Flett, G.L., Hewitt, P.L., Oliver, J.M., & Macdonald, S. (2002). Perfectionism in children and their parents: A developmental analysis. In G.L. Flett & P.L. Hewitt (Eds.), *Perfectionism* (pp. 89-132). Washington, DC: American Psychological Association.

- Flett, G.L., Besser, A., Davis, R.A., & Hewitt, P.L. (2003). Dimensions of perfectionism, unconditional self-acceptance, and depression. *Journal of Rational-Emotive and Cognitive-Behavior Therapy*, 21, 119–138.
- Flett, G.L., Hewitt, P.L., Demerjian, A., Sturman, E.D., Sherry, S.B. & Cheng, W. (2011). Perfectionistic Automatic Thoughts and Psychological Distress in Adolescents: An Analysis of the Perfectionism Cognitions Inventory. *Journal of Rational-Emotive Cognitive-Behavioral Therapy*. Retrieved from [http://personality.psychology.dal.ca/pdfs/Flett,Hewitt,Demerjian,Sturman,Sherry,%26Cheng\(2011\).pdf](http://personality.psychology.dal.ca/pdfs/Flett,Hewitt,Demerjian,Sturman,Sherry,%26Cheng(2011).pdf)
- Forbush, K., Heatherton, T.F., & Keel, P.K. (2007). The relationship between perfectionism and specific disordered eating behaviours. *International Journal of Eating Disorders*, 40(1), 37–41.
- Fox, S. (2014). *Thinking about grounded theory*. [Kindle DX Version]. Retrieved from Amazon.es
- Freund, K., Walsh, J.M.E., & Wheat, M.E. (2000). Detection, Evaluation, and Treatment of Eating Disorders: The Role of the Primary Care Physician. *Journal of General Internal Medicine*, 15(8), 577–590.
- Frost, R., Marten, P., Lahart, C., & Rosenblate, R. (1990). The dimensions of perfectionism. *Cognitive Therapy and Research*, 14, 449–468.

Gaudreau, P., & Thompson, A. (2010). Testing a 2 x 2 model of dispositional perfectionism. *Personality and Individual Differences, 48*, 532–537.

*General Information.* (n.d.). Retrieved June 9, 2013, from <http://www.anad.org/get-information/about-eating-disorders/general-information/>

Ghent (2005). *Traits and Eating Disorders: Associations with cognitive and behavioural characteristics* (Doctoral thesis, Department of Psychiatry, Ghent University). Retrieved from [http://lib.ugent.be/fulltxt/RUG01/000/897/516/RUG01-000897516\\_2010\\_0001\\_AC.pdf](http://lib.ugent.be/fulltxt/RUG01/000/897/516/RUG01-000897516_2010_0001_AC.pdf)

Gilbert, P., Clark, M., Hempel, S., Miles, J.N.V. & Irons, C. (2004) Criticising and reassuring oneself: An exploration of forms, styles and reasons in female students. *British Journal of Clinical Psychology, 43*, 31-50.

Gilgun, J. (2010). Current Issues in Qualitative Research: An Occasional Publication for Field Researchers from a Variety of Disciplines. *The Intellectual Roots of Grounded Theory, 1*(9). Retrieved from <http://www.ssnpstudents.com/wp/wp-content/uploads/2015/02/gt-.pdf>

Giorgi, A. (1975). An application of phenomenological method in psychology. In A. Giorgi, C. Fischer & E. Murray (Eds.), *Duquesne studies in phenomenological psychology, 2*, 72-79.

- Giorgi, A. (1983). Concerning the possibility of phenomenological psychological research. *Journal of Phenomenological Psychology, 14*(2), 136-138.
- Giorgi, A. (1985). Sketch of a psychological phenomenological method. In A. Giorgi (Ed.), *Phenomenology and psychological research* (pp. 8-22). Pittsburgh, PA: Duquesne University Press.
- Giorgi, A. (1994). A phenomenological perspective on certain qualitative research methods. *Journal of Phenomenological Psychology, 25*, 190-220.
- Giorgi, A. (1997). The theory, practice and evaluation of the phenomenological method as a qualitative research procedure. *Journal of Phenomenological Psychology, 28*, 235-260.
- Giorgi, A.P., & Giorgi, B.M. (2003). The descriptive phenomenological psychological method. In P.M. Camic, J.E. Rhodes & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 243-273). Washington, DC: American Psychological Association.
- Gitau, T.M., Micklesfield, L.K., Pettifor, J.M., & Norris, S.A. (2014). Changes in Eating Attitudes, Body Esteem and Weight Control Behaviours during Adolescents in a South African Cohort. *PLoS ONE, 9*(10).
- Glaser, B.G. (1978). *Theoretical sensitivity*. Mill Valley, CA: Sociology Press.

Glaser, B.G. (1992). *Basics of grounded theory analysis*. Mill Valley, CA: Sociology Press.

Glaser, B.G. (1998). *Doing Grounded Theory: Issues and Discussions*. Mill Valley, CA: Sociology Press.

Glaser, B.G. (2001). *The grounded theory perspective: Conceptualization contrasted with description*. Mill Valley, CA: Sociology Press.

Glaser, B.G., & Strauss, A.L. (1967). *The Discovery of Grounded Theory*. Mill Valley: Sociology Press.

Goh, R. (2015). A case series investigation of association between co-morbid psychiatric disorder and the improvement in body mass index among patients with anorexia nervosa and eating disorder not otherwise specified of the anorexia nervosa type. *Journal of Eating Disorders*, 3(10), Retrieved from <http://jeatdisord.biomedcentral.com/articles/10.1186/s40337-015-0049-z>

Gordon, R.A. (2000). *Eating Disorders: Anatomy of a Social Epidemic*. Malden: Blackwell Publishers.

Gordon, R.A. (2001). Eating disorders East and West: A culture-bound syndrome abound. In M. Nasser, M.A. Katzman & A.R. Gordon (Eds.), *Eating disorders and cultures in transition* (pp. 1-24). East Sussex, England: Brunner-Routledge.

- Glossary*. (2011). Retrieved February 19, 2011, from  
[http://www.virginia.edu/vpr/irb/sbs\\_glossary.html](http://www.virginia.edu/vpr/irb/sbs_glossary.html)
- Goulding, C. (1999). *Grounded Theory: some reflections on paradigm, procedures and misconceptions*. Retrieved February 1, 2016, from  
<http://wlv.openrepository.com/wlv/bitstream/2436/11403/1/Goulding.pdf>
- Grigg, M., Bowman, J. & Redman, S. (1996). Disordered eating and unhealthy weight reduction practices among adolescent females. *Preventive Medicine*, 25(115), 748- 756.
- Grylli, V., Hafferl-Gattermayer, A., Wagner, G., & Schober, E. (2005). Eating Disorders and Eating Problems among Adolescents with Type 1 Diabetes: Exploring Relationships with Temperament and Character. *Journal of Paediatric Psychology*, 30(2), 197 - 206. Retrieved from  
<http://jpepsy.oxfordjournals.org/content/30/2/197.full.pdf>
- Halling, S., & Nill, J.D. (1995). A brief history of existential phenomenological psychiatry and psychotherapy. *Journal of Phenomenological Psychology*, 26, 1-45.
- Halmi, K.A. (2005). The multimodal treatment of eating disorders. *World Psychiatry*, 4(2), 69 - 73. Retrieved from  
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1414734/?tool=pmcentrez>

- Halmi, K.A., Sunday, S.R., Strober, M., Kaplan, A., Woodside, B., Fichter, M., Treasure, J., Berrettini, W., & Kaye, W. (2000). Perfectionism in anorexia nervosa: Variation by clinical subtype, obsessionality and pathological eating disorders. *American Journal of Psychiatry*, *157*(11), 1799–1805.
- Hamachek, D.E. (1978). Psychodynamics of normal and neurotic perfectionism. *Psychology*, *15*, 27–33.
- Hanson, L. (2008). *It all started with poptarts....* Valencia, Spain: Shewolf Press.
- Harrison, K., & Cantor, J. (1997). The relationship between media consumption and eating disorders. *Journal of Communication*, *47*(1), 40–67.
- Heimberg, R.G., Juster, H.R., Hope, D.A., & Mattia, J.I. (1995). Cognitive behavioral group treatment for social phobia: description, case presentation, and empirical support. In M.B. Stein (Ed.), *Social Phobia: Clinical and Research Perspectives* (pp. 293–321). Washington, DC: American Psychiatric Press.
- Hergenhahn, B.R. (2009). *An introduction to the history of psychology* (6th ed.). Belmont, CA: Thomson Wadworth.
- Hewitt, P.L., & Flett, G.L. (1991a). Dimensions of perfectionism in unipolar depression. *Journal of Abnormal Psychology*, *100*, 98-101.

- Hewitt, P.L., & Flett, G.L. (1991b). Perfectionism in the self and social contexts: Conceptualisation, assessment, and association with psychopathology. *Journal of Personality and Social Psychology*, *60*, 456-470.
- Hewitt, P., & Flett, G. (2002). Perfectionism and stress enhancement, perpetuation, anticipation and generation in psychopathology. In G. Flett & P. Hewitt (Eds.), *Perfectionism: Theory, Research and Treatment* (pp. 255-284). Washington DC: American Psychological Association.
- Hewitt, P.L., Flett, G.L., Besser, A., Sherry, S.B., & McGee, B. (2003). Perfectionism is multidimensional: A reply to Shafran, Cooper and Fairburn (2002). *Behaviour Research and Therapy*, *41*, 1221-1236.
- Hewitt, P.L., Flett, C.L., & Ediger, E. (1995). Perfectionism Traits and Perfectionistic Self-presentation in Eating Disorder Attitudes, Characteristics, and Symptoms. *International Journal of Eating Disorders*, *18*(4), 317-326.
- Hewitt, P.L., Flett, G.L., Sherry, S.B., Habke, M., Parkin, M., & Lam, R.W. (2003). The interpersonal expression of perfection: Perfectionistic self-presentation and psychological distress. *Journal of Personality and Social Psychology*, *84*, 1303–1325.
- Hill, R.W., Huelsman, T.J., Furr, R., Kibler, J., Vicente, B.B., & Kennedy, C. (2004). A New Measure of Perfectionism: The Perfectionism Inventory. *Journal of Personality Assessment*, *82*(1), 80–91.

- Hollander, M.H. (1965). Perfectionism. *Comprehensive Psychiatry*, 6, 94–103.
- Hollander, M.H. (1978). Perfectionism: A neglected personality trait. *Journal of Clinical Psychiatry*, 39(5).
- Holloway, I. (2008). *A – Z of qualitative research in healthcare* (2<sup>nd</sup> ed.). Oxford: Blackwell.
- Horney, K. (1950). *Neurosis and Human Growth*. New York: W.W. Norton.
- Ihde, D., & Silverman, H.J. (Eds.). (1985). *Descriptions*. Albany State: University of New York Press.
- Ingles, C.J., Garcia-Fernandez, J.M., Vicent, M., Gonzalvez, C. & Sanmartin, R. (2016). Profiles of Perfectionism and School Anxiety: A Review of the 2 x 2 Model of Dispositional Perfectionism in Child Population. *Frontiers in Psychology*, 7, 1403. Doi:10.3389/fpsyq.2016.01403
- James, K., Verplanken, B., Rimes, K.A. (2015). Self-criticism as a mediator in the relationship between unhealthy perfectionism and distress. *Personality and Individual Differences*, 79, 123–128. Retrieved from <http://self-compassion.org/wp-content/uploads/2015/03/james.pdf>

Janesick, V.J. (1994). The dance of qualitative research design: Metaphor, methodology and meaning. In N. Denzin, & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 209-219). Thousand Oaks: Sage Publications.

Jasper, K. (1989). *Are eating disorders addictions?* Retrieved March 9, 2014, from <http://nedic.ca/sites/default/files/are-eating-disorders-addictions.pdf>

Jiyane, M.S. (2007). *Anorexia Nervosa in Black females: An interpretive interactionist perspective*. University of Johannesburg. Retrieved July 14, 2012, from <https://ujdigispace.uj.ac.za/bitstream/handle/10210/3084/Jiyane.pdf?sequence=1>

Johnson, C.L. (1991). *Psychodynamic treatment of anorexia nervosa and bulimia*. New York: The Guilford Press.

Jones, J.M., Bennet, S., Olmstead, M.P., Lawson, M.L., & Rodin, G. (2001). Disordered eating attitudes and behaviours in teenaged girls: a school based study. *Canadian Medical Association Journal*, 165(5), 547-552.

Jordan, J., McIntosh, V.V.W., Carter, J.D., Rowe, S., Taylor, K., Frampton, C.M.A., McKenzie, J.M., Latner, J., & Joyce, P.R. (2014). Bulimia Nervosa-Nonpurging Subtype: Closer to the Bulimia Nervosa-Purging Subtype or to Binge Eating Disorder?. *International Journal of Eating Disorders*, 47(3), 231–238.

Jowell, J. (2011). *Finding Sarah: A true story of living with Bulimia*. South Africa: Pan Macmillan.

Katzman, M.A., & Lee, S. (1997). Beyond body image: The integration of feminist and transcultural theories in the understanding of self starvation. *International Journal of Eating Disorders*, 22, 385-394.

Kaustav, C., & Basu, D. (2010). Management of anorexia and bulimia nervosa: An evidence-based review. *Indian Journal of Psychiatry*, 52(2), 174–186.

Retrieved from

[http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2927890/?report=printable#\\_\\_abstractid2034331](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2927890/?report=printable#__abstractid2034331)

Kaye, W., & Strober, M. (1999). The neurobiology of eating disorders. In D.S. Charney, E.J. Nestler & B.S. Bunney (Eds.), *Neurobiological foundations of mental illness* (pp.891-906). New York: Oxford University Press.

Kaye, W., Strober, M., & Jimerson, D. (2004). The neurobiology of eating disorders. In D.S. Charney & E.J. Nestler (Eds.), *The Neurobiology of Mental Illness* (pp.1112-1128). New York: Oxford Press.

Keel, P.K. (2003). Validity of categorical distinctions of eating disorders: From disorders to symptoms. In M. Maj, K. Halmi, J.J. Lopez-Ibor & N. Sartorius (Eds.), *Eating disorders: Vol. 6. WPA series evidence and experience in Psychiatry* (pp. 52-54). England: Wiley.

Keel, P.K., Baxter, M.G., Heatherton, T.F., & Joiner, T.E. (2007). A 20-Year Longitudinal Study of Body Weight, Dieting, and Eating Disorder Symptoms. *Journal of abnormal psychology, 116*(2), 422-432.

Keski-Rahkonen, A., & Mustelin, L. (2016). Epidemiology of eating disorders in Europe: prevalence, incidence, comorbidity, course, consequences, and risk factors. *Current Opinion Psychiatry, 29*(6), 340 - 345.

Khandelwal, S. & Saxena, S. (1990). Anorexia nervosa in people of Asian extraction. *British Journal of Psychiatry, 157*, 783 -784.

Kim, J. (2011). *The relationship between Perfectionism and Anorexia Nervosa*.

Retrieved from

<http://healthpsych.psy.vanderbilt.edu/2011/AnorexiaPerfectionism.htm>

Klump, K.L., Bulik, C.M., Kaye, W.H., Treasure, J., & Tyson, E. (2009). Academy for eating disorders position paper: Eating disorders are serious mental illnesses. *International Journal of Eating Disorders, 42*(2), 97 - 103.

Koch T. (1995). Interpretive approaches in nursing research: The influence of Husserl and Heidegger. *Journal of Advanced Nursing, 21*, 827 - 836.

Koch, T. (1996). Implementation of a hermeneutic inquiry in nursing: Philosophy, rigour and representation. *Journal of advanced nursing, 24*(1), 174-184.

- Krefting, L. (1991). Rigor in Qualitative Research: The Assessment of Trustworthiness. *The American journal of occupational therapy*, 4(3), 214-222.
- Kuba, S.A. & Harris, D.J. (2000). Eating disturbances in women of color: An exploratory study of contextual factors in the development of disordered eating in Mexican-American women. *Health Care for Women Journal*, 22, 281-298.
- Kvale, S. (1992). Post-modern psychology-a contradiction in terms? In S. Kvale (Ed.), *Psychology and postmodernism* (pp.31-57). London: Sage Publications.
- Lane, R.C., & Tolman, M.D. (2007). *Psychodynamic perspectives on eating disorders*. Victoria BC: Trafford.
- Langdrige, D. (2007). *Phenomenological Psychology: Theory, Research and Method*. Harlow: Pearson Education.
- Lasegue, E.C. (1873). De l'Anorexie hystérique. Archives Generales de Medecine. In R.M. Kaufmann & M. Heiman (Eds.), *Evolution of Psychosomatic Concepts. Anorexia Nervosa: A Paradigm* (pp. 384-403). New York, USA: International Universities Press.

- Lavender, J.M., Mason, T.B., Utzinger, L.M., Wonderlich, S.A., Crosby, R.D., Engel, S.G., Mitchell, J.E., Le Grange, D., Crow, S.J. & Peterson, C.B. (2016). Examining affect and perfectionism in relation to eating disorder symptoms among women with anorexia nervosa. *Psychiatry Research*, *241*, 267-272.
- Le Grange, D. & Lock, J. (2005). *Help your teenager beat an eating disorder*. New York: Guilford Press.
- Le Grange, D., Telch, C.F., & Tibbs, J. (1998). Eating attitudes and behaviours in 1,435 South African caucasian and non-caucasian college students. *American Journal of Psychiatry*, *155*, 250-254.
- Lee, S. (1996). Reconsidering the status of anorexia nervosa as a western culture bound syndrome. *Social Science and Medicine*, *42*, 21-34.
- Lee, T. (1999). *Using qualitative methods in organizational research*. Thousand Oaks: Sage Publications.
- Lee, S., Ho, T.P., & Hsu, L.K.G. (1993). Fat phobic and non-fat phobic anorexia nervosa: A comparative study of 70 Chinese patients in Hong Kong. *Psychological Medicine*, *23*, 999–1017.
- Lee, M., Roberts-Collins, C., Coughtrey, A., Phillips, L., & Shafran, R. (2011). Behavioural expressions, imagery and perfectionism. *Behavioural and Cognitive Psychotherapy*, *39*, 413-425.

Leedy, P.D., & Ormrod, J.E. (2007). *Practical Research: Planning and Design* (8<sup>th</sup> ed.). New Jersey: Merrill Prentice Hall.

Lessem, R., & Schieffer, A. (2010). *Integral Research and Innovation: Transforming Enterprise and Society*. England: Gower Publishing Limited.

Lester, S. (1999). *An introduction to phenomenological research*. United Kingdom: Taunton.

Levine, M.P. (2000). Mass media and body image: A brief review of the research. *Healthy Weight Journal*, 14(6), 84–85.

Lilenfeld, L.R., Stein, D., Bulik C.M., Strober, M., Plotnicov, K., Pollice, C., Rao, R., Merikangas, K.R., Nagy, L. & Kaye, W.H. (2000). Personality traits among currently eating disordered, recovered and never ill first-degree female relatives of bulimic and control women. *Psychological Medicine*, 30, 1399-1410.

Liu, A. (2011). *Breaking the Eating Disorder Stigma, One Story at a Time*. Retrieved February 9, 2014, from [http://www.huffingtonpost.com/aimee-liu/breaking-eating-disorder-stigma\\_b\\_848800.html](http://www.huffingtonpost.com/aimee-liu/breaking-eating-disorder-stigma_b_848800.html)

- Lobera, I.J. (2011). Bulimia Nervosa and Personality: A Review. In P. Hay (Ed.), *Bulimia Nervosa and Personality: A Review, New Insights into the Prevention and Treatment of Bulimia Nervosa* (pp. 127-146). Retrieved from <http://www.intechopen.com/books/new-insights-into-the-prevention-and-treatment-of-bulimia-nervosa/bulimia-nervosa-and-personality-a-review.html>
- Lock, J., Le Grange, D., Agras, W.S., & Dare, C. (2001). *Treatment manual for Anorexia Nervosa: A Family-based approach*. London: The Guildford Press.
- Lundh, L.G. (2004). Perfectionism and acceptance. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, 22(4), 251–265.
- Macedo A., Marques M., & Pereira A.T. (2014). Perfectionism and psychological distress: A review of the cognitive factors. *International Journal of Clinical Neurosciences and Mental Health*, 1(6), 1-10.
- Macgregor, M.W., & Lamborn, P. (2014). Personality Assessment Inventory profiles of university students with eating disorders. *Journal of Eating Disorders*, 2, 20.
- Maggs-Rapport, F. (2001). 'Best research practice': In pursuit of methodological rigour. *Journal of advanced nursing*, 35(3), 373-383.
- Maloney, G.K., Egan, S.J., Kane, R.T., & Rees, C.S. (2014). An Etiological Model of Perfectionism. *PLoS ONE*, 9(5).

Markey, K., Tilki, M., & Taylor, G. (2014). Reflecting on the challenges of choosing and using a grounded theory approach. *Nurse Researcher*, 22(2), 16-22.

Retrieved from <http://journals.rcni.com/doi/pdfplus/10.7748/nr.22.2.16.e1272>

Marrazzi, M.A., Bacon, J.P., Kinzie, J., & Luby, E.D. (1995). Naltrexone use in the treatment of Anorexia Nervosa and Bulimia Nervosa. *International Clinical Psychopharmacology*, 10, 163-72.

Martin, P.Y., & Turner, B.A. (1986). Grounded theory and organizational research. *The Journal of Applied Behavioral Science*, 22(2), 141-157.

Mas, M.B., Luisa, M., Navarro, M.L.A., López, A., Jiménez, L., Torres-Pérez, I., Del, C., Sánchez, R., Pérez, M.A., & Gregorio, S. (2011). Personality traits and eating disorders: Mediating effects of self-esteem and perfectionism. *International Journal of Clinical and Health Psychology*, 11(2), 205 – 227.

Maslow, A.H. (1970). *Motivation and Personality* (2<sup>nd</sup> ed.). New York: Harper & Row.

Mehler, P.S., & Brown, C. (2015). Anorexia-Nervosa – Medical Complications.

*Journal of Eating Disorders*, 3(11). Retrieved from

<http://jeatdisord.biomedcentral.com/articles/10.1186/s40337-015-0040-8>

Mitchell, J., & Yaqoob, T. (2007). *Catwalk girl, 18, dies six months after her model sister starved herself to death*. Retrieved April 14, 2011, from <http://www.dailymail.co.uk/news/article-436277/Catwalk-girl-18-dies-months-model-sister-starved-death.html#ixzz1JTc9jk2i>

Moustakas, C. (1994). *Phenomenological research methods*. United Kingdom: SAGE Publications.

Natenshon, A. (n.d.). *Myths and Misconceptions for Parents, Health Professionals, and Educators*. Retrieved April 15, 2011, from <http://www.empoweredparents.com/1eatingdisorders/myths.html>

National Eating Disorders Association. (2008). *NEDA: National Eating Disorder Association Fact Sheet on Eating Disorders*. Retrieved April 15, 2011 from [http://www.nationaleatingdisorders.org/uploads/file/in-the-news/NEDA-In-the-News-Fact-Sheet\(2\).pdf](http://www.nationaleatingdisorders.org/uploads/file/in-the-news/NEDA-In-the-News-Fact-Sheet(2).pdf)

*National Eating Disorders Association Fact Sheet*. (2008). Retrieved April 15, 2011, from [http://www.nationaleatingdisorders.org/uploads/file/in-the-news/NEDA-In-the-News-Fact--Sheet\(2\).pdf](http://www.nationaleatingdisorders.org/uploads/file/in-the-news/NEDA-In-the-News-Fact--Sheet(2).pdf)

*National Eating Disorders Collaboration*. (2012). Retrieved July 7, 2016, from [http://thebutterflyfoundation.org.au/wpcontent/uploads/2012/12/Butterfly\\_Report.pdf](http://thebutterflyfoundation.org.au/wpcontent/uploads/2012/12/Butterfly_Report.pdf)

- Neff, K.D. (2003). The development and validation of a scale to measure self-compassion. *Self and Identity*, 2(3), 223–250. Retrieved August 28, 2016, from <http://dx.doi.org/10.1080/15298860309027>
- Neuman, W.L. (2000). *Social research methods: Qualitative and quantitative approaches*. Boston: Allyn & Bacon.
- NHS Scotland. (2006). *Eating Disorders in Scotland: Recommendations for Management and Treatment*. Retrieved Jan 20, 2013, from [http://www.playfieldinstitute.co.uk/information/pdfs/publications/eating\\_disorders/InScotland.pdf](http://www.playfieldinstitute.co.uk/information/pdfs/publications/eating_disorders/InScotland.pdf)
- NICE Guidelines. (2004). *Eating Disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders*. Retrieved April 3, 2011, from <http://guidance.nice.org.uk/PH6>
- Nielsen, L. (2000). Black undergraduate and White undergraduate Eating Disorders and related attitudes. *College Student Journal*, 34(3), 353-370.
- Noordenbos, G. (2013). *Recovery from Eating Disorders: A Guide for Clinicians and Their Clients*. Sussex: John Wiley & Sons, Ltd.
- Nordbo, R.H.S., Espeset, E.M.S., Gulliksen, K.S., Skårderud, F., & Holte, A. (2006). The meaning of self-starvation: Qualitative study of patients' perception of anorexia nervosa. *International Journal of Eating Disorders*, 39(7), 556-564.

Norris, D.L. (1979). Clinical diagnostic criteria for primary anorexia nervosa. *South African Medical Journal*, 56, 987-993.

Norton, L. (1999). *The philosophical bases of grounded theory and their implications for research practice*. Accessed February 1, 2016, from <http://journals.rcni.com/doi/full/10.7748/nr1999.10.7.1.31.c6102>

Nwaefuna, A. (1981). Anorexia nervosa in a developing country. *British Journal of Psychiatry*, 138, 270-274.

O'Garro-Moore, J.K., Adams, A.M., Abramson, L.Y. & Alloy, L.B. (2015). Anxiety comorbidity in bipolar spectrum disorders: The meditational role of perfectionism in prospective depressive symptoms. *Journal of Affective Disorders*, 174, 180-187.

Obsessive Compulsive Cognitions Working Group (1997). Cognitive assessment of obsessive-compulsive disorder. *Behaviour Research and Therapy*, 35, 667 – 681.

Orbach, S. (1993). *Hunger strike*. England: Wiley & Sons.

Osborne, J. (1990). Some basic existential-phenomenological research methodology for counsellors. *Canadian Journal of Counselling*, 24, 79-91.

Osborne, J. (1994). Some similarities and differences among phenomenological and other methods of psychological qualitative research. *Canadian Psychology*, 35(2), 167-189.

Oyewumi, L.K., & Kazarian, S.S. (1992a). Abnormal eating attitudes among a group of Nigerian youths: I bulimic behaviour. *East African Medical Journal*, 69, 663– 666.

Oyewumi, L.K., & Kazarian, S.S. (1992b). Abnormal eating attitudes among a group of Nigerian youths: II anorexic behaviour. *East African Medical Journal*, 69, 667–669.

Parker, I. (1992) *Discourse Dynamics: Critical Analysis for Social and Individual Psychology*. London: Routledge.

Patterson, A. (2000). *Anorexic*. London: Westworld International Limited.

Paul, J. (2010). *Age Minimums in the Sport of Women's Artistic Gymnastics*.

Retrieved March 8, 2016, from

<https://willamette.edu/law/resources/journals/sportslaw/documents/Spring%202010%20-%20Paul.pdf>

Pearson, J., Goldklang, D., & Striegel-Moore, R.H. (2002). Prevention of eating disorders: Challenges and Opportunities. *International Journal of Eating Disorders*, 31(3), 233-239.

Peixoto-Placido, C., Soares, M.J., Pereira, A.T. & Macedo, A. (2015). Perfectionism and disordered eating in overweight woman. *Eating Behaviors*, 18, 76 - 80.

*Perfectionism linked to eating disorders*. (2003). Retrieved March 28, 2011, from <http://www.webmd.com/news/20030205/perfectionism-linked-to-eating-disorders>

Peterson, C.B., Mitchell, J.E., Crow, S.J., Crosby, R.D., & Wonderlich, S.A. (2009). The Efficacy of Self-Help Group Treatment and Therapist-Led Group Treatment for Binge Eating Disorder. *American Journal of Psychiatry*, 166(12), 1347-1354. Retrieved March 28, 2011, from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3041988/?tool=pmcentrez>

Pinto-Gouveia, J., Ferreira, C., & Duarte, C. (2014). Thinness in the pursuit for social safeness: An integrative model of social rank mentality to explain eating psychopathology. *Clinical Psychology and Psychotherapy*, 21, 154-165. doi: 10.1002/cpp.1820

Polkinghorne, D.E. (1983). *Methodology for the human sciences: Systems of inquiry*. Albany: State University of New York Press.

Prah, P.M. (2006). *Eating Disorders*. *The CQ Researcher*, 16(6), 121-144. Retrieved January, 20, 2013, from <http://evincent.webs.com/eating%20disorders.pdf>

*Prevalence rates.* (n.d.). Retrieved February 25, 2013, from

[http://www.aedweb.org/Prevalence\\_of\\_ED.html](http://www.aedweb.org/Prevalence_of_ED.html)

Prus, R. (1996). *Symbolic interaction and ethnographic research*. Albany, NY: State University of New York Press.

Puhl, R., & Suh, Y. (2015). Stigma and eating and weight disorders. *Curr Psychiatry Rep.*, 17(3), 552.

*Quotations page.* (n.d.). Retrieved March 13, 2013, from

<http://www.quotationspage.com/search.php3?Author=John+Steinbeck&file=other>

Reda, M. (2001). Anorexia and the holiness of Saint Catherine of Siena. *Journal of Criminal Justice and Popular Culture*, 8(1), 37-47.

Reichertz, J. (2007). Abduction: The logic of discovery of grounded theory. In A. Bryant & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp. 214– 28). London: Sage: Publications.

Rhodes, P. (2003). The Maudsley Model of Family Therapy for Children and Adolescents with Anorexia Nervosa: Theory, Clinical Practice, and Empirical Support. *Annual New Zealand Journal of Family Therapy*, 24(4), 191–198.

- Rice, K.G., Ashby, J.S., & Slaney, R.B. (1998). Self-Esteem as a Mediator Between Perfectionism and Depression: A Structural Equations Analysis. *Journal of Counselling Psychology, 45*(3), 304–314.
- Rice, K.G., & Preusser, K.J. (2002). The Adaptive/Maladaptive Perfectionism Scale. *Measurement and Evaluation in Counselling and Development, 34*, 21–222.
- Rieger, E., & Zwickert, K. (2013). Stigmatizing attitudes towards individuals with anorexia nervosa: An investigation of attribution theory. *Journal of eating disorders, 1*(5). Retrieved February 9, 2014, from <http://www.jeatdisord.com/content/1/1/5>
- Rimes, K.A., & Chalder, T. (2010). The beliefs about emotions scale: Validity, reliability and sensitivity to change. *Journal of Psychosomatic Research, 68*(3), 285–292.
- Robbeson, J.G., Havemann-Nel, L., & Wright, H.H. (2013). The Female Athlete Triad in Student Track and Field Athletes. *South African Journal of Clinical Nutrition, 26*(2), 19-24.
- Robertson, M., Rushton, P., & Wurm, C. (2008). Interpersonal Psychotherapy: An overview. *Psychotherapy in Australia, 14*(3), 46-54. Retrieved from [http://www.psychotherapy.com.au/fileadmin/site\\_files/pdfs/InterpersonalPsychotherapy.pdf](http://www.psychotherapy.com.au/fileadmin/site_files/pdfs/InterpersonalPsychotherapy.pdf)

- Roehrig, J., & McLean, C. (2010). A comparison of stigma toward eating disorders versus depression. *International Journal of Eating Disorders, 43*, 671–673.
- Russell, G.F.M. (1995). Anorexia nervosa through time. In G. Szukler, C. Dare & J. Treasure (Eds.), *Handbook of eating disorders: Theory, treatment and research* (pp. 5 – 27). England: Penguin.
- Sadock, B.J., & Sadock, V.A. (2003). *Kaplan and Sadock's Synopsis of Psychiatry: Behavioural Sciences/Clinical Psychiatry* (9th ed.). USA: Lippincott Williams & Wilkins.
- Salafia, E.H., Jones, M.E., Haugen, E.C., & Schaefer, M.K. (2015). Perceptions of the causes of eating disorders: a comparison of individuals with and without eating disorders. *Journal of Eating Disorders, 3*(32). Retrieved July 7, 2016, from [https://cfe.keltyeatingdisorders.ca/sites/default/files/resource/40337\\_2015\\_Article\\_69.pdf](https://cfe.keltyeatingdisorders.ca/sites/default/files/resource/40337_2015_Article_69.pdf)
- Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing, 8*(3), 27-37.
- Schmidt, U., & Treasure, J. (2006). Anorexia Nervosa: Valued and Visible. A cognitive-interpersonal maintenance model and its implications for research and practice. *British Journal of Clinical Psychology, 45*, 343-366.

- Selvini-Palazzoli, M. (1985). Anorexia nervosa: A syndrome of the affluent society. *Transcultural Psychiatric Research Review*, 22(1), 199–207.
- Senekal, M., Steyn, N.P., Mashego, T.B. & Nel, J.H. (2001). Evaluation of body shape, eating disorders and weight management related parameters in black female students of rural and urban origins. *South African Journal of Psychology*, 31(1), 45- 53.
- Shafran, R., Cooper, Z., & Fairburn, C.G. (2002). Clinical perfectionism: A cognitive-behavioural analysis. *Behaviour Research and Therapy*, 40, 773-791.
- Shafran, R., Cooper, Z. & Fairburn, C.G. (2003). “Clinical Perfectionism” is not “multidimensional perfectionism”: A reply to Hewitt, Flett, Besser, Sherry, & McGee. *Behaviour Research and Therapy*, 41, 1217-1220.
- Shafran, R., Egan, S., & Wade, T. (2010). *Overcoming perfectionism: A self-help guide to using cognitive behavioral techniques*. London, UK: Constable & Robinson.
- Shaw, H., Stice, E., & Becker, C.B. (2009). Preventing Eating Disorders. *Child and Adolescent Psychiatric Clinics of North America*, 18(1), 199-207. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2938770/?tool=pmcentrez>
- Slade, P. (1982). Towards a functional analysis of anorexia nervosa and bulimia nervosa. *British Journal of Clinical Psychology*, 21, 167–179.

Slof-Op't Landt, M.C.T., Claes, L., & Van Furth, E.F. (2016). Classifying eating disorders based on “healthy” and “unhealthy” perfectionism and impulsivity: Classifying EDS with Perfectionism and Impulsivity. *International Journal of Eating Disorders*, 1 – 8.

Smink, F.R.E., van Hoeken, D. & Hoek, H.W. (2012). Epidemiology of Eating Disorders: Incidence, Prevalence and Mortality Rates. *Curr Psychiatry Rep*, 14, 406 - 414.

Smith, B. (2010). *Oxford Dictionary of Quotations by Subject* (2nd ed.). New York: Oxford University Press.

Smith, K., & Biley, F. (1997). Understanding grounded theory: Principles and evaluation. *Nurse Researcher*, 4(3), 17-30.

Sowar, K. (2015). *Eating Disorders in Children and Adolescents* [PowerPoint slides]. Retrieved July 1, 2016, from [https://www.ihs.gov/telebehavioral/includes/themes/newihsttheme/display\\_objects/documents/slides/nationalchildandadolescent/eatingdisorders102015.pdf](https://www.ihs.gov/telebehavioral/includes/themes/newihsttheme/display_objects/documents/slides/nationalchildandadolescent/eatingdisorders102015.pdf)

South Carolina Department of Mental Health. (n.d.). *Eating Disorder Statistics*. Retrieved May 13, 2011, from <http://www.state.sc.us/dmh/anorexia/statistics.htm>

- Spiegelberg, H. (1975). *Doing Phenomenology: Essays on and in Phenomenology*. The Hague: Nijhoff.
- Spinelli, E. (1989). *The Interpreted world: An introduction to phenomenological psychology*. London, England: Sage publications.
- Spokas, M., Luterek, J.A., & Heimberg, R.G. (2009). Social anxiety and emotional suppression: The mediating role of beliefs. *Journal of Behavior Therapy and Experimental Psychiatry*, 40, 283–291.
- Srinivasagam, N.M., Kaye, W.H., Plotnicov, K.H., Greeno, C., Weltzin, T.E., & Rao, R. (1995). Persistent perfectionism, symmetry, and exactness after long-term recovery from anorexia nervosa. *American Journal of Psychiatry*, 152, 1630–1634.
- Stern, P.N. (1994). Grounded Theory Methodology: Its Uses and Processes. In B.G. Glaser (Ed.), *More Grounded Theory Methodology: A Reader*. Mill Valley, CA: Sociology Press.
- Stice, E., Schupk-Neuberg, E., Shaw, H.E., & Stein, R.I. (1994). Relation of media exposure to eating disorder symptomatology: An examination of mediating mechanisms. *Journal of Abnormal Psychology*, 103, 836-840.
- Strauss, A.L., & Corbin, J.M. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage Publications.

Strauss, A.L. & Corbin, J.M. (1994) Grounded theory methodology: An overview. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 273-285). Thousand Oaks, CA: Sage Publications.

Strauss, A.L., & Corbin, J.M. (1998). *Basics of Qualitative Research; Techniques and Procedures for developing Grounded Theory*. New York: Sage Publications.

Strober, M. (1980). Personality and symptomological features in young, nonchronic anorexia nervosa patients. *Journal of Psychosomatic Research*, 24, 353-359.

Sutandar-Pinnock, K. (2001). *Perfectionism in Anorexia Nervosa: A 6-24 month follow-up study*. Retrieved June 3, 2015, from <https://tspace.library.utoronto.ca/bitstream/1807/15237/1/MQ63154.pdf?ref=Guzels.TV>

Stoeber, J., & Otto, K. (2006). Positive conceptions of perfectionism: Approaches, evidence, challenges. *Personality and Social Psychology Review*, 10, 295-319.

Stoeber, J., & Corr, P. J. (2016). A short empirical note on perfectionism and flourishing. *Personality and Individual Differences*, 90, 50-53. Retrieved from [https://kar.kent.ac.uk/50896/1/Stoeber%20%26%20Corr%20\(2016\)%20Flourishing%20-%20PAID.pdf](https://kar.kent.ac.uk/50896/1/Stoeber%20%26%20Corr%20(2016)%20Flourishing%20-%20PAID.pdf)

Sutandar-Pinnock, K., Woodside, D.B., Carter, J.C., Olmsted, M.P., & Kaplan, A.

(2003). Perfectionism in anorexia nervosa: A 6-24-month follow-up study.

*International Journal of Eating Disorders*, 33, 225–229.

Szabo, C.P. (2009). *Eating Disorders*. Wandsbeck, South Africa: Reach Publishers.

Szabo, C.P., Berk, M., Tlou, E., & Allwood, C.W. (1995). Eating disorders in Black

South Africans: A series of cases. *South African Medical Journal*, 85(6), 588-

590.

Szabo, C.P., & Hollands, C. (1997). Abnormal eating attitudes in secondary-school

girls in South Africa – a preliminary study. *South African Medical Journal*,

87(4), 524-526, 528-530.

Szymanski, J. (2011). *The Perfectionist's Handbook: Take Risks, Invite Criticism,*

*and Make the Most of Your Mistakes*. New Jersey, USA: John Wiley & Sons.

Tancredi, S. (2013). *Anorexia through the Ages: From Sainthood to Psychiatry*.

Retrieved September 15, 2016, from <http://eibalance.com>

Taranis, L. (2010). *Compulsive exercise and eating disorder related pathology*

(Doctoral Thesis). Loughborough University. Retrieved from

<http://www.ncbi.nlm.nih.gov/pubmed/21584911>

Taunton, R. [Rachel]. (n.d.). Vitruvian Woman – Sketch Art Print [Pinterest Post].

Retrieved January 7, 2017, from

<https://za.pinterest.com/pin/57901690248889272/>

The British Psychological Society & The Royal College of Psychiatrists. (2004).

*Eating Disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa, and related eating disorders.* London, England: Gaskell.

*The history of the classification of eating disorders.* (n.d.). Retrieved February 25, 2013, from <http://www.e-womenhealth.com/2010/12/history-of-classification-of-eating.html>

The Royal College of Psychiatrists' Public Education Sub-Committee. (2013).

*Anorexia and Bulimia.* Retrieved June 9, 2013, from

<http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/eatingdisorders/eatingdisorders.aspx>

The Victorian Centre of Excellence in Eating Disorders. (n.d.). *Facts and Findings.*

Retrieved June 9, 2013 from <http://www.ceed.org.au/facts-and-findings/w1/i1001246/>

Thompson, R., & Zuroff, D.C. (2004). The levels of self-criticism scale: Comparative self-criticism and internalised self-criticism. *Personality and Individual Differences, 36*, 419–430.

*Treatment*. (n.d.). Retrieved November 23, 2011, from <http://aedtest.sherwood-group.com/Treatment.html>

Trinder, H., & Salkovskis, P.M. (1994). Personally relevant intrusions outside the laboratory: Long-term suppression increases intrusion. *Behaviour Research and Therapy*, 32(8), 833–842.

Valle, R.S., & Halling, S. (Eds.). (1995). *Existential – phenomenological perspectives in psychology*. New York: Plenum Press.

Van der Ham, T., Meulman, J., Van Strien, D., & Van Engeland, H. (1997). Empirically based sub-grouping of eating disorders in adolescents: A longitudinal perspective. *British Journal of Psychiatry*, 170, 363-368.

Van der Walt, E. (1995). *Anorexia Nervosa: 'n epidemiologiese ondersoek in die Rocklands gemeenskap* (Magister tesis). Universiteit van die Oranje Vrystaat, Departement van Sielkunde, Bloemfontein, Suid-Afrika.

Van Heerden, I.V. (2009). *Girl athletes risk eating disorders*. Retrieved April 11, 2011, from [http://www.health24.com/dietnfood/Weight\\_Centre/15-51-2988,50876.asp](http://www.health24.com/dietnfood/Weight_Centre/15-51-2988,50876.asp)

Von Lojewski, A. & Abraham, S. (2014). Personality factors and eating disorders: Self-uncertainty. *Eating Behaviours*, 15, 106 - 109.

- Van Tonder, J. (2004). *Cultural Differences in Age of Onset and Prevalence of Disordered Eating Attitudes and Behaviours* (Master's thesis, University of the Free State, Bloemfontein, South Africa). Retrieved from <http://scholar.ufs.ac.za:8080/xmlui/bitstream/handle/11660/1939/VANTONDERJ.pdf?sequence=1>
- Vitousek, K.B., & Hollon, S.D. (1990). The investigation of schematic content and processing in eating disorders. *Cognitive Therapy and Research, 14*, 191–214.
- Volpe, U., Tortorella, A., Manchia, M., Monteleone, A.M., Albert, U., & Monteleone, P. (2016). Eating disorders: What age at onset? *Psychiatry res, 30*, 225 - 227.
- Wade, T.D., & Tiggemann, M. (2013). The role of perfectionism in body dissatisfaction. *Journal of Eating Disorders, 1*(2).
- Waller, G., Cordery, H., Corstorphine, E., Hinrichsen, H., Lawson, R., Mountford, V., & Russel, K. (2007). *Cognitive-behavioural treatment for eating disorders: A comprehensive treatment guide*. New York: Cambridge University Press.
- Wassenaar, D., Le Grange, D., Winship, J., & Lachenicht, L. (2000). The Prevalence of Eating Disorder Pathology in a Cross-Ethnic Population of Female Students in South Africa. *European Eating Disorders Review, 8*, 225-235.

Weisenberg, M. (1994). Cognitive aspects of pain. In P.D. Wall, & R. Melzack (Eds.), *Textbook of pain* (pp. 275-289). New York: Churchill Livingstone.

Williams, C. (2015). *Perfectionism, Health and Preventative Health Behaviours* (Doctorate Thesis). University of Surrey. Retrieved from <https://epubs.surrey.ac.uk/807953/>

Williams, K., King, J. & Fox, J.R.E. (2016). Sense of self and anorexia nervosa: A grounded theory. *Psychology and Psychotherapy: Theory, Research and Practice*, 89, 211–228.

Williams, J.M., Watts, F.N., MacLeod, C., & Mathews, A. (1997). *Cognitive psychology and emotional disorder*. Chichester, England: Wiley.

Wilson, J. (2004). Beyond psychiatry: How social workers conceptualise women and self-starvation. *Australian Social Work*, 57(2), 150-160.

Wilson, G.T., Vitousek, K.M., & Loeb, K.L. (2000). Stepped care treatment for eating disorders. *Journal Consultation Clinical Psychology*, 68(4), 564-72. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/10965631>

Young, S., Rhodes, P., Touyz, S., & Hay, P. (2013). The role of exercise in the treatment and recovery process of anorexia nervosa. *Journal of Eating Disorders*, 1(1), 08.

Zucker, N. (2003). *The many faces of perfectionism. Eating Disorders Recovery*

*Today*. Retrieved March 13, 2013, from

[http://www.eatingdisordersreview.com/nl/nl\\_edt\\_2\\_2\\_1.html](http://www.eatingdisordersreview.com/nl/nl_edt_2_2_1.html)