A PSYCHO-EDUCATIONAL PROGRAMME FOR ADOLESCENTS WITH UNHEALTHY EATING HABITS

by

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DECLARATION

I hereby declare that: “A PSYCHO-EDUCATIONAL PROGRAMME FOR ADOLESCENTS WITH UNHEALTHY EATING HABITS is my own work and that all the resources that I have used or quoted have been indicated and acknowledged by means of complete references.”

________________________     _________________

NADINE DE BEER      DATE

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DEDICATION
Dedicated to:

MY WONDERFUL FATHER, JOHNNY DE BEER
who died in August 2005,

MY LOVING MOTHER, HEATHER

and

MY HUSBAND, DR. DR. ROMI SCHNEL
for providing me with a fountain of encouragement.

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A PSYCHO-EDUCATIONAL PROGRAMME FOR ADOLESCENTS
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SUMMARY

Due to the fact that there has been a dramatic increase in the number of adolescents with unhealthy eating habits there is a growing recognition on the part of professionals, educators and parents for the development and implementation of an intervention programme for the facilitation of healthy eating habits.

Relevant literature on eating behaviour indicated that low self-concept is associated with health compromising behaviours such as unhealthy eating habits. The nature of self-concept and eating habits was explained in order to determine important exogenous and endogenous factors as well as perspectives to use as a background for the development of a Psycho-educational intervention programme. Theoretical principles and practical applications of cognitive-behaviour therapy and hypnotherapy were analysed and used as a foundation for the development of the intervention programme.

The researcher developed an Interactionism Model of Self-concept and Eating habits and a Psycho-educational programme involving cognitive-behaviour therapy and hypnotherapy to improve eating habits of adolescents.

Valid and reliable measuring instruments were used in order to measure self-concept and eating habits. A pre-test post-test design was implemented to nine participants using the Adolescent Self-concept Scale (ASCS), Eating Habits Questionnaire for Adolescents (EHQA)
developed by the researcher (2001) and Body Mass Index (BMI). Diagnostic measuring instruments also included the Emotions Profile Index (EPI), Draw A Person (DAP), Sentence Completion, Dietary Record and interview.

Results from the empirical study indicated that adolescents with low self-concept and unhealthy eating habits responded positively to the Psycho-educational programme involving cognitive-behaviour and hypnotherapy. Specifically, there was a significant increase in self-concept and a satisfactory improvement in eating habits. Recommendations for psychotherapy practice, educators and parents were made, based on the current research results.

The contribution of the study lies in the fact that a hands-on practical implementation of the Psycho-educational programme was developed to facilitate the improvement of eating habits and it further contributes to the psychological well-being and healthy life-style of adolescents having positive implications for society.

KEY WORDS
self-concept, eating habits, eating disorders, cognitive-behaviour therapy, hypnotherapy, Ericksonian therapy, adolescents, development, endogenous, exogenous.
“SELF ESTEEM”

I am me

In all the world, there is no one else like me.

There are persons who have some parts like me, but no one adds up exactly like me.

Therefore, everything that comes out of me is authentically mine because I alone chose it. I own everything about me, my body including everything it does; my mind, including all its thoughts and ideas; my eyes, including the images of all they behold; my feelings, whatever they may be, anger, joy, frustration, love, disappointment, excitement; my mouth, and all the words that come out of it, polite, sweet or rough, correct or incorrect; my voice, loud or soft; and all my actions, whether they be to others or to myself. I own my fantasies, my dreams, my hopes, my fears. I own all my triumphs and successes, all my failures and mistakes. Because I own all of me, I can become intimately acquainted with me. By so doing I can love me and be friendly with me in all my parts. I can then make it possible for all of me to work in my best interest. I know there are aspects about myself that puzzle me, and other aspects that I do not know. But as long as I am friendly and loving to myself, I can courageously and hopefully look for the solutions to the puzzles and for ways to find out more about me. However I look and sound, whatever I say and do and whatever I think and feel at a given moment in time is me. This is authentic and represents where I am at that moment in time. When I review later how I looked and sounded, what I said and did, and how I thought and felt, some parts may turn out to be unfitting, I can discard that which is unfitting, and keep that which proved fitting, and invent something new for that which I discarded. I can see, hear, feel, think, say, and do. I have the tools to survive, to be close to others, to be productive, and to make sense and order out of the world of people and things outside of me. I own me, and therefore I can engineer me, I am me, and I am okay.

Virginia Satir
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CHAPTER ONE

INTRODUCTORY ORIENTATION

1.1 BACKGROUND

Education on eating habits is on the one hand often considered by some people to be an infringement on an individuals right to choose his/her eating behaviour. On the other hand it is considered to be important to educate young people about eating habits to ensure that they have the knowledge to deal with health choices in order to maximize their quality of life (Blinkhorn & Palmer 2001:99).

Both being underweight and overweight feature in the top ten risks in terms of the global burden of disease (World Health Organisation 2002:1). Adolescence is a period of time in which children are prone to a higher prevalence of risk taking behaviour such as overeating and undereating. Overeating and undereating can be a displacement for other problems such as low self-concept, interpersonal problems, and an acute sense of shame and doubt (Segal 2001:29).

There has been a dramatic increase in the number of adolescents with unhealthy eating habits over the past twenty years. The prevalence of unhealthy eating habits has increased in all socio economic classes in the last two decades and as a result, there is growing recognition on the part of professionals, parents and educators for an intervention programme to deal with unhealthy eating habits (Adolfsson, Carlson, Undén, Rössner 2002:244). Over the last ten years there has been an increase in the number of adolescents who are preoccupied with weight and therefore populations can be at great risk for developing unhealthy eating habits (Collins 1991; Graham 1998:262; Hill, Oliver & Rogers 1992).

A South African Youth Risk Behaviour Survey conducted in 2002 among South Africans aged 15 – 24 years revealed that 17,2 percent of learners are overweight, 4,0
percent of learners are obese, 9.0 percent of learners are underweight as indicated by weight for age and 4.0 percent of learners are extremely underweight as indicated by weight for height (South African National Youth Risk Behaviour Survey 2003:58).

There is a massive promotion of high energy, fat rich snack foods and soft drinks by the food industry that can lead to overeating. In South Africa 38.8 percent of learners eat fast foods frequently, 47.4 percent of learners eat cakes and biscuits frequently and 52 percent drink cold drinks and eat sweets frequently (South African National Youth Risk Behaviour Survey 2003:61). At the same time society’s emphasis on good looks can lead to undereating in an attempt to try to achieve impossible standards of perfection. Unhealthy eating habits are a real problem particularly in Western civilization and adolescents from all walks of life experience difficulties in developing healthy eating habits. As a consequence of unhealthy eating habits we are seeing very significant increases in chronic disease morbidity in many countries at an earlier age (Catford 2003:1; Hartley 1998:133).

A number of studies have shown that knowledge about nutrition among school children was sound and that many children have a clear understanding of ‘healthy’ and ‘unhealthy’ foods (Ross 1995:312; Seaman 1997:19). Recent research however reveals that unhealthy eating habits have a psychological and psychosocial function (Schnel 2001:165; Thomas, Ricciardelli & Williams 2000:441). Research grounded in a psychological perspective suggests that unhealthy eating habits tend to be symptomatic of a struggle for self-concept but research has not adequately verified which dimensions or how self plays a significant role in eating habits (Brook & Tepper 1997:284; Geller, Srikanth, Cockell & Zaitsoff 2000:339; Hoare & Cosgrove 1998:425).

There is an awareness that low self-concept is associated with health compromising behaviours such as unhealthy eating habits but very little longitudinal research addressing this issue has been done (McGee & Williams 2000:569). In reviews of
coping research only a few references are made to work carried out in the domain of self-concept and eating habits (Compas 1987:393). Based on the Educational database (ERIC) and the Psychological database (Psyc Info) only four articles with regard to eating habits and self-concept has been published since 2000. According to Stern (1991:105) an adolescents’ self-concept tends to be greatly influenced by how well they are able to negotiate inherent tension between a sense of relationship with other people and a sense of autonomy from them. Adolescents who better negotiate the tension between autonomy and relatedness are more likely to have a more positive self-concept and this in turn, leads to healthier eating habits (Hesse-Biber & Marino 1999:385; McGee & Williams 2000:569). This was verified by Jacobi (2003:31) who examined the specificity of self-concept disturbances in eating disordered patients and found that they displayed a more negative self-concept than people who demonstrated healthy eating habits.

In South Africa perceptions of body weight among adolescents reveal that significantly more males than females perceive themselves to be underweight and more females (17,5 percent) than males (9,7 percent) consider themselves overweight. These results are consistent with the “obesogenic” environments, which promote the stereotypical image of the “slim” female and “macho” male figure, in which adolescents are growing up (South African National Youth Risk Behaviour Survey 2003:58). Rather than accepting diverse body sizes and appearances society tends to move towards narrow standards for beauty and acceptance. It is therefore essential for adolescents to challenge the scripts that society writes for them e.g. “to be successful in life one must be thin”.

By enhancing self-concept it may be possible to reduce health compromising behaviour such as unhealthy eating habits. According to Taylor, Kemeny, Reed, Bower and Gruenewald (2000:99) even small enhancements in one’s self-concept is important because positive self-perception protects one against physical illness. Programmes designed to identify deficits in self-concept and eating habits could help
adolescents make the changes necessary to prevent the later risk of developing eating disorders (Newns, Bell & Thomas 2003:64; West & Sweeting 1997:161).

Practitioners are in the ideal situation to become scientific knowledge developers. The researcher would like to argue that by using existing theory to interpret data in order to employ intervention, the practitioner does not become action orientated in the process of conceptualizing and analyzing during their daily practice. Practitioners should engage in modifying existing theory which if proved to be effective should be shared with other professionals.

1.2 ANALYSIS OF THE PROBLEM
In the investigation of the problem attention will be given to the awareness of the problem, the preliminary investigation of the problem, factors influencing the self-concept and the influence of self-concept on eating habits after which the research question will be stated.

1.2.1 Awareness of the problem
In the researcher’s line of work with adolescents she has found that adolescents who have a low self-concept tend to adopt unhealthy eating habits and find it extremely stressful to change their unhealthy life styles to healthier ones. She has also found that unhealthy eating tends to start with negative cognitive appraisals followed by a repetition of unhealthy eating habits which when practiced often and long enough becomes a spontaneous reflex and is very difficult to change.

From experience it has been found that parents and adolescents are unaware of specific coping skills they could acquire from professionals. Adolescents are unaware that their unhealthy eating habits may be attributed to a low self-concept that with psycho-educational intervention strategies may be changed.
During interviews the researcher as an Educational Psychologist experienced an awareness of low self-concept among adolescents with unhealthy eating habits that gave rise to the following questions:

- How does low self-concept affect eating habits?
- How do significant others influence the development of self-concept?
- Can a Psycho-educational programme improve self-concept and eating habits?

The dynamics of the self-concept and eating habits becomes more complex during adolescence since they attempt to identify with and seek acceptance from significant others. A further aspect which is presented as being problematic is the influence of parents and family members, the media, teachers and peers on the way adolescents perceive themselves which can have a negative influence on their eating habits. Adolescents did not produce this as their presenting problem but they did however refer to the above during the interview when information about their external frame of reference was collected by the therapist. The researcher realized that adolescents are unaware that significant others and their perception of self can affect their self-concept and may have an influence on eating habits.

The preliminary study embraces:

- factors that influence the development of self concept
- the influence of self-concept on eating habits.

1.2.2 Preliminary literature study

A preliminary literature study is done to investigate how the endogenous factor (perception of self) and exogenous factors (parents and family members, the media, teachers and peers) influence self-concept and possibly the eating habits of adolescents.

A person’s self-concept is formed as a result of interaction with other people and the way that people behave towards them. How others confirm or disconfirm aspects of
our selves can have a profound influence on our conception of self. Swann and Hill (1982:59) found that people go to great lengths to confirm their self-perceptions by attending to information given by significant others that fits their view of the self and by trying to arrange their environment so as to acquire self-confirming evidence. It was found that people with a low self-concept are more likely to react to negative affect, which can lead to self-defeating behaviour such as unhealthy eating habits (Griffiths & McCabe 2000:301). In a study done by Stice and Agras (1998:257) it was found that social reinforcement for the thin ideal from family, the media and peers correlated with disordered eating. An adolescent’s sense of self is influenced by the support they receive across the contexts of their lives. This support includes parents, friends and teachers who help them with decision making and coping with daily life (Thomas & Moloney 2001:385). The perception of self as an endogenous factor is briefly outlined below.

1.2.2.1 Perception of self as an endogenous factor

The self is the means by which individuals become aware of and understand themselves. Perception of the self refers to the image that people have of themselves and includes the value they attach to themselves, their characteristics and how they judge themselves in areas of talents, goals, ideals, ability, social interactions, relationships and appearance. The actual self can be defined as what you believe about yourself and the ideal self can be defined in terms of hopes and aspirations (Buss 2001:263). An ideal self is the self-concept a person would most like to have and can be valuable for development because it provides ideals towards which an adolescent strives (Meyer, Moore & Viljoen 1990:379). The image that a person creates for himself is important for this study because a discrepancy between the perceived self and ideal self may be experienced as distressing by the adolescent and may negatively influence self-concept (Posavac & Posavac 2002:153).

Rogers (1961:498) maintains that the purpose of life is to become “... that self which one truly is”. He further maintains that the individual’s potential is actualized in an
atmosphere of unconditional acceptance by others without external restrictions. Gerdes (1989:63) has a similar view to Rogers that if people are accepted unconditionally by others, they will be able to develop a sense of self and self-worth which is of importance for psychological well-being. In a study done by Paradise and Kernis (2002:345) it was found that high self-esteem was associated with greater well-being than was low self-esteem.

By fifteen years old the category of appearance increases as an indication of the importance to adolescents of their body image and attractiveness to members of the opposite sex. In some adolescents, the difference between what they are and what they should be with regard to the above attributes is very marked. When there is a marked difference between the real and ideal picture the person experiences a sense of failure. The Rogerian view (1951) holds that increasing discrepancy implies maladjustment, which the researcher of this study argues could manifest in unhealthy eating habits, guilt and anxiety because physical attributes and their evaluation are a central feature of self-conception. Overvalued attitudes about physical appearance result in a drive for thinness and body dissatisfaction (Sprangler 2002:87). Adolescents tend to be alert to how others perceive them and they tend to internalize stereotypes about their group, which can lead to poor self-concept. For example, an adolescent who internalizes the stereotype of a group that values attractiveness would be sensitive to a negative remark regarding their physical appearance and this could negatively affect their self-esteem (Umaña-Taylor, Diversi, & Fine 2002:303).

1.2.2.2 Exogenous factors

In order to explore the influence of significant others on the development of a person’s self-concept, the following factors will be described: parents and family members, the media, teachers and peers as exogenous factors.
1.2.2.2.1 **Parents and family members**

The development of self-concept is profoundly influenced by parents and other family members, since adolescents are able to gauge verbal and non-verbal reactions of family members. An individual’s relationship with their parents is an important factor and positive communication as well as parental interest can result in the development of positive self-concept. Thompson, Heinberg, Altabe and Tantleff-Dunn (1999) point out that being teased by family members can lead to a low self-image and contributes to dissatisfaction with one’s body. Monks and Ferguson (1983:281) point out that potential problems can occur when adolescents seek autonomy from their parents. If parent-child communication is strained during this time it could have a negative impact on the development of the adolescent’s self-concept.

Phelan (1996:97) disagrees with Rogers’ concept of unconditional acceptance, or positive regard from parents but rather advocates enduring commitment to their welfare where children are taught that rules and limits exist and are enforced consistently. He also points out that parent modeling has a strong influence on the development of self-concept since children imitate their parents. This means that if parents show characteristics of high self-esteem such as staying in shape and having confidence in their own abilities then their children will also take on these characteristics.

1.2.2.2 **The Media**

The media dictates an ideal body shape by presenting models in magazines and television to which adolescents compare their ideal and real selves (Buss 2001:41). Garner (1997:32) found that 27 per cent of women compare themselves to models in magazines very often or always and that the impact of models starts early in adolescence. Concerns about body appearance occurs among females and males. People who experience appearance-related teasing are said to be more inclined to be affected by media stereotypes (Tiggemann 2001:133; Vartarian, Giant & Passino 2001:711).
Physical appearance is emphasized daily through numerous advertisements in the media. Women are portrayed in the media as slender and attractive and girls with these attributes can be expected to have a more positive self-image than girls who are overweight and unattractive. Media portrayals of the female body have become thinner over time and women report feeling worse about their bodies after viewing thin media models (Monteath & McCabe 1997:708; Morry & Staska 2001:269). Anxiety can be fostered if an adolescent’s body does not comply with the expected norm and could develop into eating disorder manifestations.

Men are portrayed in the media as masculine with a broad chest and a male who experiences himself as masculine would most likely have an enhanced self-concept because he complies with the body image depicted in the media (Mampa 1995:39). On the other hand boys who perceive their characteristics as less masculine could experience lower self-esteem, a need for approval from others and food preoccupation (Labre 2002:233).

1.2.2.2.3  Teachers

Adolescents derive a sense of worth from being recognized as a valued member in class. Successful achievement encourages people to evaluate themselves as competent and this is necessary for the development of positive self-concept. Teachers allow learners to develop new skills, providing the adolescent with more evaluative contexts in which to compare themselves and others thereby augmenting the processes that are involved in developing self-concept.

Teachers provide feedback to their students concerning academic achievement, social competencies and physical appearance through subtle verbal and non-verbal communication. Standards set by educators are important for the development of the self-concept because they provide a means of measuring self-progress and competence. A teacher’s behaviour that is understanding and friendly can have a positive influence on the development of children’s self-concept, since they feel that
they are accepted unconditionally. Adolescents who experience humiliating remarks with reference to their physique from teachers may develop negative feelings that may hamper the development of positive self-concept (Buss 2001:41; Hickox 2005; Raath & Jacobs 1993:58).

1.2.2.2.4 Peers
If an adolescent associates with peers who stress the importance of physical appearance then this dimension could become part of his/her own self-concept. Adolescents who adopt a normative style of processing self-concept tend to conform to expectations and prescriptions of their peers because they internalize the values of the group (Berzonsky, Macek & Nurmi 2003:113).

Once adolescents become concerned about their bodies, the focus may become reinforced by friends. Paxton, Schultz, Wertheim and Muir (1999:262) found that adolescents who compared their bodies to those of other peers and who were teased more about their weight by peers experienced more body image dissatisfaction.

As adolescents seek independence they turn to their peers for support and acceptance, since peers replace the family as a major source of feedback. The crucial arena for gaining a clearer and realistic picture of their assets and liabilities seem to be that of peer interaction. Acceptance by the peer group helps the adolescent to form positive self-concept. The penalties of failure are self-concept components of failure and rejection from self and others. Hendrick (1991:224) as well as Jacobs, Vernon and Eccles (2004:57) point out that individuals behave much like peers they admire by conforming to their expectations in order to gain their support and approval.

In Western countries, being overweight has negative connotations and may result in biases, which may affect peer relationships. Various studies have found that adolescents who do not interact positively with their peers have low self-confidence
and feelings of inadequacy that may result in the development of low self-concept (Claes 1992:29).

1.2.2.3 The influence of self-concept on eating habits
Self-concept in itself is not behaviour but it may guide and regulate behaviour. The conception that people have of themselves can affect the way they behave and changes in behaviour are more likely to occur when there are discrepancies between cognitive appraisals of self and idealistic visual objectives.

Mori, Chaiken and Pliner (1987:693) found that self-concept discrepancies may contribute significantly to the development of negative self-evaluation and could lead to unhealthy eating habits. Straus and Ryan (1987:254) studied eating disordered subjects and concluded that they display a poorer self-concept than matched controls. This was verified by Patel, Greydanus, Pratt and Phillips (2003:280) who found that the discrepancy between the actual and the self-defined ideal body was significantly greater among patients with eating disorders. Body satisfaction is an important component of self-concept therefore low body esteem can result in body dissatisfaction and may become manifested in unhealthy eating habits.

The self-discrepancy theory postulates that discrepancies between the actual self and ideal self lead to negative emotional-motivational states that lead to self-defeating behaviour (Tchanturia, Troop & Katzman 2002:110). Incongruent thoughts experienced by the adolescent with regard to the actual self and the ideal self can result in negative affect and develop into disordered eating. In an attempt to lessen the perceived discrepancy, people might undereat in an attempt to control their weight or overeat in an attempt to experience comfort as coping mechanisms. According to Paradise and Kernis (2002:347) unstable self-concept reflects vulnerable feelings of self-worth and people tend to adopt defensive self-protection measures to avoid the aversiveness of fragile feelings of low self-worth.
Researchers have reported that body shape dissatisfaction involves the cognitive belief that a person’s appearance does not meet some personally relevant ideal standard (Cash & Green 1986:290). Strauman, Higgins, Vookles, Berentein and Chaiken (1991:954) verify that dissatisfaction with one’s appearance and maladaptive eating habits have psychological roots in specific standards for one’s appearance and inconsistencies among self-beliefs. As a psychological coping mechanism adolescents who are teased or ridiculed about their shape and weight by family members, teachers or peers, could develop a low self-concept and engage in unhealthy eating habits. Button and Warren (2002:399); Fairburn, Marcus and Wilson (1993:361) hold that underlying concerns about shape and weight are feelings of ineffectiveness and worthlessness characteristic of low self-concept.

Research proves that discrepancies in self-concept are cognitive structures and this is of importance for this study since cognitive coping skills could enable the adolescent to change an idealistic self-concept into a more realistic one which would in turn facilitate changes in unhealthy eating habits (Ronen 2003:49).

1.2.3 **Research question**

The researcher’s contact with adolescents in both an educational environment and as a psychologist, as well as a literature study, has made her aware that self-concept is a set of beliefs. The relationships between these beliefs that people have about themselves are formed largely as a result of their interaction with others. The researcher is further aware that self-concept may guide and regulate behaviour (which is verified in a literature study) and therefore proposes that adolescents may manifest unhealthy eating habits due to low self-concept.

Based on this awareness and the fact that self-concept can be viewed as dynamic and “active, forceful and capable of change” (Hattie 1992:99), the researcher would like to formulate the underpinning research question as follows: **Will low self-concept and unhealthy eating habits of adolescents improve when they are exposed to a**
Psycho-educational programme involving the principles of cognitive-behaviour therapy and hypnotherapy?

During the process of the analysis of the problem certain questions come to the fore regarding the research problem. The problems that the researcher will attempt to answer during her literature study and empirical investigation are as follows:

- What is the nature of self-concept?
- What is the nature of eating habits?
- How does self-concept develop during adolescence?
- How does self-concept influence eating habits?
- Can adolescents who have low self-concept and unhealthy eating habits be supported by a Psycho-educational programme involving cognitive-behaviour therapy and hypnotherapy?

1.3 **AIM OF THE STUDY**

The aims of the research are:

- to establish the nature of unhealthy eating habits among adolescents by means of a literature study (see 2.2)
- to obtain a theoretical background on the development of self-concept during adolescence by means of a literature study (see 2.4)
- to investigate the effect of self-concept on eating habits by means of a literature study (see 1.2.3, 2.5)
- to develop a model that explains the interaction between self-concept and eating habits. The usefulness of this therapeutic model will be tested during group therapy sessions (see 3.2, 4.2.4, 6.3.3)
- to investigate a Psycho-educational intervention programme to help adolescents with a low self-concept and unhealthy eating habits (see 3.3, 3.4).
Furthermore the aim of this investigation is to:

- develop a support programme to enhance self-concept and improve the eating habits of adolescents (see 4.2, 5.6)
- to apply the Psycho-educational programme to adolescents (see 4.2, 5.6)
- to determine the effect of the programme on
  - self-concept (see 6.4.5.2, 6.5)
  - eating habits (see 6.4.5.1, 6.5).

The researcher will be able to determine the effectiveness of the intervention programme by pre- and post-testing of self-concept and eating habits and the results will be compared.

1.4 RESEARCH METHOD

With the aim of obtaining a better understanding of the nature of self-concept and eating habits, a literature study and an empirical investigation will be conducted by the researcher.

1.4.1 Literature study

A literature study will be conducted to describe the nature of self-concept and manifestations of unhealthy eating habits. The study will also include a theoretical investigation into the use of cognitive-behaviour therapy and hypnotherapy as Psycho-educational intervention strategies.

1.4.2 Empirical study

Owing to the exploratory nature of this study a multi-method mode of enquiry involving qualitative and quantitative designs will be chosen, involving active participation from the subjects so as to encourage the role of teenagers in research. Interactive research will include phenomenological, case study and grounded theory designs. Quantitative design involves the measuring of eating habits and self-concept.
The target population for the study will be adolescents and a cross-section of different ethnic and socio-economic classes will be taken into consideration, including a research design of individual case studies to demonstrate the influence of low self-concept on unhealthy eating habits.

A literature study done into the field of eating habits reveals that more quantitative than qualitative research designs have been done and recommendations are made that further research should include self-reported data through case studies in this field (Moreno & Thelen 1995:171; Rubin, Fits & Becker 2003:50).

1.5 SIGNIFICANCE OF THE STUDY

An Interactionism model of Self-concept and Eating Habits will be developed and therefore the research will hope to make a contribution to a new and better understanding of the dynamics of self-concept and eating habits.

This research will also make a valuable contribution to developing professional interventions that will assist adolescents improve self-concept and eating habits by using strategies of cognitive-behaviour therapy and hypnotherapy.

The development of a Psycho-educational programme will help professionals to increase their understanding of the effect of self-concept on eating habits and enable them to use the programme effectively in order to help individuals.

1.6 EXPLANATION OF TERMS

A definition of the terms that are essential to this study are provided in order to give the reader a clear understanding of the problem and approach to this investigation.

1.6.1 Eating habits

Eating habits can be defined as an eating action, which by repetition has become more or less spontaneous (Saunders 1994:727). There are both healthy and unhealthy
eating habits characterized by a conditioned reflex resulting from a repeated consumption or non-consumption of food with a desire to continue its use.

1.6.2 **Self-concept**
Self-concept is the total picture that people have of themselves; how they see themselves; what their characteristics are; how they judge themselves in appearance, ability, talents, attitudes, feelings, motives, goals and ideals; as well as values communicated by other people and own experiences (Mampa 1995:26; McVey & Davis 2002:99). Self-concept can be changed by setting aside negative influences that inhibit the development of positive self-concept (Woolfolk 1990:100).

1.6.3 **Cognitive therapy**
Since emotion is an outcome of a person’s thinking, cognitive-behaviour therapy aims to modify emotions by learning to identify and change thoughts in order to change behaviour. An important underlying principle of cognitive therapy is that when a person’s attention is directed to cognitive distortions, the person can consciously modify or change their cognitive reasoning and make it more rational (Fairburn, Marcus & Wilson 1993:361; Williamson, White, York-Crowe & Stewart 2004:719). For the purpose of this study the focus would be on encouraging individuals to become actively involved in dealing with their cognitive distortions to enable them to develop a healthy self-schema.

1.6.4 **Behaviour therapy**
Behaviour therapy attempts to modify behaviour directly by extinguishing or counter-conditioning maladaptive reactions or by manipulating environmental contingencies using reward or suspension of reward. The ultimate goal is to achieve the desired responses and to bring them under the control and self-monitoring of the individual (Carson & Butcher 1992:638). Behaviour therapy focuses on teaching a client to correct his/her behaviour and for the purpose of this study the focus would be on teaching clients how to correct their eating habits. Procedures used may include
suppression techniques to reduce maladaptive food-related behaviour, self-control techniques to produce appropriate stimulus cueing and positive reinforcement techniques to maintain improved weight control behaviour (Qi & Dennis 2000:23).

1.6.5 **Hypnotherapy**
Hypnotherapy is a treatment strategy with therapeutic goals utilized while the client is in a state of hypnosis. It is a system of skilled, interactive and influential communication and is characterised by an altered state of consciousness, a potential of alteration in perceptions, heightened responsiveness to suggestions and focused attention (Hartman 1995:4). For the purpose of this study the therapeutic goal would be to change maladaptive patterns of eating habits with the aim to help the adolescent to develop ego strengths that promote the development of a positive self-concept.

1.6.6 **Coping skills**
Coping involves cognitions and behaviour used by a person to evaluate stressors and initiating activities with the aim of decreasing their impact (Margalit, Raviv & Ankonia 1992:2002). Coping skills is behaviour acquired by a person to enable him/her to perform effectively. For the purpose of this study the counseling of adolescents with low self-concept and unhealthy eating habits would provide adolescents with coping skills relating to emotional (self-concept) and practical (eating habits) issues, with the aim of equipping them with skills to develop healthier behaviour.

1.6.7 **External frame of reference**
An external frame of reference indicates how another person sees the client. During an interview, clients talk about external factors as they appear to them and the therapist must interpret what is said from the view or perception of the client (Jacobs & Griesel 1992:25).
1.7 DEMARCATION
The research will be open to all adolescent population groups from the Nelspruit area of which nine adolescents with low self-concept and unhealthy eating habits will be selected. The participants will be subjected to a Psycho-educational intervention programme involving cognitive-behaviour therapy and hypnotherapy to improve their self-concept and eating habits.

1.8 PROGRAMME OF STUDY
The researcher intends to apply a theory that will involve a Psycho-educational programme for adolescents who have low self-concept and unhealthy eating habits and the research programme will be comprised of the following chapters:

Chapter one: Introductory orientation
An introductory orientation is provided to make the reader aware of the background, analysis of the problem, research question, aim of the study, the research method to be used, the significance of the study and an explanation of terms used in the investigation.

Chapter two: The nature of self-concept and eating habits of the adolescent
The nature of self-concept and eating habits is defined and explained with the aim of gaining a better understanding of these phenomena. The nature of self-concept will include an investigation into the various dimensions of self-concept (physical, personal, family, social, moral-ethical, self-criticism) and the development of self-concept during adolescence. The nature of eating habits will include an outline of various unhealthy eating habits (eating of junk food, overeating, undereating) and the manifestations of unhealthy eating habits (obesity, anorexia nervosa, bulimia) in relation to self-concept.
Chapter three: Psychotherapy intervention for adolescents with low self-concept and unhealthy eating habits

By means of a literature study, the researcher will investigate psycho-therapy intervention strategies for adolescents with low self-concept and unhealthy eating habits. A model designed by the researcher namely An Interactionism Model of Self-concept and Eating Habits will be introduced in section 3.2 Figure 3.1. An exposition of an intervention programme involving cognitive-behaviour therapy is provided with regard to an overview of the principles, the advantages and disadvantages and the approaches to be used in the current study. An exposition of hypnotherapy as part of the intervention programme is provided with regard to an overview of the historical background, perspectives and principles, the advantages and disadvantages and the approaches to be used in the current study.

Chapter four: The development and content of the Psycho-educational programme for adolescents with unhealthy eating habits

The development and content of the programme will be described in relation to cognitive-behaviour therapy and hypnotherapy and the objectives, content and duration of the ten sessions will be outlined.

Chapter five: The research design

The psychotherapy design implemented in this study is described according to the research problem, the aim of the empirical investigation, the research paradigm, the research method and tools (questionnaires, projection tests, interviews, dietary records and observation), the selection of the sample, ethical issues and trustworthiness, the researcher as participant and the processing of the results.

Chapter six: Findings from the empirical investigation

The results and a discussion of the empirical investigation are provided and individual case studies are discussed in relation to: background, findings of the pre-and post-
tests, findings from diagnostic tools, individualized gift-wrapping and feedback from adolescents on therapy, followed by an integration of the results.

Chapter seven: Conclusion of the research
This chapter includes: the findings emanating from the literature study, findings derived from the empirical investigation, recommendations, conclusion of the investigation, contributions of the study, limitations of the current study and matters requiring further research.

1.9 CONCLUSION
In this chapter the researcher has outlined the background of the problem, statement of the problem, aim and programme of the study. Terms have been defined and the research has been demarcated. A preliminary literature study reveals that unhealthy eating habits are not solely detected physiologically, like diseases but may be a learned behaviour that exists in the language of cognitive distortions as a result of low self-concept. It further indicates that endogenous and exogenous factors influence self-concept and eating habits. It is important to understand the nature of the self-concept and eating habits in order to develop a Psycho-educational programme for adolescents with low self-concept and unhealthy eating habits. In chapter two the nature of self-concept and eating habits is discussed.
2.1 INTRODUCTION

It would be of practical value to have knowledge about the nature of self-concept and eating habits, since an increasing number of researchers admit that there is relationship between low self-concept and unhealthy eating habits. In a study done by Thomas et al. (2000:453) self-concept was found to predict problem eating for males and females.

In this chapter the researcher reports on the nature of self-concept (various dimensions and the development of the self-concept during adolescence), the nature of the eating habits (eating junk food, overeating, undereating) and manifestations of unhealthy eating habits (obesity, anorexia nervosa, bulimia) in relation to self-concept.

2.2 THE NATURE OF SELF-CONCEPT

Because of its dynamic quality, the nature of self-concept can be considered to be both positive and negative (Raath & Jacobs 1993:1). Philosophers and psychologists have discussed the nature of self-concept for many years and a brief historical overview outlined by Hattie (1992:11) of perspectives claimed about self-concept is provided below.

Philosophers such as Socrates and Plato equated the self with the soul and whereas Socrates viewed the soul as the true self, Plato divided the soul into two parts, the rational principle and the irrational principle. These two principles are the means by which humans are said to love and experience hunger, thirst and feel.

Descartes (1596 – 1650) viewed the self in terms of cognitive factors and focused on the dualism of a person’s mind and body whereas Locke (1632 – 1704) proposed that a person discovers the self by means of experience and his philosophy has formed the
basis for the view of self-concept according to psychologists such as Allport (1961), Royce (1973) and Skinner (1974).

Hume (1711–1776) argued that the self is not only formed as a result of experience but also as a result of perceptions that are repeated frequently. Kant (1724-1804) has a similar view and further proposed that the forming of the self can be influenced and distorted by the cognitive processing of information and therefore the forming of the self does not always reflect the truth.

In the 19th century, a new branch of psychology began to develop, with the emphasis on various dimensions of self-concept. James (1890) claimed that self-concept is comprised of four components namely: the body, the social self, the spiritual self and the pure ego. He argued that man has an inborn reflex to look after the body, that the social self involves an inborn desire to be noticed favourably by significant others, that the spiritual self involves a person's thinking about himself and is reflective and the ego is known in subsequent reflection in an abstract or conceptual way as an obscure feeling of something more. He acknowledged that perceptions of the self play an important role in self-concept development and two opposite emotions namely self-complacency and self-dissatisfaction exists in the self-concept.

Cooley (1902) developed the principle of the “looking-glass self” which involves a person's ability to see himself through the reactions of others towards him and his sociological perspective is supported by Sherif and Sherif (1964) who claimed that a person develops a frame of reference derived from reference groups which provides anchors for a person's perception, judgment and behaviour.

Freud (1914) and the Neo-Freudians focused on reconciling the demands of the self and others. According to Freud the ‘id’ aims to experience pleasure and avoid pain, the ‘superego’ provides a person with expectations and the ‘ego’ is the link between the id and the superego and is able to differentiate between concepts in the mind and concepts that exist in the external environment.
Existentialists such as Sartre (1965) claimed that the self can only be understood in terms of the environment in which the self is in and behaviourists such as Skinner (1974) reasoned that a person's attitude to the self develops as a result of the modeling of behaviour as well as attitude of significant others. Rogers (1989) views the self as a pattern of perceptions and relationships of the 'I' and the values attached to these concepts.

From the above overview one can conclude that the nature of self-concept can be viewed as part of a cognitive construct and perceptions are formed as a result of experience and interpretation of the environment. This means that self-concept can be defined as a person's mental representation of himself or herself, based on self-perceptions whether accurate or not. According to Bracken and Lamprecht (2003:116) “… Developing a positive self-concept is a reasonable life goal for all people, with no one person necessarily starting life at a disadvantage”.

2.2.1 Dimensions of Self-concept

Empirical research conducted prior to the 1970’s emphasized a global self-concept whereas Shavelston, Hubner and Stanton (1976:407) emphasized a multifaceted model of self-concept and found that self-concept becomes increasingly multifaceted as a person moves from infancy to adulthood.

According to Jacobs (1981:150) the mutual interaction of components such as the forming of relations, the living sphere and pedagogic climate form the intra-psychic structure of self-concept and determines behaviour. Marsh (1990:100) verifies that knowledge of specific facets of self-concept are more useful than a global self-concept for the prediction of behaviour as well as intervention and argues that more emphasis should be placed on content-specific dimensions of self-concept. In a study done by Marsh and Ayotte (2003:703) a new theoretical perspective on self-concept is based on the assumption that with increasing age and cognitive development, there are counterbalancing processes of integration and differentiation. Kowalski, Crocker, Kowalski, Chad and Humbert (2003:5) have a similar view questioning the validity of
hierarchical self-concept models but emphasize that the nature of self-concept remains unclear.

According to Harter’s Model of Self-Esteem (1983:275) self-concept refers to how the four dimensions of self-esteem namely competence, power, moral worth and acceptance are manifested. A recent definition of self-concept states that it is “... the sum total of the ways in which the individual sees him- or herself” (Hayes & Stratton 2003:254). It is considered to have two major dimensions namely self-image and self-esteem; the descriptive component refers to the self-image and the evaluative component refers to self-esteem. For the purpose of this study self-concept is defined as “... the set of beliefs and images we all have and hold to be true of ourselves” and self-esteem is defined as “... the measure of how much we like and approve of our self-concept” (Kansi, Wichstrom & Bergman 2003:325; Sanford & Donavan 1985:7).

A cognitive view of self-concept places emphasis on an internal, judging of “self” rather than the influence of the external environment whereas a behaviourist view of self-concept places emphasis on a person’s direct and indirect interaction with the environment, which result in perceived successes (reinforcements) and failures (punishment) (Bracken & Lamprecht 2003:106). Every experience that a person has whether pleasant or unpleasant has a positive or a negative influence on the development of self-concept and a realistic self-concept develops when a person accepts both the positive and negative aspects of his/her life. One negative dimension may influence all the other dimensions negatively and problems may arise when the total image of self-concept is unrealistically negative (Raath & Jacobs 1993:20).

With regard to the integrated dimensions, people who are able to accept themselves with their positive and negative characteristics are likely to have a balanced and high self-concept that is a prerequisite for psychological well-being (Ryff & Singer 1996:14). In a study conducted by Flett, Besser, Davis and Hewitt (2003:132) low self-concept was found to be associated with the perception that unrealistic standards are being imposed on the self. According to Vrey (1992:3) the physical self, personal self, family
self, social self, moral-ethical self and self-criticism are dimensions of self-concept and are outlined below.

2.2.1.1 **The physical dimension of self-concept**

The physical dimension of self-concept describes the self in relation to physical aspects and the development of a physical self-concept occurs as a result of visual exploration of self, cognitive and fine motor skills (Jones 1988:252; Sprangler 2002:87). People with positive self-concept with regard to the physical self tend to be satisfied with their appearance and attempt to take care of their body. During adolescence the individual places emphasis on physical attributes and deficiencies that can be real or imagined and can have a profound influence on the overall development of self-concept.

Physically attractive people hold high status and people spend a lot of money on diets, designer clothes and exercise equipment in an attempt to attain physical beauty. Hoskins (2002:235) found that increasing numbers of girls are visiting plastic surgeons, believing that if they change their physical appearance, they will attain higher status and an increased sense of self-worth. In a study done by Harter (2000:134) it was found that the evaluation of one’s appearance takes precedence over all other domains of self-concept. She argues that this could be as a result of this domain always being on display for others to observe and evaluate. This was verified by Kломstен, Skaalvik and Espnes (2004:119) who found that physical appearance was the dimension that most strongly predicted the total self-concept.

Adolescents whose physical appearance deviates from an “ideal” physical appearance may find it difficult to develop positive self-concept. Adolescents with a negative self-concept regarding this dimension tend to find fault with their body and self-talk with regard to this dimension may include statements such as “I am too fat”, “I am too short”, “I am ugly”. Adolescents who have an ideal physical image based on cultural norms and stereotypes may experience anxiety when they feel that their body does not
comply with the expected norm. Likewise, adolescents who cannot live up to the ideal physical attributes emphasized by media can also experience a sense of self-defeat.

Some people internalize the media message of perfectionism and this can result in a self-image of worthlessness. Adolescents need to learn to separate self from context by developing the ability to discern the difference between a real woman and an ideal representation of all women (Bann 2001:169). The researcher argues that it is very important that adolescents take an objective look at the ideal body image prescribed by the media and society. Research done by Schreiber, Robins, Striegel-Moore, Obarzanek, Morrison and Wright (1996:63) reveal that white girls are more likely to internalize thin standards of attractiveness whereas black girls equate greater body fat with being healthy and womanly. For male adolescents greater body size offers prestige and power and a comment such as “you are just skin and bones” could have a negative impact on the development of positive self-concept. The way people perceive their body may have psychological consequences. For example, if a child is told that he is fat by significant others it may generate a response of self-consciousness which could manifest itself in the development of low self-concept and unhealthy eating behaviour. Likewise, a boy who is told that he is a beanpole may perceive his body as being effeminate and may overeat in an attempt to look more masculine.

Studies done by McVey and Davis (2002:99) report a link between low appearance esteem and disordered eating among twelve to eighteen year old girls and found that the importance of success that adolescents place on their physical appearance modifies the association between physical esteem and disordered eating. We can therefore say that with regard to the physical dimension an adolescent’s weight becomes associated with attitudes to the self and feelings of acceptability since the body is said to play a central role in much of a person’s self-perception (Mampa 1995:39).
2.2.1.2 The personal dimension of self-concept

The personal dimension of self-concept describes the self in its own psychological relationships (Vrey & Venter 1983:3). According to Strauman, Higgins, Vookles, Berenstein and Chaiken (1991:946), Buss (2001:264) and Posavac (2002:154) there are three basic domains of the personal self and the greater the discrepancy between these components of the self, the greater the intensity of discomfort experienced by a person. The three domains include:

- the actual self which refers to the attributes that people believe they actually possess
- the ideal self which refers to the attributes that people would like to have
- the ought self which refers to the attributes that people believe they should possess.

Discrepancies between the actual and the ideal self are hypothesized to be an underlying factor of eating disorders. The greater the discrepancy between these components of the self, the greater the intensity of discomfort experienced by a person (Higgins 1987:324). Research done by Hart, Field, Garfinkle and Singer (1999:77) revealed that a discrepancy between one’s actual self and one’s ideal self produces a sense of failure and self-criticism. Adolescents who are precise thinkers tend to take the need for precision of self to an extreme and may become absolutistic (all or nothing) thinkers that could result in eating disorders in an attempt to achieve perfection (Strop 2002:28).

According to Raath and Jacobs (1993:8) the description of one’s self is a product of learning, which is structured in the form of the interaction of emotional and cognitive elements. We can therefore say that self-conceptions are cognitive appraisals of attributes about ourselves. Self-descriptions of adolescents tend to be abstract and include psychological characteristics, self-evaluations, interpersonal relationships and conflicting feelings (Harter & Bresnick in Huston 1990:418). Adolescents tend to experience themselves as being able to fulfill various roles as a person and are therefore aware of different aspects of the self and personality that are unique to them.
Therefore, the achievement of a sense of self is crucial in order to develop a positive self-concept (Vrey 1992:78).

2.2.1.3 **The family dimension of self-concept**

There is general agreement that parents and family members provide information and feedback that shape the formation of adolescents’ self-concept (Harter 1999:20). The family dimension of self-concept describes the self in family relationships and the family environment has a great effect on the development of self-concept (Raath & Jacobs 1993:87). Both male and female adolescent’s sense of self-worth have been found to be influenced by parental relationships (Hay, Ashman & Ballinger 2000 in Marsh & Craven: 263).

Adolescents with a positive self-concept with regard to the family dimension tend to experience approval from their family and are therefore more able to accept themselves whereas adolescents who experiences rejection may develop low self-concept and problem behaviour (Raath & Jacobs 1993:63). Each experience of love or rejection, approval or disapproval from significant others may cause them to view themselves in the same way.

Robin and Foster (1989) identified eight themes that describe cognitive distortions among parents and children in a maladaptive family:

- **perfectionism** - parents expect their children to behave perfectly and adolescents see their parents as always having the correct answer
- **ruination** - a belief that if the adolescent engages in problem behaviour it will ruin the lives of every family member and the adolescent sees restrictions placed by parents as ruining his/her life
- **fairness** - the belief that life should be fair for everyone
- **love and approval** - the belief that everyone should always approve of other’s behaviour
- **obedience** - the adolescent must agree with the parents without question
- **self-blame** - the adolescent and parents do not accept blame for their mistakes
• **malicious intent** - if a person misbehaves it is done deliberately to hurt family members and criticism or constructive feedback is experienced as hurtful
• **autonomy** - adolescents’ view that they must be able to do as they want without any restrictions.

Parents who instill these cognitive distortions in their children could foster an unrealistic self-concept and conditional acceptance. Unrealistic self-concepts and a conditional acceptance of self could develop into cognitive distortions related to self that could manifest themselves in maladaptive behaviour such as unhealthy eating habits.

According to Martin and Martin (2000:785) the family is the major social unit for emotional development in adolescents and a lack of or negative family interaction can result in risk behaviour being adopted by teenagers. Permissive or laissez-faire parenting can result in children having a poor self-image since adolescents view their parents as disinterested and they do not develop the skills required in order to compete in today’s society.

Adolescents who are raised in families that are hypercritical of weight are more likely to develop eating disorders (Keel, Harnden, Heatherton & Hornig 1997:216). McVey and Davis (2002:105) found that parental support modified the association between negative life events and disordered eating in adolescent girls. Swarr and Richards (1996:636) found that closeness with the mother and the father was a contributing factor in the prevention of eating problems in adolescents.

### 2.2.1.4 The social dimension of self-concept

The social dimension of self-concept describes the self in social relationships (Raath & Jacobs 1993:87). Children tend to emulate significant models in society in an attempt to become like these models and in the process they can develop socially.

According to social identity theory, an adolescent’s self-concept is derived from the knowledge that they are members of social groups (Tajfel 1981:13; Jacobs, Vernon &
Eccles 2004:59). Adolescents who are unable to become part of a social group may develop negative self-concept because for them it is of great importance to be socially successful. A person’s social self-concept relates to the nature of their involvement with others and the reaction of people to them (Jacobs, et al. 2004:58). An adolescent with positive self-concept with regard to the social dimension tends to be friendly towards others and makes friends easily. Adolescents with negative self-concept are unable to be spontaneous in the presence of the social group possibly because they are afraid of rejection and ridicule. In order to protect themselves they may isolate themselves from friendships, which are necessary for positive social development and people who perceive that they are unaccepted by the group may experience feelings of rejection and a lack of self-confidence.

Adolescent’s relations with their peers become important and peer-group influence tends to be at a peak during the middle of adolescence (Burns 1982:179). As a result of peer interaction adolescents develop a picture of their assets and liabilities and the body build of a broad-shouldered muscular boy and a slim girl are more likely to gain social approval.

2.2.1.5 The moral-ethical dimension of self-concept
The moral-ethical dimension of self-concept describes the self in relation to moral and religious norms (Raath & Jacobs 1993:87). This dimension includes a person’s inner moral control, a respect for moral rules and a rational scale of values. These moral values enable a person to make stable choices and decisions. It also includes spiritual beliefs, which often determine what a person considers to be right or wrong.

In a study done by Kochanska (2002:339) it was found that committed compliance rather than situational compliance plays a significant role in the emerging view of self on the moral dimension. Committed compliance is self-regulated, willing compliance in which the child embraces the caregivers’ norms and rules and integrates them with their self-systems. It is accompanied by positive affect and pride, which facilitates its incorporation into a person’s moral dimension of self. Situational compliance describes
the child responding or cooperating with neutral affect and the child’s experience of complying does not affect his/her view of the moral dimension of self.

Morals can be defined as rules of conduct in a given society (Gerdes 1989:79; Halstead & Taylor 2000:169). These rules are internalized and develop into the moral-ethical dimension of self-concept. The morals become a point of view from which a person can be judged and portrays values of a person’s own personal views and the views of significant others. Value systems of female adolescents include being well liked by others, interpersonal harmony, success, honesty and aesthetic appreciation whereas value systems of male adolescents include physical courage, dominance and versatility. An adolescent with positive self-concept with regard to the moral-ethical dimension tends to hold high value to honesty, friendliness, patience and love. Adolescents with low self-concept and who demonstrate unhealthy eating habits are said to be prone to Thought-Shape Fusion (TSF) distortions where when thinking about eating forbidden food, a perception of moral-ethical wrongdoing is elicited and makes the individual feel fat (Shafran, Bethany, Teachman & Rachman 1999:167).

2.2.1.6 The self-criticism dimension of self-concept
The self-criticism dimension of self-concept describes how a person is critical of himself/herself and how he/she responds to self-criticism. With regard to the home environment adolescents tend to feel that they must be love-worthy and with regard to the peer group they may feel that they must be accepted, competent, competitive and respect-worthy. Failure to live up to these aspirations may result in self-criticism accompanied by feelings of humiliation, rejection and detraction from self and others (Vrey & Venter 1983:3). Shahar, Henrich, Blatt, Ryan & Little (2003:470) argue that self-criticism is a maladaptive form of self-definition and tends to predict less positive events.

In a study done by Shahar et al. (2003:478) self-criticism was found to be associated with reduced autonomous motivation that in turn related to adolescents’ failure to generate positive life events. This implies that self-criticism exerts a great effect on
functioning and severe self-criticism could push an adolescent to attain increasingly unrealistic standards of physical appearance.

Thus, the result of severe self-criticism may be that adolescents with low self-concept might struggle to identify with others and tend to be afraid of criticism. Individuals may become pre-occupied with their problems unable to confront their weaknesses in a positive manner and in such cases they might withdraw from social groups and parents because they are afraid of criticism and ridicule.

Likewise, adolescents who are critical of themselves may develop defense mechanisms such as undereating or overeating in order to cope with discrepancies experienced between how they would like to be as opposed to how they really are. Teenagers who are analytical thinkers often shift their ability to see flaws negatively by criticizing the self and may feel overwhelmed by their perceived personal, physical and social skills that may lead to a low self-concept (Strop 2002:28). Adolescents with good critical thinking skills can employ these skills in a non-productive or negative manner, by being overly critical of themselves and their appearance, which can result in the development of eating disorders.

2.3 THE NATURE OF EATING HABITS
According to Ryan (in Kinoy 1994:111) “... a person’s relationship to food can be viewed as a metaphor for how they connect to the world”. Eating habits of people can therefore be a way of using one’s body to express one’s feelings about oneself and the world. Normal eating can be defined as eating that occurs in response to hunger cues and ends in response to satiety cues whereas eating disturbances can be defined as symptom pictures existing on a continuum from food-restricting to overeating behaviour (Polivy & Herman 1987:641).

A person’s body weight and shape is influenced by a biological predisposition (Nowak 1998:389). Adolescents who do not accept this morphological reality and who attempt
to become their unrealistic ideal self employ unhealthy eating habits to obtain their physical goal or to cope with their inability to attain their goal.

Endomorphs have a body build in which tissues derived from the endoderm predominate and characteristically display a preponderance of soft roundness throughout the body, large digestive viscera and accumulations of fat, large thighs and tapering extremities (Saunders 1994:554). An adolescent girl with a predisposed endomorph body build may undereat in an attempt to look slimmer.

Ectomorphs have a body build in which tissues derived from the ectoderm predominate and characteristically display a preponderance of linearity and fragility, thin muscles and subcutaneous tissue (Saunders 1994:527). An adolescent boy with a predisposed ectomorph body build may overeat in an attempt to look more masculine.

Mesomorphs have a body build in which tissues derived from the mesoderm predominate and characteristically display a preponderance of muscle, bone and connective tissue, heavy, hard physique of rectangular outline (Saunders 1994:1019). An adolescent girl with a predisposed mesomorph body build may undereat in an attempt to look more feminine whereas an adolescent boy may overeat in an attempt to enhance his heavy physique.

Researchers such as Klajner, Herman, Polivy, Chabra (1981:195) attribute unhealthy eating habits to physiological processes whereas James, Phelps and Bross (2001:491); as well as Ronen (2003:49) attribute unhealthy eating habits to cognitive factors as more important determinants than physiological factors. This means that the adoption of unhealthy eating habits tend to be deliberate rather than automatic. Eating habits can also include behaviour, which has some other significance in life than satisfying hunger. Some people may eat in order to soothe feelings of worry, sadness, to contribute to relaxation, to relieve boredom and as a symbol of reward. Being overweight has negative connotations and may result in biases that affect peer
relationships, date opportunities, self-concept, stigmatizing experiences and dieting (Neumark-Sztainer, Story & Faibisch 1998:264).

Since puberty is characterized by rapid growth and the production of hormones, nutritional requirements are important. Adolescents should avoid eating too many fatty as well as sweet foods since they may aggravate skin conditions that can result in self-consciousness. Their diet should include fresh fruit and vegetables, sufficient protein for muscle tissue growth, sufficient iron, particularly for girls to avoid anaemia, which may develop with menstruation and large amounts of calcium, phosphorus and vitamin D for rapid bone growth (Halkett 2006:13).

2.3.1 Unhealthy eating habits
Unhealthy dietary behaviours are said to begin early in adolescence with a progression of increasingly unhealthy eating patterns (Jacobson 1997:18). In order to understand the nature of eating habits it is necessary to define unhealthy eating patterns among adolescents such as eating junk food, overeating and undereating.

2.3.1.1 Eating Junk food
Over-consumption of junk foods such as saturated fats (ice-cream, chips, pies, hamburgers) and sugars (cake, ice-cream) is commonly associated with overweight. The media promotes high energy and fat rich food and most television adverts have been found to be about food (Hill 1997:174). Diets should contain as much “whole” food as possible. Potatoes can be considered to be “whole” food when they look the same as when they come out of the ground but when they are turned into chips they cannot be considered to be “whole” food. Breads are also examples of processed foods and white bread has a high glycemic index (Smith 2005). The glycemic index is the rate at which food is digested into sugar that increases a person’s insulin levels. High insulin levels causes fat to break down slowly which means that a person burns off the energy from blood sugar rather than fat and if one is not too active and eats food with a high glycemic index, the breaking down of fat becomes slower, causing people to put on weight.
Junk foods are considered to be harmful when they replace other types of foods in the daily diet since vitamin and mineral deficiency as well as other health problems can occur. Fast food chains usually offer food high in saturated fat because it tends to withstand high cooking temperatures e.g. fried chicken, burgers and hot chips. Saturated fats can cause greater weight gain and contributes to the risk of heart disease by increasing cholesterol levels in the blood. A moderate intake of salt is necessary for metabolic functions in the body but junk food tends to have high amounts of salt that is associated with a risk of high blood pressure. Soft drinks have been found to be a leading source of added sugar in the diets of adolescents, which has significantly increased the incidence of obesity (Blasi 2003:321).

In South African high schools, 38 percent of learners frequently eat fast foods and 50 percent eat large amounts of chocolate, sweets and cold drinks. A 30g packet of chips, a 50g bar of chocolate and a 500ml sports drink provides a quarter of the energy needed of a moderately active 13 year old (Woodley 2005:48). When this food is eaten as well as regular meals without being active, a person can gain weight.

2.3.1.2 **Overeating**

Overeating is a contributor to obesity and includes binge eating. Binging refers to the eating of large quantities of food in a short period of time. The relationship between binging and overweight is that excess calories taken in during the binge are manifested in accumulated weight.

A person who engages in overeating ignores physiological regulatory pressures of satiety and when the intake of energy exceeds expenditure it results in weight gain, which can lead to obesity. People who overeat tend to diet constantly and this may change their ability to read the body’s cues about hunger and satiety (Smith, Bem & Noelen-Hoeksema 2001:308).

Overeating can have emotional roots in terms of stress-reducing or symbolically rewarding functions. Some adolescents may overeat in an attempt to reduce the
stress experienced because they are unable to attain society’s preference for slimness (Heatherton, Mohamedi, Striepe, Field & Keel 1997:117). Emotion and factors related to overeating include soothing or satisfying feelings of tiredness, sadness, aggression, loneliness, worry and pain. The researcher is of the opinion that an adolescent who is unsuccessful in establishing good relationships with peers may use food as a means of bolstering self-esteem and eating becomes a substitute for friendship.

2.3.1.3 **Undereating**

People who undereat are restrained eaters who restrict their food intake to control their weight (Santrock 2000:377). A person that undereats when food is available ignores physiological regulatory pressures of hunger and allows cognitive controls to regulate weight in line with the dieter’s personal aspiration.

Current society considers it normal for people to diet and undereat in order to achieve a thin physique. Posavac and Posavac (2002:153) argue that a perceived ideal discrepancy in relation to the media can result in weight concern and undereating. During puberty a girl experiences an increase in body fat which might make her feel removed from societal’s ideal body physique for females. This could result in body dissatisfaction and adolescent girls may restrict their eating such as meal skipping or undereating as a strategy for weight control (Swarr & Richards 1996:636).

2.4 **THE DEVELOPMENT OF SELF-CONCEPT DURING ADOLESCENCE**

According to Rosenberg (1979:220) an adolescent has the ability to “... probe beneath the surface of things, to achieve new intellectual synthesis of the materials of experience which impinge upon his senses, effects a profound change in his self-concept”. The self-concept of adolescents includes an image of their strengths, weaknesses and this assessment can cause perceptions and behaviours to correspond with this image (Gerdes 1989:88). Cognitive functioning during adolescence involves more complex abstract processing of information and formal operations with an increased ability to think hypothetically, apply formal logic and use abstract concepts.
During early adolescence children have not fully developed an integrated consistent self and they tend to feel good about themselves one day and dislike themselves the next day. The lack of a consistent integration of self can result in confusion as to who they really are and parents, teachers and significant others need to help adolescents to understand that this is a natural experience. When feelings of confusion and distress become intense and prolonged, adolescents can experience feelings of hopelessness (Jacobs, Bleeker & Constantino 2003:42). During middle adolescence, they begin to develop more distinct definitions of self in different roles but conflict can arise as they try to live up to the various expectations of parents, peers and teachers which can lead to a decrease in self-esteem (Wigfield, Eccles, Mac Iver, Reuman & Midgley 1991:552). During late adolescence, children are able to realize that they do not have to behave in a consistent fashion in all situations and self-concept becomes a more organized system of beliefs that involves moral standards as well as personal choices. Low self-esteem has been found to be lowest among adolescents who base their self-esteem on appearance and recent studies indicate that more than half of adolescent girls consider themselves to be overweight and base their self-esteem on appearance (Fisher, Golden, Katzman, Kriepe, Rees & Schebendack 1995:420; Jacobs et al. 2003:50).

Self-monitoring can be defined as the individual management of self-presentation, nonverbal displays of affect and expressive behaviour (Snyder 1987). Adolescents are aware they are being observed by others, attempt to see themselves through the eyes of others and tend to be concerned about the impression that they make on others. Rosenberg (1986:185 in Sults & Greenwald) points out that adolescents who are heavily dependent on the reflected appraisals and who may have different perspectives can experience contradictory feedback that can create confusion with regard to the development of self-concept. Cambell (1999:538) found that people with low self-concept react more strongly to negative feedback and are susceptible to and influenced by external information about how they are perceived by others. For example, an underweight adolescent girl may be told by some people that she should
consider modeling because she is so thin and may be told by other people that she looks malnourished which could result in confusion with regard to perceptions of self.

In the Erikson (1968) tradition the expression of identity achievement as the fifth stage of ego-identity development suggests that the adolescent achieves a form of self-actualization during adolescence and self-conception as well as identity formation as facets of self-concept development, is central to adolescence in his view. Identity development as a part of self-concept is a critical factor since it guides inspirations and expectations. According to Marcia (1994 in Umaña-Taylor 2002:304) physical, cognitive and psychosocial changes enable the adolescent to examine their identity and adolescents who achieve identity formation tend to be more self-accepting and have a stable definition of self-concept. Erikson (1968) argued that identity achievement bestows confidence due to the integration of a sense of self with commitment to the future and he claimed that in social situations, identity-achieved adolescents are likely to be consistent in their self-presentation.

Puberty is associated with transformations in body shape, size and appearance and these changes may be associated with how the social environment responds to the adolescent (Hay, Ashman & van Kraayenoord 1997:311; Mboya 1995:831). At puberty the adolescent has to cope with a new physical self that can cause fluctuation in self-concept. Adolescence also includes change from primary school guided instruction to high school where instruction is less structured and more independent. This is accompanied by a change in expectations for adolescents by teachers, family and peers.

Erikson (1968) hypothesized that disturbances in self-concept occurs during adolescence and named it a period of crisis as a result of physiological change and psychological maturation. Coleman’s research (1974) does not support this theory and reports that self-concept is relatively stable during adolescence. He believes that adolescents with low self-concept have always had problems with their self-image definition. Current research reveals that self-perceptions particularly with regard to the
social dimension has the greatest impact during early and middle adolescence (Jacobs et al. 2004:57)

Failure to cope with demands can have a negative effect on an adolescents cognitive functioning, self-concept and behaviour. For example, somatic changes can make demands on the adolescents, which they process both cognitively and affectively. Should adolescents find that they do not have the resources to cope with the demands of somatic change they may develop maladaptive defenses of behaviour such as unhealthy eating habits.

The Amygdala is the emotional center of the brain and is concerned with feelings such as fear and rage. When processing emotional information adolescents tend to rely on the Amygdala whereas adults depend more on the pre-frontal cortex (Park 2004:53). This could result in adolescents misreading emotional signals and seeing criticism and hostility where none exists. Outbursts such as “everyone thinks I am fat” could be symptomatic of an adolescents misreading of peoples reactions to their body and could result in the development of a low self-concept.

An underlying conflict that is pronounced during adolescence is the successful handling of indications of deficiencies while maintaining a sense of personal worth (Bosma & Jackson 1990:89). These deficiencies include attributes of physical attractiveness and partial social rejection. Adolescents may find it difficult to maintain a high level of self-confidence and a stable self-reflective process that may result in a decrease in self-concept. Keel, Fulkerson and Leon (1997:203) found a marked decline in self-concept among adolescent girls and Button, Loan, Davies and Sonuga-Barke (1997:39) found that the decline in self-concept can be attributed to increased levels of body dissatisfaction and can result in unhealthy eating habits.

With regard to the six dimensions outlined in section 2.2.1, the following development of self-concept during adolescence is of relevance. Self-attributes such as physical attractiveness is important for adolescents and they tend to be less able to fulfill self-
guides which may make them vulnerable to negative emotions as a result of self-discrepancies with regard to the physical dimension of the self-concept (Strauman et al. 1991:946).

The personal dimension of self-concept of adolescents is influenced by the various roles that they have to take which creates different impressions of the self. For example, the role of daughter may be that of being obedient, the role as a member of a peer group may be disobedient, the role as a learner may be a lack of self-confidence and the role as a girlfriend may be self-consciousness which may result in a confused perception of the real self.

With regard to the family dimension of self-concept adolescents attempt to become more independent from their parents and should experience themselves as individuals who are not fully dependent on their parents’ views and need to be able to express their own ideas of which their parents might not approve. Seifert and Hoffnung (1987:689) stress the importance of parent-adolescent relationship for the development of a high self-concept by saying “... The quality of the relationship between the teenager and her parents encourage her to see herself as a unique, worthwhile, competent, independent person who is capable of entering the adult world”.

The social dimension of self-concept develops through social interaction and demands made by significant others, influence the development of an adolescent’s self-concept. Individuals are evaluated by members of their group and their group in turn is evaluated by people outside the group. An adolescent who is a member of a popular group is likely to develop positive self-concept with regard to the social dimension. Adolescence is characterized by a need for autonomy and significant others in the social environment become very influential in shaping self-concept (Tseung & Schott 2004:22). Research has shown that peer influences and friendships assume greater significance during adolescence and can have an important influence on eating behaviour and body image (Lieberman, Gauvin, Bukowski & White 2001:215).
The moral-ethical dimension of self-concept of adolescents develop in that they have the ability to reason and to tell right from wrong. With regard to the self-criticism dimension of self-concept the researcher proposes that adolescents are able to criticize themselves as they answer questions in terms of psychological interior with regard to self-knowledge, pride, shame, sense of belonging, sense of commonality as well distinctiveness and of possible future self.

2.5 MANIFESTATIONS OF UNHEALTHY EATING HABITS IN RELATION TO SELF-CONCEPT

A person’s self-concept is a determinant of human behaviour because of the continuous interaction between self-concept and self-actualization. Evaluations of oneself tend to promote behaviour consistent with self-knowledge according to standards and values which have been internalized from significant others and society. Kansi, Wichstrom and Bergman (2003:325) as well as Jacobs and Vrey (1982:26), verified that self-concept is the prime factor controlling human behaviour. Research shows that body dissatisfaction is the single strongest predictor of eating disorders and occurs when individuals internalize a culturally determined body ideal, which upon self-comparison, determines their body to be discrepant from the ideal (James, Phelps & Bross 2001:491).

The American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM – IV 2000:583) defines eating disorders as “… severe disturbances in eating behaviour”. Current empirical research reports an increasing presence of eating disorders among male and female adolescents (Lee & Lee 2000:317; Mulholland & Mintz 2001:111). Research further reveals that eating disorders have become the third most common form of chronic illness among adolescents aged 15 to 19 years (Fisher 1995:420; Rosen 2003:49).

Eating disorders have the following characteristics in common:

- disturbances in eating behaviour
- disturbance in perception of body shape
• fear about not being able to control weight
• use of compensatory behaviours to lose weight such as purging, excessive exercise, dieting and misuse of laxatives.

According to Shur, Sanders and Steiner (2000:74) the etiology of eating disorders can be ascribed to a combination of the following factors: genetic, developmental, psychological, self-concept, body dissatisfaction, negative emotionality, socio-cultural (media influence), physical abuse, sexual abuse and a lack of introspective awareness. Low self-esteem is recognized as a predisposing, precipitating and maintaining factor in the etiology of eating disorders (Newns, Bell & Thomas 2003:64). For the purpose of this study manifestations of unhealthy eating habits in relation to dimensions of self-concept will be considered.

Markus, Hamill and Sentis (1987:50) found that self-concept particularly in vulnerability to the physical dimension is linked to eating disorders. People with eating disorders display pathological eating patterns and they tend to be obsessively concerned about weight and appearance. Cooper and Fairburn (1993:385) verified that eating disorders are characterized by dissatisfaction with body shape and over valued ideas about body appearance and weight. In a study done on adolescents with mental health problems, Willoughby, Polatajko, Currado, Harris and King (2000:236) found that physical appearance and behavioural conduct correlated significantly with self-esteem.

Hay and Ashman (2003:85) found that physical attractiveness significantly influenced males’ and females’ sense of self-worth and that high standards for and frequent negative feedback with regard to the physical dimension can be associated with eating disorders. Given the prominence of the physical dimension in self-concept and eating disorders, the implication is that interventions that counter unrealistic expectations about physical appearance need to be employed.

With regard to the personal dimension of self-concept, most features of eating disorders are said to be secondary to a person’s extreme concerns about shape and
weight as a result of errors in cognitive reasoning. Eating disorders involve automatic dysfunctional cognitions about eating, weight and shape and underlying these cognitions are beliefs, which constitute the assumptions ruling the persons thoughts and behaviour. McMahon, Showers, Rieder, Abramson and Hogan (2003:167) found that people with disordered eating display less integrated cognitive thinking. For example, the person may develop a belief, “I am unattractive and unacceptable to people”. The significant meaning that people with eating disorders attach to weight and eating therefore provides a window to understanding their system of self-evaluation and therefore their self-concept. Over concern about one’s shape and weight can occur as a result of judging or evaluating the personal self in terms of shape and weight, which in turn promotes and maintains unhealthy eating habits. Personal evaluation based on concern about shape and weight is associated with feelings of ineffectiveness and worthlessness characteristic of a low self-concept (Hawton, Salkovskis, Kirk & Clark 1989:284). Wade and Lowes (2002:39) verify that over valued ideas about the personal implications of body shape and weight can be viewed as the central cognitive substrate of eating disorders. They argue that these overvalued ideas fully account for the relationship between self-concept and disturbed eating patterns. Undereating and overeating could therefore result in a temporary alleviation of feelings of inadequacy.

The social dimension of self-concept is linked to the manifestation of eating disorders since significant others and societal systems can have an influence on the development of eating disorders. Whereas most adolescents are able to shift between external feedback and internal standards, adolescents with eating disorders are bound to extrinsic factors. This means that adolescents can be vulnerable to influences of the media, peers, teachers and significant others to attain a physique that is fashionable.

According to Hoskins (2002:233) one cannot base research projects and clinical expertise on a model of self that ignores the influence of context or culture. She points out that difficulties in deciding how to live in relation to cultural expectations often
manifest themselves in the symptomology of an eating disorder. She argues that an eating disorder becomes the sight for certain struggles related to creating oneself.

Recent research reveals that teenage boys are increasingly suffering from eating disorders and not only teenage girls (van der Merwe 2005:90). Senekal (in van der Merwe 2005:90) the head of the Dietetics Department at the University of Stellenbosch is of the opinion that the underlying cause has to do with appearance and that men strive “... *to obtain a perfect V-shaped body – broad shoulders, a six-pack and narrow hips*. In order to achieve this ideal appearance they tend to over-exert themselves in the gym with weight training and consume a lot of supplements. The researcher would like to argue that teenage boys are just as preoccupied about their appearance as girls and that whereas boys previously wanted to resemble the body build of wrestlers they would rather look like the thinner physiques of sporting heroes in skimpy swimming trunks seen in most magazines.

Eating behaviour is said to modify social perception and evaluations of males and females. Eating lightly projects a desirable feminine image to others and acts as a social indicator of femininity (Mori, Chaiken & Pliner 1987:693). Female adolescents who practice eating smaller meals and who diet may rate themselves as being more feminine and may develop anorexia. Likewise, eating larger meals can be associated with masculinity and male adolescents who practice consuming larger meals may rate themselves as being more masculine and may become obese (Bock & Kanarek 1995:109).

With regard to the family dimension of self-concept, recent research concluded that a negative body image and family relationships increase an adolescent’s risk for developing an eating disorder (Gross, Ireys & Kinsman 2000:87; Stice, Presnell & Bearman 2001:608). Since adolescence is a period marked by a struggle for autonomy and competence, failure on the part of parents and family members to recognize and confirm an adolescent’s needs, can lead to psychological deficits such as dieting as a mechanism for autonomy, competence and self-control.
With regard to the moral-ethical dimension of self-concept, key symptoms of unhealthy eating habits such as compensatory behaviours of binging, induced purging and fasting are perceived as socially inappropriate and can result in the adolescent feeling ashamed which leads them to practice them in secrecy (Klingenspor 2002:51). Conflict in this domain can lead to a vicious circle of low self-concept leading to a desire for improvement in body appearance which leads to the practicing of unhealthy eating habits which in turn further reduces the individual’s self-concept. Although research reveals that a feature of eating disorders is low self-concept, it fails to describe the dynamics involved (Leon, Keel, Klump & Fulkerson 1997:405; Newns et al. 2003:64). Manifestations of unhealthy eating habits (obesity, anorexia, bulimia) in relation to self-concept are outlined below.

2.5.1 Obesity

Obesity is included in the International Classification of Diseases (ICD) as a general medical condition but is not included in the DSM-IV since it is said not to be consistently associated with a psychological or behavioural syndrome (American Psychiatric Association: 2000:583). Binge-eating disorder is a new eating disorder classified according to the Diagnostic and Statistical Manual of Mental Disorders – IV. According to Pull (2004:43) binges are frequently observed in obesity and therefore the researcher has included binge eating as an eating disorder, which can contribute towards obesity. The prevalence of binge eating disorder in people with obesity is twenty five percent more than people in the general population. In South Africa, 12 percent of children are classed as grossly overweight (Woodley 2005:48). In a study done by Tseng, Lee, Chen, Lee, Lin, Chen and Lai (2004:283) it was found that body image was an important concern for teenagers and subjects with an early onset of obesity are distressed about their weight and diet more frequently which result in the development of binge eating.

Obesity can be defined as being 30 percent or more in excess of the recommended weight for one’s height and frame (Smith et al. 2001:306). Many obese people engage
in binge eating and according to the American Psychiatric Association (2000:785), binge eating disorder has the following criteria:

A. **Recurrent episodes of binge-eating characterized by:**
   1. *eating, in a discrete period of time, an amount of food that is larger than most people would eat in a similar period of time under similar circumstances*
   2. *a sense of lack of control over eating during the episode.*

B. **The binge-eating episodes are associated with at least three of the following:**
   1. *eating much more rapidly than normal*
   2. *eating until feeling uncomfortably full*
   3. *eating large amounts of food when not feeling physically hungry*
   4. *eating alone because of embarrassment about amount eaten*
   5. *feeling disgusted with oneself, depressed or very guilty after overeating.*

C. **Marked distress is experienced regarding binge-eating.**

D. **The binge-eating occurs, on average at least two days a week for six months.**

E. **The binge-eating is not associated with the regular use of inappropriate compensatory behaviours (e.g. purging, fasting, excessive exercise).**

Obesity with binge-eating disorder is characterized by more weight-fluctuation, more dietary disinhibition, more disturbances in eating attitudes and body dissatisfaction, increased adiposity, earlier onset of overweight and dieting, lower self-esteem than obesity without binge eating disorder (Sorbara & Geliebter 2002:416).

The etiology of binge eating disorder includes genetic factors, racial/ethnic influences, body dissatisfaction, negative affect, pressure to be thin and emotional eating (Stice, Presnell & Sprangler 2002:131). In a study done by Pike, Dohm and Striegel-Moore (2001:1455) it was found that black women with binge eating disorder reported more binge episodes per week, less dietary restraint as well as less concern with weight and shape than white women with binge eating disorder.
In a study conducted by Loro and Orleans (1981:155) 50 percent of overweight patients were found to engage in binge eating behaviour and when the intake of energy exceeds the output of energy the result is weight gain that eventually leads to obesity. The growth in type -2- diabetes among adolescents as a result of overeating and binging is increasing as well as the risk of developing diabetes with a Body Mass Index of 31 is > 25 compared to a normal weight person and a Body Mass Index of 35 is < 50 (Colditz, Willett, Rotnitzky & Manson 1995:481).

Stunkard and Stella (1984:10) found self-image disorder to be an obesity-related disturbance and reported that patients whose obesity started during infancy or adolescence are more inclined to maintain their obese condition. Some studies have found a relationship between Body Mass Index and self-concept among adolescents and the greater the body weight, the lower the self-concept (Drake 1988:1581; O’Dea & Abrahams 1999:69).

Research supports the hypothesis that people who overeat have a negative view of self and in an attempt to escape from the negative view of self, they binge or overeat (Schwarze, Oliver & Handal 2003:644). According to Williamson, White, York-Crow and Stewart (2004:715) binge eating is viewed as a possible consequence of increased emotionality such as feelings of fatness. In an attempt to reduce the negative emotion, the person engages in binge eating which negatively reinforces the behaviour and confirms the cognitive distortion that shape/size are indicators of self worth.

2.5.2 Anorexia nervosa

Anorexia nervosa can be defined as an extreme, self-imposed weight loss of at least 15 percent of normal weight (Smith et al. 2001:309). According to the American Psychiatric Association (2000:583) anorexia nervosa has four criteria:
1. Refusal to maintain body weight over a normal weight for age and height.
2. An intense fear of gaining weight or becoming fat, even though underweight.
3. A disturbance in the way a person’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation; or denial of the seriousness of the current low body weight.

4. In females, absence of at least three consecutive menstrual cycles when otherwise expected to occur.

Lupton (1996) views anorexics as being obsessed with control. Hunger is regarded as a temptation to abandon control whereas denial of food intake is experienced as triumph of control and extreme thinness is the physical manifestation of control. He further claims that people with anorexia nervosa tend to have low self-concept and dietary restriction is seen as evidence of self-control, which is perceived to improve self-concept.

Anorexics tend to have self-concept deficiencies, which include a belief that to be able to evaluate oneself favourably, their thoughts must be accurate and must meet the approval of others. People with anorexia tend to be preoccupied with the image they create and question their worthiness of respect. They fear that they are inadequate and despised by others and in an attempt to be perfect starve themselves (Garner & Garfinkle 1985:14).

For women being thin is often associated with being successful and accepted. It may also be characterized by being happy, wearing clothes well, having a good job, being propositioned by the opposite sex and possessing control. Fairburn, Shafran and Cooper (1999:1) point out that anorexia is rooted in a concern for shape and weight and that sufferers monitor their weight too closely in the early stages of dieting. At a later stage the hyper-vigilant body checking becomes aversive and leads to an avoidance of monitoring and a continued feeling of not being able to control their shape and weight leads to continued dieting.

Anorexia is associated with an actual/ought discrepancy and Strauman et al. (1991:946) found that the self-discrepancy attributes of anorexics involved vulnerability
to body dissatisfaction. Anorexics tend to have a distorted body image in that they overestimate their size and weight. Adolescents can erroneously and subjectively misinterpret their physical appearance and may diet excessively because they perceive themselves as fat and this may manifest itself in anorexia nervosa.

2.5.3 Bulimia

Bulimia can be defined as recurrent episodes of binge eating often followed by attempts to purge excess eating my means of vomiting and laxatives (Smith et al. 2001:309). According to the American Psychiatric Association (2000:589) Bulimia has the following criteria:

1. Recurrent episodes of binge eating characterized by:
   i) eating in a discrete period of time an amount of food that is larger than most people would eat during a similar period or under similar circumstances.
   ii) a sense of lack of control over eating during the episode.

2. Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, enemas or other medications, fasting or excessive exercise.

3. The binge eating and inappropriate compensatory behaviours both occur, on average, at lease twice a week for three months.

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

According to Polivy and Herman (1985:197) the majority of research suggests that the role of cognitions and situational pressures is crucial to binge eating of bulimics and Lester and Petrie (1998:315) found that low self-esteem is significantly related to bulimia.

Bulimic eating disorders have been found to be particularly common among adolescent girls as a result of a high occurrence of body and weight dissatisfaction as well as a discrepancy between their own bodies and the thin ideal (Klingenspor 2002:52). Bulimics tend to demonstrate actual/idealistic discrepancies that result in emotions of
failure, feeling helpless and a loss of control over their life. Strauman et al. (1991:952) found that self-discrepancy attributes of bulimics involved vulnerability to failure to meet a person’s positive potential.

2.6 CONCLUSION
A multi-dimensional construction of the self-concept is confirmed and can be used as a predictor of behaviour. A literature study on the nature of self-concept and eating habits reveals that the materialization of unhealthy eating habits such as overeating or undereating can be related to dimensions of self-concept (physical, personal, family, social, moral-ethical, self-criticism) and can result in eating disorders.

Developmental research indicates that contributing factors such as relationships with significant others and society’s expectations particularly with regard to appearance plays an important role in the development of self-concept during adolescence. Selective cognitive processes may lead to a discrepancy between realistic and ideal self-perceptions, which could result in manifestations of unhealthy eating habits in an endeavour to eliminate or cope with the discrepancy. The development of self-concept is a dynamic process and it is therefore possible through the application of psychotherapy to change low self-concept. It is important to note that according to the continuity hypothesis, eating problems differ from eating disorders only in the degree of disordered eating (Stice et al. 1998:228). The findings are of significance since if self-concept can be changed it could bring about a positive behavioural modification in eating habits before they manifest in eating disorders.

In the following chapter an Interactionism Model of Self-concept and Eating Habits will be introduced and principles of cognitive-behaviour therapy and hypnotherapy as intervention strategies will be outlined.
CHAPTER THREE

PSYCHO-THERAPY INTERVENTION FOR ADOLESCENTS WITH LOW SELF-CONCEPT AND UNHEALTHY EATING HABITS

3.1 INTRODUCTION

Since low self-concept is widely recognized as a predisposing, precipitating and maintaining factor in the etiology of unhealthy eating behaviour, it is the aim of the researcher to develop a Psycho-educational programme that will improve low self-concept and unhealthy eating habits of adolescents. In this chapter, an Interactionism Model of Self-concept and Eating Habits developed by the researcher is introduced and cognitive-behaviour therapy as well as hypnotherapy as intervention strategies will be discussed.

Based on the premise that self-concept is an initiator of behaviour and that the cognitive component of a person determines behaviour one would have to consider a psychotherapy programme designed to change self-concept. The Eudaimonic perspective of psychological well-being argues that people are psychologically healthy when they live according to their true self or daemon (Ryan & Deci 2001:141).

The researcher introduces a diagrammatic proposal of the interactionism between self-concept and eating habits, which could be used as an instrument in therapy to help the client to glean an understanding of how self-concept and eating habits influence one another. The discussion on cognitive-behaviour therapy includes an overview of the principles, advantages and disadvantages and approaches to be used in the current study. The discussion on hypnotherapy will include an overview of the historical background, perspectives and principles and approaches to be used in the current study.
3.2 **AN INTERACTIONISM MODEL OF SELF-CONCEPT AND EATING HABITS**

Interactionism is based on the theory that physical occurrences are the causes of mental modifications and mental modifications give rise to physical changes (Webster 1995:661). According to Webber and Coleman (1988:32) feeling, thinking and behaving are interactional variables. Physical appearance is a source of self-esteem and cognitive mechanisms maintain self-esteem. In a study done by Harter (1993 in Baumeister: 88-116) it was found that 50 percent of adolescents say that appearance determined self-esteem and 50 percent of adolescents say that self-esteem is determined by their evaluation of their appearance. Cognitive distortions can lead to erroneous processing of information relating to self-concept and the information errors in cognitive processing can contribute to the maintenance of unhealthy eating habits.

The researcher introduces a model (**Figure 3.1**) which addresses the interactionism between physical and psychological elements namely deficits in self-concept and idiosyncratic beliefs (mental modifications) related to food and weight. According to Chopra (1991:329) a healthy mind and body is better equipped to face challenges in life positively and therefore the objective of the model is to help the client to better understand how self-concept and eating habits influence each other. The model can be used in therapy to explore the dimensions of self-concept in relation to exogenous factors and the consequences of making self-acceptance contingent on external factors and acceptance from others. This could lead adolescents to a realization that perpetual comparison to others and a drive to become the ideal self can lead to self-defeating behaviour such as unhealthy eating habits.

Endogenous and exogenous factors, self-concept and eating habits do not exist in dualism but have a dialectical and interdependent relationship with each other (Bester & Schnel 2004:189). Disordered eating behaviour and psychological dysfunctions may be attributed to complex interactions between cognitive processes, products, affect, overt behaviours, environmental contexts and experiences. **Figure 3.1** depicts an Interactionism Model of Self-concept and Eating Habits developed by the researcher and illustrates that A ↔ B ↔ C ↔ D. **Self-concept (A)** leads to mental
FIGURE 3.1 INTERACTIONISM MODEL OF SELF-CONCEPT AND EATING HABITS (DEVELOPED BY THE RESEARCHER)
modification (B) that leads to physical occurrence (C) such as eating habits (D) and visa versa. D ↔ C ↔ B ↔ A. It illustrates a high (positive) self-concept (A₁) occurs as a result of positive mental modifications (B₁) such as a congruency between real and ideal self, absence of cognitive distortions, positive feedback from significant others and can lead to physical occurrence (C) such as eating habits (D) – healthy eating habits (D₁). Feedback from significant others such as parents, peers, teachers and the media contribute to mental modifications (B) which can be positive (B₁) or negative (B₂). Negative self-concept (A₂) occurs as a result of negative mental modifications (B₂) such as incongruency between real and ideal self, cognitive distortions, negative feedback from significant others and can lead to physical occurrences (C) such as eating habits (D) – unhealthy eating habits (D₂).

Perceptions with regard to the real and ideal self of self-concept dimensions (physical, personal, family, social, moral-ethical self, self-criticism) can be linked to the acceptance that behaviour (physical occurrence - C) and thinking (mental modification - B) is determined by the expectations of others and not always by the person. Factors that play an important role in self-evaluation include how successful the person is, how successful the person would like to be and how others evaluate the person and can influence a person’s self-concept. Cognitive distortions are negative thoughts (B₂) or self-suggestions that can lead to unhealthy eating habits and include:

- **overgeneralization** - developing a rule based on one event and applying it to other situations
- **magnification** - surplus meaning is attached to a stimulus without objective analysis
- **selective abstraction** - the forming of a conclusion based on isolated details
- **dichotomous reasoning or all-or-none thinking** - thinking in terms of extreme terms
- **personalization and self-reference** - egocentric interpretations of events
- **superstitious thinking** - believing a cause-effect relationship of unrelated events (Garner & Garfinkel 1985:123; Williamson, Muller, Reas & Thaw 1999:556).
In a study done by Hesse-Biber et al. (1999:399) it was found that a number of women with eating disorders reported that while growing up, their families exhibited an over-emphasis on physical appearance with particular concern for the importance of being thin. Comments such as “You’re getting a fat belly”; “You look good, you have lost weight”, had a profound interactional effect on their self-concept and eating habits.

In the current study the Interactionism Model of Self-concept and Eating Habits will be used in group therapy to gain a more specific understanding of the complex relationship between self-concept and eating habits. The dynamics of the interrelationship between self-concept and eating habits will be explained and adolescents will be encouraged to provide examples from their own life experiences. The model will enable them to identify and modify their negative thoughts \((B_2)\) in triggering and maintaining unhealthy eating habits \((D_2)\).

3.3 COGNITIVE-BEHAVIOUR THERAPY (CBT)

Cognitive-behaviour therapy represents an integration of cognitive and behavioural approaches and appears to be the treatment of choice when working with eating disorders (Fossati, Amati, Painot, Reiner, Haenni & Golay 2004:137; Hall & Tarriers 2004:117; Thackwray, Smith, Bodfish & Meyers 1993:639; Walsh, Wilson, Loeb, Pike & Devlin 1997:523; Wilson 1994:371). People with eating disorders have been found to have rigid cognitive thinking marked by inflexible / dichotomous thinking and cognitive-behaviour therapy uses strategies to modify distortions (Williamson et al. 1999:556).

In order to achieve healthy eating habits, cognitive perceptions, knowledge and barriers to change would have to be identified and modified. A person’s shape, weight and food issues may become intertwined with self-concept and cognitive methods to alter aspects of self-concept can prove to be valuable (Guidano & Liotti 1983:299; Mansell & Lam 2003:363). It has been found that perceived self-efficacy grounded in the belief that a person can carry out a specific behaviour is strongly related to healthy eating patterns (Kingery 1990:26). Glantz, Kristal, Sorenson, Palombo, Heimendinger
and Probert (1998:373) as well as Blatt, Ryan and Little (2003:470) agree that motivation to adopt healthy eating habits and self-efficacy are important determinants of behavioural change.

The discussion on cognitive-behaviour therapy will include:

- an overview of the principles of cognitive-behaviour therapy
- the advantages and disadvantages of cognitive-behaviour therapy
- cognitive-behaviour approaches used in the current study.

3.3.1 Overview of the principles of cognitive-behaviour therapy

Cognitive-behaviour therapy can be defined as a structured, short-term, present-orientated psychotherapy based on the idea that behaviour, thoughts and feelings are learned, and can therefore be unlearned, or modified (Beck 1995:2). The aim of the therapy is to help the client to develop an understanding of what maintains their problem behaviour and to promote change by enabling them to modify the schema underlying the thoughts and feelings involved in triggering and maintaining the behaviour (Gilbert 2000:43).

Empirical foundations of cognitive-behaviour therapy can be traced back to animal learning research, generalized to humans. The principle of classical conditioning was discovered by Pavlov, who conducted experiments on dogs by ringing a bell and then feeding them and when once this sequence was repeated often, the dogs began to salivate when a bell was rung, before they were fed. Russian researchers found that emotional responses such as fear can be conditioned which has had implications for psychotherapy (Hawton, Salkovskis, Kirk & Clark 1989:1).

The principle of operant conditioning was derived from research done by Thorndike, Tolman and Guthrie who found that when a particular behaviour was followed by a reward the behaviour would occur again. This phenomenon became known as the ‘Law of Effect’ which states that if behaviour is followed by satisfying consequences it
is likely to be repeated whereas if behaviour is followed by unpleasant consequences it is less likely to be repeated (Hawton et al. 1989:3).

The principle of operant conditioning states that reinforcement takes place when behaviour is followed by a particular event and increases in frequency. When behaviour occurs more frequently, followed by positive consequences, it is termed positive reinforcement and when it is followed by the absence of an anticipated unpleasant consequence, it is termed negative reinforcement. Consequences usually resulting in a decrease in the frequency of behaviour involve punishment or frustrative non-regard. Punishment involves a decrease in behaviour as a result of the behaviour being followed by an unpleasant event. Frustrative non-regard involves a decrease in behaviour as a result of the behaviour no longer being followed by a pleasant event. Behaviour therapy was used by Gull (1874:22), where anorexic patients were separated from their families and not allowed to see family members, until they had gained weight. The principle of negative reinforcement was used where the client behaves in a certain way (eats) to remove an unpleasant event (isolation from family members).

Lazarus (1971:1) criticized the mechanistic techniques used in the practice of behaviour therapy and discontent with the prescriptive manner in which behaviour therapy was applied, resulted in adding cognitive components to behaviour therapy. Bandura’s work on observational learning drew attention to cognitive aspects of behaviour therapy when he discovered that a person learns by watching someone else performing a behaviour. He developed a model called ‘self-efficacy’ in which he describes all voluntary behaviour change as a result of a person’s perceptions of his/her ability to perform the behaviour in question (Bandura 1977:191).

Ellis and Harper (1975:23) proposed that people tend to create their own problems and conflicts by engaging in irrational thinking and maintained that it is the way in which people view events that causes emotional reactions. Albert Ellis became dissatisfied with the operant behaviour psychotherapeutic approach and he proposed the Rational-
Emotive Therapy Technique (RET), which has had a significant influence on the practice of psychotherapy (Kendall & Haaga 1995:169). He developed the ABC theory of emotional disturbance. The “A” represents the activating stimulus, event, object, person or situation. The “B” represents the thoughts that the person has about the event. The “C” represents the emotions that result from the event. The therapist commences by identifying the client’s emotions (C) about the event (A) and then proceeds to uncover the thoughts (B) that precipitate the negative emotion (C) (Morris 1989:252).

The central principle of cognitive-behavioural assessment is that a person behaves in a manner that is determined by situations and the person’s interpretation of them. The therapist’s ultimate objective is to help people to help themselves toward a more effective way of behaving and living by disputing their irrational thoughts and beliefs (Russell & Morrill 1989:185).

In order to conduct therapy a trusting and warm atmosphere must be created in order that the client feels safe enough to disclose distressing problems and the client is helped to recognize patterns of distorted thinking resulting in dysfunctional behaviour. The therapeutic mode is based on the assumption that affect and behaviour are determined by the way in which a person structures the world and involves both individual as well as group therapy (Mahoney 1991:1).

Cognitive-behaviour therapy for people with eating disorders has three major components:

- psycho-education
- cognitive restructuring
- relapse prevention.

In the first phase clients are given information regarding the disorder, the role of thinking in maintaining the disorder and information on nutrition. In the second phase clients are taught to identify and restructure thoughts about food and weight. The third
phase involves identifying problems that the client is experiencing which may impede recovery and progress (Agras & Apple 1997:207; Wilson & Fairburn 1993:261). In the current study it would be possible to apply the Rational-Emotive Therapy to figure 3.1: Interactionism model of Self-concept and Eating Habits. The following example could be used to demonstrate the application to Rational-Emotive Therapy to Figure 3.1.

A – the stimulus, event, object, person, situation in RET could represent Eating habits [Figure 3.1:(D) which could be unhealthy (Figure 3.1:(D_2)] e.g. overeating.

B – the thoughts that the person has of the event could represent mental modifications [Figure 3.1:(B)] that may be negative [Figure 3.1: (B_2)] such as cognitive distorted thoughts (overgeneralization, magnification, selective abstraction, dichotomous or all-or-none thinking). For example, the person who believes that “fat people never make it in life” is using the cognitive distorsion of magnification.

C – the client’s emotions could represent the self-concept [Figure 3.1: (A)] that may be negative [Figure 3.1: (A_2)] resulting in possible emotions of worthlessness. For example, “Since I overeat and since I am overweight, I am a worthless person who will never make it in life”.

The therapist together with the client would identify the client’s emotions of worthlessness (C) about the event of overeating (A) and undercover the thoughts (B) that precipitate and maintain the negative emotion (C).

3.3.2 The advantages and disadvantages of cognitive-behaviour therapy

According to Agras and Apple (1997:208) cognitive-behaviour therapy results in approximately 50 percent of clients with bulimia recovering and is maintained after a five-year follow up. Cognitive-behaviour therapy involves techniques directly concerned with the client’s thoughts and feelings which are important in the interactionism of self-concept and eating habits. Assessment emphasizes the possibility of change and helps clients to focus on what they can achieve rather than focusing on problems (Hawton et al. 1989:15). When clients become aware that their eating habits are out of control as a result of faulty reasoning they may come to realize that these overvalued ideas can be modified in order that a normal eating pattern be recovered.
Cognitive-behaviour therapy teaches clients to become less liable to depend on social conformity in order to achieve approval from others (Maharaj 1998:111). It enables clients to train themselves to be more self-accepting, to take responsibility for their own reasoning and to see themselves as responsible for creating their own intra-personal and interpersonal problems.

Cognitive-behaviour therapy provides clients with a method, that involves self-observation and self-assessment that can be used for the rest of their lives since it enables them to separate rational from irrational thoughts and beliefs (Lawrence & Huber 1982:211). In cognitive-behaviour therapy the client becomes an active participant in the treatment process and moves beyond being helpless and passive, aim to discover their positive real selves, to develop competence, trust their own decisions and respect their own opinions. Cognitive-behaviour therapy can therefore be considered to be an educational element, which teaches clients about cognitive conceptualization of their disorder and about the disorder in general (Gilbert 2000:37).

Group therapy helps clients to feel less isolated and to explore emotional involvement outside the family. It can help clients to confirm problems with self-concept and to accept support from group members to maintain a behavioural change. Peer confrontation can help clients examine their reasoning and provides an opportunity for creative solutions to evolve through brainstorming with group members (O'Leary, Brown, Colby et al. 2002:890).

Disadvantages of cognitive-behaviour therapy include a client’s resistance to treatment because of the fear of mental aspects of themselves being brought into the open (Hawton et al. 1989:298). Clients may worry that while self-monitoring takes place their Dietary Record would fall into the wrong hands and to show the therapist what they eat may make them ashamed (Schmidt, Tiller & Treasure 1993:273). Although cognitive-behaviour therapy is said to have a less immediate effect on symptoms, it is said to produce a more lasting improvement (Gilbert 2000:49).
3.3.3 **Cognitive-behaviour approaches used in the current study**


Although cognitive-behaviour therapy is applied to clients with eating disorders, appropriate steps need to be taken to minimize unhealthy eating patterns, which may escalate to the level of pathology i.e. eating disorders. People with chronic anorexia are said to resist change and often develop a history of negative treatment experiences and repeated treatment failures (George, Thornton, Touyz, Waller & Beumont 2004:81). Motivation or readiness to change has become a focus of theoretical and empirical investigation in the field of eating disorders and findings have revealed the need to provide interventions to enhance motivation for people with eating disorders. In a study done by McGee and Williams (2000:580) it was found that low self-esteem may result in the later prevalence of health compromising behaviour such as problem eating and have a similar view to Overholser, Adams, Lehnert and Brinkman (1995:919) that treatment programmes designed to identify deficits in self-esteem could reduce the risk of health compromising behaviour.

Self-acceptance is defined as a central feature of mental health, self-actualization, optimal functioning, maturity and a fully functioning person is described as having an internal locus of evaluation (Ryff & Singer 1996:14; Harter 2000:133). This implies that positive self-regard is central to positive psychological and behavioural functioning and by facilitating progression toward the restoration of positive self-regard, the therapist can contribute positively to the development of healthy eating habits. According to the model of eating behaviour, eating is triggered and terminated by introspectively
detected signals associated with phenomenal states of hunger and satiety. In people with unhealthy eating habits an intermediate condition between hunger and satiety exists and is called a zone of indifference. Eating that takes place in the zone of indifference is under the primary control of cognitive, social and environmental factors (Herman & Polivy 1984:141 in Stunkard & Steller). This means that healthy eating habits can be returned to physiological normality when cognitive attitudes regarding weight and appearance are modified and cognitive-behaviour therapy would be the treatment of choice.

Based on the rationale above the researcher has decided to use cognitive-behaviour therapy as part of the treatment program and involving the three major components of cognitive-behaviour therapy: psycho-education, cognitive restructuring and relapse prevention.

3.3.3.1 **Psycho-education**

When assessing and listening to the client the therapist will gather information with regard to the following:

- what covert or overt behaviour does the client want to change?
- in what environment does the problem occur?
- what precipitates the behaviour (situation or mental thoughts or internal emotions)?
- what are the consequences of the problem behaviour?

Gracey, Stanley, Burke, Corti and Beilin (1996:198) found that ignorance about nutrient content of food was recognized as a barrier to change eating habits. Teaching clients to compile their meal plan according to the Swedish Plate Model proved to be successful when educating clients about healthy eating. Half the plate is filled with vegetables, one quarter with protein-rich food (e.g. eggs, meat, fish) and one quarter with carbohydrates (e.g. rice, potatoes, pasta) (Adolfsson, Carlson, Unden & Rössner 2002:247).
Clients are encouraged to eat three meals each day plus one or two snacks with no more than three hours between meal times. Mahoney and Mahoney (1976) developed a technique used to treat obesity to help clients to adhere to an eating pattern and the following behaviour stimulus control techniques are used:

- Clients may not engage in any other activity while eating e.g. watching television, reading, talking on the cellphone. This will avoid automatic eating in order to enjoy and savour their food.
- Eating at a specific place in a particular room. This place must be set aside for eating only and the client is to set the place formally.
- Eating a predetermined amount of food. If bread is to be eaten then the person must take out how many slices of bread is to be eaten and put the rest away.
- Discarding leftover food. Leftover food should rather be discarded or made inedible.
- Limiting the amount of ‘problem-food’. Food that is considered to be problem food should be stored out of sight.

Adolescents with unhealthy eating habits need to be educated about the physical consequences of undereating and overeating, which could ultimately result in eating disorders. The importance of developing healthy eating habits during adolescence needs to be emphasized because of the high rates of physical growth in adolescence that brings heightened nutritional needs. Particular dangers of eating disorders could include:

- menstrual irregularities and amenorrhoea
- electrolyte disturbances in cases where people purge or take laxatives
- salivary gland enlargement which gives a persons face a fat appearance
- erosion of dental enamel which is permanent
- obesity is associated with diseases such as cardiac infarction, type-2- diabetes and hypertension
- dehydration coupled with exercise leads to compromised heart function, decreased blood volume, decreased blood flow to the kidneys, severe muscle cell breakdown, and impaired temperature regulation
• the use of syrup of ipecac used by adolescents to induce vomiting may result in cardiomyopathy from ipecac toxicity
• osteoporosis resulting from the inability to accrue bone mass since the majority of bone mass is acquired during adolescence
• overweight people tend to suffer from sleep apnea (interrupted breathing while sleeping) which can lead to problems with learning and memory (Blasi 2003:321; Fisher, Golden, Katzman, Kreipe, Rees & Schebendach 1995:420).

In a study done by Polivy and Herman (1985:193) it was argued that dieting causes binging. It would therefore be advantageous to educate clients as to how dieting behaviour can cause binging. Dieting results in an increased preoccupation with food, eating and weight and tends to dominate the dieter’s thoughts. Since binge eating tends to be cognitive in nature, cognitive manipulations might be effective in preventing binging and clients must be taught that occasional splurges are acceptable which enables dieters to think less dichotomously. In order to eliminate dieting the therapist should explain to the client that no dieting should occur during treatment.

3.3.3.2 Cognitive restructuring
Cognitive restructuring techniques are used to question the client’s principles of assessing self-worth and helps them to address low self-concept. Overvalued ideas about shape and weight are of diagnostic significance in eating disorders and the researcher proposes that adolescents with unhealthy eating habits tend to judge their self-concept in terms of shape and weight, striving either to avoid ‘fatness’ by undereating or overeating in an attempt to cope with ratings of low self-concept. In cases of overeating and undereating clients may have lost control over eating as a result of errors in mental reasoning and therefore the aim of treatment is to change attitudes to shape and weight (cognitive distortions) to be able to change eating habits (Watson, Gordon, Stermac, Kalogerakos & Steckley 2003:773). The approach of cognitive restructuring involves helping the client to question distorted or cognitive thoughts. Garner and Bemis (1982:123) suggest that procedures to elicit problematic thoughts include:
• giving the client homework assignments which provoke problematic thoughts e.g. comparing their figure to other people and inspecting themselves in front of a full length mirror
• recording of thoughts under naturally occurring circumstances e.g. while overeating, seeing their reflection, receiving comments about their appearance. Monitoring helps the client examine eating habits and the situations/environment surrounding eating. In this study a Dietary Record will be kept of what the client eats, and the thoughts and feelings surrounding eating.

Using the Interactionism Model of Self-concept and Eating Habits, the therapist points out errors in reasoning (see 3.2) and examples of the various cognitive distortions:
• **overgeneralization**: For example, “When I used to eat carbohydrates, I was fat; therefore, I must avoid them now so I won’t become obese”
• **magnification**: For example, “I’ve gained two kilograms, so I can’t wear shorts any more”
• **selective abstraction**: For example, “I am special if I am thin”
• **dichotomous or all-or-none reasoning**: For example, “If I gain one kilogram, I’ll go on and gain a hundred kilograms”
• **personalization and self-reference**: For example, “Two people whispered something to each other when I walked past them. They were probably saying that I am ugly and fat”
• **superstitious thinking**: For example, “If I eat a sweet, it will be converted into fat thighs”.

According to Gilbert (2000:106) negative automatic thoughts can be challenged by asking the client the following questions:
• Can you think of any evidence for / against the idea? i.e. How far is it true?
• What is the advantage / disadvantage of thinking this way? i.e. How helpful is it to think like this?
• Is there an alternative way to look at the situation?
- What would be the advantages / disadvantages of looking at things in this different way?
- How might someone else in your situation view this?
- Is this true for other people too? Think of an example of a friend of yours. Do you apply the same rules? Why should you apply different standards to yourself?

The therapist also encourages clients to provoke thoughts in a treatment session e.g. clients are told that they must imagine putting on clothes that feel too tight. Problematic thoughts are then examined according to the following four steps:

1. **The thought is reduced to its core.** For example, a client whose thought is ‘I feel like a hippopotamus’ may mean that the client has certain affective states, which makes the client feel unattractive.

2. **Arguments and evidence to support the fact should be marshaled.** For example, if the client judges that her clothes are too tight, this fact could support the thought ‘I am a hippopotamus’.

3. **Evidence and arguments which cast doubt on the thought, needs to be identified.** For example, a client whose clothes feel tight cannot be attributed to her becoming obese. In this instance the client would have to answer questions such as, “Can fatness be reduced to a clothes size?” and “What specific shape or weight makes one equal to a hippopotamus?” Possible subjective impressions need to be compared with objective facts. For example, the impression of feeling as large as a hippopotamus needs to be compared with the person’s real weight, which statistically may be considered to be overweight, underweight or normal weight.

4. **Clients are encouraged to reach a logical conclusion, which should be used to govern their behaviour.** The conclusion is recited each time the distorted thought occurs and clients are encouraged to practice the technique on their own and as often as possible. For example, a person who concludes that he/she is huge and therefore good for nothing may be using an excuse to hide other interpersonal problems such as a low self-concept. They could practice reciting, ‘I should not evaluate my self-worth in terms of weight and
shape’. Using the Interactionism Model of Self-concept and Eating Habits (Figure 3.1) adolescents can be encouraged to reflect on the evolution of the development of their unhealthy eating habits and consider the influence of family, peers, significant others and media.

Decentering is a strategy used to help clients to be less egocentric in that they may believe that they are central to other people’s attention. For example, clients may say, ‘If I wear shorts in public people will notice that I have gained two kilograms’. To help them to realize that they are not the object of other people’s preoccupation, the therapist would ask clients if they are able to notice how much weight other people have gained when they wear shorts.

Challenging the client’s over-valuation of thinness helps clients to explore the meaning of thinness since many people have internalized the cultural norm that thinness equals success, beauty and control (Tiggemann 2001:133). Clients are required to consider the psychological, biological, political and economic implications of the current norm since the business sector exploits women’s preoccupation with thinness. Challenging cultural values regarding shape is a valuable strategy since unrealistic shapes are promoted in the media equating self-worth with thinness.

3.3.3.3 Relapse prevention
Relapse prevention forms a final stage of cognitive-behaviour therapy and involves the identification of problems that the client feels may impede recovery and progress since relapse in eating disorders is said to be common. Treatment must enable clients to cope with relapses which could entail writing out a plan on how they will cope if a relapse occurs in distorted thinking and disordered eating.

3.4 HYPNOTHERAPY
Because no commonly accepted definition of hypnosis could be found, the following definitions are provided with an indication of the nature of hypnosis. Hypnosis comes from the Greek work ‘hypnos’ which means sleep. According to Olness and Gardner
Hypnosis is not a therapy in itself but when combined with psychotherapy becomes hypnotherapy.

Hypnosis is defined as an altered state of awareness effected by total concentration on the voice of the therapist which results in physical, neurological and psychological changes in which the distortion of emotion, sensation, image and time may be produced (Waxman 1981:3).

Erickson (1976:2) defines hypnosis as “… a successful clinical hypnotic experience, then, is one in which it alters habitual attitudes and modes of functioning so that carefully formulated hypnotic suggestions can evoke and utilize other associations and potentials within the patient to implement certain therapeutic goals”. Kirch (1994:143) defines hypnosis as “… a procedure during which a health professional or researcher suggests that a client, patient or subject experiences changes in sensations, perceptions, thoughts or behaviours”. Valente (2004:3) defines hypnosis as “… a state of mind ranging within a multitude of depths that allow for greater learning, and astounding control of one’s body and mind”.

Hypnotherapy has become increasingly popular and accepted scientifically and its application is used vastly by therapists (Barton, Strauss & Reilly 1995:267; Shand 2004:1). In this section, hypnosis will be considered as an approach that could be used to help adolescents to develop positive self-concept and healthier eating habits. An overview of the historical background of hypnotherapy will be provided, followed by perspectives and principles of hypnotherapy, the advantages and disadvantages of hypnotherapy, and hypnotherapy approaches to be used in the current study.

3.4.1 Overview of the historical background of hypnotherapy

Hypnosis can be traced back to Greek and Egyptian manuscripts and paintings that depict people being treated in “Sleep Temples of the Sick” by means of hypnosis induced by dance, chanting and drugs (Rowley 1986:2).
The following overview on hypnosis is provided by Gauld (1992):

- Franz Mesmer (1734 – 1815) a medical practitioner concluded that for people to be healthy they must be in electro-chemical equilibrium with the stars and the planets and introduced the theory of animal magnetism. He induced trances and produced what was viewed as miraculous cures, referred to as “mesmerism”.
- Marquis de Puységur (1751 – 1825) a retired military man, was one of Mesmer’s followers, recognized that a state of artificial somnambulism exists.
- Josi di Faria (1756 – 1819) further proposed that somnambulism (a nervous sleep) was produced by the person’s receptivity and expectancy.
- James Braid (1795 – 1860) a surgeon, introduced “neurohypnology” (nervous sleep) that was later shortened to “hypnosis”.
- James Esdaile (1808 – 1859) a medical practitioner used hypnosis in surgical operations done in India.
- Ambrose Liebault (1823 – 1904) a medical practitioner in France found that he was able to induce hypnosis in most patients by combining prolonged staring with verbal suggestions of sleep.
- Jean Charcot (1825 – 1893) a neurologist found that hysterical symptoms such as deafness and paralysis could be removed by hypnosis and made hypnosis more acceptable to the medical profession.
- Hippolyte Bernheim (1837 – 1919) investigated hypnosis scientifically and found that the phenomenon of hypnotic suggestion was the main underlying factor in hypnosis.
- Joseph Breuer (1842 – 1925) suggested that emotions and memories cause hysteria and could be elevated when the patient talks about his experiences under hypnosis.
- Sigmund Freud (1856 – 1939) believed that hypnosis enables one to gain access to the unconscious mind and used it to treat patients with neurotic symptoms. He focused his attention however on popularizing the concept of psychoanalysis and this led to the decrease in hypnosis in the 1900’s.
- Pierre Janet (1859 – 1947) proposed that during hypnosis the subconscious mind takes over because the conscious mind is suppressed.
• During the 1950’s Clark Hull, Milton Erickson and Ernest Hilgard brought hypnosis back into the research world (Hartman 1995:3).

• Interest in hypnotherapy with eating disorders started to develop in the 1970’s. Research done by Kroger and Fezler (1976) entailed behaviour modification by means of post-hypnotic suggestions to enhance the sensation of hunger in anorexics.

• In 1978 hypnotherapy with bulimic patients was reported. Lankton and Lankton (1983) reported the successful use of suggestions of self-control and attitude restructuring during hypnotherapy.

3.4.2 Perspectives and principles of hypnotherapy
Various views regarding the nature of hypnosis exist since hypnosis is a complex phenomenon. According to Gibson and Heap (1991:7) the main characteristics of hypnosis include:

• selective attention focused on the range of ideas and happenings that the hypnotherapist calls to their attention

• reduced reality testing since the client tends to accept ideas and perceptions that are presented to them

• an enhanced capacity for enacting roles i.e. when regression to a younger age takes place the person will enact the younger role.

The Neodissociation theory proposes that a person has cognitive systems which are arranged hierarchically and which work together under executive or primary control. During hypnosis the systems dissociate from each other and some cognitive systems are involved while others do not respond. This perspective is based on Peirre Janet’s theory of an altered state of consciousness and is a popular perspective in contemporary hypnotherapy (Lynn & Rhue 1991 in Guse 2002:82). The alternative paradigm perspective is rooted in the belief that people have motivation, expectations and task orientated attitudes that permit them to be receptive to suggestions allowing contrary thought to be ignored.
Hypnosis as a relaxation perspective argues that relaxation and hypnosis are similar. According to Edmonston (in Rowley 1986:21) a person who has undergone induction in hypnosis goes into a psychobiological state of relaxation. The psychoanalytic perspective views hypnosis as regression under the control of the ego and can be ended when the ego chooses to terminate the hypnotic state. Strategic enactment theory postulates that hypnosis is not a unique experience but is determined by social contextual demands. Spanos (1991 in Rowley 1986:21) developed this theory and stipulated that hypnosis is goal directed and does not occur automatically.

The Ericksonian approach to hypnotherapy is based on the work of Milton H. Erickson and will be used in the current study. The Ericksonian perspective focuses on hypnosis as the “... evocation and utilization of unconscious learnings” (Rosen 1982:28). The aims common to hypnotherapy include:

- helping the client to develop coping strategies and strengths
- the development of insight into problems
- changing maladaptive patterns of relationships and behaviour

A variety of hypnotherapy techniques exist but the therapist chooses an approach that suits the person’s characteristics, needs, objectives and the nature of the problem. The relationship between the therapist and the client is one of voluntary cooperation and the client is informed as to what they can expect in hypnosis. The explanation commonly used includes the following statements, which can be elaborated on:

- the unconscious mind is the intuitive part of the brain
- the right side of the brain works during hypnosis and sees things globally
- translogic is possible since a person can be seated in a therapist’s chair but can be thinking about something at home
- one works with the client’s imagination
- hypnosis is a form of interactive communication
• hypnosis can be compared to being absorbed in watching a movie or reading a book.

The induction and trance state provides clients with a psychological state in which they can reorganize their inner psychological problems in a manner that is in accordance with their own experiences and the therapist should make the client feel comfortable and confident about their ability to go into a trance (Erickson 1980 in Rossi 1980:38).

According to Phillips and Frederick (1995:28) the hypnotherapeutic relationship between the client and the therapist is the most important hypnotic tool. The relationship is described as a cooperative one with positive expectancies towards hypnotherapy treatment. Positive expectancy can be created in an atmosphere of safety and trust by means of communication skills that convey unconditional positive regard, empathy for the client’s experiences, beliefs, and warmth.

3.4.3 The advantages and disadvantages of hypnotherapy

One of the advantages of hypnotherapy is that it helps clients to develop insight into their problems and to use their own resources to help them to overcome problems, therefore, motivating people to solve their own problems. Clients benefit from hypnotherapy because the state of self-absorption helps them to gain access to their inner experience (Erickson & Rossi 1977:36).

Hypnotherapy is a learning process in which clients learn through using their own resources to understand inner experiences, based on life experiences, memories, attitudes and ideas (Fromm & Gardner 1979:43). Hypnotherapy allows clients to dissociate themselves from their problems in order to take an objective view of themselves and helps the client to deal with problems one at a time without being overwhelmed by all the problems they might be experiencing (Rossi 1980:34). Whereas cognitive-behaviour therapy focuses on conscious thoughts hypnotherapy focuses on unconscious processes and it is therefore advantageous to combine both therapies.
The disadvantage of hypnotherapy is the misconceptions that some people have about hypnosis. Some clients view hypnosis as the “devils” work rather than a therapy that can benefit the client. Some clients fear that the therapist can make the person say or do something against their will have unlimited control over the patient even after hypnosis (Fredericks 1998:33). Resistance to hypnotherapy may also include a client’s unwillingness to give up a symptom that serves as a major defensive function (Hartman 1995:12). For example, a client who overeats may be reluctant to give up this symptom since it serves as a defense mechanism.

3.4.4 Hypnotherapy approaches used in the current study
In the current study, hypnotherapy will be conceptualized in the framework of the Ericksonian approach. The researcher has chosen his approach because his techniques are naturalistic and utilize an individual’s unique capabilities to bring about change. The nature and rationale for using the Ericksonian approach is outlined in: a metamodel of psychotherapy: the Ericksonian Diamond; principles of the Ericksonian approach; linguistic patterns and hypnotic phenomena.

3.4.4.1 A metamodel of psychotherapy: The Ericksonian Diamond (Zeig, 1994)
A metamodel of Ericksonian psychotherapy, was compiled by Zeig (1994:264) and is based on the principle of utilization, which he defines as the ability of the therapist to respond to all aspects of the client or the environment. It is based on facets, namely:

- goal
- gift-wrapping
- processing
- tailoring
- utilization.

The model of Zeig is presented graphically as a diamond shape in Figure 3.2. Guiding questions of the five facets are outlined and the heuristics according to Hartman (2004) are described.
3.4.4.1.1  **Goal**

The goal (1) refers to the question that the therapist must answer with reference to what the therapist wants to communicate to the client. This question could relate to the phenomenology of trance, the elicitation of resources or to deliver a solution. In the current study the main question that the therapist must answer is “What do I want to communicate to the client?” This goal might be, for example, to communicate to the client that by changing cognitive distortions of reasoning the client’s self-concept and eating habits may improve. The heuristics of the various goals include:

- **concrete goals** – these goals refer to how the client sees the problem. For example, the therapist could ask the client “If I had to see you on T.V., how would I know that it is you?”

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**Figure 3.2: The Ericksonian Diamond**

[Diagram of the Ericksonian Diamond with labels for Goal, Tailoring, Gift-wrapping, Utilization, and Processing]
• **future orientated goals** – these goals refer to where the therapist and client want to be when the problem is solved. For example, the client may learn to be more accepting of the self in future.

• **minimal steps** – these goals refer to the smallest steps that the client can take. For example, the therapist may ask the client to walk around the block at least once a day.

• **resources** – these goals refer to resources the client had in the past. For example, the adolescent may have been in a leadership role in primary school or acknowledged for some achievement.

• **being recursive** – these goals allow the client to apply the main goal in different ways. For example, clients can make a collage of their future self or allow the future self write to the present self.

• **to assess and not to diagnose** – psychology is not to be viewed as an algorithmic science but rather a heuristic science and therefore the therapist needs to assess and not diagnose the problem.

• **redefinition of the problem** – if necessary the problem may have to be redefined.

3.4.4.1.2 **Gift-wrapping**

Gift-wrapping (2) refers to the question of how the therapist wants to communicate the goal. In psychotherapy, techniques used do not cure clients but are ways of gift-wrapping solutions or ideas. Psychotherapy can therefore be viewed as a process of “exchanging gifts”. The client gift-wraps the problem for the therapist by covering it with symptoms. For example, the client may say “I’m so unhappy” and the therapist would have to unwrap the problem and look inside and assess the problem that in the current study may be an eating habits problem and the therapist creates a technique to gift-wrap the solution. Techniques, which can be used, include direct or indirect suggestions, collage work, solution therapy, metaphors and sand tray therapy. In the current study for example, the therapist could gift-wrap the goal by means of presenting a story of how an ugly duckling transforms into a beautiful swan.
The heuristics of gift-wrapping are based on the following premises:

- the techniques do not cure but are “tricks” to achieve the solution.
- the amount of indirection is directly proportional to the amount of resistance encountered.
- a severe problem deserves a severe solution. For example, the therapist could say, “Your eating habits is a severe problem and we will have to take severe measures to solve it. From today you will have to walk for 20 minutes in the afternoon”.
- clients need experiences and not understanding. They need to experience how to accept themselves in order to be happy.

3.4.4.1.3 Tailoring

Tailoring (3) refers to the question of how the therapist wants to individualize the treatment, taking the uniqueness of the client into consideration. The therapist attempts to create individualized therapy for each client in light of the assessment categories. In the current study the questions that the therapist must answer is “What is the current position of the client with regard to his/her self-concept and eating habits?” and “What resources does the client have to overcome the problem?” For example, the client may be good at painting or writing poetry and these resources could be used by the therapist in the facet of processing. The heuristics of tailoring include:

- speaking the clients experiential language i.e. how the client views the problem.
- viewing the client’s problem through the client’s lenses
- utilizing what the client brings to therapy with regard to intrapsychic and inter-personal categories
- what the client values – examples include religion, power, conformity, money, people, respect or clothing brands
- assessing what the client values as - positive in their lives
  - negative in their lives
  - neutral in their lives.
In order to tailor the treatment for each client the therapist uses assessment categories namely: **Intrapersonal category** and **Social interpersonal category**. The **Intrapersonal assessment** category includes what is going on inside a person and how they give their attention to something. The **Social interpersonal category** refers to the profile of the person in relation to society. In the current study the therapist would have to establish how the clients low self-concept and unhealthy eating habits are influenced by their intrapsychic and social interpersonal functioning.

The **Intrapersonal category** is divided into **attention** and **process profiles**. Attention assessment includes:

- if the person is internally or externally orientated. People that are internally focused would blame themselves for their unhealthy eating habits whereas people that are externally focused would blame other people for their unhealthy eating habits.
- if the person is more focused or diffuse. If focused the person can concentrate on one thing whereas if diffuse the person can do many things at the same time.
- which sensory system is more developed, visual, auditory, kinaesthetic or tactile. For example, a client that is visual would frequently say “I can see it,” a client that is auditory would say, “Can you hear what I mean?” A client that is kinaesthetic talks about his/her feelings and a client that is tactile talks about touching objects and people.

If for example, one finds that the person is internal and focused, the therapist would want to make the person more external and diffuse.

**Process refers** to the way in which the client processes information and clients are assessed according to whether they are more linear or mosaic. If linear, they tend to be systematical and perfectionistic. If mosaic they are able to use different methods to process information. Intrapersonal assessment also includes assessing the person as an enhancer or a reducer. An enhancer makes something bigger and may use phrases like “Of course we can”. A reducer makes something smaller and may use phrases like “No, we can't do that” or “Is this the right way?” The intrapersonal
category that stands out the most and seems to be out of balance is the one the therapist will work with more.

**Social interpersonal assessment** involves the therapist obtaining information with regard to:

- the position of the child in the family i.e. oldest, middle or youngest.
- where the client grew up i.e. in the country, a village, a city or a suburban area.
- whether the client is more intrapunitive or extrapunitive. Intrapunitive people tend to absorb blame whereas extrapunitive people tend to give blame.
- if the client absorbs energy from others or emits energy.
- whether the client is a pursuer (action orientated) or a distancer (withdrawn).
- if the person is a one up person or a one down person. A one up person may use phrases like “I will work with you”. A one down person may use phrases like “Who will choose to work with me?”

The social interpersonal assessment category that stands out the most and seems to be out of balance is the one the therapist will pay most attention to.

3.4.4.1.4  **Processing**

Processing (4) answers the question of how to present the tailored and gift-wrapped goal. In the current study the therapist must answer the question, “How will I present the tailored gift-wrapped goal?” The therapist would have to think of creative ways to bring about change in the adolescents self-concept and eating habits. Processing occurs in three stages known as the SIFT method (Zeig 1985 in Guse 2002:88). The three stages involve: **set-up, intervene and follow-through**.

The **set-up** involves using pre-hypnotic suggestions such as eliciting, seeding and induction. The **intervention** is presented and thereafter the therapist **follows through** using various techniques such as hypnotic phenomena or tasks.
The heuristics of processing includes:

- using the SIFT technique.
- deciding if the intervention will be used as an ‘entrée’, ‘main course’ or a ‘dessert’. The therapist must decide whether hypnosis will be used as a starter in the treatment process or a cure (which would be a ‘main course’) or to end off treatment.
- a drama of change. In the current study the drama of change refers to the client adopting/acting out healthy eating habits.
- seeding or hints of what is to come. In the current study the ‘hint’ would include self-acceptance and healthy eating habits.

3.4.4.1.5 **Utilization**

Utilization (5) answers the question of what the position of the therapist is. The therapist needs to be able to respond to all aspects of the client’s life world. The therapist would have to wear many different “hats” of being confronting, passive or compassionate depending on what the client needs from the therapist. The utilization theory emphasis that a person’s particular abilities and personality characteristics must be surveyed in order to determine which modes of functioning can be utilized for therapeutic purposes (Rossi 1980:147).

In the current study the therapist attempts to gain an understanding of the client’s personal goals such as self-acceptance, self-confidence, self-efficiency and healthy eating habits. The client’s personal and subjective needs, experiences, and learning are taken into consideration so that the client can experience acceptance and a response of personal fulfillment i.e. a positive self-concept and healthy eating habits.

The heuristics of utilization include:

- positive expectation – for example, the therapist could say “of course you can improve your eating habits”.
- the therapist being flexible. A therapist who encounters resistance from the client can change one or a combination of the facets in order to suite the client’s needs.
• the therapist trusting his/her intuition. A therapist does not follow a recipe that is universally designed for all clients but uses his/her own gut feeling of what the client will respond to in treatment in order to bring about change.

• utilizing what is given to the therapist. This could include the client’s way of dressing. For example, if adolescents dress in a unique manner, the therapist could use this to emphasise their uniqueness so as to enhance self-concept.

3.4.4.2 Principles of the Ericksonian approach
Ericksonian approach focuses on an interpersonal relationship and the principles central to his approach are outlined by Gilligan (1987:27):
• each person is unique. Erickson helped his patients to utilize their own circumstances as the basis for self-development.

• hypnosis is an experiential process of communicating ideas. Hypnotic suggestions activate ideas already contained in a person’s field of self-identification and the goal is experiential participation and not conceptual understanding.

• each person has generative resources. People are believed to have abilities and resources that they might not be consciously aware of. These resources when utilized can enable to client to lead a satisfying life.

• trance potentiates resources. Trance enables a person to move away from rigid thinking to more flexible thinking that allows the client to restructure and reorganize self-systems.

• trance is naturalistic. Trance is not considered to be artificial but resembles processes commonly experienced by people such as daydreaming or being absorbed while watching a movie.

• approaches orient to course – alignment rather than error-correction. Goals are focused on the needs of the present self and not on understanding and correcting the past.

• a person’s uniqueness can be appreciated on many levels. Four levels are distinguished namely: the deep self, the unconscious mind, the conscious mind and the contents of consciousness. The deep self refers to the life energy that makes the person unique. The unconscious mind refers to differentiations of self
over time which gives rise to organizational identity. The conscious mind is the mental framework which structures information, sequences and computes conceptual relationships. The contents of consciousness include individual perceptions, motor expressions, images, cognitions and sensations. These elements are units by which experience is represented, manipulated and communicated.

- **unconscious processes can operate generatively and autonomously.** Unconscious processes are described as organized, intelligent and creative resources that can operate autonomously from conscious processes.

- **The aim of therapy is to achieve needs and goals of a person’s present self and how the present self will develop or grow further.** The approach is aimed at a teleological orientation towards the future. The hypnotic phenomenon of age-progression is often used and the client progresses into an imagined future. This is important for the current study since the client will be encouraged to imagine a transition into practicing healthier eating habits.

Resourcefulness is a principle of Ericksonian therapy, which will be taken into account in the current study. People are viewed to have their own resources and the role of the therapist is to help the client to draw on these dormant resources and to utilize them. This approach differs from other traditional hypnotherapists who tend to put resources from the outside into the client as opposed to Ericksonian therapists that focus on the client’s inherent resources (Guse 2002:91).

By means of trance the client is better able to tap into their resources. According to Gilligan (1987:17) hypnosis can “... deframe a person from rigid sets and thereby enable restructuring and reorganization of self-systems”. The restructuring of self-systems is of relevance to this study, since the self-concept of the client may need restructuring in the current study.

Various induction techniques are used in Ericksonian hypnotherapy and the therapist will use an eye-fixation technique combined with a relaxation method. Eye-fixation
induces trance by creating feelings of heaviness in the eyelids and eye muscles. Relaxation involves suggestions of relaxation and breathing techniques. Deepening of trance techniques to be used by the therapist will include hand levitation, hand delevitation, relaxation imagery and stairway image. Hand levitation will be used with undereaters since it indirectly suggests the eating process as the hand moves upwards towards the mouth. Hand delevitation will be used with overeaters since it indirectly suggests the hand moving away from the mouth. Relaxation imagery deepens trance as the client imagines taking a walk for example, along the beach. The stairway image helps clients to enter a deeper state of hypnosis as they imagine walking down a stairway. Young (1995:148) found the above techniques to be successful when working with clients with eating disorders and warns therapist not to use the phrase “getting heavier and heavier” since clients tend to react negatively to these words because of the association of gaining weight. Termination of trance involves the clients re-orientating themselves or counting backwards from ten.

Hypnotherapy holds a permissive approach to therapy since it will be up to clients to make choices of what they choose to respond to (O’Hanlon 1987). Permissive language is used and words such as “may”, “can”, “maybe” and “might” are used (Edgette & Edgette 1995:16). A permissive approach is used in the current study, since the therapist respects the clients’s ability to experience hypnosis in their own unique way.

According to Hartman (2002) the A-R-E model of hypnotic suggestion can be used during the process of hypnosis and includes the following steps:

- **Absorption**: the client is absorbed into trance by memory, fantasy, sensation, perception, hypnotic phenomena, stories, metaphors or anecdotes
- **Ratification**: hypnotic constellations are ratified by acknowledging changes. For example, “I can see that your eyes are blinking and that your chest is moving up and down as you breathe”
- **Elicitation**: the goal is to elicit responses by utilizing things appropriate and present.
Erickson views the unconscious mind as any process that lies outside the awareness of the personality but plays a part in determining bodily and conscious phenomena and is expressed nonverbally (Lankton & Lankton 1983:330). Metaphors are used to communicate and activate the client’s unconscious processes and Ericksonian metaphors are designed to suite the client’s situation and subjective view of himself/herself and of the world. He argues that the unconscious mind contains the resources that clients need to resolve their problems.

The mobilizing of inner resources in the current study will be done by means of ego-strengthening. Ego-strengthening is usually done in the initial stages of treatment to enhance self-esteem and to improve problem-solving abilities (Phillips & Frederick 1995:82). During ego-strengthening the therapist activates strength in the client in order to feel strong enough to give up their symptoms which in this study would be unhealthy eating habits.

Ericksonian hypnotherapy uses techniques of interspersal, embedding and seeding (Phillips & Frederick 1995:97). The cooperation principle recognizes that clients have a right and reason to live in the world just as they are and by accepting the client unconditionally the therapist intends to increase self-confidence and self-esteem in the client.

3.4.4.3 Linguistic patterns

Linguistic patterns are characteristically used in hypnotherapy to stimulate associations in a person’s mind. An analogy can be made with throwing a stone into water and it has a ripple effect since words are vehicles of our thoughts and structure a person’s thinking (Edgette & Edgette 1995:32; Erickson & Rossi 1979:85).

Types of linguistic patterns to be used in the current study include:

- **positive suggestions** – these suggestions are encouraging and are used to create a positive response. For example, “You can remember a time when you felt very proud of yourself”.

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• **process suggestions** – are used to enable the client to do the searching since the suggestion is sparse in detail. For example, “You might notice a certain pleasant sensation in your body (pause) comfortably”.

• **compound suggestions** – the word ‘and’ is used to join two separate suggestions. For example, “With each breath that you take you can become aware of your breathing and feelings of relaxation that develop”.

• **paradoxical suggestions** – incompatible components are used within the same suggestion. For example, “You can take all the time in the world in the next minute to complete your inner experience of your new learning of the self”.

• **post-hypnotic suggestions** – these suggestions describe feelings and behaviour that the client may have in future. For example, “You will be surprised how easy it will be to feel more in control of your eating habits when you go out to dinner again”.

• **accessing questions / conversational postulates** - these questions encourage clients to respond at an experiential level by focusing on particular aspects of their experiences. For example, “I am wondering if you can … allow yourself creative ways of solving your problem to enter your mind”.

• **conscious – unconscious double bind** – dissociation statements are used to split the conscious / unconscious mind in order that therapeutic work may take place. The formula used is:
  
  1 can 2 (but / and / or / while) 3 can
  4 because 5 where

  1 is the conscious state of awareness
  2 is the pacing statement to focus the client’s attention externally
  3 is the hypnotic state
  4 is the eliciting statement used to focus the clients attention internally
  5 is the motivation where the client’s wish or goal is stated positively (Battino & South 1999).

  For example, the therapist could say: “consciously [1] you can hear [2] my voice as I am talking to you but unconsciously [3] you can listen [4] to the voice of your inner mind because [5] this is what hypnosis is all about”.

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- **presuppositions** - are used in therapy to focus the client’s attention and create expectations for change. Presuppositions include reference to process, time, place or quantity. For example:

  “I don’t know how you are experiencing the solution to the problem” (presupposition of process).

  “I don’t know when you will experience the change in eating habits” (presupposition of time).

  “I don’t know where the inner place of comfort will be” (presupposition of place).

  “I don’t know how much more time you will need to achieve your inner goal” (presupposition of quantity).

The use of indirection is often utilized suggestions being made in a covert manner (Yapko 1995). Indirection facilitates the use of stories and metaphors and permits clients to explore the meaning in a way that is relevant to them. Yapko (1986:224) has promoted the use of indirect hypnotic suggestion to challenge poor self-esteem associated with eating disorders and his approach consists of metaphors, behaviour prescriptions that are paradoxical and involve cognitive reframing. Metaphors used by the therapist passes information to the client in an indirect way and helps to bypass the objections of the conscious mind. Messages that convey endurance and triumph creates an atmosphere of safety and stability for the client (Phillips & Frederick 1995:97). In the current study the therapist makes use of metaphors and stories by means of an indirect approach to allow the client to use the unconscious mind’s resources to facilitate a change in self-concept and eating habits.

By using an indirect suggestion clients are able to experience the processes of reorganizing and re-associating their inner real experience. A person with unhealthy eating habits would have to undergo the inner process of re-associating and reorganizing his experiences for effective results to occur.

Clients can give themselves positive, constructive suggestions during trance and can increase their motivation by reminding themselves of their goals and the reasons why
they want to achieve these goals. Imagery can be used in conjunction with a suggestion. The imagery stage of the self-image thinking structure is when the therapist helps clients to “step inside” the picture of them enjoying a desired goal (Lankton & Lankton 1983:331). This form of visualizing the self helps the client to experience the world when they reach their goal.

In this study, imaginary rehearsal is practiced while the client is guided to imagine eating balanced meals. The script that is written is tailored to suite the client’s needs. For example, while the client gives the suggestion “I can stop overeating”, he/she can imagine himself/herself resisting food for seconds and experience losing weight. Clients are encouraged to avoid authoritarian suggestions such as “I will never overeat again” since “musts”, “shoulds”, “will never” statements are unrealistic as well as rigid and often result in cognitive distortions of what the person must be like in order to be accepted by significant others (Golden, Dowd & Friedberg 1987:131). The person could rather use a more flexible suggestion, such as “I could learn to adopt healthier eating habits as I learn to accept myself”.

3.4.4.4 Hypnotic phenomena

Hypnotic phenomena are the building blocks for the therapeutic applications of hypnosis and can be presented as opposites on the continua of trance phenomena. The therapist can select the phenomenon that is the opposite to the one causing the problem and use it during treatment (Edgette & Edgette 1995; Shand 2004:1). The hypnotic phenomena are presented in pairs as follows:
Age regression --------------------------------------------- Age progression
Amnesia ----------------------------------------------- Hyperamnesia
Anaesthesia -------------- Analgesia -------------- Hypersensitivity / Hyperesthesia
Cataplexy ------------------------------------------ Flexibility / Movement
Dissociation ---------------------------------------- Association
Positive hallucination ----------------------------- Negative hallucination
Time expansion -------------------------------------- Time condensation
Post-hypnotic suggestion -------------------------- Pre-hypnotic suggestion
(Edgette & Edgette 1995:17).

When planning intervention it is useful to select the phenomenon that complements the one generating the problem. For example, a person with a low self-concept on the physical dimension may reject their physical appearance (phenomena of dissociation) and the aim of therapy would be to enable the client to be more accepting of the self with regard to the physical dimension (phenomena of association).

3.4.4.1 Age regression / Age progression
These hypnotic phenomena are related to time perception. Age regression involves going back to a specific time in order to re-experience it (Battino & South 1999:238). This strategy could be implemented to go back to a negative experience or to make use of a client’s resources that he/she possessed earlier in life. The aim would be to help the client to find their inner resources by going back to reflect on their previous successes. The therapist will make use of this phenomenon in the current study by using the ego-strengthening technique. Age regression can be structured or unstructured and the therapist will mainly use structured age regressions to enable the client to retrieve previous positive experiences such as times when they felt accepted and when they displayed positive eating habits. Useful approaches could include using a train, plane or lift as vehicles to past events.
Age progression involves the use of projections of the future. The therapist helps clients to imagine the future self after achieving their goals. In the current study this projection will be used to help clients to mentally rehearse accepting them and adopt
healthy eating habits. Useful approaches could include a movie screen as a vehicle to the new and imagined event.

3.4.4.4.2 **Amnesia / Hyperamnesia**
These hypnotic phenomena are related to memory functions. Amnesia refers to a loss of memory and is sometimes used as a defense mechanism to suppress an unpleasant experience (Yapko 1995:224). This phenomenon can be used to repress hurtful memories that have occurred prior to or during trance.

Hyperamnesia refers to detailed remembering and allows the client to recall earlier memories in detail. These memories could include past successes (Edgette & Edgette 1995). In the current study this phenomenon will be used to enable clients to recall a previous experience when they felt good about themselves.

3.4.4.4.3 **Anaesthesia / Analgesia / Hyperesthesia**
These hypnotic phenomena are related to modified perception. Anaesthesia and analgesia are seen as phenomena on a continuum of diminishing bodily sensations (Guse 2002:101). A person that displays the phenomena of anaesthesia experiences a lack of sensation, a feeling of numbness and may say, “I feel nothing for my family.” A person that displays the phenomena of analgesia experiences an alteration of sensation and may say, “I have lost some feelings for my parents.” These phenomena are usually used in pain management by eliminating sensation in all or part of the body. For example, these phenomena can be used to alleviate pain during childbirth (Guse 2002:101).

A client that displays hyperesthesia tends to be hypersensitive and may for example, burst out crying and say, “Everyone hates me and everyone always teases me about the way I look.” According to Edgette and Edgette (1995) hyperesthesia is a marked sensitivity to physical sensations such as touch, warmth and coldness. In the current study the phenomenon can be used to help the clients experience a sensation of warmth as they learn to accept and love the self.
3.4.4.4 **Catalepsy / Flexibility / Movement**

These hypnotic phenomena are related to dissociated movement. Catalepsy refers to the inhibition of voluntary movement associated with intense focusing on a specific stimulus (Yapko 1995:228). Examples of catalepsy include: general immobility, a fixed gaze, muscular rigidity and a slowing of blinking, breathing and swallowing. This phenomenon is used to focus and maintain attention, to facilitate the unconscious mind to act more independently or to assist a client whose movements must be minimal to enable recovery to take place.

Flexibility and movement enables the client to venture forward and to bring about change. In the current study the researcher will use ideomotor movement of arm levitation and arm delevitation in order to deepen a trance and as a catalyst for changed self-concept and eating habits.

3.4.4.5 **Dissociation / Association**

These hypnotic phenomena are related to the duality of reality. It is the process of breaking global experiences into parts where experiential emphasis is placed on one part while diminishing awareness of the other parts (Battino & South 1999). It is often used to dissociate the person from pain being experienced in a particular part of the body. The researcher is of the opinion that people who overeat or undereat may have dissociated themselves from the ideal-self and the actual-self. This is grounded in her experience with adolescents with low self-concept and unhealthy eating habits who find it difficult to disengage from mental immersions of their failings and shortcomings.

Association would entail re-associating component parts into a global experience. In the current study the therapist will make use of this phenomenon by using metaphors such as, The Ugly Duckling and a computerized transformation of self-concept called “gathering resources” to create an integrated self-concept and healthy eating behaviour.
3.4.4.4.6  Positive hallucination / Negative hallucination
These hypnotic phenomena are related to sensory perceptions. A hallucination refers to a sensory experience that does not occur as a result of external stimulation. A positive hallucination includes visual, auditory, kinaesthetic, olfactory or gustatory experiences that are not objectively present. Negative hallucinations refer to an inability to experience what is objectively present. Hallucinations created hypnotically allow clients to experience things that are removed from current objective realities. In the current study the phenomenon of a positive hallucination will be used to facilitate the client to experience the selection of healthy food at a dinner party.

3.4.4.4.7  Time expansion / Time condensation
These hypnotic phenomena are related to time perception. Time expansion refers to experiencing time longer than it is whereas time condensation refers to experiencing time shorter than it is. It can be used to lengthen the time experienced as a positive event or to shorten the time experienced as a negative event. Time condensation could be used in the current study in the case where a client may feel that the development of healthy eating habits will take forever and the client can experience the adoption of healthy eating habits in a shorter period of time during hypnosis.

3.4.4.4.8  Post-hypnotic suggestions / Pre-hypnotic suggestions
These hypnotic phenomena are related to memory functions. Post-hypnotic suggestion refers to a client’s ability to respond to a suggestion made during trance at a later stage (Edgette & Edgette 1995). The suggestion can be directed towards feelings and behaviours. In the current study, the therapist will make use of post-hypnotic suggestions in order to enable clients to experience the desired change in eating habits.
3.5 **CONCLUSION**

In this chapter the researcher has introduced an Interactionism Model of Self-concept and Eating Habits (Figure 3.1). Disruptive eating behaviour (overeating / undereating) is an interactionism phenomenon between self-concept (Figure 3.1 A), mental modifications (Figure 3.1 B) and physical occurrences (Figure 3.1 C), which can result in unhealthy eating habits (Figure 3.1 D).

In the literature study it became clear that intervention programmes that counter unrealistic expectations with regard to the self, need to be employed to treat unhealthy eating habits. Psycho-educational programmes that involve cognitive-behaviour therapy and hypnotherapy could prove to be effective in helping adolescents to improve their low self-concept and unhealthy eating habits. Both cognitive-behaviour therapy and hypnotherapy could help the adolescent to identify and change the thought and behaviour patterns that contribute to low self-concept and unhealthy eating habits. Whereas cognitive-behaviour therapy focuses on remediating cognitive distortions of the conscious mind, hypnotherapy focuses on unconscious processes to facilitate the restoration of the real self and therefore the combination of these intervention programmes could prove to be successful in therapy. It is the researchers view that psychotherapy is the process of reorganizing the internal life of a person and can result in a change in the habitual pattern of behaviour. In the following chapter the development and content of the Psycho-educational programme is discussed.
CHAPTER FOUR

THE DEVELOPMENT AND CONTENT OF THE PSYCHO-EDUCATIONAL PROGRAMME
FOR ADOLESCENTS WITH UNHEALTHY EATING HABITS

4.1 INTRODUCTION

In the literature study it became clear that self-concept and eating habits are interrelated and intervention programmes such as cognitive-behaviour therapy and hypnotherapy may enable clients to enhance their self-concept and eating habits. The interaction between self-concept and eating habits in relation to cognitive thinking and physical occurrence was discussed (Figure 3:1 Interactionism Model of Self-Concept and Eating Habits). The researcher is not of the opinion that self-concept may be the only determining factor of eating disorders and is aware that other factors may contribute to unhealthy eating habits. However, during her practicing as a psychologist as well as studying the literature, it has become evident that self-concept is a determining factor of eating habits and will therefore be considered in the intervention programme. The researcher will attempt to use a Psycho-educational programme to help adolescents to improve their low self-concept and change unhealthy eating habits. The effectiveness of the programme will be tested once it has been implemented.

In this chapter the Psycho-educational programme for adolescents with unhealthy eating habits will be presented. Many research designs do not provide the reader with examples of the format and content of their intervention programmes and therefore objectives will be outlined and include the content to be used in each session. The duration of the session will also be provided.

4.2 DESCRIPTION OF THE PROGRAMME CONTENT

The programme includes ten sessions of which six sessions involve individual therapy, three sessions involve group therapy and one session involves post-testing and feedback on the programme. The research will be done over a period of ten sessions to ensure that there would be less chance of adolescents dropping out of therapy or
moving to another town or province. One session takes place every two weeks, which means that the first nine sessions take place over a period of four and a half months. Session ten takes place after a period of eight months after the ninth session and involves post-testing and feedback on the programme, thus the research takes place over a period of twelve and a half months. The duration of the sessions vary from 30 minutes to 90 minutes depending on the nature of therapy (see Psycho-educational programme below).

**PSYCHO-EDUCATIONAL PROGRAMME**

<table>
<thead>
<tr>
<th>INDIVIDUAL THERAPY 6 SESSIONS</th>
<th>GROUP THERAPY 3 SESSIONS</th>
<th>WINDOW PERIOD</th>
<th>POST-TESTING 1 SESSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1: (30 minutes) Feedback on psychometric testing</td>
<td>Session 4: (60 minutes) Interactionism Model of Self-concept and Eating Habits as well as collage of the Inner Self</td>
<td></td>
<td>Session 10: (90 minutes) Post-testing and feedback on programme</td>
</tr>
<tr>
<td>Session 2: (45 minutes) Interview and ego-strengthening</td>
<td>Session 6: (90 minutes) Education on healthy eating habits: theory and practice</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Group therapy sessions tend to be longer because the clients need to feel that they have had equal opportunities to benefit and give their input into the programme. As discovered in the literature study (see 3.3.2) the group format, in this study, nine members, increases the opportunity for prosocial peer feedback and discussions. Group interventions can also be useful because of adolescent developmental relevance. The group therapeutic method is also economical and time saving (see 3.3.3). In this study a Psycho-educational group is formed to help clients work through didactic knowledge about cognitive thinking, sense of self, and eating habits. Through the learning process, clients will be able to reflect on their own thought processes, their sense of self and their eating habits.

Group cohesion is said to be a concept closely related to therapeutic alliance and includes a sense of bonding, a sense of working together toward common goals, engagement, support and identification with the group which can result in a positive outcome in group psychotherapy (Woody & Adessky 2002:7). The shared concerns of the group provide impetus for dialogue between them and the internal transformation of a psychotherapy group can lead to maturation of its members. Ettin (2000:146) provides an apt description of the processes that affect members when he likens it to a caterpillar going into stasis: “… When a caterpillar enters its pupil stage it goes into stasis, neither eating nor moving. Observed from the outside, the pupa or chrysalis appears to be resting. On the inside, its larval tissues are breaking down totally and reorganizing within the pupil skin. What emerges from the chrysalis is a fully formed adult butterfly”.

Group therapy enables clients to explore new ways of relating to self and others in an environment of shared safety and intimacy. Federici-Nebbioso (2003:715) argues that for adolescents, the primary aim of group therapy is to offer new affective experiences that promote a greater ability to establish a relationship with others and with oneself, a stronger sense of existence and contributes to the consolidation of the self. Adolescents spend a lot of their time in peer groups that become regulators in
behaviour and have an input on the way adolescents see themselves in relational situations.

The individual and group therapy sessions involve homework because it can prove to be a beneficial technique used in therapy. Homework denotes therapist-assigned tasks given to discover thoughts, behaviours and feelings that the client is experiencing and the client is informed that there are no right or wrong answers (Hay & Kinnier 1998:122). Clients must feel that they are actively involved in the intervention programme in order to experience improvements and a sense of self-efficacy. Prochaska, Di Clement and Norcross (1992:1102) noted that by moving the client into active involvement means that the client has already decided that change would benefit them. Hay and Kinnier (1998:122) further agree that by taking responsibility for oneself, empowerment and self-esteem are likely to increase. Detweiler and Whisman (1999:279) as well as Coon and Gallagher-Thompson (2002:549) verify that homework adherence is associated with positive outcome expectancies.

Homework assignments are said to be a standard feature of most types of cognitive-behaviour therapy (Woods, Chambless & Steketee 2002:88). Activities assigned for homework in this study include a Dietary Record, cognitive restructuring, self-directed exposure of a collage of the Inner Self and a message from the future self to the present self. The therapist used some of the strategies to increase homework adherence as set out by Malouff and Schutte (2004:118) namely: by giving assignments that relate closely to the client’s therapy goals; including a variety of activities such as collecting items, writing, collage work, singing, acting; praising the client for completing an assignment; using simple words to make the assignments clear and specific. The researcher is of the opinion that a client’s level of motivation is a predictor of the outcome of treatment. When a client agrees to do homework and does not do it for the next session, it may indicate a low level of motivation and may predict an unsuccessful treatment outcome.
The programme involves cognitive-behaviour therapy and hypnotherapy. Although each session has a specific focus, threads are woven into all the sessions involving rational/cognitive thought processes; inner resources; the seeding of self-acceptance, self-confidence and adopting healthy eating habits. This type of intervention can be considered to be an educational therapeutic approach and is based on the premise that people with problems can be taught to recognize as well as modify negative thoughts and beliefs by testing and challenging their cognitions and behaviours. The aim is to give clients skills they can use throughout their lives (see 1.1, 1.2.2.3 and 2.5).

Cognitive-behaviour therapy stresses an assignment framework of affect, behaviour and cognition (ABC; see 3.3.1). According to Ellis (2004:86) human thinking, feeling and behaviour are all distinctly interrelated. He advocates that Rational Emotive Behaviour Therapy (REBT) is cognitive, emotive and behavioural and is the most comprehensive and most effective form of behaviour therapy. The aim of REBT is for the client to get better rather than feel better (see 3.2 and 3.3.3.2).

According to Stewart and Williamson (2003:154) very limited evidence demonstrating the success of cognitive-behavioural therapy aimed at body image treatment exists. Treatment aimed at evolving overvalued ideas of physical appearance is an important element of the treatment of eating disorders (see 1.2.2.1, 2.2.1.1 and 2.4). Cognitive theory incorporates both the unconscious level of functioning that is the primary force of behavioural conditioning as well as the conscious metacognitive levels. Cognitive theory stipulates three cognitive systems namely: the preconscious, unintentional, automatic level; the conscious level; and the metacognitive level. The metacognitive level involves “thinking about thinking” and is used to convey the active control function of conscious awareness (Alford & Lantka 2000:575). Cognitive therapeutic techniques used in this study include: cognitive structuring to modify misconceptions about self; problem analysis to explore the link between self-concept and eating habits, and self-control practice to acquire skills for overcoming and changing behaviour. In this study the client will practice using the metacognitive level since it regulates the lower
cognitive levels. The metacognitive level will use the reported cognitive content presented by the lower levels and identify and change processing operations and errors such as cognitive distortions.

Cognitive-behaviour therapy not only analyses the client’s dysfunctional beliefs and changes them into more functional ones but it also helps clients to develop a sense of unconditional self-acceptance. This means that they will respect and accept their self regardless of the approval of significant others. The literature study reveals that by enhancing self-concept it may be possible to reduce health compromising behaviour (see 1.1 and 2.2.1) and verifies that very few references are made to work carried out in the domain of self-concept and eating habits (see 1.1).

Hypnotherapy is becoming popular and is accepted scientifically for its application (see 3.4.3 and 3.4.4). People with eating problems tend to be good hypnotic subjects because they are able to dissociate in hypnotherapy that could stem from possible dissociation from their body in everyday life (Segal 2001: 30). It is also clear that hypnosis applied with Ericksonian therapy could be effective in improving self-concept and eating habits.

For the purposes of this study, hypnosis will be used to: alter body image; increase and decrease food intake; develop a more balanced and healthy lifestyle; increase self-confidence, interpersonal effectiveness and introspective awareness. The protocol involving the objectives, and duration of the Psycho-educational programme are outlined below.

4.2.1 Session 1: Individual therapy: Feedback on psychometric assessment

4.2.1.1 Objectives

The objectives of the first session are:

- to provide the client with feedback on the psychometric assessment done
- to measure the clients Body Mass Index.
4.2.1.2 **Content**

The client is reminded of the psychometric assessment done namely Adolescent Self-concept Scale, Emotions Profile Index, Eating Habits Questionnaire for Adolescents, Draw A Person and Sentence Completion. Feedback on the assessment is provided and the client is invited to comment on the results. Body Mass Index is calculated by the therapist in order that the client may realistically classify his/her weight.

4.2.1.3 **Duration**

The duration of this session is approximately 30 minutes.

4.2.2 **Session 2: Individual therapy: Interview and ego-strengthening**

4.2.2.1 **Objectives**

The objectives of the second session are:

- to conduct an interview with the client in order to identify resources that can be used in therapy
- to guide the client to get in touch with his/her inner resources
- to prepare the client for further hypnotherapy work.

4.2.2.2 **Content**

A questionnaire (Appendix I) will be used to interview the client. Once the therapist has interviewed the client, resources are identified and will be used in trance by means of the ego-strengthening technique.

Ego-strengthening is done to enable the client to get in touch with their inner strength in order to improve their self-esteem and to increase a client’s sense of internal control (see 3.4.4.2). The script is presented on the left-hand side of the page and the notes regarding hypnotic phenomena and Ericksonian principles appear on the right-hand side of the page (see 3.4.4.3 and 3.4.4.4).
After absorbing the client into trance by using the eye fixation technique (see 3.4.4.2), a script has been adapted by the researcher from the Phillips and Frederick (1995:87) Inner Strength script.

*(Name), you can sit comfortably ...*  
and look at a dot ... over there on the *future* wall ... and while you look at the dot ... you are going to notice some interesting changes that take place in your *body* ... as you prepare yourself for a journey *inside* yourself ... perhaps your eyes feel watery ... maybe your eyes blink more often ... they may even feel like closing ... and you can close them when you want to ... while looking at the dot it is interesting to note that it can become a distant memory ... maybe the circle becomes a circle within a circle ... and you can allow the circle to become a distant memory ... and now you can focus on what is going on *inside* you ... you can feel the chair supporting you ... maybe you are aware of certain sounds around you (therapist names sounds outside room and then sounds inside the room) ... you can feel your hands on your lap ... maybe you can feel your chest moving up and down ... and as you become

*(TRANCE INDUCTION)*

- absorption
- seeding of future self
- seeding of change in eating habits
- metaphor
- ratification
- seeding of internal control
- seeding of internal control
- elicitation
- compound suggestion
aware of your breathing ... you can allow yourself to move into your own inner world ... a place where you feel safe ... a place where you feel secure ... a place where you can spoil yourself ... a place where you feel that everything is okay ... and when you have found that place ...
it is possible for you to have a sense of finding a part of yourself ... a sense of self ... and you can take some time inside your inner space to find your inner strength ... you can nod your head when you have found your inner self ... the part of you that has helped you to overcome difficulties in the past ... and you can take all the time in the world in a matter of a minute to complete your inner experience of your new learning of the self ... maybe you can remember a time when you felt very proud of yourself ... the part of you that (the therapist names all the positive resources obtained in the interview) and when you have found your inner strength you might feel more confident with the knowledge that you have inside yourself ... all the resources you need to achieve your future goals ... and

(INTENSIFICATION OF TRANCE)

- seeding of self-acceptance
- seeding of self-concept
- ideomotor response
- paradoxical suggestion
- positive suggestion
- ego-strengthening
- tailoring
- seeding of positive self-esteem
- age progression
when you want to communicate with your inner self ... you can do so at the blink of an eye ... and in the next few days and weeks to come ... you may find yourself becoming more accepting and optimistic about yourself ... and you may find that at any time of the day you will be able to get in touch with your inner self ... your inner strength ... by merely closing your eyes ... and reminding yourself that you have within you ... all the resources you really need ... and the more you use these methods ... and practice these healthy habits ... the easier it will be to be in touch with your inner self ... the more you will be able to trust your inner self ... your intuition ... your rational thinking ... and use them as your guide ... and (name) when you have completed your inner experience of the inner self ... you can drift back with my voice ... back here ... completely back ... here ... now.

- seeding of self-concept
- post-hypnotic suggestion
- seeding of self-acceptance / guiding associations towards the future
- seeding of internal locus of control
- seeding of exercising healthier eating habits
- seeding of cognitive thought

(TERMINATION OF TRANCE)

Clients are encouraged to share their experiences after coming out of trance. They are asked to describe images, bodily sensations, thoughts that were perceived to be manifestations of Inner Strength. For homework, clients are given a Dietary Record sheet to complete for the next session (Appendix H).
4.2.3.3 **Duration**
The duration of this session is approximately 45 minutes.

4.2.3 **Session 3: Individual therapy: Cognitive distortions**

4.2.3.1 **Objectives**
The objectives of the third session are:

- to make the client aware of how cognitive distortions can negatively influence a person’s self-concept and eating habits
- to pinpoint the client’s negative thoughts or self-suggestions that lead to negative self-concept and unhealthy eating habits.

4.2.3.2 **Content**
The therapist introduces the client to the concept of cognitive distortions (see 3.3.3.2) and the client reviews the Dietary Record to identify cognitive, emotional and situational antecedents associated with negative self-concept and unhealthy eating habits.

Negative thoughts and self-suggestions identified by the therapist in the Draw A Person and the Sentence Completion projection tests are discussed with the client with the emphasis on how cognitive distortions can interfere with the individual’s ability to adopt healthy eating habits. Once negative thoughts and self-suggestions have been identified, both the client and the therapist offer therapeutic suggestions for the replacement of negative thoughts. For example, a negative thought such as “Boys hate my fat body,” could be replaced by a therapeutic suggestion such as “Not all boys care whether I am fat or not. Some boys are interested in my personality.” Homework includes making a collage using words and pictures to describe the topic: “The Inner Self.”

4.2.3.3 **Duration**
The duration of this session is approximately 45 minutes.
4.2.4 Session 4: Group therapy: Application of Figure 3.1: An Interactionism Model of Self-concept and Eating Habits and a collage of the Inner Self

4.2.4.1 Objectives
The objectives of the fourth session are:

- to draw up a contract between group therapy clients
- to encourage adolescents to become researchers as they apply the knowledge gained on cognitive distortions to Figure 3.1: An Interactionism Model of Self-concept and Eating Habits
- to share the collage of the Inner Self with the members of the group.

4.2.4.2 Content
As an ice-breaker each client introduces himself/herself and shares any positive or significant experience that they have encountered during the past week. Thereafter the group members draw up a Group Therapy Contract in which they decide on ground rules that they agree to abide by in group therapy. For example, confidentiality may be one of the ground rules decided upon. Each member of the group signs the contract and receives a copy of the contract.

The concept of Figure 3.1: An Interactionism Model of Self-concept and Eating Habits will be introduced to the group (see 3.2). The group members will be encouraged to apply their own cognitive distortions identified in session two to the model. The adolescents will be encouraged to participate as researchers in the concept of the interactionism of self-concept and eating habits.

Once the group therapy members have discussed the merit of the model, they will take it in voluntary turns to share their collage of the Inner Self. Group members are encouraged to comment on each other’s collages as part of the therapeutic process of addressing negative self-concept and unhealthy eating habits.
Homework includes being aware of and recording self-defeating thoughts that may hamper the development of a positive self-concept and healthy eating habits as well as the replacement of negative mental modifications with positive suggestions. The session ends with a Mexican hug where group members stand in a tight circle with their arms linked and on calling out “Hondilah, hondilah” they take a step with their right foot into the middle of the circle. This technique usually causes much laughing on the part of group members as a sense of relief after being placed in a vulnerable position of sharing their collage of the Inner Self.

4.2.4.3 Duration
The duration of this session is approximately 60 minutes.

4.2.5 Session 5: Individual therapy: Hypnotherapy: Transformation of self-concept

4.2.5.1 Objectives
The objectives of the fifth session are:
- to transform the client’s negative self-concept into a more positive one by using a metaphor during hypnotherapy
- to help the client to develop an integrated self-concept using the technique a computerized Self-concept Index during hypnotherapy.

4.2.5.2 Content
After absorbing the client into trance by using the eye fixation technique, a script has been adapted by the researcher from the Erickson (in Rossi 1980:470) ‘The Ugly Duckling’ metaphor and the Hartman (2004) ‘Gathering Resources’ practical demonstration. The script is presented on the left-hand side of the page and the notes regarding hypnotic phenomena and Ericksonian principles appear on the right-hand side of the page.
(Name) you can sit comfortably ... and look at an imaginary circle ... over there on the future wall ... and you might imagine some interesting changes that take place in your body ... as you think back ... to a time when ... perhaps your eyes feel watery ... and blink more often ... you may even feel like closing them ... and you can think back ... to a time ... when you needed to learn ... to write ... some letters had to be ... practiced ... and you can feel the chair beneath you to support you ... and (Name) ... you can remember that some letters had to be ... practiced ... such as a ‘p’ and a ‘q’ ... as well as a ‘b’ and a ‘d’ ... your conscious mind is intelligent ... but your unconscious mind is even ... wiser ... remember how difficult it was ... to write in the lines ... until ... you (Name) ... got it right ... and this reminds me of an egg ... in a nest ... maybe the chicken was very excited to

(TRANSCEND INDUCTION)
- seeding of imagination of transformed self
- seeding of projection of future self
- interspersal
- seeding of change in eating habits
- age regression
- seeding of expectancy
- ratification
- seeding that the technique of transformation can be a learned behaviour
- seeding of practicing of healthy eating habits
- elicitation of reassurance of support
- practicing of healthy eating habits

(INTENSIFICATION OF TRANCE)
- seeding of self-esteem
- seeding of self-confidence and parameters of healthy eating habits
come out of the egg ... and when it did ... all the chicken needed was a warm wing to be under ... but when it came out ... all it got ... was a peck on the head ... so it crawled into the reeds ... where it could not be found ... one day ... in winter it looked up and saw swallows ... who move away to places with summer ... and it longed to be like a swallow ... and it thought “Don’t be stupid. I can never be a swallow” ... and the chicken felt ... that this winter ... was so long ... and that the winter ... would carry on forever ... but you (Name) and I know ... that winters do not ... carry on forever ... and this reminds me of a duckling ... who discovers that ... she is a ... swan ...

One spring morning ... the birds said “What beautiful swans we are” ... and the duckling looks into the water ... and sees a reflection of herself ... she sees it with her head ... but maybe ... she does not feel it ... in her heart ... her body ... and then ... she starts to fly ... and she looks down ... and sees how the dams ... get smaller ... and ... smaller ... and now she can see ... other swans ... in other dams ... and she knew ... now ... that she is a beautiful (Name) swan ... and like you

- seeding of transformation
- association
- analogy of low self-concept
- catalepsy
- flexibility/movement
- seeding of hope and change
- seeding of transformation
- seeding of new self-concept
- association
- seeding of concept of interactionism between mind and body
- flexibility / movement
- dissociation
- association
- confirmation of transformation of self-concept
(Name) ... who learned to write essays at school ... you too ... can write your own life story ... and I wonder ... if you would be prepared ... to stretch your imagination ... even further ... perhaps you can imagine ... that you are ... standing on top of ten stairs ... and I don’t know what these stairs will look like ... maybe they are stairs that you may have seen somewhere before ... or maybe they are fantasy ones ... but when you are ready ... you can proceed to walk down the stairs ... you can go down ... the first step ... the second step ... the third step ... the fourth step ... the fifth step ... and maybe there is even ... a railing to hold onto ... and now you can go down the sixth step ... the seventh step ... the eighth step ... the ninth step ... and the tenth step ... and walk away to a new place ... a calm ... beautiful place ... within you ... and maybe you can put the two of us ... in this safe inner place ... maybe you can even put others there too ... you can now imagine that you are sitting in front of a computer ... I am going to teach you something ... interesting ... because you know (Name) ... that with any problem ... and we all

- seeding of healthy eating habits
- seeding of uniqueness
- flexibility / movement
(FURTHER INTENSIFICATION OF TRANCE)
- covering all possibilities
- seeding of internal locus of control
- seeding of support in transformation of self and eating habits
- seeding of changing from old self to new self
- reassurance of being with the client during transformation process
- seeding of new learned behaviour of healthy eating habits
experience problems … and sometimes our self-concept … reaches a low ebb … a low tide … when you feel like … pulling back … when you feel like … giving up … and we say that … our self-confidence … our self-esteem … has reached a low ebb … a low tide … but 

I am going to teach you … a guaranteed cure … so when you are at a low ebb … you can get yourself on a … high tide … of your new … self … imagine that you’re going to … open files … in the computer … in front of you … you can open a file for your … self … which you can call … file one … your “Strong points” … those things (Name) that you acquired … over a period of time … like learning to read and write … like learning to walk … like learning to ride a bicycle … like learning to eat all by yourself … and you can make a C.D. recording … in your mind … of all your strong points … I wonder what you will select … as the very best of your inner best … self … you can allow … these strong points to pop up in your conscious mind … while on an unconscious level … you can save this information … let us move to file two … which you can call your “Frailties file” … those things that (Name) … is convinced you can … improve on

- seeding of learning new behaviour
- seeding of internal locus of control
- seeding of positive self-concept
- seeding of educational process of adopting healthy eating habits
- covering all possibilities
- conversational postulates
- flexibility / movement
... can **change** ... it is like going **shopping** at a supermarket ... and you notice items on a shelf ... that are unhealthy ... and on an unconscious level ... you can become aware of them ... you can even take them **off** the shelf ... and you can even **dust** them off ... you can put these frailties on a C.D. ... and they may even include ... **accepting yourself** ... and adopting **healthy eating habits** ... you know ... frailties can be worked on ... So far we have opened two files ... to build up ... your **high tide** ... we have done it in the (Name) way ... like the heavens ... with all the **unique stars** ... you can be your ... own ... **unique** ... **shining** ... star ... Let us **move** onto file three and you can call it “Successes of the past” ... those times when (Name) ... was a **winner** ... were you perhaps ... (therapist names successes obtained during the interview which were also used during ego-strengthening) ... were you perhaps the one ... who put on a costume ... and **walked** ... **comfortably** ... **confidently** ... along the beach? ... you can make a C.D. and save it as “My successes of the past” ... We have opened three files ... number one ... your “Strong points” ... number two ... your “Frailties file” ... number

- **seeding of choosing healthy food**
- **seeding of changing unhealthy eating habits**
- **seeding of positive self-concept and healthy eating habits**
- **seeding of positive self-concept**

- **tailoring**
- **age regression**
- **hyperamnesia**
- **seeding of succeeding**
- **tailoring**

- **ego-strengthening**
- **seeding of self-confidence**
three … your “Successes of the past” … so let us move onto file four and you can call it “Clarifying the SHOULDs” (therapist spells out word) … shoulds … you get outer shoulds … and inner shoulds … outer shoulds is like when your mother says … you should be like this … and your teacher says … you must be like that … these shoulds are important … because they give you hints … on how to … behave appropriately … but your inner shoulds are very important … your inner shoulds … should … know what is best for you … maybe your shoulds … could include … accepting your inner self … maybe your shoulds … could include … adopting healthy eating habits … you can make a C.D. and save this file … Let us move onto file five and you can call it “Present and future” … this is the working file (Name) … you can … cut things out … or you can … add things in … from the other files … and stick it in this file … and high … light … it … and you can stick it in file five … and you can … transform it … into something new … something that will help you … to accept … your self … in the present and the future … self … I am going to ask you (Name) … to do even more than that … you know … tough problems … need tough solutions (therapist says this loudly and in an

- seeding of self-acceptance
- seeding of adopting healthy eating habits
- seeding of adding in healthy eating habits
- seeding of sticking to healthy eating habits
- post-hypnotic suggestion
- age progression
authoritative manner) … go to file one “Your strong points” … and stick one of your many … positive … characteristics of the … self in it …
go to your “frailties file” … and stick your new transformation … of your inner self …
and your new … lifestyle transformation … and stick it in the Present and
future file … and you can allow your
self to experience … the new transformation … Let us move to file three … your
“Successes” … and choose one … that will be the energy … behind
the energy … and stick it in the Present
and future file … Let us move to file
four … your “Shoulds file” … and you can think of a helpful outer should … maybe
it could be … a healthy lifestyle … and
you can also choose a helpful inner
should … maybe it could be … accepting
and nurturing … your inner self … and you can stick it in your Present and
future file … and it can be used … out of
hypnosis … in your everyday life …
imagine you are in file five … and you are in a … future place … where you can learn
from this file five … ways that will … enhance your inner self and your healthy eating habits … and you can give yourself … a positive suggestion … that you will be able to
carry it over … into any situation … in which you find yourself … Let us make sure that we

• seeding of healthy eating habits

• post-hypnotic suggestion
save each file … one … your “Strong points” …
two … your “Frailities file” … three … your
“Successes of the past” … four … your
“Shoulds file” … five … your ”Present and
future file” … now the heavens are the limit
(Name) … and as a sign of your own ability to
… accept yourself … and stick to a healthy
lifestyle … you can allow your unconscious
mind … to give you … a sensation … that can
develop in your body … maybe it is a
satisfying … warm … tingling … sensation …
that can develop in your body … as a reminder
… that you have … inner control … as well as
… outer control … and with this in your inner
… and your outer … thoughts … you can
reorientate yourself to the … present … and
… future … self.

• hyperesthesia
• process suggestion
• seeding of
interactionism of mind
and body

(The TERMINATION OF TRANCE)

The client is encouraged to share their experiences after coming out of trance.

4.2.5.3 Duration
The duration of this session is approximately 60 minutes.

4.2.6 Session 6: Group therapy: Education on healthy eating habits: theory and practice

4.2.6.1 Objectives
The objectives of the sixth session are:
• to educate clients on healthy eating habits
• to enable clients to practice healthy eating habits
• to educate clients about the dangers of eating disorders.
4.2.6.2 Content

As an ice-breaker clients stand in pairs and one person becomes the tickler and the other person becomes the ticklee. The tickler compliments the ticklee with reference to physical and personality characteristics until the ticklee laughs. The roles are then reversed. A short discussion follows on how they experienced the exercise and why they think one tends to laugh when people complement us.

Using information sheets obtained from the Department of Health and the Directorate Nutrition in Pretoria the therapist educates the adolescents on healthy eating habits with regard to:
- why chicken, fish, meat, milk and eggs are needed by the body
- the importance of starchy foods in ones diet
- information about fortified foods
- the importance of including dry beans, split peas, lentils and soya regularly in ones diet
- why plenty of vegetables and fruits should be eaten every day
- why our bodies need fat, which fats and oils are good choices, and which fats and oils are not good choices
- using food and drinks containing sugar sparingly
- using salt sparingly and the importance of using iodated salt
- the importance of drinking clean water
- the health implications of eating junk food
- the importance of being active.

The therapist introduces the group therapy members to the Swedish Plate Model (see 3.3.3.1). Psycho-education continues with the therapist pointing out the dangers of eating disorders (see 3.3.3.1). Using a brochure on obesity obtained from the Heart Foundation South Africa, fad diets are discussed and clients are encouraged to share their personal experiences or views on dieting.
A discussion on hunger and satiety as well as alternative behaviour strategies (see 3.3.3) follows. Clients are asked to list and rank their three most avoidance foods and to share them with the group.

A practical application of the education with regard to healthy eating habits follows where clients are taken to lunch at a hostel. The therapist organizes a menu with the caterer, which would enable clients to experience the Swedish Plate Model recommendation. While eating, group therapy interaction is encouraged.

4.2.6.3 **Duration**
The duration of this session is approximately 90 minutes.

4.2.7 **Session 7: Individual therapy: Hypnotherapy: Hand levitation for undereaters and hand delevitation for overeaters**

4.2.7.1 **Objectives**
The objectives of the seventh session are:
- to facilitate the experience of the acceptance of self
- to facilitate the adoption of healthy eating habits.

4.2.7.2 **Content**
In this session the client will experience a mental rehearsal of accepting the self and adopting healthy eating habits. A hand levitation technique will be used for undereaters involving the symbolism of bringing food towards the mouth. A hand deleviation technique will be used for overeaters involving the symbolism of moving the hand away from the mouth in an attempt to stop the reflex of automatic eating.

The script for hand levitation is followed by the script for hand delevitation and is presented on the left-hand side of the page and the notes regarding hypnotic phenomena and Ericksonian principles appear on the right-hand side of the page.
HAND LEVITATION

Like your eating habits ... your unconscious mind has its own ... inner resources ... to help you ... to think ... rationally ... about your inner ... future ... self ... and it is going to be interesting ... to see if this is the right time ... to explore the problem of eating habits ... and on a conscious level ... you may begin ... to think ... which hand feels ... the lightest ... and on an unconscious level ... you can allow yourself ... to relax ... and to close your eyes ... On a conscious level you may ... think ... which hand feels the lightest ... and on an unconscious level ... you may experience ... which hand feels ... lighter ... and ... less heavy ... I do not know ... which hand it will be ... but ... let us ... think ... to the future ... to see what happens ... On an unconscious level ... you might be aware ... that under one of your hands ... air could flow ... or water could flow ... underneath ... as light as a feather ... as buoyant ... as a ... water molecule ... and perhaps

(TRAVERSE INDUCTION)

- seeding of rational thinking
- age progression
- seeding of problem becoming manageable
- age progression
you can ... give me an indication ... of which hand it is ... and then in your imagination, imagine how air moves ... it upwards ... as if a helium balloon ... is tied to it ... and lifts it into the air ... and imagine ... in your imagination ... how water ... can gently ... flow ... under your hand ... as it lifts off your leg ... that’s right ... as light as a feather ... as buoyant as a water molecule ... effortlessly ... lifting with every ... breath you take ... your hand feels lighter ... and lighter ... and this reminds me of a story ... of Nemo ... maybe you have even seen the movie ... Nemo is a fish ... who hurt his fin ... and his father wanted him to stop swimming ... but Nemo badly wanted to swim ... so he swam away with other fish ... who encouraged him ... to swim ... despite his fragile ... fin ... they encouraged him by singing ... “Keep on swimming ... swimming ... swimming” ... they were really saying (Name) ... “Keep on trying ... trying ... trying” ... well done ... your unconscious mind is ... thinking great work ... that’s right ... as your hand moves ... effortlessly ... every breath ... that

- seeding of ease of experiencing transformation

(DEEPENING OF TRANCE)
- metaphor

- seeding of fragile self
- flexibility / movement

- seeding of ease of experiencing transformation
you take … you may experience … your energy … **flowing** through into my hand (therapist positions hand lightly and helps to elevate client’s hand without touching it) … there we are … that’s right … just like Nemo … you can keep on trying … to achieve … **healthy ways** … to succeed … at things … you want to achieve … You can ask your unconscious mind … to lead your hand to your face … here near your **chin** … and you can ask your unconscious mind … if it is possible … to allow your hand … to become still … as if … it has a **support** … like a **table** under it … nice and **appetizingly** … **set** … and you can think … of your favourite food … and maybe you can … step inside … the picture … inside your imagination … and you can see … your favourite fruit … and you can … wash it off … and hold it up to the **light** … and the water molecules … reflect the beautiful colours … of a rainbow … and you can picture yourself … sitting comfortably … at the table … and your glands … undergo **changes** as they **anticipate** … the taste of the fruit … and you can

(DEEPENING OF TRANCE)

- seeding of comfort
- positive hallucination
- imagery
- seeding of anticipated changes
- positive hallucination
imagine yourself … taking a bite of … your favourite fruit … and you can allow yourself to experience … how you nourish … your body
(Name) … in a new manner … or … habit … of practicing … your healthy experience … in your one of a kind … kind of way … and you can remind yourself that you are you … in all the world there is no-one else like you … and you can allow your hand to lower itself slowly towards … your lap … and on the way down … you can imagine … how you will apply … your new habits of eating … as you nourish your inner self and your outer self … and I don’t know when you will experience the change in eating habits because … (Name) … you and I both know … that you own … everything about you … your mind … including all its thoughts … your body … and everything it does … and as you trust your … healthy unconscious mind … you can congratulate yourself … by opening and closing your mouth … and you will be surprised how easy it will be … to feel more in control of your eating habits … and like Nemo … you can keep on … swimming … swimming …

- seeding of the importance of nutrition
- seeding of practicing healthy eating habits
- seeding of self-efficacy
- association
- seeding of uniqueness and of being kind to the self
- seeding of being special
- seeding of eating process
- post-hypnotic suggestion
- flexibility / movement
swimming ... and ... trying ... trying ... trying... you can congratulate (Name) ... for allowing your ... inner self ... to have this ... appetizing ... positive ... experience ... and when you have completed this ... new ... experience ... you can re-orientate yourself to the here and now.

HAND DELIVITATON
May I touch your left hand? ... lift it up ... and find a spot ... on your thumb ... or on your index finger ... and like your eating habits ... your unconscious mind has its own ... unique ... inner resources ... to help you ... to think ... rationally ... about ... your inner future ... self ... and it is going to be ... interesting ... to see if this is the right time ... to explore the problem of eating habits ... and on a conscious level ... you may begin ... to think ... about what interesting changes ... are going to take place ... in your hand ... which is part of ... your body ... and on an unconscious level ... you can ... allow yourself ... to relax ... and to close your eyes ... ...

(TERMINATION OF TRANCE)
• seeding of looking forward to eating

(TRANCE INDUCTION)
• seeding of rational thinking
• age progression
• seeding of problem becoming manageable

... On a conscious level you will
begin to think ... when your hand will begin to feel heavier ... and on an unconscious level ... you can allow ... your hand ... and your arm ... to feel heavy ... and allow it ... to start ... lowering itself ... as it drifts downwards ... like a river ... effortlessly ... without any cares in the world ... that's right ... as energetic as water molecules ... and this reminds me of a story ... of Nemo ... maybe you have even seen the movie ... Nemo is a fish ... who hurt his fin ... and his father wanted him to stop swimming ... but Nemo ... badly wanted to swim ... so he swam away with other fish ... who encouraged him ... to swim ... despite his ... fragile ... fin ... they encouraged him by singing ... “Keep on swimming ... swimming ... swimming” ... they were really saying (Name) ... “Keep on trying ... trying ... trying” ... well done ... your unconscious mind is thinking great work ... that's right ... as your hand moves ... effortlessly ... with every breath ... that you take ... flowing through ... into my hand (therapist positions

- flexibility / movement
  (DEEPENING OF TRANCE)
- metaphor

- seeding of fragile self

- flexibility / movement

- seeding of ease of experiencing transformation
hand lightly midway down to help
to lower hand without touching it) …
there we are … that’s right … like a
magnet that pulls your hand … towards
your lap … you can allow yourself … to
judge how far it is … from your lap … as
you feel lighter … maybe it is 40 cm …
or 30 cm … or 20 cm … closer … lighter
... and as your hand moves closer …
to reduced … centimeters … you can
allow yourself to experience … your own
sense … of self control … your own
sense of soothing … your own … inner
… self … and as your hand touches your
lap … you can allow yourself … to take a
journey to your inner world … of a movie
... and as you imagine … a movie screen
... you can step inside … the picture ...
inside your imagination … and you can
see … your new self … going out to
dinner … and you can imagine
that you are dancing … to
soothing music with someone
special … and as you dance …
you can allow the music to fill you
... in a satisfied kind of … habit
... and maybe on an unconscious
level … you can think … it does not
make sense … but maybe on
a conscious level … you can
experience what … makes sense

• self-efficacy
• seeding of losing weight
• seeding of internal locus of control
• seeding of satiety
• imagery
• flexibility / movement
• positive hallucination
• seeding of alternative behaviour to overeating
• seeding of satiety
to you ... as you spoil yourself ...
to think what you want to think ...
as you nourish ... your body
(Name) ... in a new manner ...
in your one of a kind ... kind of
way ... and you can remind your
self that you are you ... in all the world
there is no-one else like you
... and you can imagine ... how you
will apply ... your new healthy
habits ... you will be surprised how
easy it will be to feel more in
control of your eating habits ...
as you nourish your inner self ...
and your outer self ... because
(Name) ... you and I both know ...
that you own ... everything about
you ... your mind ... including all
its thoughts ... your body ... and
everything it does ... and as you
trust your ... healthy unconscious
mind ... you can congratulate
yourself ... as you dance ... in a
... fitting ... outfit ... and like
Nemo ... you can keep on ...
dancing ... dancing ... dancing ...
and ... trying ... trying ... trying ...
you can congratulate ...
yourself (Name) ... for allowing
your ... inner self to have this
... fulfilling ... satisfying ...

• tailoring
• seeding of new way of
  nourishing body
• seeding of self-esteem

• post-hypnotic suggestion

• positive hallucination
• seeding of a more comfortable
  body
• flexibility / movement
• seeding of feelings of satiety
experience … and when you
have completed this … new …
experience … you can
re-orientate yourself to the here
and now. (TERMINATION OF TRANCE)

The client is encouraged to share the experience with the therapist when re-orientated. As homework, the client is asked to allow his/her future self to write a letter or a rap or a poem or a song to his/her present self.

4.2.7.3 Duration
The duration of this session is approximately 45 minutes.

4.2.8 Session 8: Group therapy: Picture Perfect and message from the future self to the present self

4.2.8.1 Objectives
The objectives of the eighth session are:
• to make clients aware of how the media creates a “picture perfect” image of what the ideal appearance of a male or female should be in order to be acceptable in society
• to enhance the client’s transformation of self by inviting them to share the message of their future self to their present self.

4.2.8.2 Content
As an ice-breaker clients say their name in such a way that one can detect how they feel at the moment. For example, if they feel tired, they would say their name in a slow and tired manner.

The first part of the session is spent discussing how the media depicts picture perfect men and women and how these ideal portrayals can be internalized by people
resulting in a possible low self-concept and unhealthy eating habits. A practical application to what has been discussed follows, whereby clients choose a picture in a magazine that falsely informs the reader of what a male and female should look like in order to comply with the norms in society. Each group member shares his/her picture and motivates why it depicts a picture perfect scenario and the detrimental effect it could have on the reader with regard to self-concept and eating habits.

The second part of the session is spent sharing their letter or rap or poem or song in which their future self speaks to their present self. The session terminates with members standing in a circle and turning to their right and giving the person in front of them a shoulder rub followed by their turning to the left and giving the person in front of them a shoulder rub.

4.2.8.3  Duration
The duration of this session is approximately 60 minutes.

4.2.9  Session 9: Individual therapy: Gift-wrapping

4.2.9.1  Objectives
The objectives of the ninth session are:

- to present the client with a gift that is wrapped and tailored to suit his/her needs
- to discuss relapse prevention.

4.2.9.2  Content
Depending on what the client brings to the fore during therapy, the therapist will present the client with a gift in hypnotherapy that has been tailored and gift-wrapped according to The Ericksonian Diamond (see 3.4.4.1). The gift will be presented in chapter 6 since the therapist would have to utilize what the client reveals during therapy. A discussion on relapse prevention will take place in which the client brainstorms how he/she will cope with situations where he/she relapses with regard to eating habits.
4.2.9.3  **Duration**  
The duration of this session is approximately 30 minutes.

4.2.10  **Session 10: Post-testing and feedback on programme**

4.2.10.1  **Objectives**  
The objectives of the tenth session are:

- to measure self-concept
- to measure eating habits
- to measure Body Mass Index
- to obtain feedback on the programme.

4.2.10.2  **Content**  
After a period of eight months the client’s self-concept, eating habits and Body Mass Index will be measured to establish if improvement with regard to these variables have taken place. The same measuring instruments used in table 5.1 will be used. The therapist will provide feedback as to their progress and a general discussion will follow on how the client has viewed the process of cognitive-behaviour and hypnotherapy as intervention programmes.

4.2.10.3  **Duration**  
The duration of this session is approximately 90 minutes.

4.3  **CONCLUSION**  
This chapter focused on the development and content of the Psycho-educational programme for adolescents with unhealthy eating habits. Each session was described in terms of objectives, content and duration. Chapter five deals with the research design.
5.1 INTRODUCTION
In this study multiple methods of data collection and analysis are used involving mainly a qualitative design. A qualitative mode of inquiry, which includes phenomenological and descriptive case studies have been chosen. Since it involves a small number of subjects and concerns the person-in-totality, an idiographic approach is used encouraging active participation of clients so as to emphasize the important role of adolescents as researchers.

In this chapter, a description of the research paradigm and methods using idiographic principles will be outlined. The chapter will consist of the research problem, aim of the empirical investigation, the research paradigm, the research method and research tools. Thereafter, a selection of the sample, ethical issues, trustworthiness, the researcher as participant and processing of the results will follow.

5.2 THE RESEARCH PROBLEM
The underpinning research question of this study is: Will low self-concept and unhealthy eating habits of adolescents improve when they are exposed to a Psycho-educational programme involving the principles of cognitive-behaviour therapy and hypnotherapy?

5.3 THE AIM OF THE EMPIRICAL INVESTIGATION
The investigation is aimed at:
- applying a support programme to improve low self-concept and unhealthy eating habits of adolescents
- implementing the principles of cognitive-behaviour therapy and hypnotherapy in a Psycho-educational programme
• determining the influence of the Psycho-educational programme on self-concept and eating habits of adolescents.

5.4 THE RESEARCH PARADIGM
The ontology of the study is based on the belief that the reality of unhealthy eating habits and low self-concept consists of people’s subjective experiences of the internal and external world as well as a socially constructed reality and is therefore both interpretative and constructionist in nature. This study involves an empathetic, observer intersubjectivity, interactional epistemological stance towards reality. Methodologies used (such as interactional, interpretative, qualitative, textual analysis) are positivist, interpretative, constructionist in nature and rely on an objective assessment of eating habits and self-concept as well as a subjective relationship between the researcher and subject.

5.5 THE RESEARCH METHOD
Various approaches are implemented in different phases of the research process. The programme involves a pre-test post-test follow-up design. Adolescents were recruited by means of introducing the study at schools in Nelspruit. Volunteers completed a self-concept and eating habits questionnaire. Participants were selected according to the criteria of having low self-concept and unhealthy eating habits.

Nine adolescents participated in the programme involving interviews, projection tests, observation, cognitive-behaviour and hypnotherapy. The procedure for gathering data included audio taped interviews that were transcribed as well as written responses. Research involved a post-test follow-up eight months after treatment. The post-test included a questionnaire on self-concept and eating habits and a pre-test post-test follow-up of Body Mass Index was conducted.
Qualitative research attempts to describe the life worlds of the people who participate and therefore contributes to a better understanding of social realities (Flick, von Kardorff & Steinke 2004:3). The literature study reveals that more quantitative than qualitative research has been done in the field of eating habits (see 1.4.1). Qualitative modes of inquiry have been chosen for this study, involving the active participation of the clients in order to encourage the important role of adolescents in research. The research design will include methods of inquiry such as phenomenological, descriptive case studies and ground theory research designs.

The phenomenological research design will involve in-depth interviews with adolescents to obtain their perspectives on how to make sense out of the experience of low self-concept and unhealthy eating habits and includes:

- increasing an understanding of the lived experience of low self-concept and unhealthy eating habits
- transforming the lived experience into a description to understand more fully its essence.

The case study research design involves an extensive description of the cases based on a variety of data sourced such as observation, questionnaires, interviews and dietary records, to gain an in-depth understanding of the practice of unhealthy eating habits.

Because the problem of self-concept and eating habits is dealt with in a person-orientated manner, the idiographic approach is used but more than one case study and group therapy will be approached.
5.6 MEASURING INSTRUMENTS

The inclusion of a variety of assessment media enables the client to gain more self-knowledge and to help the client to give meaning to aspects of the self. When clients have a realistic understanding of self-concept and eating habits, they may gain more self-confidence in their ability to adopt a healthier lifestyle.

A summary of the measuring instruments used and the variables measured is provided in Table 5.1. The researcher has included an example of the measuring instruments in Appendix A - I. A description and motivation for using these instruments follows the table.

Table 5.1 Measuring instruments and variables measured

<table>
<thead>
<tr>
<th>Measuring instruments</th>
<th>Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Body Mass Index (BMI)</td>
<td>• weight</td>
</tr>
<tr>
<td>• Adolescent Self-concept Scale (ASCS)</td>
<td>• self-concept</td>
</tr>
<tr>
<td>• Eating Habits Questionnaire for Adolescents (EHQA)</td>
<td>• eating habits</td>
</tr>
<tr>
<td>• Emotions Profile Index (EPI)</td>
<td>• emotions</td>
</tr>
<tr>
<td>• Draw A Person (DAP)</td>
<td>• self-concept</td>
</tr>
<tr>
<td>• Sentence Completion</td>
<td>• self-concept / eating habits</td>
</tr>
<tr>
<td>• Dietary Record</td>
<td>• eating habits / cognitive thinking</td>
</tr>
<tr>
<td>• Interview</td>
<td>• resources</td>
</tr>
<tr>
<td>• Observation</td>
<td>• self-concept / eating habits</td>
</tr>
</tbody>
</table>
5.6.1 **Body Mass Index (BMI)**

The measuring and classification of body mass is done by calculating a person’s Body Mass Index. It is calculated by dividing a person’s weight in kilograms by the square of his/her height in metres and is compared to a BMI classification table.

The World Health Organisation uses the BMI classification that appears in Table 5.2 (Gleick 1999:52). For example, a person who weights 70 kg and is 1,75m tall will have a BMI of 22,9 that lies within the normal range (18,5 – 24,9) of weight classification i.e. \( 70 \div (1,75 \times 1,75) = 22,9 \).

**Table 5.2 BMI classification (Gleick 1999:52)**

<table>
<thead>
<tr>
<th>CLASSIFICATION</th>
<th>BMI (kg/m²)</th>
<th>RISK OF CO-MORBIDITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>&lt; 18,5</td>
<td>Low (but risk of other clinical problems increase)</td>
</tr>
<tr>
<td>Normal range</td>
<td>18,5 – 24,9</td>
<td>Average</td>
</tr>
<tr>
<td>Overweight</td>
<td>&gt;25</td>
<td>Increase</td>
</tr>
<tr>
<td>Pre-obese</td>
<td>25 – 29,9</td>
<td>Increase</td>
</tr>
<tr>
<td>Obese class I</td>
<td>30,0 – 39,9</td>
<td>Moderate</td>
</tr>
<tr>
<td>Obese class II</td>
<td>35,0 – 39,9</td>
<td>Severe</td>
</tr>
<tr>
<td>Obese class III</td>
<td>35,0 – 39,9</td>
<td>Very severe</td>
</tr>
</tbody>
</table>

In private, a bathroom scale is used to measure weight and a tape measure is used to measure height as the client stands against the wall.
5.6.2 Adolescent Self-concept Scale (ASCS)

The Adolescent Self-concept Scale will be used to measure the self-concept of the subjects. The test consists of the following constructs:

- an overall self-concept
- Dimension I - the physical self – the self in relation to physical factors
- Dimension II - the personal self – the self in relation to its own psychological relationships
- Dimension III - the family self – the self in relation to family relationships
- Dimension IV - the social self – the self in relation to social relationships
- Dimension V - the moral-ethical self – the self in relation to moral, religious norms
- Dimension VI - self-criticism – the self in relation to self-criticism.

Each dimension is measured with regard to identity, acceptance and behaviour in that particular dimension (Vrey & Venter 1983). The measuring instrument is based upon the premise that "... the self-concept is a configuration of convictions concerning oneself and attitudes towards oneself that is dynamic and of which one normally is aware or can become aware of" (Fredericks 1998:50). The statements in the measuring tool requires that the testees indicate: how they identify with each dimension; to what extent they experience acceptance and satisfaction with regard to each dimension and the behaviour that the person is involved in, in respect of the six dimensions of self-concept.

A person receives a booklet and pencil. Two contrasting descriptions are provided and the subject decides which of the descriptions A or B best describes him/her (Appendix A). No time limit is enforced. The correct responses are added to calculate the total general self-concept. The testee’s total self-concept scores are divided into the three categories as follows in Table 5.3.
Table 5.3 Categories of the Self-concept Scale

<table>
<thead>
<tr>
<th>Raw Score</th>
<th>Stanine</th>
<th>Total Self-concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 – 55</td>
<td>1, 2, 3</td>
<td>Low</td>
</tr>
<tr>
<td>56 – 70</td>
<td>4, 5, 6</td>
<td>Average</td>
</tr>
<tr>
<td>71 - 90</td>
<td>7, 8, 9</td>
<td>High</td>
</tr>
</tbody>
</table>

The items have also been grouped according to the different dimensions of the self-concept and the score for each dimension is calculated separately. After the administering of a Psycho-educational programme, the Adolescent Self-concept Scale will again be administered and the results will be compared, to establish if the self-concept has improved.

5.6.3 Eating Habits Questionnaire for Adolescents (EHQA)

The Eating Attitudes Test (EAT – 26) and the Eating Behaviour Test (EBT) measure symptoms characteristic of eating disorders. The researcher therefore developed a questionnaire that could be used to measure eating habits of adolescents (Schnel 2001:105).

The questionnaire (Appendix B) consists of two sections namely Section A and Section B. In Section A, biographical information is obtained and consists of 28 items. Biographical information is obtained with regard to the following factors:

- participation in sport
- relationship with parents
- knowledge of nutrition
- birth order
- physical appearance of parents
- physical profile – height and weight
- gender.
Section B measures a person’s eating habits and consists of 86 items. Dimensions measured include four dimensions namely:

(i) external factors (the influence of parents, friends and the media)
(ii) emotional aspects (the effect of emotions on eating habits)
(iii) knowledge of nutrition
(iv) behaviour (type of eating behaviour and participation in physical activities).

In Section B, each item has a negative and a positive pole with a scale of 1 to 4 ranging in-between. The following numbers and codes are used:

1 = ALWAYS
2 = USUALLY (OFTEN)
3 = RARELY (HARDLY EVER)
4 = NEVER

If the testee chooses “always” for certain items, he/she scores 4 points and for other items “always” scores 1 point. “Always” is a negative alternative when the item scores 4 points and a positive alternative when the item scores 1 point.

The scoring is reversed when code number 1 “always” is chosen as a positive alternative and therefore scores 1 point.

The following items are reversed: 1, 2, 3, 5, 9, 12, 28, 30, 32, 37, 39, 41, 42, 43, 45, 46, 47, 49, 53, 54, 55, 56, 57, 58, 60, 63, 64, 67, 71,

A total score for the questionnaire is obtained and the higher the score, the unhealthier the eating habits. The raw scores of the EHQA are transformed into stanines and appear in Appendix C. The limits and areas of stanines and the classification of eating habits appear in Table 5.4. The researcher agrees to the inclusion of the norms in the appendices.
Table 5.4 Limits, areas and classification of Eating Habits Questionnaire for Adolescents

<table>
<thead>
<tr>
<th>Stanine</th>
<th>Limits</th>
<th>% of Area</th>
<th>Classification of eating habits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>64 – 105</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>106 – 112</td>
<td>7</td>
<td>Good</td>
</tr>
<tr>
<td>3</td>
<td>113 – 120</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>121 – 128</td>
<td>17</td>
<td>Average</td>
</tr>
<tr>
<td>5</td>
<td>129 – 138</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>139 – 147</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>148 – 158</td>
<td>12</td>
<td>Bad</td>
</tr>
<tr>
<td>8</td>
<td>159 – 172</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>173 – ∞</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

For the purpose of this study the researcher used the total score as an indicator of the person’s eating habits. It is recommended that further research should include the four dimensions in the assessment of eating habits. The distribution of the items in the various dimensions, used in Section B, appear in Appendix D.

5.6.4 Emotions Profile Index (EPI)

The Emotions Profile Index is a measuring instrument developed on the theory of Plutchik and Kellerman (1974) that states “the theory postulates that personality traits are generated by the mixture of basic emotions. This proposition implies that a wide variety of personality traits may be analyzed by reference to a few basic categories” (Laubscher 1993:128). The measuring instrument provides information with regard to the emotions and conflicts that pertain to a person. It reveals problem areas and the nature of these problems. Conflict areas on the Emotions Profile Index can indicate the insecurities and emotions that may prevent the development, in the case of this study, of a positive self-concept and healthy eating habits.
Two contrasting descriptions are provided and the subject decides which characteristic best describes him/her (Appendix E) for which there is no time limit. The raw score is converted into a percentile and a separate score sheet is used for males and females. A percentile of 70 and higher and a percentile of 40 and lower are indicative of unstable emotions with regard to that dimension. The following dimensions are measured, namely:

- Gregarious dimension (Reproduction)
- Trustful dimension (Incorporation)
- Dyscontrol dimension (Orientation)
- Timid dimension (Protection)
- Depressed dimension (Reintegration)
- Distrustful dimension (Rejection)
- Control dimension (Exploration)
- Aggressive dimension (Destruction).

The results are presented in a circular profile that makes it easy to interpret emotional behaviour and conflict areas.

5.6.5 **Draw A Person (DAP)**

Projective techniques are instruments in which the client can feel encouraged to freely describe inner feelings, by projecting them onto a setting that is supposedly unrelated to the respondent (Parasuraman in Vollaster & Koll 2003:45). Human Figure Drawings are used to measure the developmental level and emotional characteristics of a person (Dorfman & Hersen 2001:275).

The Draw A Person projection test will be used in this study to glean an understanding of the client’s life world and to create a relaxed atmosphere between the therapist and the client. The client is asked to draw a person and on completion the therapist asks the clients questions. For the purpose of this study the therapist has formulated some of her own questions designed to focus on the client’s relationship with the self, others

5.6.6 Sentence Completion

According to Pablo (in Jacobs 1985:231) projection is “... a sort of a psychological screen on which we project an adventurous film of our inner experience, of our inner world, sometimes as it is, at other times as we would like it to be”. Sentence Completion is a non-standardized test in which clients complete sentences and can be used to identify interests and problem areas.

The researcher has developed a Sentence Completion sheet of twenty questions (Appendix G). The test will be administered individually, there is no time limit and reactions of the client to particular sentences will be noted.

The interpretation of the Sentence Completion will involve:

1. Reading the sentences to obtain an overall picture of the content and a report on the following questions:
   - is the general (affective) undertone positive, neutral or negative?
   - what impression does one have with regard to the client’s involvement with the task to complete the sentences? (absorbed, half hearted / role active / role passive).

2. Reading the sentences again in order to identify themes and state hypotheses regarding:
   - the clients relationships.
   - the client’s involvement, experience and significance attribution (Dorfman & Hersen 2001:140).
5.6.7 **Dietary Record**

The Dietary Record will be used to identify the cognitive, emotional and situational antecedents associated with unhealthy eating habits (Golden, Dowd & Friedberg 1987:75). The client keeps a record of the time, place, activity, thoughts and feelings experienced during eating (Appendix H). The Dietary Record will be analyzed by the therapist and client during therapy.

5.6.8 **Interview**

The therapist will attempt to conduct the interview from an external frame of reference in order to gain an understanding of the client’s experiences, circumstances and emotions. A client’s frame of reference is formed by:

- ideals and expectations obtained in identification with significant others
- cognitive structure and development
- feelings and values determined by his/her norm’s
- self-knowledge and previous experiences

(Laubsch 1993:134).

In order to gain insight into the client's internal frame of reference, the therapist would have to develop an atmosphere of trust, empathy, awareness, understanding and unconditional acceptance. An interview (Appendix I) is conducted with the client to obtain information about the person and to enable the therapist to develop a psychological profile. The positive resources are identified and used in hypnotherapy. The interview enables the therapist to gather information with regard to:

- biographical information
- medical history
- behaviour patterns
- earlier history (resources)
- relationships
- faith
- physical activities
- hobbies
• reason for living
• what the client expects from therapy.

5.6.9 Observation
The technique of observation allows one to grasp individuals’ behaviour at the moment it occurs and one of the major weaknesses of observing behaviour of the observed group is that ‘natural’ behaviour may be replaced by ‘strategic’ behaviour (Vollaster & Koll 2003:45). The researcher is aware that one can observe inaccurately and seek to avoid such errors by making observation a deliberate and careful activity. The researcher is also aware that one tends to jump to general conclusions on the basis of only a few observations and has therefore used a variety of media for diagnosis of low self-concept and unhealthy eating habits. In this study prior approval of the observation procedure by the group members may enable them to behave naturally in group therapy.

5.7 SELECTION OF THE SAMPLE
The research sample consists of a sample of adolescents based in Nelspruit and the greater Nelspruit area who volunteered to become involved in the research programme since people who volunteer their participation tend to be more motivated (de Vos, Strydom, Fouché & Delport 2002:336). The adolescent’s ages would range from 12 to 18 years and no differentiation will be made in respect of culture, religion, race or socio-economic status.

In this study thirteen girls and two boys wrote the Adolescent Self-concept Scale and Eating Habits Questionnaire for Adolescents. The two boys dropped out of the programme because they did not want to participate in group therapy; four of the girls had high self-concepts and average eating habits and were therefore excluded from the programme. The remaining nine girls were selected as case studies and subjected to further assessment namely: Body Mass Index, Emotions Profile Index, Draw A Person and Sentence Completion.
5.8 ETHICAL ISSUES

Ethics can be defined as a set of moral principles widely accepted, and offer rules and behavioural expectations about correct conduct towards subjects (de Vos, Strydom, Fouché & Delport 2002:63). The researcher is aware that ethical issues need to be taken into consideration when conducting research.

Interviewing clients is a form of social interaction and the combined behaviour of the interviewer and the interviewee dictate the nature of the relationship that develops. The researcher argues that interviewing is far more constructive when therapists invest their own personality in the relationship instead of a hierarchical one. It is the researchers experience that adolescents do not ‘open up’ when a hierarchical relationship such as teacher-learner, parent-child is created. Considering that the researcher sees the client for ten sessions it would be impossible to avoid personal investment and reciprocity in the interview sessions.

In this study the researcher’s commitment is to black and white youth and is therefore adhering to ethical fundamental principles of equality and participating democracy. Clients were informed that they would be participating in group therapy and would engage in homework assignments. They were also informed that they would not be passive recipients of treatment and would have to become active participants that gave clients an opportunity to drop out of therapy.

The research was conducted by the researcher as an educational psychologist in private practice. Participation in the research programme was voluntary and participants were in no way forced to participate. The fundamental ethical rule that the research design must not bring any harm to the research subjects was adhered to. Although subjects shared private details of their lives, the researcher maintained confidentiality. The subjects were in no way deceived as to the purpose of the research and information released was done with the clients informed consent so as to avoid embarrassing subjects, endangering their relationships with significant others or threatening their self-image. Subjects felt that since they were part of the research
process the publishing of some of their research results could benefit other researchers. The researcher has given participants the opportunity, as a matter of principle, of expressing their opinion on the planned content before publication. The participants and their parents signed a document as proof of their informed consent (see Appendix K).

Permission was obtained from participants to record interviews on tape. The researcher acknowledges that a tape recorder allows the researcher to gain a fuller record of information but argues that participants tend to feel uncomfortable when being taped and in her experience has found that clients talk softer making it difficult for the therapist to ‘stay with the client’s’ thoughts and emotions.

5.9 TRUSTWORTHINESS
When a measuring instrument is developed, an attempt is made to obtain a reliability coefficient as close to 1 as possible. The closer the reliability of a measuring instrument is to 1, the smaller the difference is between the variance of the actual score and the observed score.

In the current study the Adolescent Self-concept Scale and the Eating Habits Questionnaire for Adolescents in conjunction with the Body Mass Index will be used during pre-testing and post-testing of self-concept and eating habits. The reliability of the Adolescent Self-concept scale using the test re-test method was found to be 0,89 (Vrey & Venter 1983:24). The Alpha reliability coefficient for the Eating Habits Questionnaire for Adolescents was found to be 0,83 (Schnel 2001:108). A variety of other media such as the Emotions Profile Index, Draw A Person, Sentence Completion, Dietary Record, interview and observation is used to gain a clearer understanding of the client’s life world, frame of reference and inner resources which the client projects through these media and is used in therapy.
The researcher is aware that the internal and external validity of a qualitative inquiry may be debatable. Lincoln and Guba (2002:35 in de Vos, Strydom, Fouché & Delport) propose alternative constructs namely credibility, transferability, dependability and confirmability that reflect the assumptions of the qualitative paradigm. Credibility refers to the internal validity in which the subject is accurately identified and described. Transferability refers to the external validity in which one set of findings is generalised to another context. The researcher realises that this could be problematic since qualitative findings cannot always be generalized to other populations and would therefore have to clearly define the theoretical parameters of the research. Dependability refers to reliability and researchers would have to take into account that the social world is not unchanging and therefore replication could be problematic. Confirmability refers to objectivity and that the findings of the research could be confirmed by another when considering the data.

5.10 THE RESEARCHER AS PARTICIPANT

Educational practice is said to become the test before theory, and its practitioners become the active participants (Welland & Pugsley 2002:11). Although the research was done from the domain of a private practitioner, the researcher has remained in the education sector and is able to be a participant in research since she does not have to market any criteria. The researcher spends time observing, recording and participating in some aspects of the clients' lives, their routines and experiences. Participation on the part of the researcher is a learning experience and an opportunity to gain more knowledge about the phenomenon being investigated.

In group therapy the group's formal leader remains the psychotherapist but in order to provide psychotherapy for the group members, the researcher/therapist as participant has to locate and work with the group processes. As a therapist working with a group of adolescents, one would have to become attuned to the group. As a participant, the therapist would have to become competent in the group processes on both a verbal and a non-verbal dimension.
5.11 PROCESSING THE RESULTS
The researcher, by means of pre- and post-test administration of the Adolescent Self-concept Scale, Eating Habits Questionnaire for Adolescents and Body Mass Index would interpret and report the data and assessment findings. The researcher would use ideographic research tests that would then be marked and interpreted. By comparing the pre- and post-test results the researcher will determine whether there was an improvement in self-concept and eating habits.

5.12 CONCLUSION
The research design was described in this chapter. Attention was given to the research problem, aim of the investigation, the research paradigm, the research method, the research tools, selection of the sample, ethical issues, trustworthiness, the researcher as participant and processing the results. It must be noted that cognitive-behaviour therapy and hypnotherapy takes place over a period of four and a half months and that the post-testing takes place eight months after the ninth session. Chapter 6 deals with the report of the findings of the empirical investigation.
CHAPTER SIX
FINDINGS OF THE EMPIRICAL INVESTIGATION

6.1 INTRODUCTION
By means of idiographic research, nine case studies are reported of which four will be presented in this chapter and the remaining five can be found in Appendix L. With regard to the empirical investigation, findings are described according to: diagnostic assessment, group therapy and findings after applying the programme which includes a presentation of the case studies, an integration of the results and feedback regarding the Psycho-educational programme.

For ethical reasons, the names of the clients have been changed but the information about the client provided remains authentic. All the case studies were females because the male subjects who initially participated in testing dropped out when they heard that they would participate in group therapy. Of the nine case studies, eight participants had low self-concepts and all participants had unhealthy eating habits. The client with a medium self-concept was included because her self-concept was bordering a low self-concept, her eating habits were classified as extremely unhealthy, she was very overweight and she was very enthusiastic about participating in the Psycho-educational programme. Pictures and quotes from the findings are provided which will make the study more information-rich as well as integrating the voice of the subjects.

6.2 FINDINGS OF DIAGNOSTIC ASSESSMENT
An outline of the findings of the diagnostic assessment using the Eating Habits Questionnaire for Adolescents, Body Mass Index, Adolescent Self-concept Scale, Emotions Profile Index, Draw A Person, Sentence Completion, Dietary Record and the interview are provided below.

6.2.1 Eating Habits Questionnaire for Adolescents and Body Mass Index
Findings of the Eating Habits Questionnaire for Adolescents indicated that every participant could be diagnosed with unhealthy eating habits. According to the Body Mass Index of the nine case studies, three were diagnosed as underweight (case studies A, B, C), three were of normal weight (D, E, F) and three were overweight
Case studies D, E, F was included because they could be diagnosed with unhealthy eating habits and low self-concept.

6.2.2 Adolescent Self-concept Scale
According to the Adolescent Self-concept Scale, eight of the case studies were diagnosed with low self-concept and one with a medium self-concept bordering on a low self-concept. The lowest dimension of the self-concept in eight of the nine case studies was the Physical dimension and one case study, the Values dimension. Pre-test and post-test scores are provided in table 6.6.

6.2.3 Emotions Profile Index
The Emotions Profile Index revealed that the emotions profile was unique to each participant and no significant pattern of emotions could be diagnosed pertaining to all clients. The results are outlined in Table 6.1.

Table 6.1: Results of Emotions Profile Index

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Number of Case Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High scores</td>
</tr>
<tr>
<td>GREGARIOUS</td>
<td>4</td>
</tr>
<tr>
<td>TRUSTFUL</td>
<td>3</td>
</tr>
<tr>
<td>DYSCONTROL</td>
<td>2</td>
</tr>
<tr>
<td>TIMID</td>
<td>2</td>
</tr>
<tr>
<td>DEPRESSED</td>
<td>3</td>
</tr>
<tr>
<td>DISTRUSTFUL</td>
<td>1</td>
</tr>
<tr>
<td>CONTROL</td>
<td>1</td>
</tr>
<tr>
<td>AGGRESSIVE</td>
<td>2</td>
</tr>
<tr>
<td>BIAS</td>
<td>1</td>
</tr>
</tbody>
</table>
6.2.4 **Draw A Person**

Emotional indicators of Draw A Person include:

- short arms in relation to body size which may indicate a tendency to withdraw or turning inward in an attempt to inhibit impulses
- light lines, rubbing out, extensive colouring in, shading of face which may indicate anxiousness, insecurity and low self-concept
- feet in opposite directions which significantly occurred in five of the case studies and may indicate a problem with feelings towards their education or upbringing
- a left out chin which may indicate feelings of inferiority
- shading of arms and hair which may indicate aggressive impulses
- arms or hands behind the back which may indicate feelings of guilt or hiding something
- head only which may indicate fearfulness of thoughts concerning the body
- drawing done in middle of page or left side of page which may indicate tension, self-awareness and insecurity
- faces illustrating blank stares and lack of emotion which may indicate a negative disposition.

Recurring themes that emerged from the questions asked about the person drawn included: a popular person because of having a nice body, a perfect body, a sexy body; wanting to eat a lot, eat if no-one could see them; wanting to change their physical appearance if they were granted a wish to change something about them. These findings are in agreement with the study done by Hickox (2005 : 15) of the self-concept of behavioural disordered children where Draw A Person illustrations were found to include dark colours, self-size of a small scale, faces with blank stares and lack of emotion representing an unhappiness with self.

6.2.5 **Sentence Completion**

Responses to the following items became significant as common themes that were projected by the participants.

10. I **secretly**: “check how much fat there is in food before I eat it”, “dislike my appearance”, “eat food sometimes”, “try to eat chocolate after chocolate”.
11. **I want to change:** “my waist, its flabby and fat”, “the way I look”, “my top legs, they are very big”, “my body and face”, “a lot about me”, “the way I look physically”, “my looks and body shape”.

14. **When I see models in magazines:** “I feel real ugly”, “I wish I could be like them”, “I hope to be like one of them one day”.

16. **My body:** “is very long”, “is something I hate”, “I accept because I have no choice but I would trade it if I could”.

17. **Food:** “is good and bad at the same time. It gets you satisfied and fat”, “is not really my favourite. I don’t like eating”, “is something that makes me upset”, “is something that I eat and sometimes it makes me guilty like I am the cause of being overweight”.

The themes of the responses of the clients tend to revolve around:

- being uncomfortable about their weight
- feelings of guilt about eating habits and overeating
- a need to change the way they look, their body and their appearance
- fear of others commenting on their weight
- wanting to be like the models portrayed in magazines
- a fear of getting fat
- a need to be accepted by others
- a negative attitude to food
- a fear of being ridiculed.

**6.2.6 Dietary Record**

The junk food eaten by the participants included: hot dogs, chips, pies, pizza, Chelsea buns, hamburgers, fizzy cold drinks, sweets, ice cream, bubble gum, chocolates and doughnuts. Activities while eating included: watching television, sitting in the bedroom, doing homework, sitting in the car, listening to music, talking to friends, sitting on a bench and lying down.

Thoughts recorded while eating included: irrational ones such as relating grams of food eaten to the amount of possible weight gain, wanting to eat more, thinking about friends, analyzing food eaten, and negative self-talk. Feelings that revolved
around eating included: guilt, hunger, disappointment, unhappiness, fatigue, moodiness, depressed, confused, scared, sad, anger, boredom, fear of never being able to feel full.

6.2.7 Interview
The aim of the interview was to gain access to the client’s achievements and inner resources to be used in hypnotherapy. The inner resources were unique to each individual and will be outlined in the case study presentations. The interviews did however reveal a lack of participation in physical activities. The information gleaned in the interview with regard to what the client wants from therapy, was also used to decide on the metaphor to be used in ‘gift-wrapping’ during hypnotherapy.

6.3 FINDINGS OF GROUP THERAPY
In this section feedback on group therapy during the Psycho-educational programme will be given with regard to: the group contract, collage of the Inner Self, cognitive distortions, picture perfect and education on nutrition.

6.3.1 Group Contract
Group psychotherapy occurs in an atmosphere that is closer to the real world more than individual psychotherapy and in a well-functioning group emergent cohesion members need to take part in a safe place where they feel understood (Etin 2000: 137). In order to form a trusting alliance the group members developed a group Therapy Contract and agreed to abide by their pledge to: confidentiality, punctuality and respect for one another. A contract was signed by each member, and a copy was given to each participant.

6.3.2 Collage of Inner Self
Group members followed the homework procedure (see 4.2.4) and each person had a turn to present their collage to the group of their Inner Self. Some collages focused on their talents, others focused on magazines with preferred figures that they would like to model and others focused on food preferences.
With the consent of case study A the researcher wishes to show the reader the collage of her Inner Self.

Siyabonga has presented a person in the middle of the page with a net. Surrounding the person are pictures of fast foods and junk foods. The person in the middle is said to be chasing the food out of the way which the client said was as difficult as trying to chase after and catch butterflies with a net. The collage further depicted a heart that represented her ability to be a loving person; a teddy bear with a present that represented her enjoyment of receiving surprises and a picture of a girl graduating which represented her future goals.
The group members complemented her on her collage and pointed out that she was being hard on herself by trying to abstain completely from eating fast foods and junk foods and that she must feel anxious when analyzing the food that she eats.

6.3.3 **Cognitive Distortions**

The therapist told the group that people often have overvalued ideas about shape and weight and therefore, tend to judge their self-concept in terms of shape and weight. By focusing their thinking on shape and weight they tend to strive to either avoid being fat by undereating or overeating in an attempt to cope with ratings of low self-concept. People can lose control over their eating as a result of errors in mental reasoning. The therapist gave the clients a list of cognitive distortions and they had to identify the distortion they used most often and apply it to the Interactionism Model of Self-concept and Eating Habits (see 4.2.4).

Cognitive distortions of the group members included:

- **magnification** – “If I eat this chocolate, I will be 8 grams heavier”
- **overgeneralization** – “Fat people are unattractive to the opposite sex”
- **selective abstraction** – “In order to be accepted, I must change everything about me”
- **personalisation** – “People are probably saying that I am fat”.

With the consent of case study G, the researcher wishes to share her responses. Nomfundo identified the cognitive distortion that she uses most often to be overgeneralization with repeated cognitive self-talk of “Fat people are unattractive to the opposite sex”. When asked for any evidence for or against the idea she replied that some of her friends are fat and dating boys. When asked for the advantage or disadvantage of thinking this way, she replied that her thoughts might negatively affect her self-esteem. When asked if there is an alternative way to look at the situation she replied that she acknowledges that not all fat people are unattractive to the opposite sex. When asked what the advantages or disadvantages of looking at things in a different way would be, she replied “I would have better self-esteem and I would not think that every guy that asks me out is playing a prank on me”. When asked if the overgeneralization applies to other
people too she replied “No, I have friends that are fat and I think that they are beautiful. I don’t apply the same standards to them because they look as if they don’t feel the way I do”.

She applied her cognitive thinking to the Interactionism Model of Self-concept and Eating Habits by reasoning “I have a negative self-concept and my negative mental modification of overgeneralizing can result in my unhealthy eating habits because when I eat, I feel even more guilty and I don’t like it. This makes me unhappy and as a result I eat more, which makes me overweight and this again leads to my negative self-concept”. Applied to the model (Figure 3.1) her “negative self-concept” (A₂) and “negative mental modification of overgeneralization” (B₂) result in “unhealthy eating habits” (D₂) because she “eats”, (D) she feels “guilty” (B₂) and this makes her “unhappy” (B₂) and therefore she “eats more” (D₂) resulting in her being “overweight” (C).

6.3.4 **Picture Perfect**

Clients presented examples of models in magazines that could influence adolescents to strive to adopt an ‘ideal’ physique according to society (see 4.2.8). Some of the group members presented examples from magazines of products advertised that falsely guarantee weight-loss. The topic of Picture Perfect lead to much discussion and group members shared their experiences of either trying out dieting products on the market or idolising thin models with the hope of looking like them.

6.3.5 **Education on nutrition**

The educational aspect included providing the clients with knowledge on nutrition, the negative effects of eating disorders on health and practicing eating a balanced meal by going to lunch during which time the therapist observed their eating behaviour and interaction with group members.

6.3.5.1 **Theory**

Handouts with information on nutrition (see 4.2.6) were given to the clients and the therapist highlighted some of the important facts of healthy eating. The detrimental effects of eating disorders were explained and an example of how to select food in
healthy proportions was demonstrated (see 4.2.6.2). Case study D, Spud felt that she benefited from this session and presented the therapist with a file that she had started developing on nutrition. She adds information to her file as she comes across useful articles on the nutritional value of food.

6.3.5.2 Practical demonstration
The therapist asked the caterers to have the following food available to the clients: chicken, rice, gravy, mixed vegetables, salad, fruit and juice and the group members sat around a large table together. Observation is a method that has the capacity to generate rich description since the researcher has the potential to develop an understanding of behaviour through first hand experience (Tope, Chamberlain, Crowley & Hodson 2005: 470). The following observations were made by the therapist during the practical demonstration: Case study C, Gaby who is not talkative by nature became very talkative and pushed her food around in her plate, Case Study G, Nomfundo pointed out to Gaby that she is not eating. Gaby spent time picking out any visible onions from the gravy and said that she does not eat onions. Case Study F, Lolly pushed her rice to one side of the plate and said that she is allergic to rice. Case Study E, Velvet felt that other people in the dining room were watching her eat and therefore, put her knife and fork down. Case Study H, Zabida agreed to exchange places so that no one could watch Velvet eat. Most clients were reluctant to eat the fruit after their meal and said that they would save it for later. The therapist found the eating of a meal to be most useful since it created a pleasant atmosphere among group members and provided an opportunity to observe the clients’ eating behaviour. Clients reported having thoroughly enjoyed the session.

6.3.6 Future Self to Present Self
In this session clients had to read out their homework of their future self-communicating a message to their present self in whatever format they chose (see 4.2.8). Some clients wrote letters and other clients wrote poems. The group members found this session very difficult and some members cried. Although they experienced this session as difficult, they felt that it bonded the group even more.
With the consent of case study F, the therapist would like the reader to see the poem written by Lolly.

I see you as a better you
a greater you
a smarter you
Although you think not what I do
you don't see what the future holds for you

There will be hard times
Bad times too
Sad times
rough times
tough times *
No I'm not trying to punish you, but to make you
stronger through and through
The way life is, you have no clue
I'm just trying to make you a better you

Somedays you'll feel you don't belong that life
is wrong and that you can't go on
just know that deep inside your soul
I've placed an even greater goal

Happiness will guide you to what's true
Faith will help you find the real you
I may seem far but yet I'm so near
Just wait we'll meet it will all be clear
6.4 FINDINGS ON INDIVIDUAL CASE STUDIES

Case studies A, B, H and I will be reported and a report on case studies C, D, E, F and G can be found in the indices attached (see Appendix L). An integration of the results with regard to eating habits, Body Mass Index and self-concept is presented and feedback of the Psycho-educational programme is outlined. Gift-wrapping involved an individualized metaphor used by the therapist to address the unique needs expressed by the client in the diagnostic assessment and during therapy sessions.

6.4.1 Case Study A

In the discussion of the findings regarding case study A, a brief background of the participant is given. This is followed by the results of the pre-and post-tests, the findings from the diagnostic tools, the individualized gift-wrapping and feedback of the participant on therapy.

6.4.1.1 Background

Siyabonga is a sixteen-year-old black female and is in grade eleven. She lives with both parents and is the third eldest of four children. The physical activity that she participates in is dancing. The physical appearance of her parents is of normal
weight. She obtains most of her information about nutrition from television. She suffers from asthma.

6.4.1.2 **Findings of the pre-and post-tests**

The Adolescent Self-concept Scale (ASCS), Eating Habits Questionnaire for Adolescents (EHQA) and Body Mass Index (BMI) were used for pre-and post-test assessment to determine whether the therapy involving a psycho-educational programme proved to be successful. The results are given in Table 6.2.

**Table 6.2 Results of the pre-and post-tests of case study A**

<table>
<thead>
<tr>
<th>Tool</th>
<th>Pre-test</th>
<th>Post-test</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASCS</td>
<td>55</td>
<td>85</td>
<td>30 points improvement</td>
</tr>
<tr>
<td>EHQA</td>
<td>203</td>
<td>194</td>
<td>9 points improvement</td>
</tr>
<tr>
<td>BMI</td>
<td>17</td>
<td>18.6</td>
<td>Improvement</td>
</tr>
</tbody>
</table>

The lowest dimension of the self-concept was the Physical dimension. The overall self-concept score for case study A shows an improvement of 30 points. The client’s self-concept changed from a low (negative) self-concept to a high (positive) self-concept. The reader is reminded that the higher the score the unhealthier the eating habits (see 5.6.3). The eating habits score of case study A has improved with 9 points but remains within the bad eating habits range. Siyabonga is 1.57m tall, weighed 43 kilograms at the start of the intervention programme and weighed 46 kilograms after intervention. Her Body Mass Index score improved from 17 kg/m² to 18.6 kg/m² and she moved from the range of being underweight to the normal range.

6.4.1.3 **Findings from diagnostic tools**

The Emotions Profile Index (EPI), Draw A Person (DAP), Sentence Completion, Dietary Record and interviews were used as diagnostic tools to: determine the themes that revolve around self-concept and eating habits, identify the client’s inner resources, gain insight into the emotions profile of the client, identify negative
cognitive modifications that may contribute to negative self-concept and unhealthy eating habits.

6.4.1.3.1 Emotions Profile Index (EPI)
The following findings from the EPI may contribute to the participant’s view of eating and have an effect on her self-concept. The Dyscontrol Dimension indicates that Siyabonga is not impulsive and tends to be reluctant to try out new things and have new experiences. It also came to the fore that she may experience some depression and she tends to be dissatisfied with certain aspects of her life. In therapy her inner resources were used in hypnosis in an attempt to improve her depressed mood and the metaphor used in individualized gift-wrapping encouraged her to try out new things and become more adventurous.

6.4.1.3.2 Draw A Person (DAP; see Appendix J)
The emotional indicators include: short arms in relation to body size which may indicate a tendency to withdraw; turning inward in an attempt to inhibit impulses; light lines indicate possible anxiousness and insecurity. According to the Draw A Person questionnaire of Appendix F, Siyabonga has presented a sixteen year old girl Emelda, who when she looks in the mirror sees a ‘new physical self’. Emelda is a popular girl because she has a nice body and if nobody could see her, the thing that she would like to do most is “eat a lot”. One day, Emelda cried and went to bed because someone told her that she is ugly and she dreamt that she was a ‘super model’.

From the above one can see that she projects an unhappiness with self that implies a negative self-concept. The responses further imply that she is internally focused and that an attempt to inhibit impulses of eating may contribute to feelings of anxiousness. In therapy she was given the opportunity to experience healthy eating during hand levitation in hypnotherapy (see 4.2.7) and to experience positive self-concept during the metaphor used in transformation of self-concept (see 4.2.5).

6.4.1.3.3 Sentence Completion
Noteworthy responses to the Sentence Completion (see Appendix G) are as follows: My greatest fear “is being laughed at ”; When I eat “I feel terrible, I’ll gain
weight and be fat and ugly”; I need “to eat less and exercise more”; I secretly “check how much fat there is in food before I eat it”; I want to change “my waist, it’s flabby with fat”; I wish “I could eat and not gain any weight at all”; Most girls “laugh at my legs at how skinny and skew they are”; I hate “it when I have to go on a diet because I have over-indulged”; Food “is good and bad at the same time. It gets you satisfied and fat”; “A thin person “can wear anything and pursue a career in modeling”.

From the above responses one can see that the theme of the responses revolve around a fear of rejection, of being ridiculed and of getting fat. In therapy Sentence Completion was used to identify negative cognitive thought processes used by the client that may influence self-concept and eating habits.

6.4.1.3.4 Dietary Record

Food recorded eaten by the client most frequently included: hot dogs, chips, cookies, toast with butter and jam. Although the client eats junk food, she tends to skip meals to compensate for the guilt feelings experienced when eating and this may contribute to her being underweight. Activities while eating included: watching movies, walking, sitting in her room and doing homework. Thoughts while eating included: an urge to exercise in order to work off the calories eaten “I really need to exercise, I could have had one hot dog but I had to have two”; guessing the grams of fat in food and relating it to weight gain, “that packet of chips has a possible 2 g of fat. The cookies could have 2 g, I need to work it off”. Feelings record while eating included: disappointment because she should have eaten less, guilt for not checking the amount of calories on a bottle of sauce, and feelings of being worried. The Dietary Record was used in therapy to help her identify feelings and thoughts that may negatively influence self-concept and eating habits (see 4.2.3 and 4.2.4).

6.4.1.3.5 Interview

From the initial interview the therapist gained access to the clients achievements at primary school which included: being in the top ten academically every term, receiving a prize for the best student in grade six, participating in the choir and being a prefect. At high school she has been in the top twenty on two occasions, received a prestige award in the poetry category at the Eisteddfod and she sings in
the school choir. Her hobbies include singing and watching television. She does not participate in any physical activities at present. From therapy she expected to learn to be more self-confident and to accept that she needs to gain more weight.

The information gleaned from the interview was used as ego-strengthening in hypnotherapy in session two (see 3.4.4 and 4.2.2) and in session five: transformation of self-concept (see 3.4.1.5, 3.4.4.2, 4.2.5) and the information was also used in individualized gift-wrapping (see 6.4.1.4).

6.4.1.4 Gift-wrapping

Using the Ericksonian Diamond (see 3.4.4.1) and information obtained from the diagnostic tools (see 6.4.1.3) the therapist’s goal was to communicate to the client that she tends to judge her inner and outer self too harshly and that gaining a little more weight as well as adopting healthier eating habits would be to her advantage.

Gift-wrapping included reminders of all her inner resources used during hypnotherapy as well as an individualized metaphor based on an African story: The rubbish dump, which the researcher modified (Chimombo in Africa – Innes 1992:73). The Intrapersonal category of tailoring involved an attempt to make the client more external and diffuse since she was internally orientated and focused. She judges and blames herself harshly. The Social interpersonal category of tailoring indicated that she grew up in a village, that she tends to be intrapunitive, gives energy to others, is a pursuer and a one up person. Processing involved the modification of the metaphor and utilization involved her leadership abilities, her personality characteristics and personal goal of self-acceptance.

The metaphor was used to encourage her to refrain from over-analyzing her diet and not to forget the educational aspect of learning to accept herself and follow a balanced diet. The many interruptions in the story were used to make her more diffuse and the aeroplane was used as a form of progression into a positive future.

After putting the client in hypnosis the therapist told the story of:

a boy named Joey who was sitting on a rubbish dump … playing with an aeroplane made from wire … singing … “bya ndzi rilisa (Traditional Tsonga beer) … byala bya
xinto ... (makes me weep) ... ji ndzi tsundzuxa ... (It reminds me of my grandparents) a kokwana” (and their pure ways of life) ... he was interrupted by the squeek and thump of a wheelbarrow ... it was Mazambezi ... that’s what everyone called him behind his back ... He was bringing in rubbish from the plane ... that landed ... There was a piercing whine of the plane ... about to take off ... The corrugated-iron rooftops rattled with the thundering roar ... as the pane took to the sky ... and Joey was filled with awe and reverence ... at the intelligence ... that could make big things ... fly like that ... in the sky ... He wondered who would be on it ... and where it would be going ... “Morning Joey” ... the man greeted the boy ... “You haven’t gone to school today”” ... “I missed the bus” ... replied Joey ... The tattered rags of the old man ... were more suitable for the rubbish dump ... than for wearing ... The old man took a few pieces of cheese ... out of the rubbish ... He piled it onto a piece of paper ... and ate it ... Joey was careful not to crinkle his face ... in disgust as he watched the old man ... eat the cheese ... Joey looked at the rubbish ... maize meal scraped from the bottom of pots ... orange peel ... chaff from sugar cane ... the guts of fish and chicken ... were feasts ... for blue bottles ... and the crows circled above ... cawing noisily ... “Did all this come from the plane?” ... Joey asked ... “Yes” replied the old man ... “They must eat a lot” Joey replied ... “When the white man eats, he eats” ... said the old man ... “As I sit here ... munching bits of cheese ... a whole world is opened up to me ... How many miles has this cheese travelled? ... What places has this empty packet of biscuits visited? ... What hopes and dreams does the person who bit on this cheese have?” ... said the old man ... and then continued “As I sit here ... Russia ... Hong Kong ... America ... South Africa ... are all in my grasp ... as they all find their way ... into this rubbish dump” ... “You are right” ... Joey replied ... “I can drink Coca Cola in New York ... drink tea in London ... and eat healthy food ... in South Africa ... as I fly in my ... imaginary aeroplane” ... “Here” the old man interrupted “have a piece of cheese ... maybe it came from South Africa” ... Joey stretched out his hand ... and chewed the stale cheese ... The buzzing of the flies ... and the cries of the crows ... were interrupted by ... the sound of a plane starting up ... Mazambezi stood up and said ... “That plane is filled with students going for more education on ... how to accept the self ... and how to practice healthy eating habits” ... “I know” ... replied Joey ... “I am already on that plane” ... and you can spoil yourself ... maybe you can visualise all your achievements ... being in the top ten academically ...
receiving a prize for the best student ... singing in the choir ... serving as a prefect ... receiving a prestige award for poetry ... and you can poetically recite ... all about the new you ... and when you are ready ... you can re-orientate yourself ... to the here ... and the now.

6.4.1.5 **Feedback from Case Study A on the therapy**

Siyabonga reported that she benefited from cognitive-behaviour therapy in that it helped her to change her self-talk from negative assumptions to more positive ones. It helped her to stop making illogical conclusions and encouraged her to follow a more balanced diet. She felt that her self-confidence has improved immensely. The hypnotherapy gave her a chance to stop thinking about everyone else and to think about herself. She said, “It helped me to sort out a lot of issues which were unresolved in my head”. The group therapy helped her to realise that other teenagers have similar problems to her. The individualized metaphor was experienced as positive and left her with a sense of flexibility and movement.

As a researcher she believes that what people think of themselves contributes towards how one behaves towards food. She said that she believed that she needed to be thinner to be accepted in society and realised that in order to do this she did not follow a balanced diet. She said, “Now that I’m more confident, I can eat and not feel guilty”.

Her message to adolescents is “Instead of always trying to please other people’s eyes, try and find out what’s good for you. You’re the one that matters most in your life – if you are not happy with yourself nothing will turn out right”. Her message to psychologists is that they must “try to fit into the teenager’s shoes which is a good way to try to relate to how they are feeling”. She felt that therapy should include more physically challenging activities because “teenagers like to have fun.”

6.4.2 **Case Study B**

In the discussion of the findings regarding case study B a brief background of the participant is given. This is followed by the results of the pre-and post-tests, the findings from the diagnostic tools, the individualized gift-wrapping and feedback from the participant on therapy.
6.4.2.1 Background
Grace is a seventeen-year-old black female from Mozambique and is in grade 11. She lives with both parents and is the eldest of two children. She does not participate in any physical activities since she has a fear of competition. The physical appearance of her parents is of normal weight. She obtains most of her information about nutrition from magazines.

6.4.2.2 Findings of the pre-and post-tests
The Adolescent Self-concept Scale (ASCS), Eating Habits Questionnaire for Adolescents (EHQA) and Body Mass Index (BMI) were used for pre-and post-test assessment to determine whether the therapy involving a psycho-educational programme proved to be successful. The results are given in Table 6.3.

Table 6.3 Results of the pre-and post-tests of case study B

<table>
<thead>
<tr>
<th>Tool</th>
<th>Pre-test</th>
<th>Post-test</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASCS</td>
<td>53</td>
<td>71</td>
<td>18 points improvement</td>
</tr>
<tr>
<td>EHQA</td>
<td>198</td>
<td>190</td>
<td>8 points improvement</td>
</tr>
<tr>
<td>BMI</td>
<td>16</td>
<td>17</td>
<td>Improvement</td>
</tr>
</tbody>
</table>

The lowest dimension of the self-concept was the Physical dimension. The overall self-concept score for case study B shows an improvement of 18 points. The client's self-concept changed from a low (negative) self-concept to a high (positive) self-concept. The eating habits score of case study B has improved by 8 points but remains within the bad eating habits range. Grace is 1.61m tall, weighed 42 kilograms at the start of the intervention programme and weighed 43 kilograms eight months after intervention. Her Body Mass Index score improved from 16 kg/m^2 to 17 kg/m^2 but remains in the classification of being underweight.

6.4.2.3 Findings from diagnostic tools
The Emotions Profile Index (EPI), Draw A Person (DAP), Sentence Completion, Dietary Record and interviews were used as diagnostic tools to: determine the themes that revolve around self-concept and eating habits, identify the clients inner
resources, gain insight into the emotions profile of the client, identify negative cognitive modifications that may contribute to negative self-concept and unhealthy eating habits.

6.4.2.3.1 **Emotions Profile Index (EPI)**

The following findings from the EPI may contribute to the participant’s view of eating and have an effect on her self-concept. The Dyscontrol Dimension indicates that Grace tends to be unadventurous, she tends not to be impulsive and she withdraws from social contacts. The Timid Dimension reveals that she tends to be cautious, careful and anxious. She tends to worry about what other people think about her and say about her. She also worries about getting into trouble. The Distrustful Dimension indicates that Grace tends to be uncritical of others and the Gregarious Dimension reveals that she tends to be unsociable and introverted. In therapy the metaphor used in hand levitation was used to encourage her to be more adventurous and to try out new experiences and the metaphor used in gift-wrapping encouraged her to have some fun as she socialized with others.

6.4.2.3.2 **Draw A Person (DAP; see Appendix J)**

The emotional indicators include a left out chin which indicates possible feelings of inferiority; feet in opposite directions which could indicate a problem with feelings towards her education or upbringing; short arms in relation to body size which may indicate a tendency to be withdrawn. Sketching may indicate wanting to be the best she can be. Grace rubbed out many times and this could indicate perfectionism and anxiety. According to the Draw A Person questionnaire of Appendix H, Grace has presented a seventeen year old girl Jiselle, who when she looks in the mirror sees a beautiful face. Jiselle is a nice person and if nobody could see her the thing that she would like to do most is “eat”. One day Jiselle cried and went to bed and she did not want to talk about it, she dreamt of happy family times and wishes she could change her weakest point which is her sensitivity. (Her eyes filled with tears when she said the word ‘sensitive’)

From the above one can see that she tends to experience anxiety and is very sensitive to what others might say about her. The fact that she would like to “eat” if no-one could see her may indicate that she inhibits her urge to eat and this may
contribute to feelings of anxiety. In therapy ego-strengthening was used in hypnosis to build self-confidence (see 4.2.2) and the metaphor used in gift-wrapping (see 6.4.2.4) encouraged her to experience a variety of food choices.

6.4.2.3.3 **Sentence Completion**
Noteworthy responses to the Sentence Completion (see Appendix G) are as follows: My greatest fear “is being involved in any harm”; I suffer “from having a very sensitive side”; I secretly “hide my feelings when I am hurt, so that no-one sees me”; When I see models in magazines “I hope to be one of them one day”; Food “is delicious, depending on my tastes”; My greatest weakness “I am too sensitive”.

From the above responses one can see that the theme of the responses revolve around a fear of hurting others, hiding her true feelings and evident sensitivity. In therapy sentence completion was used to help her to identify negative thought processes such as fear of hurting others, that may affect her self-concept and eating habits.

6.4.2.3.4 **Dietary Record**
Food recorded eaten by the client most frequently included: bread, egg, cheese, pizza, Nando’s chicken, toast and Two-minute noodles. Activities while eating included sitting in her room and sitting on a sofa. Thoughts while eating included thinking that some of the food tastes horrible, not being happy with the food. Feelings while eating included: starvation, hunger, disappointment and unhappiness. From the above it is evident that Grace often feels disappointed with the food that she eats even although she is hungry. In therapy, the client identified thoughts and feelings that may negatively influence her self-concept and eating habits (see 4.2.3 and 4.2.4).

6.4.2.3.5 **Interview**
From the interview the therapist gained access to the clients achievements at primary school which included: being in the top ten in grade five, a prefect, a hostel head girl and she received a netball trophy. At high school she received a medal in grade eight for running a 400m race and she was a hostel mentor. Her hobbies
include listening to hip-hop music and reading. She does not participate in any physical activities at present. She revealed that she tends only to eat if food is appetizing, otherwise she feels too lazy to eat. From therapy she expected to learn to be less sensitive and to accept herself.

The information gleaned from the interview was used as ego-strengthening in hypnotherapy in session two (see 3.4.4 and 4.2.2) and in session five; transformation of self-concept (see 3.4.4.1.5, 3.4.4.2, 4.2.5). The information was also used in individualized gift-wrapping (see 6.4.2.4).

6.4.2.4 Gift-wrapping
Using the Ericksonian Diamond (see 3.4.4.1) and the information obtained from the diagnostic tools (see 6.4.2.3) the therapist’s goal was to communicate to the client that by broadening her sense of taste in food she may increase her appetite and that by allowing her sense of humour to develop, she may become less serious about things that she worries about.

Gift-wrapping included reminders of all her inner resources used during hypnotherapy as well as an individualized metaphor based on an African story: A matter of taste that the researcher modified (la Guma in Chapman 2004). The Intrapersonal category of tailoring involved an attempt to make the client more external and diffuse since she was internally orientated and focused. The Social interpersonal category of tailoring indicated that she grew up in a suburban area and that she tends to be extrapunitive, a distancer and a one down person. Processing involved the modification of the metaphor and utilization involved her achievements, her goal to be less sensitive and self-acceptance.

The metaphor was used to encourage her to experience different preferences for food and also to suggest that one can make light of some situations by enjoying a sense of humour. A variety of food choices are included in the metaphor and the process of imagining what they could eat instilled a sense of humour.
After putting the client in hypnosis the therapist told the story of:

a boy named Chinaboy who was blowing fire under the tin ... that balanced on two half-bricks ... “There she is”, Chinaboy said as the surface broke into bubbles ... We’ll let her draw a while” ... Grace sat on an old sleeper ... and waited ... for the ceremony ... of pouring the coffee ... Whitey asked if he could join them and Chinaboy replied “Help yourself, we should’ve had some baked bread. Nothing like a piece of baked bread with coffee” ... “Hot dogs” the white boy said ... “Hot dogs go with coffee” ... Chinaboy asked “You going somewhere, Whitey?” ... “Yes” replied Whitey “I’m going to get a job ... on a ship ... in Mozambique” ... “Lots of people want to go to Mozambique ... I heard there is plenty to eat” ... said Grace ... “I saw a picture of the food there” ... said Chinaboy “A whole lot of prawns, crabs, lobster, fried chicken, chips and gravy and new green peas. All done up in colours, too.” “Oh yes, pass me the lobster” said Grace tongue in cheek ... Whitey replied “Let me get something like that and I’ll eat till I burst wide open.” ... Chinaboy said whimsically: “I’d like to sit in a smart café one day and eat my way right out of a load of turkey, roast potatoes, beet salad and angel’s food trifle. With port and cigars at the end” ... Whitey replied “It’s all a matter of taste ... Some people like chicken and others eat sheep’s heads” ... “Do you think that we still have time for more pork chops and onions?” Grace grinned ... Whitey waved elaborately at Grace “Serve the duck girl”... Chinaboy poured the last of the coffee into their tin cups ... the fire died to a small heap of embers ... “Thanks for the supper” Whitey said “I must go” ... “Come again anytime” said Grace “We’ll see if we have a tablecloth” ... Grace turned to Chinaboy and sighed “It’s true ... its all a matter of taste” ... and you can spoil yourself ... perhaps you can visualize ... being in the top ten ... serving as a prefect ... being a head girl ... running the 400m ... being a hostel mentor ... and listening to hip-hop music ... as you hip ... hop ... your way to a new you ... and when you are ready ... you can re-orientate yourself ... to the here ... and the now.

6.4.2.5 Feedback from Case Study B on therapy

Grace reported that she benefited from cognitive-behaviour therapy in that it helped her to allow herself to be ‘who she is’ and that with more positive thinking she can be a happier person. The hypnotherapy has helped her to relax more and she does
not take things as seriously as she used to. The group therapy helped her to be more open and to learn that “people have different ways of seeing things”.

As a researcher she believes that self-concept can be linked to eating habits in that “if you have a positive mind you can be a much healthier person”. Her message to adolescents is that life is full of choices and that they must learn from mistakes made along the way to adulthood. Her message to psychologists is that they must be kind to their client’s and make them feel comfortable.

6.4.3  **Case Study H**

In the discussion of the findings regarding case study H a brief background of the participant is given. This is followed by the results of the pre-and post-tests, the findings from the diagnostic tools, the individualized gift-wrapping and feedback from the participant on therapy.

6.4.3.1  **Background**

Zabida is a sixteen-year-old black female and is in grade 10. She lives with her mother and her father is dead. She is the eldest of two children. She does not participate in any physical activities at present. The physical appearance of her mother is of normal weight and her father was of normal weight. She obtains most of her information about nutrition from magazines.

6.4.3.2  **Findings of the pre-and post-tests**

The Adolescent Self-concept Scale (ASCS), Eating Habits Questionnaire for Adolescents (EHQA) and Body Mass Index (BMI) were used for pre-and post-test assessment to determine whether the therapy involving a psycho-educational programme proved to be successful. The results are given in Table 6.4.
Table 6.4 Results of the pre-and post-tests of case study H

<table>
<thead>
<tr>
<th>Tool</th>
<th>Pre-test</th>
<th>Post-test</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASCS</td>
<td>48</td>
<td>56</td>
<td>8 points</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>improvement</td>
</tr>
<tr>
<td>EHQA</td>
<td>238</td>
<td>192</td>
<td>46 points</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>improvement</td>
</tr>
<tr>
<td>BMI</td>
<td>40</td>
<td>39.7</td>
<td>Improvement</td>
</tr>
</tbody>
</table>

The lowest dimension of self-concept was the Family and Physical dimensions. The overall self-concept score for case study H shows an improvement of 8 points. The client’s self-concept changed from a low self-concept to a medium self-concept. Although the score is indicating bad eating habits there is a great improvement of 46 points. Zabida is 1,58m tall, weighed 100 kilograms at the start of the intervention programme and weighed 98 kilograms eight months after intervention. Her Body Mass Index score changed from 40 kg/m$^2$ to 39,7 kg/m$^2$ but remains within the range for being overweight.

6.4.3.3 Findings from diagnostic tools

The Emotions Profile Index (EPI), Draw A Person (DAP), Sentence Completion, Dietary Record and interviews were used as diagnostic tools to: determine the themes that revolve around self-concept and eating habits, identify the clients inner resources, gain insight into the emotions profile of the client, identify negative cognitive modifications that may contribute to negative self-concept and unhealthy eating habits.

6.4.3.3.1 Emotions Profile Index (EPI)

The following findings from the EPI may contribute to the participant’s view of eating and have an effect on her self-concept. The Trustful Dimension indicates that Zabida tends to be trusting and obedient. The Dyscontrol Dimension reveals that she tends to be unadventurous and is not impulsive. The Timid Dimension indicates that she tends to be less fearful than the average person and the Depressed Dimension indicates feelings of sadness and dissatisfaction with aspects of her life. The Distrustful Dimension indicates that she is not rejecting and the Control Dimension indicates that she tends to live her life on a day-to-day basis.
and does not plan for the future. The Aggressive Dimension reveals that she may have a lot of anger and can express it overtly. The Gregarious Dimension indicates that she tends to be friendly and the Bias Dimension indicates that she tends to present herself negatively. Conflict is indicated in the bipolar dimensions Gregarious – Depressed and may indicate feelings of rejection. In therapy the metaphor used in transformation of self-concept was used to help her to present herself more positively and the metaphor used in gift-wrapping encouraged her to experience movement since she tends to live her life on a day-to-day basis.

6.4.3.3.2 Draw A Person (DAP; see Appendix J)

The emotional indicators include: short arms in relation to body size which may indicate a tendency to withdraw; turning inward in an attempt to inhibit impulses; drawing close on top half of page that may indicate a striving for a high level of achievement and possible feelings of futile effort. According to the Draw a Person questionnaire of Appendix H, Zabida has presented a sixteen year old boy, Thabo who when he looks in the mirror sees a very ugly person. Thabo is a friendly person and of nobody could see him he would change his face and hairstyle. One day Thabo cried and went to bed because his family was mean to him and said something bad about his father. He dreamt he could see his father in the clouds. He wishes he could change the way his life is and bring his father back to life. In therapy ego-strengthening (see 4.2.2) was used to remind her of the achievements she has accomplished and the metaphor used in The Ugly Duckling (see 4.2.5) encouraged her to experience a sense of positive self-esteem.

6.4.3.3.3 Sentence Completion

Noteworthy responses to the Sentence Completion (see Appendix G) are as follows: My greatest fear; “is becoming blind and becoming bigger than what I am”; I suffer “from obesity”; When I eat “I sometimes feel very guilty”; My mind is forever telling me that I’m very big”; I need “to lose weight”; I secretly “eat food sometimes”; I want to change “the way I look (body, physical features)”; I wish “I was very skinny (thin)”; My body “is big”; Food “disgusts me but I eat if anyway”; My greatest weakness “is food though I hate it”; A fat person “can never make it through life and will never live a normal life”; A thin person “enjoys life because they can wear anything and eat anything and not have to be careful”. From the
above responses one can see that the theme of the responses revolve around disliking her body, a need to change the way she looks and feeling guilty about overeating. In therapy Sentence Completion was used to help her to identify cognitive distortions that affect her self-concept and eating habits.

6.4.3.3.4 Dietary Record
Food recorded eaten by the client most frequently included: Chappies, bread, butter, porridge, tinned fish, chips and samp. Activities while eating included: watching television, lying down and talking to friends. Thoughts while eating include “I’m so bored”, “I just need to eat” and “I eat too much”. Feelings recorded while eating included: anger, boredom, sadness and disgust. From the above it is evident that Zabida often feels bored, ashamed and guilty of her eating habits. The client skips breakfast in the mornings and eats a lot of junk food in between meals. In therapy the client identified thoughts and feelings that may negatively influence her self-concept and eating habits (see 4.2.3 and 4.2.4).

6.4.3.3.5 Interview
From the interview the therapist gained access to the clients achievements at primary school that included: serving as a library monitor, receiving a dictionary for an Afrikaans essay, oral presentations and she was a prefect. At high school she participated in shot-put in grade 8, served on the students council for learners and sings in the choir. Her hobbies include singing and socialising with friends. She does not participate in any physical activities at present. From therapy she expects to learn to love herself and to develop healthier eating habits. The information gleaned from the interview was used as ego-strengthening in hypnotherapy in session two (see 3.4.4 and 4.2.2) and in session five: transformation of self-concept (see 3.4.4.1.5, 3.4.4.2 and 4.2.5). The information was also used in individualized gift-wrapping (refer to section 6.4.3.4).

6.4.3.4 Gift-wrapping
Using the Ericksonian Diamond (see 3.4.4.1) and the information obtained from the diagnostic tools (see 6.4.3.3) the therapist’s goal was to communicate to the client that she has the ability to control her eating habits and to succeed in life despite setbacks that she may experience. The therapist also wanted to encourage the
client to become more mobile. **Gift-wrapping** included reminders of her inner resources used during hypnotherapy as well as an individualized metaphor based on a story: The challenge, which the researcher modified (Williams in Oliphant, Scheffler & Williams 1998:167). The Intrapersonal category of **tailoring** involved an attempt to make the client more flexible, external and focused since she was found to be cataleptic, externally orientated and diffuse. The Social interpersonal category of **tailoring** indicted that she grew up in a village and that she tends to be intrapunitive, absorbs energy from others, a pursuer and a one up person. **Processing** involved the modification of the metaphor and **utilization** involved her achievements, her goal to love herself and to develop healthier eating habits.

The metaphor was used to encourage her to be positive despite setbacks (person in wheelchair) she may encounter and to allow her to experience a sense of victory in controlling her eating habits (saving a person).

After putting the client in hypnosis the therapist told the story of:

*a girl named Zabida ... who punches her card at the reception counter of ... the gymnasium ... she had been coming to for ... three years ... and she steered her wheelchair in the direction ... of the swimming bath ... She was a picture of health ... her eyes bright ... She loved the water ... aerobics class ... a time ... of exercise ... yes ... but also ... of relaxation ... a time of dreaming ... “Hi, Zabida” said Pieter ... towel over his neck ... sweating away on the treadmill ... nearby ... “I'll join you for a quick swim” he said ... In a flash ... he was in the pool ... “I challenge you to two laps” Pieter said ... She laughed ... and turned away ... to put on her swimming cap ... She fiddled with it impatiently ... before steering her chair ... to the stairs ... to lower herself ... into the water ... Something was wrong ... the surface of the water ... was still ... where was Pieter? ... He couldn't be ... playing a trick on her ... Her instincts told her ... something was horribly wrong ... She lunged forward ... and plunged ... into the water ... her strong arms ... gathering speed ... as she saw Pieter ... seemingly lifeless ... at the bottom of the pool ... She reached him ... and scooped him up ... and with ... tremendous ... effort ... she ... surged ... to the surface ... where a crowd had gathered ... Pieter was taken from her grasp ... and attended to ... immediately ... by the gymnasium staff ... Zabida ... floated on her back ... her heart ... pounding ... violently in her chest ... wondering if Pieter would*
be alright ... Then she heard ... a loud cheer from the poolside ... Pieter was moving ... coughing up water ... Zabida took a deep breath ... and turned around ... to start those ... two laps ... he had talked about before ... A challenge ... was after all ... a challenge ... and you can spoil yourself ... maybe you can visualize ... serving as a library monitor ... receiving a prize for Afrikaans ... being a prefect ... singing in the choir ... serving on the students council for learners ... pushing the shot-put ... doing oral presentations ... presentations about the new you ... and when you are ready ... you can re-orientate yourself ... to the here ... and the now.

6.4.3.5 Feedback from Case Study H on therapy

Zabida reported that she benefited from cognitive-behaviour therapy in that it helped her to deal with her insecurities about herself. The hypnotherapy relaxed her and she is able to practice it when she feels tense. The group therapy helped her to realise that she is not the only person with problems.

As a researcher she believes that people who try to bring their unhealthy eating habits under control and do not see miracles taking place within a few days often give up and repeat their unhealthy eating habits because of their irrational way of thinking. Her message to adolescents is to start to like themselves even before they decide to lose weight. Her message to psychologists is to be patient and understanding with teenagers because “being a teenager, you do have a lot of influences and stress about looks”.

6.4.4 Case Study I

In the discussion of the findings regarding case study I a brief background of the participant is given. This is followed by the results of the pre-and post-tests, the findings from the diagnostic tools, the individualized gift-wrapping and feedback from the participant on therapy.

6.4.4.1 Background

Teddy is a fifteen-year-old black female in grade nine. She lives with both parents and is the third of four children. She does not participate in any physical activities. The physical appearance of her mother is overweight and her father is of normal
weight. She obtains most of her information about nutrition from television. She was medicated for enuresis that was solved at the time of therapy.

6.4.4.2 Findings of the pre-and post tests

The Adolescent Self-concept Scale (ASCS), Eating Habits Questionnaire for Adolescents (EHQA) and Body Mass Index (BMI) were used for pre-and post-test assessment to determine whether the therapy involving a psycho-educational programme proved to be successful. The results are given in Table 6.5.

Table 6.5 Results of the pre-and post-tests of case study I

<table>
<thead>
<tr>
<th>Tool</th>
<th>Pre-test</th>
<th>Post-test</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASCS</td>
<td>55</td>
<td>82</td>
<td>27 points improvement</td>
</tr>
<tr>
<td>EHQA</td>
<td>214</td>
<td>196</td>
<td>18 points improvement</td>
</tr>
<tr>
<td>BMI</td>
<td>30</td>
<td>28</td>
<td>Improvement</td>
</tr>
</tbody>
</table>

The lowest dimension of the self-concept was the Physical dimension. The overall self-concept score for case study I shows an improvement of 27 points. The client’s self-concept changed from a low (negative) self-concept to a high (positive) self-concept. Although the score is still indicating bad eating habits there is a great improvement of 27 points. Teddy is 1.63m tall, weighed 80 kilograms at the start of the intervention programme and weighed 77 kilograms eight months after intervention. Her Body Mass Index score changed from 30 kg/m$^2$ to 28 kg/m$^2$ but still remains within the range for being overweight.

6.4.4.3 Findings from diagnostic tools

The Emotions Profile Index (EPI), Draw A Person (DAP), Sentence Completion, Dietary Record and interviews were used as diagnostic tools to: determine the themes that revolve around self-concept and eating habits, identify the clients inner resources, gain insight into the emotions profile of the client, identify negative cognitive modifications that may contribute to negative self-concept and unhealthy eating habits.
6.4.4.3.1 **Emotions Profile Index (EPI)**

The following findings from the EPI may contribute to the participant’s view of eating and have an effect on her self-concept. The Timid Dimension indicates that Teddy tends to take risks and can easily get into trouble. The Depressed Dimension reveals that she tends to be depressed and dissatisfied with aspects of her life. The Control Dimension indicates that she tends to live her life on a day-to-day basis and does not plan for the future. It came to the fore that she tends to be disorganized in her thinking and activities. The Aggressive Dimension indicates that she may have a lot of anger and can blow off steam when around others. The Bias Dimension reveals that Teddy tends to present herself negatively. In therapy the metaphor used in transformation of self-concept encouraged her to experience organized thought processes and the metaphor also enhanced her self-esteem by reminding her of all her achievements.

6.4.4.3.2 **Draw A Person (DAP; see Appendix J)**

The emotional indicators include: the drawing being done on the left of the page which may indicate self-awareness and insecurity; the drawing close to the top half of the page which may indicate a striving for a high level of achievement with frequent feelings of futility; hands behind the back may indicate guilt or hiding something; coloured in hair may indicate aggression; feet in opposite directions could indicate a problem with her feelings toward her education situation or upbringing; shading of face could indicate anxiety and shaded arms could point to aggressive impulses.

According to the Draw A Person questionnaire of Appendix H, Teddy presented a fifteen-year-old girl Nomfundo whose name means the ‘educated one’. When she looks in the mirror she sees a pretty girl and if nobody could see her the thing that she would like to do most is “laugh and laugh”. She would like to change her hands, feet and hair and her past. One day, Nomfundo cried and went to bed because someone hurt her feelings and she dreamt she was in paradise. In therapy the metaphor used in hand delevitation (see 4.2.7) encouraged her to experience herself as beautiful and ego-strengthening (see 4.2.2) was used to remind her of all her achievements.
6.4.4.3.3 Sentence Completion

Noteworthy responses to the Sentence Completion (see Appendix G), are as follows: **I suffer** “when I have to choose clothes at a shop”; **When I eat** “I think I mustn’t eat too much or else I will gain weight”; **I secretly** “try to eat chocolate after chocolate”; **I want to change** “my looks and body shape”; **I hate** “it when people tease me about my weight”; **Food** “is the most important thing to live”. From the above responses one can see that Teddy feels uncomfortable about her weight, feels guilty about her eating habits and views food as all-important. In therapy Sentence Completion was used to help her to identify negative thought processes such as regarding food as all-important that may affect her self-concept and eating habits.

6.4.4.3.4 Dietary Record

Food recorded eaten by the client most frequently included: bread, beans, cheese, Nik-Naks, chicken, rice, cake, mince and macaroni. Activities while eating included: sitting at a table and watching television. Thoughts recorded while eating included: deciding whether or not the food eaten tastes good and whether or not she is full or not. Feelings recorded while eating included: guilt about eating too much and hunger. From the above it is evident that Teddy does not experience satiety after eating a reasonable amount of food. She also seems to lack knowledge about which food is healthy or unhealthy. In therapy the client identified thoughts and feelings that may negatively influence her self-concept and eating habits (see 4.2.3 and 4.2.4) and knowledge on healthy eating habits was provided (see 4.2.6).

6.4.4.3.5 Interview

From the interview the therapist gained access to the clients achievements at primary school that included: participating in the Eisteddfod in the category of Poetry, singing in the choir and receiving a mathematics prize. At high school she has participated in the Eisteddfod in Poetry. Her hobby is to socialize with friends. She does not participate in any physical activities at present. From therapy she expects to gain more self-knowledge and education on the nutritional value of certain foods. She also wants to be more independent and to start a new life.
The information gleaned from the interview was used as ego-strengthening in hypnotherapy in session two (see 3.4.4 and 4.2.2) and in session five: transformation of self-concept (see 3.4.4.1.5, 3.4.4.2 and 4.2.5). The information was also used in individualized gift-wrapping (refer to section 6.4.4.4).

6.4.4.4 Gift-wrapping

Using the Ericksonian Diamond (see 3.4.4.1) and the information obtained from the diagnostic tools (see 6.4.4.3) the therapist’s goal was to communicate to the client that she can change her unhealthy eating habits into healthier ones and she can learn to become more independent. Gift-wrapping included reminders of her achievements as well as an individualized metaphor based on an African story: The spirit of two worlds, which the researcher modified (Reddy in Chapman 2004:70). The intrapersonal category of tailoring involved an attempt to make the client more internal and focused since she was found to be externally orientated and diffuse. The Social interpersonal category of tailoring indicated that she grew up in a village, that she tends to be extrapunitive, absorbs energy from others, a distancer and a one down person. Processing involved the modification of the metaphor and utilization involved her personal goal to gain more self-knowledge, to become more independent and to start a new life.

The metaphor was used to encourage her to take ownership of her own actions, to take responsibility for her eating habits and like the character in the story, she can start a more balanced life style.

After putting the client in hypnosis the therapist told the story of:

an old woman who pounded ... the spices in a wooden mortar ... She sat on a grass mat ... in the cool ... under a mango tree ... A shadow however ... hung over ... the normally peaceful household ... Nothing pleased her new daughter-in-law ... named Sharda ... Radha, her eldest daughter-in-law offered the old woman some tea ... and returned with the tea ... that frothed like beer ... in an enamel mug ... just the way the old woman liked it ... “There is trouble” Radha said ... Sharda wants to go to work ... but Veerhan ... her husband ... did not want her to go to work ... “She doesn’t have to work” he pointed out ... “She says she is dying of boredom” he told her ... Boredom ... the old woman reflected upon ... this new and
... alien plague ... which affected young people ... Sharda went to work ... as a hairdresser ... in an elegant ... new ... salon ... She bought a whole lot ... of new clothes ... all modern ... and fashionable ... Her hair was styled often ... and in different ways ... Jealousy and resentment ... arose among ... the other daughters ... in ... law ... Sharda learned to drive ... and bought a car ... of her own ... The car was ... small ... and sleek ... The old woman tried to hold ... her disintegrating ... family together ... but the task was ... too much for her ... She was discovering that ... her matriarchal authority ... had to give way ... to a new ... way of life ... that was becoming ... the norm ... Veeran moved ... out of his mother’s house ... and moved in with his wife ... Sharda ... The old woman ... sat with her hands ... in her lap ... numb with pain ... Veeran was her youngest son ... and best loved ... One morning ... Veeran came to see his mother ... “Ma, Sharda has a son”, he announced “You must see him ... he looks ... just like you” ... “Sharda will have to give up work now” he said ... The old woman turned to Sharda ... When their eyes met ... There was a new gentleness ... “No, she doesn’t have to” ... the old woman said ... “I will look after the child” ... she cuddled the child ... The spirit ... of two world’s had emerged ... in a new beginning ... and you can spoil yourself ... maybe you can visualise ... you reciting a poem ... singing in the choir ... receiving a maths prize ... yes ... one ... two ... three ... to the hundred percent new you ... and when you are ready ... you can re-orientate yourself ... to the here ... and the now.

6.4.4.5 Feedback from Case Study I on therapy
Teddy reported that she benefited from cognitive-behaviour therapy because she was unaware that a person’s way of thinking could influence their self-concept. The hypnotherapy was relaxing and helped to relieve her of stress. The group therapy helped her to gain access to how other people feel and has enabled her to talk to others when she feels down.

6.5 INTEGRATION OF RESULTS
The following table (see table 6.6) gives an indication of the change in the participant’s self-concepts, eating habits and Body Mass Index. Interpretation of data is outlined and feedback regarding the Psycho-education programme will follow.
<table>
<thead>
<tr>
<th>CASE STUDIES</th>
<th>SELF-CONCEPT</th>
<th>EATING HABITS</th>
<th>BMI</th>
<th>REMARKS</th>
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6.5.1 Eating Habits and Body Mass Index

From table 6.6 it is evident that case studies A – I had unhealthy eating habits of which A, B and C was underweight, D, E and F were normal weight and G, H and I were overweight. Scores for unhealthy eating habits ranged from 238 to 191 before therapy and ranged from 210 to 189 after therapy. The researcher must point out that in order for clients to move from the category of unhealthy eating habits to the category of average eating habits, they would have had to score 147 on the Eating Habits Questionnaire for Adolescents. After Psycho-educational intervention all participants improved their eating habits but remained in the category for unhealthy eating habits. The pre- and post-test eating habit scores are depicted on graph 6.1.

According to the Body Mass Index case studies A, B, C were classified as underweight before therapy and gained weight after the intervention programme. Case study A significantly improved her body mass and moved into the category of normal weight. Case studies B and C improved body mass but remained in the category for underweight (see graph 6.2).

Case studies G, H, I were classified as overweight before therapy and lost weight after the intervention programme but remained in the category for overweight (see graph 6.3). Case studies, D, E, F were classified as normal weight before therapy, gained weight after therapy and remained in the category for normal weight (see graph 6.4). It is difficult to change ones eating habits and according to the literature one often relapses into unhealthy eating habits because of:

- eating for emotional reasons. A reaction to negative affect can lead to self-defeating behaviour such as unhealthy eating habits (Caruso 2005:2; Griffiths & McCabe 2000:31)
Graph 6.1  Eating habits scores

Graph 6.2  Body Mass Index of case studies who were underweight
Graph 6.3  Body Mass Index of case studies who were overweight

Graph 6.4  Body Mass Index of case studies who were of normal weight
6.5.2 **Self-concept**

Table 6.6 indicates that case studies A, B, C, D, E, F, H, I had low self-concept and case study G had a medium self-concept before therapy. Scores ranged from 48 to 57 before the intervention programme and 56 to 85 after therapy which means that the self-concept improved in all case studies. Case studies A, B, F, I significantly moved from low to high self-concept; C, D, F, H moved from low to medium self-concept and G moved from medium to high self-concept (see graph 6.5).

![Graph 6.5 Self-concept scores](image)

The results support the findings of Hartman (1995:12); O’Leary, Brown, Colby *et al.* (2002:890); Ryff & Singer (1996:114); as well as Valente (2004:5) who argue that by helping clients to understand what maintains their problem behaviour and promote change by enabling them to modify the schema of self during cognitive-behaviour and/or hypnotherapy, clients would be able to improve their self-concept and unhealthy eating habits.

6.5.3 **Feedback regarding the Psycho-educational programme**

Verbal and written responses of the clients were analysed in order to establish how they benefited from the Psycho-educational programme. Clients reported that cognitive-behaviour therapy as part of the intervention programme helped them:
• to become aware that their self-talk was often negative, e.g. “never bring yourself down because of weight, people must like you for who you are and not your looks”
• to identify which cognitive distortions they tended to use most often, e.g. “us teenagers think irrationally without realizing it. I thought that only thin girls can do sport but now I know that it’s not true”
• to challenge their negative mental modifications, e.g. “when I think that I will never be pretty, I tell myself that I am good at many other things”.

Clients reported that hypnotherapy as part of the intervention programme helped them:
• to relax, e.g. “I was relaxed and when something affects me I can do hypnosis myself”
• to focus on their inner selves, e.g. “It gave me a chance to stop thinking about everyone else and then I could sort out a lot of issues in my head”
• to get in touch with their inner resources, e.g. “I have made many mistakes in my life and remembering all the good things I have done in hypnosis was great”
• to have more control over eating habits, e.g. “I remember the girl dancing and not overeating in the story in hypnosis”.

The subjects felt that the educational aspect about nutrition helped them to gain more knowledge about a balanced diet as well as the dangers of eating disorders. They reported that group therapy helped them to:
• realise that they are not the only adolescents with unhealthy eating habits, e.g. “It made me see that I am the not the only one with problems”
• become more open about problems that they experience, e.g. “I have learned about different aspects of different people and to be a more open person”
• gain more insight into their problems, e.g. “It was great, it was nice being with people with similar problems to me and it also helped me deal with my problems”.
The feedback above suggests that clients found the Psycho-educational programme helpful in enhancing self-concept and eating habits.

6.6 CONCLUSION

With educational knowledge about nutrition and self-concept, adolescents can avoid developing unhealthy eating habits and low self-concept. The use of cognitive-behaviour therapy and hypnotherapy in a Psycho-educational programme for adolescents with unhealthy eating habits proved beneficial for all participants in the study.

It is evident that the dynamics between self-concept and eating habits are interrelated. The Interactionism Model of Self-concept and Eating Habits could prove to be useful in helping adolescents to apply their mental modifications to physical occurrences such as eating habits. Early diagnosis and treatment of unhealthy eating habits is essential because if not properly treated, eating disorders could develop. The qualitative remarks of adolescents as fellow researchers confirm that cognitive-behaviour therapy and hypnotherapy contributed to improved self-concept and eating habits. Final conclusions and recommendations will be presented in chapter seven.
CHAPTER SEVEN

CONCLUSION OF THE RESEARCH

7.1 INTRODUCTION
To assist adolescents with low self-concept and unhealthy eating habits a Psycho-educational programme involving cognitive-behaviour and hypnotherapy was developed. To explain the dynamics of self-concept and eating habits an Interactionism Model of Self-concept and Eating Habits was developed as a therapeutic instrument. Beneficial outcomes were found for adolescents with unhealthy eating habits and for professionals such as educational psychologists and teachers.

There is no single method or technique that can change eating disorders and therefore a multi-treatment intervention programme is recommended in order to achieve lasting change (Ronen 2003:49). In this study improvement in self-concept and eating habits can be attributed to the multi-treatment Psycho-educational intervention programme, the client’s motivation and compliance with treatment. The research done did not rely exclusively on self-report data that prevented the development of an overly empiricist analysis.

Cognitive-behaviour therapy places a focus on rational thinking, constructive self-interest and unconditional self-acceptance. Although humans have a biological tendency to think irrationally, they also have a biological tendency to exercise control over their cognitive thinking, which in turn determines their behaviour, and therefore the basis of the researcher’s theory is the person as a cognitive appraiser with the ability to realize the real self to control eating habits.

Hypnotherapy is concerned with an intervention strategy embedded with the effectiveness of encouraging clients to become responsible for their own therapeutic outcome. It is used in this study to challenge negative core beliefs underlying the
maladaptive behaviour of unhealthy eating habits by increasing introspective awareness.

The researcher has used metaphors as both a tool for shaping perspectives as well as a site for constructing meaning inherent in language and used to communicate messages. In the current study African stories are converted into metaphors to express thoughts and ideas that convey implicit meaning and offer a sense of hope and optimism in developing positive self-concept and exercising healthy eating habits. It helps clients to symbolically comprehend their worlds, and to reveal knowledge that relates to profound meanings that a cultural group understands.

A multi-model approach proved to have a positive impact since the client’s needs were considered to be more important than the therapist’s theoretical framework. The view adopted of the client as a fellow researcher or scientist points to the realization that treatment outcomes that focus on using the inner resources of the client, individual self-report and observation could prove to be advantageous in therapy. Within this perspective, room was created for the democratic potential of the therapeutic relationship. The Interactionism Model of Self-concept and Eating Habits proved to be a useful tool to help clients to recognize and modify cognitive distortions and to emphasize the link between thought and behaviour.

In this study, homework was used as an adjunct to the work that occurred in the sessions and created continuity between the therapy session and the client’s life as well as maximizing available treatment time (see 4.2, 6.2.6, 6.3.2, 6.3.6). Group therapy proved to be effective in that clients could reflect on their problems and received didactic knowledge about unhealthy eating habits and the interaction between thought processes and eating behaviour.

The purpose of this chapter is to discuss findings that emanated from the literature and the empirical study after which conclusions are drawn with recommendations, based on the information gleaned from the research. Limitations of the present study
are identified and guidelines for use by educational psychologists and Life Orientation teachers are formulated.

7.2 FINDINGS EMANATING FROM LITERATURE SURVEY
The last decade has witnessed a global increase in unhealthy eating habits in children and low self-concept has been widely promoted in literature as a possible underlying cause of unhealthy eating disorders. A recent body of research in South Africa has stated that the prevalence of unhealthy eating habits has increased in all socio-economic classes and significant increases in chronic disease morbidity is being experienced at an earlier age (Adolfson et al. 2002:244). Eating disorders have become the third most common form of chronic illness among adolescents aged 15 to 19 years. Some researches argue that black women tend to be more self-accepting and view being overweight as womanly and healthy, whereas white girls are more likely to internalize thin standards of attractiveness (Schreiber et al. 1996:63).

Intervention programmes in literature studies that counter unrealistic expectations with regard to the self, need to be employed to treat unhealthy eating habits (Fosati et al. 2004:137; Mansell & Lam 2003:363; Williamson et al. 1999:556). Both cognitive-behaviour and hypnotherapy identify and change thought and behaviour patterns that contribute to low self-concept and unhealthy eating habits.

Since cognitive-behaviour therapy focuses on remediating cognitive distortions of the conscious mind and hypnotherapy focuses on unconscious processes, to facilitate the restoration of the real self, it is advantageous to combine cognitive-behaviour and hypnotherapy. Findings emanating from the literature study with regard to self-concept, eating habits, cognitive-behaviour therapy and hypnotherapy are briefly outlined.

7.2.1 Self-concept
A plethora of research on self-concept is found but a major problem in the area is that few recent theories of self-concept exist and therefore there are few predictions and
hypotheses to guide the integration and assimilation of various approaches. The literature study revealed that:

- endogenous and exogenous factors influence the formation of self-concept (see 1.2.2.1, 1.2.2.2, 2.2)
- incongruency of thoughts experienced with regard to the actual self and ideal self can result in negative affect and develop into disordered eating (see 1.2.2.1, 1.2.2.2.2, 1.2.2.3, 2.2.1.2)
- self-discrepancies in the self-concept are cognitive structures (see 1.2.2.3, 2.2.1.2)
- self-concept is dynamic and capable of change (see 2.2.1, 2.4, 3.3.1)
- low self-concept has been found to be lowest among adolescents who base their self-esteem on appearance (see 1.2.2.1, 2.2.1.1)
- self-concept is the prime factor controlling human behaviour (see 2.2, 2.4, 3.1)
- self-regard is central to positive psychological and behavioural functioning (see 2.2, 3.3).

7.2.2 Eating habits

Specific treatment of adolescents with unhealthy eating habits is absent from definitive longitudinal data and although research relating to eating disorders exists, very few studies relating to eating habits could be found. Unhealthy eating habits begin early in adolescence with a progression of increasingly unhealthy eating patterns and a summary of the literature study indicates that:

- unhealthy eating habits tend to be symptomatic of a struggle for self-concept but that very little research addressing this issue has been done (see 2.5)
- eating disordered patients display more negative self-concept than people who demonstrate healthy eating habits (see 2.5)
- by enhancing self-concept it may be possible to reduce health compromising behaviour such as unhealthy eating habits (see 2.4, 2.5)
- eating disturbances can be defined as symptom pictures existing on a continuum from food-restricting to overeating behaviour (see 2.3.1, 2.5)
- unhealthy eating behaviour involves automatic dysfunctional cognitions about eating, weight and shape (see 1.2.2.3, 2.5, 3.4.2).
7.2.3 **Cognitive-behaviour therapy**

The literature study revealed that:

- cognitive-behaviour therapy represents an integration of cognitive and behavioural approaches (see 3.3.1, 3.3.3)
- it appears to be the treatment of choice when working with eating disorders (see 3.3)
- cognitive-behaviour therapy is based on the idea that behaviour, thoughts and feelings are learned, and can therefore be unlearned, or modified (see 3.3.1, 3.3.3.2)
- the therapist’s ultimate objective is to help the client to help themselves towards a more effective way of behaving by disputing their irrational thoughts and beliefs (see 3.3.1, 3.3.3.2)
- it is comprised of three major components; psycho-education, cognitive restructuring and relapse prevention (see 3.3.1, 3.3.3)
- it teaches individual and group therapy clients to become less dependent on social conformity in order to achieve approval from others (see 3.3.2)
- it enables clients to be more self-accepting and to take responsibility for their own reasoning (see 3.3.2).

7.2.4 **Hypnotherapy**

The literature study revealed that:

- hypnotherapy helps clients to develop insight into their problems and to use their own resources to help them to overcome them (see 3.4.2, 3.4.3, 3.4.4.2)
- an Ericksonian approach to hypnotherapy is naturalistic and utilizes a client’s unique capabilities to bring about change (see 3.4.2, 3.4.3)
- it holds a permissive approach since clients make choices of what they choose to respond to (see 3.4.4.2)
- the unconscious mind plays a role in determining bodily and conscious phenomena (see 3.4.2)
- metaphors can be used to communicate and activate the client’s unconscious processes (see 3.4.4.2, 3.4.4.3)
• linguistic patterns are used to stimulate associations in the mind (see 3.4.4.3)
• hypnotic phenomena are the building blocks for the therapeutic applications of hypnotherapy and the therapist can use the phenomenon that is opposite to the one causing the problem (see 3.4.4.4).

7.3 FINDINGS DERIVED FROM EMPIRICAL INVESTIGATION
There were significant changes in the self-concept of adolescents with unhealthy eating habits and a moderate change in eating habits. The effect of the Psycho-educational programme on self-concept and eating habits of adolescents was evaluated by means of post-test designs namely the Adolescent Self-concept Scale, the Eating Habits Questionnaire for Adolescents and the Body Mass Index. All selected measuring instruments manifest good reliability indices.

A Psycho-educational programme combining cognitive-behaviour therapy and hypnotherapy was applied and resulted in the following changes:
• adolescents could understand the interactionism principle of self-concept and eating habits
• clients could identify the cognitive distortions that they used most frequently
• participants could identify models in magazines that falsely advertise the perfect man or woman
• all self-concept scores improved significantly
• all participants improved their eating habit scores but remained in the category of unhealthy eating habits
• clients with an underweight Body Mass Index improved their body mass by gaining weight
• clients with an overweight Body Mass Index lost weight
• participants could identify thoughts and feelings that surround their eating habits
• clients could recall the didactic knowledge provided with regard to a balanced diet and the dangers of eating disorders
• adolescents could practically demonstrate correct eating in a group therapy environment.
The study revealed that the Black adolescent participants are not immune to unhealthy eating habits and that they also internalize the predominant cultural ideal of the perfect man or woman. This study confirms the findings of James, Phelps and Bross (2001:491), who found that African American College females experience body dissatisfaction and internalize the accepted view of feminine beauty.

The adolescents were willing to receive help related to their problem of unhealthy eating habits. The combination of individual and group therapy proved to be very successful (see 6.3, 6.4, 6.5). Group cohesion was particularly strong and therefore contributed to the group members functioning effectively. Individuals experienced a sense of universality and relief in realizing that the problems they experience with regard to self and eating, is commonly experienced by adolescents.

Individual therapy enabled clients to express problems that were sensitive and personal in nature in privacy. It further allowed the uniqueness of the client’s personality and nature of the problem to be handled in a unique manner as was done in the handling of their individual cognitive distortions and in using metaphors that suited the client during hypnotherapy. The results replicated previous findings linking cognitive-behaviour therapy to positive treatment outcomes.

Homework exercises given to clients enabled the therapist to gain insight into their intra-psychic self-talk. The homework exercises provided clients with a therapeutic opportunity to explore and investigate their sense of self and their thought processes often related to self (see 4.2, 6.2.6, 6.3.2, 6.3.6).

The Interactionism Model of Self-concept and Eating Habits (Figure 3.1) helped adolescents to glean a better understanding of how their thoughts can affect behaviour. The model provided clients with a schematic illustration that enabled them to identify their cognitive distortions and the effect that these negative thought processes have on their self-concept and eating habits. The comments of the adolescents also confirm that they experienced an enhanced sense of self that has
increased their self-efficacy in managing their eating habits. The goal of the study has been reached since a psycho-educational programme involving cognitive and behaviour therapy was developed and applied. In so doing the research question is answered since low self-concept and unhealthy eating habits of adolescents were found to improve when exposed to a psycho-educational programme. A further aim to develop a model that explains the interaction between self-concept and eating habits was achieved and it proved to be a useful therapeutic instrument in therapy (see 3.2, 6.3.3, 6.4). Questions that came to the fore have been answered with regard to the nature of eating habits (see 2.3), the development of self-concept during adolescence (see 2.4), the relationship between self-concept and eating habits (see 1.2.2.3, 2.5, 3.2).

7.4 RECOMMENDATIONS

From the findings of the research it appears that the participants benefited from the Psycho-educational intervention programme. The researcher believes that unless these clients were subjected to the therapy programme, many of them would have developed an even lower self-concept, which could manifest itself in possible eating disorders.

It is recommended that the necessary knowledge with regard to self-concept and eating habits must be available to children in order that they may develop positive self-concepts and healthy eating habits. Adolescents who do not receive the necessary knowledge relevant to self-concept and eating habits and who develop low self-concept and unhealthy eating habits need to be guided through a psycho-educational intervention programme, in order to develop a positive self-concept and healthy eating habits.

The current study revealed that an intervention programme aimed at enhancing self-concept and eating habits could prevent the escalation of unhealthy eating habits and therefore a wider implementation of similar intervention programmes with adolescents is recommended. More attention should be given in educational practice in developing
realistic self-concepts and utilizing inner resources. Current interventions tend to be geared towards ameliorating pathological aspects rather than promoting self-enrichment.

The question arises as to who is responsible for providing children with guidance and help to gain an understanding of the need to develop positive self-concept and healthy eating habits. The researcher recommends that the Educational Psychologist, Life Orientation teacher and parents should play a significant role in the psycho-education process of developing positive self-concept and healthy eating habits. Recommendations for Educational Psychologists, Life Orientation teachers and parents are outlined below.

7.4.1 **Educational Psychologist**

An Educational Psychologist is equipped to help adolescents but unfortunately in most cases adolescents are brought to the psychologist once symptoms of eating disorders are manifested. In many cases the Educational Psychologist does not get the opportunity to help adolescents before their problems are manifested in eating disorders.

When dealing with adolescents in therapy the following recommendations are suggested:

- The nature of self-concept and cognitive distortions must be explained in a simple and understandable way.
- The interaction of self-concept and eating habits must be explained to the client using a schematic diagram such an Interactionism Model of Self-concept and Eating Habits (Figure 3.1).
- The client must be given the opportunity to identify their cognitive distortions and describe how they might affect their eating habits.
- The therapist needs to accurately identify inner resources that the client has in order to use these effectively in hypnotherapy.
• The therapist must be aware of the contemporary role of the media with regard to the “perfect man” and the “perfect woman”. Adolescents need to be taught how to be objective about media representations without involving their own egos.

• The therapist must understand the role of the peer group influence during early adolescence, resulting in the meaning given to the self.

• Since the peer group is important to adolescents, the therapist should realize the importance of using group therapy as part of a Psycho-educational programme.

• Should therapists choose to use hypnotherapy then they should prepare the client in order to eliminate false expectations and ignorance.

• Provide homework for clients using a systematic approach specifying how the activity is relevant to the client’s treatment goals and give the client a brief note that describes the homework activity and specifies when, where and how long the homework should be practiced. Therapists are encouraged to give a lot of feedback and positive reinforcement when homework is completed.

7.4.2 Life Orientation Teachers

According to the Department of Education (2002:4) “… Life Orientation guides and prepares learners for life and its possibilities. It equips learners for meaningful and successful living in a rapidly changing and transforming society. Life Orientation is central to the all-round development of learners. It is concerned with the social, personal, intellectual, emotional, spiritual and physical growth of learners, as well as the way in which these facets are interrelated.”

It is recommended that Life Orientation teachers take the opportunity, as part of the curriculum to provide learners with information regarding self-concept, healthy eating habits and the importance of exercise. The question here is whether or not teachers have the necessary knowledge and expertise to teach this knowledge in a meaningful way.

It is evident that self-concept and eating habits are included in Life Orientation in both the Outcomes Based Education and the Further Education and Training phases and
management at schools should make sure that enough time is allocated to the Life Orientation teachers teaching the subject and that the teacher has the necessary training in teaching the subject in a meaningful way.

7.4.3 Parents
It is recommended that parents play a role in helping their children to develop a positive self-concept and to adopt healthy eating habits since they are available to and responsible for the well being of their child. Should parents have failed in guiding their children accordingly then the therapist recommends that they identify unhealthy eating habits in their children and take responsibility for seeing to it that their children have access to a psycho-educational programme provided by a psychotherapist. The responsibility rests more heavily on the parents in guiding, supporting or putting their child in contact with a psychologist who can provide the necessary help.

7.5 CONCLUSION OF THE INVESTIGATION
Significant others have a very important role to play in the development of positive self-concept and healthy eating habits, and with education, low self-concept and unhealthy eating habits can be avoided. Parents of adolescents with unhealthy eating habits and professionals who work with them need to acquire an urgent and optimistic view that unhealthy eating habits if diagnosed early can be treated effectively. It is only through the adoption of a philosophy of urgency and optimism that the reality of unhealthy eating habits and low self-concept among adolescents can be dealt with.

A lack of self-knowledge experienced by many adolescents particularly with regard to negative thought processes can lead to unhealthy eating habits and by gaining more self-knowledge, adolescents will be able to develop a sense of self-acceptance and healthier eating habits. By educating adolescents about the importance of adopting a healthy diet and providing knowledge about the dangers of developing eating disorders, one enables the adolescent to realize the implications of unhealthy eating habits. It was significant to note that adolescents with unhealthy eating habits had a low self-concept and that low self-concept has a negative affect on eating habits.
The use of cognitive-behaviour therapy and hypnotherapy in the Psycho-educational intervention programme proved beneficial for all the adolescents who participated in the study. Improved self-concept and eating habits were manifested in the results of the Adolescent Self-concept Scale, Eating Habits Questionnaire for Adolescents, Body Mass Index and feedback from participants.

A treatment that promotes unconditional self-acceptance and body nurturance but rejects dominant cultural ethos, which encourages men and women to reshape their bodies to emulate the cultural ideal is promoted. The researcher / educational psychologist helped adolescents to accept themselves unconditionally and provided adolescents with educational knowledge on the importance of following a balanced diet.

The Interactionism Model of Self-concept and Eating Habits played a successful role during cognitive-behaviour therapy. By understanding the dynamics of the model, the participants could identify and change their negative thought processes in relation to eating habits. Adolescents were eager to follow the programme since they were able to develop more self-knowledge and an understanding of how their cognitive thinking can determine behaviour. They became aware of the importance of developing a realistic self-concept and how cognitive distortions can negatively influence self-image. They also became educationally aware of the health risks of unhealthy eating habits and the danger of developing eating disorders.

It was evident that the hypnotherapeutic programme contributed to a significant increase in self-concept and a satisfactory improvement in unhealthy eating habits. The strongest theme that emerged was that the programme assisted them in developing a more realistic image and acceptance of self by using their inner resources or strengths. All adolescents were encouraged to have contact with the researcher after the programme concerning any fears they may encounter regarding relapsing into low self-concept and unhealthy eating habits.
7.6 CONTRIBUTIONS OF THE STUDY

The research investigation contributed to the knowledge of the interaction between self-concept and eating habits. Findings from the current study could contribute to the enhancement and maintenance of positive self-concept and healthy eating habits among adolescents.

Results of the current study provide evidence that self-concept and eating habits improved using cognitive-behaviour therapy and hypnotherapy. The research has contributed to the scientific and clinical understanding of hypnotherapy, specifically in the field of Ericksonian therapy approaches, since very little empirical research has been done and a need exists for empirically based research (Mathews 2000:418).

These research findings have significant benefits for:

- adolescents with low self-concept and unhealthy eating habits
- educators who have the ideal opportunity in educating children about the importance of healthy eating habits
- parents in realizing the importance of observing their child’s eating habits
- educational psychologists in developing a Psycho-educational programme for adolescents with low self-concept and unhealthy eating habits
- all the professionals, service providers, administrators and curriculum developers concerned with education in South Africa.

Finally, on a theoretical level, the study has contributed to an expanded approach of cognitive-behaviour and hypnotherapy and provides the therapist with a practical hands on intervention programme for implementation.

7.7 LIMITATIONS OF THE CURRENT STUDY

The main limitation of the current study was the relatively small number of participants, which suggests that caution should be applied in generalizing the results. It is also a
limitation that no males wanted to participate, and thus no tendencies/ideas could be formed.

There are indications that cognitive-behaviour therapy and hypnotherapy could be an effective technique to build positive self-concept and healthy eating habits, but this will have to be researched further. Other interacting variables could have played a role in the increase in self-concept and improved eating habits and therefore a control group could have been formed so that the results of the case studies could have been compared to that of the control group.

The researcher is aware that diagnostic tools to measure self-concept and eating habits exist other than the Adolescent Self-concept Scale and Eating Habits Questionnaire for Adolescents.

7.8 MATTERS REQUIRING FURTHER RESEARCH

As the researcher worked with female adolescents as a result of males not wanting to participate in group work, further research using larger groups which include both male and female adolescents is needed to further confirm the current findings.

Research regarding the education programme by Life Orientation teachers with regard to the expertise of these educators in helping adolescents to develop a positive self-concept and healthy eating habits needs to be investigated. Meaningful content, method and techniques need to be assessed and mastered in order that learners can be enriched to develop skills needed to live a balanced and healthy life.

The current programme could be elaborated on, with the aim of including an exercise programme as well as continuing with reinforcing psycho-education intervention at various intervals after the ten sessions of therapy in order to prevent the client from relapsing into low self-concept and unhealthy eating habits. Although more research is needed, it is accepted that physical activity has positive outcomes on both the physical and mental health of adolescents (Pastor, Balaguer, Pons & García-Merita 2003:718).
There is a need within cognitive-behaviour therapy and Ericksonian hypnotherapy for empirical studies regarding the effectiveness of these approaches in dealing with unhealthy eating habits prior to their manifestation in eating disorders. The nature of hypnotherapy is clouded by misconceptions and a way should be found to rectify the situation so that people are informed as to the positive aspects of hypnotherapy. Continued exploration for predictors of unhealthy eating habits among adolescents is a worthwhile pursuit.

7.9 CONCLUSION

The research findings are important for all professionals as well as adolescents with unhealthy eating habits. The findings have tremendous implications for education in South Africa particularly for Life Orientation teachers. This research was embarked as a Psycho-educational process conducted by an educational psychologist and educator. It is hoped that professionals will adopt these techniques that can be modified to meet their respective needs. The projected outcomes are positive and worth the time and effort invested and the findings confirm that the aims of the research have been achieved.

Should the interactionism between low self-concept and unhealthy eating habits not be addressed, adolescents will continue to develop unrealistic self-concepts and stand the chance of developing unhealthier eating habits which may have a detrimental effect on their health. It can be concluded that a Psycho-educational programme involving cognitive-behaviour therapy and hypnotherapy could enable adolescents to develop positive self-concepts and healthy eating habits.

As a researcher I was privileged to share in the lives of black and white adolescents who eagerly wanted to contribute to the research investigation in order to help other adolescents with similar problems. It is hoped that adolescents who have a positive self-concept and healthy eating habits display a more able functioning in society, more adaptability to differences among others, more insight in and more control over future behaviour outcomes associated with eating habits.
The therapist does not intend to convince anyone about a particular intervention programme and is aware that multiple treatment options exist but it is important however for therapists to provide convincing treatment rationale in order to determine the success of cognitive-behaviour and hypnotherapy.

Atkinson (2000:322) aptly formulated the purpose of educational research as:

“... not merely to provide ‘answers’ to the problems of the next decade or so, but to continue to inform discussion, among practitioners, researchers and policy makers, about the nature, purpose and content of the educational enterprise”.

This research ought not to be seen as an end product but the beginning of a process of discourse.

“Give me a fish and I will eat today. Teach me to fish and I will eat for a lifetime.”

Chinese Proverb
BIBLIOGRAPHY


Appendix A:
Adolescent Self-concept Scale Questionnaire (continued)

12. A often postpones to the next day what should be done today
    B never postpones work to another day

13. A likes to be well-dressed and neat in all circumstances
    B dislikes always being neat

14. A is often peevish and moody for long periods
    B is seldom if ever in a bad mood

15. A usually looks forward to family gatherings
    B does not like family gatherings

16. A wishes that others would show interest in him more often
    B is satisfied with the attention he gets

17. A usually takes the side of the majority
    B usually decides for himself what is right and stands by this decision even though he stands alone

18. A sometimes drives through a stop street without stopping
    B never drives through a stop street without stopping

19. A is usually aware of pain somewhere in his body
    B is seldom aware of any pain

20. A is completely satisfied with himself
    B is not satisfied with himself

21. A is usually suspicious of his family's conversations and conduct
    B is never suspicious of his relatives

22. A is someone who makes friends very easily
    B does not usually make friends easily
Appendix A:

Adolescent Self-concept Scale Questionnaire (continued)

23. A often does things which cause him to feel ashamed afterwards  
    B seldom does things which cause him to feel ashamed afterwards .................................

24. A sometimes feels like swearing when things go wrong  
    B never becomes so upset when things go wrong ......

25. A is usually untidy  
    B is seldom really untidy .................................

26. A is as friendly to other people as he would like to be  
    B is not as friendly to everyone as he would like to be ..................................................

27. A is very sensitive to what his family says about him  
    B does not easily feel hurt by what his family says about him ..........................................

28. A usually gets on very well with other people  
    B's relationships are easily disturbed by trivialities ......................................................

29. A sometimes uses questionable methods in order to be ahead  
    B never considers using questionable methods ......

30. A is inclined to gossip too much  
    B never gossips ..............................................

31. A is usually aware of feeling unwell  
    B seldom feels unwell ........................................

32. A knows that he can usually solve his problems  
    B is always afraid that he will not be able to solve his problems ....................................

33. A often feels unhappy because he has so little love for his family .................................
Appendix A:

Adolescent Self-concept Scale Questionnaire (continued)

34. A always sees other people's good points
   B seldom sees other people's good points ............

35. A often feels unhappy because his life does not
   measure up to the high standards which others
   set for him
   B seldom cares what others expect of him ............

36. A is someone who often enjoys a shady joke
   B never laughs at shady jokes .........................

37. A feels that his weight is correct
   B often feels worried about his weight ..............

38. A often experiences despair because he does not
   keep to his principles
   B never experiences despair because he does not
   keep to his principles .................................

39. A would never be unfair to his family
   B is not particularly scrupulous about being fair
   to his family ........................................

40. A always finds it difficult to forgive someone
    who has accused him falsely
   B readily forgives others ..............................

41. A does not like everyone that he knows
   B likes everyone he knows ...........................

42. A is satisfied with his appearance
   B does not feel happy about his appearance .......

43. A is always envious of traits of character which he
    perceives in others
   B is never envious of character traits which he
    perceives in others .................................

44. A is someone with little love for his fellowman
    B will often do himself down in order to favour
    others ................................................
Appendix A:

Adolescent Self-concept Scale Questionnaire (continued)

45. A always feels self-conscious in the company of strangers
    B seldom feels self-conscious in the company of strangers ...........................................

46. A's behaviour is always irreproachable and honourable in all circumstances
    B worries about his behaviour which often leaves much to be desired ................................

47. A takes little interest in the doings of other people
    B takes an intense interest in the actions and conversations of other people ..................

48. A feels perfectly happy about his height
    B is often selfconscious about his height ........

49. A can never persevere with a task until it is finished
    B perseveres to the end with every task he undertakes ...........................................

50. A always treats his parents very well
    B often neglects his parents ...........................................

51. A finds it very difficult to enter into a conversation with strangers
    B talks to strangers with the greatest of ease ......

52. A will always return change when he is given too much
    B does not trouble to return change when it is too much ..........................................

53. A often feels that he is angry with the whole world
    B rarely feels irritable or sulky .....................

54. A feels dissatisfied with certain aspects of his physical appearance and would change them if he could
    B is satisfied with his physical appearance just as it is ..........................................

55. A can usually hold his own in any situation
    B finds it difficult to hold his own in all
Appendix A:

Adolescent Self-concept Scale Questionnaire (continued)

56. A usually ignores the wishes of his parents
    B always considers the wishes of his parents ...... A B

57. A is very religious
    B is not very religious .............................. A B

58. A feels that other find it difficult to make
    friends with him
    B is sure that others make friends easily with him A B

59. A feels dissatisfied because he is often unwell
    B is satisfied with the state of his health ...... A B

60. A does not become annoyed when he is rebuked
    B cannot tolerate rebuke ............................ A B

61. A sometimes has serious quarrels with members of his family
    B never has serious quarrels with members of his family A B

62. A is always friendly
    B is not always friendly ............................ A B

63. A's family seldom ask his opinion
    B's family consults him about most of their affairs. A B

64. A longs for more attention from the opposite sex
    B is satisfied with the attention he gets from the opposite sex A B

65. A usually performs well
    B often performs badly ............................. A B

66. A's family criticize him often
    B seldom offends in the eyes of his family....... A B

67. A is sometimes irritable when he is unwell
    B is never irritable when he is unwell .......... A B

68. A is particularly popular amongst friends of his own sex
    B is not very popular amongst friends of his own sex .............................. A B
Appendix A:

Adolescent Self-concept Scale Questionnaire (continued)

69. A thinks that his family does not love him  
    B is completely sure of his family's love ............ A  B

70. A likes to care for his body to the best of his  
    ability  
    B often feels guilty because he neglects his body... A  B

71. A often acts without first considering the  
    consequences of his deeds  
    B carefully considers the consequences before he  
    takes action .................................................. A  B

72. A is particularly popular with the opposite sex  
    B is not very popular with the opposite sex ......... A  B

73. A feels that his family is suspicious of  
    everything he does  
    B is sure that he is trusted by his family in  
    everything ...................................................... A  B

74. A occasionally thinks about improper things which  
    cannot be discussed  
    B never thinks about improper things ............... A  B

75. A enjoys exacting work  
    B prefers routine work ...................................... A  B

76. A easily changes his opinions; he never disagrees  
    B firmly adheres to his convictions ..................... A  B

77. A has relatives who will support him in any situation  
    B does not have relatives on whom he can rely in any  
    situation .......................................................... A  B

78. A is calm and composed in almost any circumstances  
    B can never defend his viewpoint in a calm and  
    composed manner .............................................. A  B

79. A often gets cross when he is thwarted  
    B seldom gets cross when he is thwarted .............. A  B

80. A feels very energetic most of the time  
    B feels tired and lethargic most of the time ....... A  B
Appendix A:

Adolescent Self-concept Scale Questionnaire (continued)

81. A is a member of a very happy family
    B's family is not very happy

82. A does not feel inferior to his friends
    B feels inferior to his friends and acquaintances
    in many ways

83. A usually finds it very difficult to reach a decision
    B considers the available information and usually
    decides quickly

84. A is usually cheerful irrespective of circumstances
    B is only cheerful when things go well

85. A feels that he is highly respected by his family
    B thinks that he is unimportant in the eyes of his family

86. A often regards himself as a bad person
    B regards himself as a good person

87. A is a good mixer and usually enlivens the company
    B often wishes that he could be more sociable

88. A feels guilty because he seldom goes to church
    B finds his church attendance satisfactory

89. A takes an interest in his family and visits them often
    B does not take much interest in his family

90. A is always very polite to strangers
    B often finds himself lacking in courtesy

91. A is very clumsy and awkward in certain situations
    B seldom suffers from clumsiness and awkwardness

92. A is satisfied that he faithfully observes the virtues of honesty, integrity, loyalty, truthfulness, etc.
    B often feels guilty because he neglects these
Appendix A:
Adolescent Self-concept Scale Questionnaire (continued)

93. A is almost never reserved or selfconscious
    B is usually reserved and selfconscious with
    strangers and particularly with people in
    authority .................................................

94. A is very nervous when he has to appear before a
    group of people
    B almost never suffers from nervousness ..........

95. A is someone who does not feel particularly guilty
    if he is compelled to tell a small lie
    B is someone who never tells a lie ...............  

96. A's religion offers him considerable inspiration,
    comfort and hope
    B constantly worries about his religion ............

97. A is easily worried
    B seldom suffers anxiety ..............................

98. A often feels guilty about his frequent
    irresponsible behaviour
    B is satisfied that he fulfils his responsibilities

99. A usually understands the members of his family
    very well
    B frequently misunderstands his family .............

100. A is someone who sacrifices much to help the
    underprivileged
    B is hardly aware of the poor, cripples, blind
    people etc. and ignores rather than helps them ..
Appendix B:
Eating Habits Questionnaire for Adolescents (developed by the researcher)

SECTION A: BIOGRAPHICAL INFORMATION

1. SURNAME: ___________________ INITIALS: ___________________ DATE: ________

2. ALLOTTED NUMBER: ____________

3. GRADE: (08 ; 09; 10; 11; 12) ____________

4. GENDER: MALE = 1
   FEMALE = 2

5. AGE IN YEARS: (EG. 12, 13, 14 ETC.) ____________

6. TYPE OF PARENTS:
   1 = LIVING WITH BOTH PARENTS
   2 = DIVORCED PARENTS - LIVING WITH MOTHER
   3 = DIVORCED PARENTS - LIVING WITH FATHER
   4 = DIVORCED PARENTS - LIVING WITH GRANDPARENTS / GUARDIAN

7. BIRTH ORDER:
   1 = YOUNGEST
   2 = ELDEST
   3 = MIDDLE
   4 = ONLY CHILD

8. HEIGHT (IN CM. EG. 155.6 OR 155.0 ETC.) ____________

9. WEIGHT (IN KILOGRAMS EG. 080, 090, 100 ETC) ____________

10. HEALTH:
    1 = POOR
    2 = EXCELLENT
    3 = MEDIUM

11. PARTICIPATION IN SPORT:
    1 = YES
    2 = NO
Appendix B:
Eating Habits Questionnaire for Adolescents (continued)

12. PHYSICAL DISABILITIES (EG. EYES, EARS, LIMBS)
   1 = YES
   2 = NO

13. AGGREGATE PERCENTAGE OBTAINED IN NOVEMBER 1999

14. THE NUMBER OF CHILDREN IN YOUR FAMILY

15. PHYSICAL APPEARANCE OF MOTHER
   1 = THIN
   2 = OVERWEIGHT
   3 = NORMAL WEIGHT

16. PHYSICAL APPEARANCE OF FATHER
   1 = THIN
   2 = OVERWEIGHT
   3 = NORMAL WEIGHT

17. ARE YOU A VEGETARIAN? (DO NOT EAT MEAT)
   1 = YES
   2 = NO

18. DO YOU BELONG TO A RELIGION WHERE THE EATING OF CERTAIN FOODS IS FORBIDDEN?
   1 = YES
   2 = NO

19. DO YOU BELONG TO A RELIGION WHERE FASTING IS PRACTICED BY YOU?
   1 = YES
   2 = NO

20. DO YOU HAVE A GOOD RELATIONSHIP WITH YOUR MOTHER?
   1 = YES
   2 = NO

21. DO YOU HAVE A GOOD RELATIONSHIP WITH YOUR FATHER?
   1 = YES
   2 = NO
Appendix B:
Eating Habits Questionnaire for Adolescents (continued)

22. DO YOU KNOW WHAT THE RISKS OF OBESITY ARE?
   1 = YES
   2 = NO

23. DO YOU KNOW WHAT THE DANGERS OF EXCESSIVE DIETING ARE?
   1 = YES
   2 = NO

24. WHAT RACE GROUP DO YOU BELONG TO?
   1 = BLACK
   2 = WHITE
   3 = ASIAN
   4 = OTHER

25. ARE YOU AN ACTIVE PARTICIPANT IN SPORT?
   1 = YES
   2 = NO

26. WHERE DO YOU OBTAIN MOST OF YOUR INFORMATION ABOUT NUTRITION?
   1 = T.V.
   2 = PARENTS / GUARDIANS
   3 = FRIENDS
   4 = SCHOOL TEACHERS
   5 = MAGAZINES
   6 = PHYSICIANS
   7 = RADIO

27. DO YOU THINK THAT LEARNING MORE ABOUT NUTRITION SHOULD BE INTEGRATED INTO THE SCHOOL CURRICULUM?
   1 = YES
   2 = NO

28. WORKING STATUS OF PARENTS.
   1 = BOTH PARENTS WORK
   2 = MOTHER STAYS AT HOME AND FATHER WORKS
   3 = FATHER STAYS AT HOME AND MOTHER WORKS
   4 = NEITHER OF YOUR PARENTS HAVE A JOB
Appendix B:

Eating Habits Questionnaire for Adolescents (continued)

SECTION B:

CONSIDER EACH STATEMENT BELOW AND ANSWER AS HONESTLY AS YOU CAN. INDICATE YOUR PREFERENCE BY MEANS OF THE CODE NUMBER AS INDICATED ON THE SCORE. PLACE THE CODE NUMBER IN THE BLOCK NEXT TO THE STATEMENT.

CODE:
1 = ALWAYS
2 = USUALLY (SOMETIMES)
3 = RARELY (HARDLY EVER)
4 = NEVER

1. WHEN YOU EAT OUT WITH YOUR PARENTS, HOW OFTEN ARE YOU FREE TO CHOOSE WHICH MEAL YOU WANT TO ORDER?

2. HOW OFTEN DO YOU TAKE MINERAL SUPPLEMENTS?

3. HOW OFTEN DO YOU EAT A MEAL WITH YOUR PARENTS?

4. HOW OFTEN DO YOU FEEL TOO EMBARRASSED OF YOUR PHYSIQUE TO PARTICIPATE IN PHYSICAL ACTIVITIES SUCH AS SWIMMING AND ATHLETICS?

5. HOW OFTEN DO YOUR PARENTS DISCUSS THE NUTRITIONAL VALUE OF FOOD WITH YOU?

6. HOW OFTEN DO YOU AVOID PARTICIPATING IN PHYSICAL ACTIVITIES?

7. HOW OFTEN DO YOUR PARENTS BUY TAKE-AWAY FOODS?

8. HOW OFTEN DO YOU ENGAGE IN DIETING BEHAVIOUR?

9. HOW OFTEN DO YOU EAT DIET FOODS? (IE. LOW CALORIE FOOD)

10. HOW OFTEN DO YOU FEEL OBLIGED TO EAT CRISPS, SWEETS, BISCUITS ETC. WHEN OFFERED TO YOU BY YOUR FRIENDS?
Appendix B:

Eating Habits Questionnaire for Adolescents (continued)

11. HOW OFTEN DO YOU BINGE ON FOOD WHEN YOU HAVE NEGATIVE FEELINGS SUCH AS ANGER, FRUSTRATION, SADNESS ETC.

12. HOW OFTEN DO YOU DISCUSS THE NUTRITIONAL VALUE OF FOOD WITH YOUR FRIENDS?

13. HOW OFTEN DO YOU EAT MEALS WHILE WATCHING TELEVISION?

14. HOW OFTEN DO YOU FEEL THAT FOOD CONTROLS YOUR LIFE?

15. HOW OFTEN DO YOU RAID THE KITCHEN FOR SOMETHING TO NIBBLE ON WHEN FOOD IS ADVERTISED ON TELEVISION?

16. HOW OFTEN ARE YOU DISSATISFIED WITH YOUR WEIGHT?

17. HOW OFTEN DO YOU THINK THAT LIFE WOULD BE PERFECT AND HAPPY IF YOU COULD LOOK LIKE THE SLIM MODELS THAT YOU SEE ON TELEVISION?

18. HOW OFTEN DO YOU FEEL THAT YOU GIVE TOO MUCH TIME AND THOUGHT TO FOOD?

19. DO YOU FIND THAT YOU SNACK ON CHIPS, SWEETS ETC. MORE FREQUENTLY WHEN STUDYING FOR TESTS AND EXAMS?

20. IS FOOD AN IMPORTANT FEATURE WHEN YOU GET TOGETHER WITH FRIENDS?

21. HOW OFTEN DO YOU SNACK ON CRISPS, CHOCOLATES ETC. WHEN YOU FEEL BORED?

22. WHEN YOU SEE A NEW KIND OF CHOCOLATE, ICE CREAM, BEVERAGE ETC. ADVERTISED ON TELEVISION DO YOU BUY IT IN ORDER TO TRY IT?

23. HOW OFTEN DO YOU FEEL GUILTY AFTER EATING?
Appendix B:
Eating Habits Questionnaire for Adolescents (continued)

24. HOW OFTEN DO YOU GO TO THE FRIDGE IN SEARCH OF A FIZZY COOL DRINK WHEN YOU SEE A COCA-COLA ADVERT ON TELEVISION? 

25. HOW OFTEN DO YOU FEEL YOU MAY NOT BE ABLE TO STOP EATING? 

26. HOW OFTEN DO YOU FEEL UNCOMFORTABLE WHEN TELEVISION PROGRAMS AND ADVERTISEMENTS GIVE THE MESSAGE, "THIN IS IN"? 

27. HOW OFTEN IS YOUR CHOICE OF FOOD DETERMINED BY WHAT YOUR FRIENDS EAT WHEN YOU ARE IN THEIR COMPANY? 

28. HOW OFTEN DO YOU TAKE VITAMIN SUPPLEMENTS? 

29. HOW OFTEN ARE YOU SECRETIVE ABOUT YOUR EATING HABITS? 

30. HOW OFTEN DO YOU AVOID FOODS WITH SUGAR IN THEM? 

31. HOW OFTEN ARE YOU WORRIED THAT YOU MAY HAVE AN EATING DISORDER? 

32. HOW OFTEN IS YOUR CHOICE OF FOODS INFLUENCED BY YOUR KNOWLEDGE OF A BALANCED DIET? 

33. HOW OFTEN DO YOU EAT A HIGH CALORIE DIET WITH EXCESSIVE PROTEIN? 

34. HOW OFTEN DO YOU WORRY ABOUT NOT GETTING ENOUGH TO EAT WHEN GOING TO A PARTY? 

35. HOW OFTEN DO YOU EAT FOOD WITH A HIGH FAT CONTENT? 

36. HOW OFTEN DO YOU FEEL UNCOMFORTABLE WHEN PEOPLE COMMENT ON YOUR WEIGHT? 

37. HOW OFTEN DO YOU KNOW THE CALORIE CONTENT OF THE FOODS THAT YOU EAT?
Appendix B:
Eating Habits Questionnaire for Adolescents (continued)

38. HOW OFTEN DO YOU HEAR NEGATIVE MESSAGES IN YOUR HEAD BECAUSE OF YOUR PHYSICAL APPEARANCE?

39. HOW OFTEN DO YOU AVOID FOOD WITH A HIGH CARBOHYDRATE CONTENT (I.E. BREAD, RICE, POTATOES ETC.?)

40. HOW OFTEN DO YOU SPEND TIME WISHING THAT YOU COULD BE THINNER?

41. HOW OFTEN DO YOU KNOW THE SUGAR CONTENT OF THE BEVERAGES THAT YOU DRINK?

42. HOW OFTEN DO YOU EAT SALAD DURING THE DAY?

43. HOW OFTEN ARE YOU ABLE TO IDENTIFY FOODS HIGH IN FAT?

44. HOW OFTEN DO YOU EAT SNACK FOODS SUCH AS CHIPS, BISCUITS, SWEETS ETC. DURING THE DAY?

45. HOW OFTEN ARE YOU AWARE OF THE CHOLESTEROL CONTENT OF FOOD THAT YOU EAT?

46. HOW OFTEN DO YOU EAT FRUIT DURING THE DAY?

47. HOW OFTEN DO YOU KNOW WHICH VITAMINS ARE FOUND IN THE FOOD THAT YOU EAT?

48. HOW OFTEN DO YOU EAT FAST FOODS FROM A CANTEEN OR A RESTAURANT?

49. HOW OFTEN DO YOU SAY NO TO CERTAIN FOODS OR BEVERAGES BECAUSE OF THE NEGATIVE EFFECT THAT THEY MAY HAVE ON YOUR TEETH?

50. HOW OFTEN DO YOU USE CONDIMENTS SUCH AS TOMATO SAUCE, CHUTNEY ETC.?

51. HOW OFTEN DO YOU SKIP BREAKFAST?

52. HOW OFTEN DO YOUR FRIENDS INFLUENCE YOU TO BUY AND / OR TO EAT JUNK FOODS SUCH AS CRISPS, ICE CREAMS, SWEETS, FIZZY COOL DRINKS ETC.?
Appendix B:

Eating Habits Questionnaire for Adolescents (continued)

53. HOW OFTEN DO YOU CHOOSE BETWEEN FOODS ON THE BASIS OF THEIR FIBRE CONTENT?

54. HOW OFTEN DO YOU EAT VEGETABLES DURING THE DAY?

55. HOW OFTEN DO YOU READ THE NUTRITIONAL LABELS ON FOODS?

56. HOW OFTEN DO YOU EAT PROTEIN (MEAT, FISH, CHICKEN ETC.)?

57. DO YOU KNOW WHICH MINERALS ARE FOUND IN THE FOOD THAT YOU EAT?

58. HOW OFTEN IS FRUIT MADE AVAILABLE TO YOU AT HOME?

59. HOW OFTEN DO YOU DRINK FIZZY COOL DRINKS?

60. HOW OFTEN ARE YOU ABLE TO CLASSIFY THE FOOD THAT YOU EAT ACCORDING TO THE FOOD GROUPS: CARBOHYDRATES, LIPIDS, AND PROTEINS?

61. HOW OFTEN DO YOU CONSIDER YOUR INTAKE OF SALT TO BE HIGH? (I.E. YOU ADD SALT TO FOOD THAT HAS BEEN SALTED?)

62. HOW OFTEN DO YOU WORK AT A COMPUTER FOR MORE THAN 3 HOURS DURING THE DAY?

63. HOW OFTEN DO YOU DRINK WATER DURING THE DAY?

64. HOW OFTEN DO YOU EXERCISE AT A GYM AND / OR AT HOME?

65. HOW OFTEN DO YOU USE LAXATIVES TO LOSE WEIGHT?

66. HOW OFTEN DO YOU WATCH TELEVISION FOR MORE THAN 3 HOURS DURING THE DAY?

67. HOW OFTEN DO YOU PARTICIPATE IN PHYSICAL EXTRA-MURAL ACTIVITIES AT SCHOOL?
Appendix B:
Eating Habits Questionnaire for Adolescents (continued)

68. HOW OFTEN DO YOU USE SMOKING TO CONTROL YOUR APPETITE AND WEIGHT?  

69. HOW OFTEN DO YOU EXERCISE IN ORDER TO WORK OFF CALORIES RATHER THAN TO STAY FIT?  

70. HOW OFTEN DO YOU USE DIET PILLS TO CONTROL YOUR WEIGHT?  

71. HOW OFTEN DO YOU VIEW PHYSICAL EXERCISE AS A PLEASURABLE ACTIVITY?  

72. HOW OFTEN DO YOUR PARENTS QUESTION YOUR EATING HABITS? (I.E. THEY ARE NOT HAPPY WITH YOUR EATING HABITS)  

73. HOW OFTEN DO YOU FEEL THAT THE FOOD PREPARED BY YOUR PARENTS FOR YOU IS NUTRITIONALLY UNBALANCED?  

74. HOW OFTEN DO YOU HAVE TO PREPARE YOUR OWN MEALS?  

75. HOW OFTEN DO YOU FEEL THAT YOU ARE OVERWEIGHT?  

76. HOW OFTEN DO YOU WISH THAT YOU WERE THINNER?  

77. HOW OFTEN DO YOU HAVE A NEGATIVE ATTITUDE TOWARDS PEOPLE WHO ARE OBESE?  

78. HOW OFTEN DO YOU WEIGH YOURSELF DURING THE WEEK?  

79. HOW OFTEN HAS YOUR MOTHER DIETED?  

80. HOW OFTEN HAS YOUR FATHER DIETED?  

81. HOW OFTEN DO YOU FEEL SCARED OF BECOMING OVERWEIGHT?  

82. HOW OFTEN DO YOU FEEL THE REFLEX TO THROW UP AFTER MEALS?
Appendix B:
Eating Habits Questionnaire for Adolescents (continued)

83. HOW OFTEN DO YOU THINK THAT DATING SOMEONE OF THE OPPOSITE SEX IS EXTREMELY IMPORTANT?  

84. HOW OFTEN DO YOU THINK THAT SLIMNESS IS AN IMPORTANT FACTOR IN DATING AND POPULARITY WITH THE OPPOSITE SEX?

85. HOW OFTEN DO YOU EAT BETWEEN MEALS?

86. HOW OFTEN DO YOU DO THE GROCERY SHOPPING FOR THE FAMILY?
Appendix C:
Transformation of raw scores into stanines for total Eating Habits Questionnaire for Adolescents

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Appendix C:
Transformation of raw scores into stanines for total Eating Habits Questionnaire for Adolescents (continued)

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Appendix D:
Distribution of the items in the various dimensions used in Section B of the eating Habits Questionnaire for Adolescents

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<td>• Physical exercise</td>
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Appendix E:
Emotions Profile Index (Plutchik & Kellerman 1974)

**DEFINITIONS**

**ADVENTUROUS:** Someone who often tries new activities for excitement.

**AFFECTIONATE:** Someone who often shows his warmth and love for others.

**BROODING:** Someone who silently stewes with anger and keeps it to himself.

**CAUTIOUS:** Someone who is usually careful because he is afraid of what might happen to him.

**GLOOMY:** Someone who mopes around and feels in a sad and dark kind of mood.

**IMPULSIVE:** Someone who usually acts on the spur of the moment because of an urge, without thinking of the consequences.

**OBEDIENT:** Someone who will usually do what he is told, without objecting.

**QUARRELSOME:** Someone who often starts arguments.

**RESENTFUL:** Someone who walks around with a "chip on his shoulder" and is easily made angry.

**SELF-CONSCIOUS:** Someone who usually worries about other people's opinion of him when he is with them.

**SHY:** Someone who usually feels timid with other people and in new situations.

**SOCIAL:** Someone who is friendly and who usually likes to be with other people.

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<th>Column 3-Ti</th>
<th>Column 4-De</th>
<th>Column 5-Di</th>
<th>Column 6-Co</th>
<th>Column 7-Ag</th>
<th>Column 8-Gr</th>
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<tr>
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</tr>
</tbody>
</table>
Appendix F :
Draw A Person

1. Is this a boy or a girl? Give this person a name. How old is he/she?

2. Would you like to be like him/her? Why?

3. How does he/she feel at the moment?

4. When he/she looks in the mirror what does he/she see?

5. What makes him/her most happy?

6. What is his/her favourite food?

7. Do other children like him/her? Why (not)?

8. What makes him/her most angry?

9. If he/she could change his/her physical appearance which part(s) would he/she change?

10. If nobody could see him/her what would he/she like to do most?

11. If he/she had another life and could be an animal, what sort of animal would he/she like to be? Why?

12. Suppose he/she could turn other people into animals who would he/she turn then into?

13. One day he/she cried and went to bed. Why?
Appendix F:

Draw A Person (continued)

14. When he/she fell asleep he/she had a dream. What about? 

15. He/she woke up in the middle of the night and he/she was scared. Why? What did he/she do then? 

16. When he/she went to sleep again, a fairy came to him/her and said, "I'll give you three whishes. Something to have, something to do and something to change." What did he/she wish? 

__________________________

__________________________

__________________________
Appendix G:
Sentence Completion

Sentence Completion

Name: ____________________________  Date: _________________________
Sex: ____________________________  Age: _______________

Complete these sentences to express your real feelings. Make full sentences.

1. I feel ____________________________

2. My mother ____________________________

3. My greatest fear ____________________________

4. I suffer ____________________________

5. When I eat ____________________________

6. My mind ____________________________

7. I need ____________________________

8. Most boys ____________________________

9. My father ____________________________

10. I secretly ____________________________
Appendix G:
Sentence Completion (continued)

11. I want to change ____________________________

12. I wish ____________________________

13. Most girls ____________________________

14. When I see models in magazines ____________________________

15. I hate ____________________________

16. My body ____________________________

17. Food ____________________________

18. My greatest weakness ____________________________

19. A fat person ____________________________

20. A thin person ____________________________
### Appendix H:
Dietary Record (Golden, Dowd & Friedberg 1987)

| Day / Time | Food & Amount | Activity | Location | Thoughts | Feelings |
|------------|---------------|----------|----------|----------|----------|----------|
|            |               |          |          |          |          |
|            |               |          |          |          |          |
|            |               |          |          |          |          |
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|            |               |          |          |          |          |
|            |               |          |          |          |          |
|            |               |          |          |          |          |
Appendix I:
Interview

1. Biographical Information
   Name: 
   Age: 
   Standard: 

2. Medical History
   Illnesses: 
   Operations: 
   Medication: 

3. Behaviour Patterns
   Sleep pattern: 
   Eating Pattern: 
   Previous Professional Help: 
   Smoking, Drugs, Alcohol: 
   How do you experience your body?
Appendix 1:
Interview (continued)

4. Earlier History (Resources)
Tell me about your primary school years – how well did you do at sport, school etc.:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Sum up in one word or sentence your childhood years.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

If I was Big Brother and I looked in through a window at you in your childhood years, what type of child would I look at? What would you be doing?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

High School: Tell me about your high school years – how well have done so far?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Appendix 1:
Interview (continued)

5. Relationships:

Boyfriends:

Elaborate: Were the relationships positive or negative?

6. Do you have a faith?
What is your viewpoint on religion?

7. Do you do any physical activities?
Appendix I:
Interview (continued)

8. **Hobbies?**

9. **What is exciting in your life?**

10. **What do you expect from therapy?**
Appendix J:
Draw A Person - Case Studies A, B, H and I

DAP Case Study A

DAP Case Study B

DAP Case Study H

DAP Case Study I
Appendix K:
Letter of consent

Dear ____________________

I am presently doing my Doctorate / PhD in Educational Psychology. I am a guidance teacher and Educational Psychologist.

I am researching unhealthy eating habits (under-eating and over-eating) and low self-esteem. I have invited pupils to volunteer their interest in participating in the programme free of charge. The psychotherapy programme includes both individual and group therapy for ± 8 sessions.

If you are willing to allow your child to participate in my research programme then please fill in the tear off slip below.

Yours sincerely

NADINE DE BEER

I _______________________________ the parent / guardian of _______________________________
will allow my child to participate in Mrs de Beer’s psychotherapy programme.

I _______________________________ the participant agree to participate in the psychotherapy programme and to have items of work published.
APPENDIX L:
CASE STUDIES C, D, E, F AND G

CASE STUDY C

Background
Gaby is a thirteen-year-old white female and is in grade eight. She lives with both her parents and is the youngest of three children. The physical activity that she participates in is hockey. The physical appearance of her mother is overweight and the physical appearance of her father is of normal weight. She obtains most of her information about nutrition from magazines. She is anaemic.

Adolescent Self-concept Scale (ASCS)
The respective self-concept scores for Gaby have been calculated. The score before the Psycho-educational programme is given and compared to the score after intervention has taken place.

Case study C ASCS scores

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>Low self-concept</th>
<th>Medium self-concept</th>
<th>High self-concept</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>28 - 55</td>
<td>56 - 70</td>
<td>71 – 90</td>
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<tr>
<td>Before therapy</td>
<td>48</td>
<td></td>
<td></td>
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<tr>
<td>After therapy</td>
<td></td>
<td>59</td>
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</tbody>
</table>

The lowest dimension of the self-concept was the Physical and Personal dimensions. The overall self-concept score for case study C shows a significant improvement from 48 to 59. The client’s self-concept has changed from a low self-concept to a medium self-concept.
Eating Habits Questionnaire for Adolescents (EHQA)
The overall score for the Eating Habits Questionnaire for Adolescents has been calculated. The score before the Psycho-educational programme is given and compared to the score after intervention has taken place.

Case Study C EHQA scores

<table>
<thead>
<tr>
<th>CLASSIFICATION</th>
<th>Good eating habits</th>
<th>Average eating habits</th>
<th>Bad eating habits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>64 - 120</td>
<td>121 - 147</td>
<td>148 - ∞</td>
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<tr>
<td>Before therapy</td>
<td></td>
<td></td>
<td>214</td>
</tr>
<tr>
<td>After therapy</td>
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<td></td>
<td>201</td>
</tr>
</tbody>
</table>

The score of case study C has improved from 214 to 201 but remains within the bad eating habits range.

Body Mass Index (BMI)
The Body Mass Index of case study C has been calculated. The classification of weight before the Psycho-educational programme is given and compared to be Body Mass Index after intervention has taken place.

Case study C BMI scores

<table>
<thead>
<tr>
<th>CLASSIFICATION</th>
<th>Underweight</th>
<th>Normal range</th>
<th>Overweight</th>
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<td>&lt; 18,5 kg/m²</td>
<td>18,5 – 24,9 kg/kg/m²</td>
<td>&gt; 25 kg/m²</td>
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<tr>
<td>Before therapy</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After therapy</td>
<td>16</td>
<td></td>
<td></td>
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</tbody>
</table>
Gaby is 1.51 m tall, weighed 34 kilograms at the start of the intervention programme and weighed 36 kilograms eight months after intervention. Her Body Mass Index score has improved from 15 kg/m² to 16 kg/m² but remains in the range of being underweight.

**Emotions Profile Index (EPI)**

[Emotions Profile Index Diagram]

**Emotions Profile Index of case study C**

A high score of 92 on the Timid Dimension reveals that she tends to be careful, cautious and anxious. She worries about getting into trouble and about what people think and say of her. A percentile of 10 on the Depressed Dimension could indicate that she is satisfied with her style of life or possible denial. A low score of 20 on the Distrustful Dimension reveals that Gaby tends to be uncritical and not rejecting. A high percentile of 96 on the Controlled Dimension indicates a tendency to organise her life and a need for order. She likes to be organised. A low percentile of 26 on the Aggressive Dimension indicates that Gaby has little anger or is reluctant to express it overtly.

**Draw A Person (DAP)**

With the consent of case study C, the researcher has provided the reader with the person drawn by the client.
Draw A Person of case study C

The emotional indicators include: the position of the drawing at the bottom of the page which may indicate unhappiness and possible depression; feet in opposite directions which may indicate a problem with her feelings towards her education situation or upbringing. According to the Draw a Person questionnaire of Appendix H, Gaby has presented a nine year old girl, Cindy who when she looks in the mirror sees a sportive person. Cindy is liked by other children because she is pretty and if nobody could see her the thing she would like to do most is “run around like wild”. One day, Cindy cried and went to bed because she had a big fight with her mom and she dreamt that she and her mother could be “very, very good friends”.
**Sentence Completion**

Significant responses to the sentence completion area as follows: *I suffer* “most when I hear people have been talking about me”; *I secretly* “dislike my appearance”; *I want to change* “the way I look”; *I wish* “I was pretty”; *When I see models in magazines* “I feel real ugly”.

From the above responses one can see that the theme of the responses revolves around dissatisfaction with her appearance.

**Dietary Record**

Food recorded eaten by the client most frequently included: doughnuts, Chappies, toast, bread, sweets, coffee and pasta. Activities while eating included: watching television, sitting in a car, standing and lying down. Thoughts while eating included: not liking the food eaten, wanting more food. Feelings recorded while eating included: tiredness and moodiness.

Gaby tends to eat a lot of fast foods and junk food such as chips, sweets and biscuits. A theme of feeling down and exhausted is evident. The therapist explored the possibility of her exhaustion being attributed to her condition of anaemia but the client is being treated medicinally for the anaemia.

**Interview**

From the interview the therapist gained access to the clients achievements at primary school which included: being in the top twenty academically, receiving a gold certificate for English, receiving the award for the best hockey player of the year, receiving certificates for perseverance and diligence. At high school she has played in the A team for hockey, participated in the Mpumalanga hockey final trials and participated in athletics as a sprinter. Her hobby is art and she plays hockey. From therapy she expects to learn to be more self-accepting and to develop healthier eating habits.

The information gleaned from the interview was used as ego-strengthening in hypnotherapy in session two (see 4.2.2) and in session five: transformation of self-concept (see 4.2.5). The information was also used in individualised gift-wrapping.
Gift-wrapping

According to the Ericksonian Diamond (see 3.4.4.1) the therapist’s goal was to communicate to the client that she can learn to accept herself as a unique person and that by gaining more self-knowledge about her biological and psychological self she can own her hopes and fears.

Gift-wrapping, tailoring, processing and utilisation were used during the Psycho-educational programme as set out in section 3.4.4.1. Individualized gift-wrapping included a metaphor based on a Poem written by Virginia Satir.

After putting the client in hypnosis the therapist told the story of:

a girl, who on unwrapping her birthday present found a talking number plate. (The therapist used a number plate because the client had told her that she dreamt she received a number plate the night before) and the number plate said “I am me … In all the world, there is no one else like me … There are persons who have some parts … like me, but no one adds up exactly like me … Therefore … everything that comes out of me is authentically mine … because I alone chose it … I own everything about me … my body, including everything it does … my mind, including all its thoughts … and ideas … my eyes, including the images of all they behold … my feelings, whatever they may be … anger, joy, frustration, love, disappointment, excitement … my mouth, and all the words that come out of it … polite, sweet or rough … correct or incorrect … my voice, loud or soft … and all my actions … whether they be to others or to myself … I own my fantasies … my dreams …. my hopes … my fears … I own all my triumphs and successes … all my failures and mistakes … because I own all of me … I can become intimately acquainted with me … By doing so I can love me and be friendly with me in all my parts … I can then make it possible for all of me to work in my best healthy interests … I know there are aspects about myself that puzzle me … and other aspects that I do not know … But as long as I am friendly and loving to myself … I can courageously and hopefully look for the solutions to the puzzles and for ways to find out more about me … However, I look and sound … whatever I say and do … and whatever I think and feel at a given moment in time … is me … This is authentic and represents where I am at that moment in time … When I review later how I looked … and sounded … what I said and did … and how I thought and felt … some parts may turn out to be unfitting … I can discard that
which is unfitting ... and keep that which proved fitting ... and invent something new and healthy for that which I discarded ... I can see, hear, feel, think, say, eat and do ... I have the tools to survive ... to be close to others ... to be productive ... and to make sense and order out of the world of people ... and things ... outside of me ... I own me ... and therefore I can engineer me ... I am me ... and I am okay” ... and you can spoil yourself ... maybe you can visualise ... being on the top twenty ... receiving a gold certificate for English ... receiving the award for the best hockey player of the year ... receiving certificates for perseverance ... and diligence ... and sprinting ... sprinting your way to the enjoyment of the new you ... and when you are ready ... you can re-orientate yourself to the here ... and the now.

The metaphor was used to help the client to acknowledge that she is unique and that she can feel comfortable with her inner and outer self.

Feedback from Adolescent C on therapy
Gaby reported that she benefited from cognitive behaviour therapy in that she discovered new things about her thought processes. It helped her to realise that her thoughts about herself were negative and could influence the way she feels when she feels down and moody. The hypnotherapy gave her a chance to “take time and see my inner self and talk to myself”. She felt that the hypnotherapy was refreshing and kept her ‘stable’. The group therapy helped her to talk to people and to hear what they think of themselves.

As a researcher she believes that self-concept can influence eating habits in that if a person thinks that they are fat they will tend to eat less. Her message to adolescents is not to place too much emphasis on what other people say about them. She also said “If you can believe in yourself enough, you can do anything”. Her message to psychologists is that they must “make their patients trust them otherwise it’s a waste of time” and they must “try to be a friend so that they open up to you”.


CASE STUDY D

Background
Spud (not her real name) is a fourteen-year-old white female and is in grade eight. She lives with her mother, her father died two years ago from inhaling gas from a leaking cylinder when on holiday, and she is the middle child of three children. The physical activities she participates in is hockey and tibo (self defense). The physical appearance of her parents is of normal weight. She obtains most of her information about nutrition from teachers.

Adolescent Self-concept Scale (ASCS)
The respective self-concept scores for Spud have been calculated. The score before the Psycho-educational programme is given and compared to the score after intervention has taken place.

Case study D ASCS scores

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>Low self-concept</th>
<th>Medium self-concept</th>
<th>High self-concept</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>28 - 55</td>
<td>56 – 70</td>
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<tr>
<td>Before therapy</td>
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</tr>
<tr>
<td>After therapy</td>
<td></td>
<td>57</td>
<td></td>
</tr>
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</table>

The lowest dimension of the self-concept was the Physical dimension. The overall self-concept score for case study D shows an improvement from 55 to 57. The client’s self-concept has changed from a low self-concept to a medium self-concept.

Eating Habits Questionnaire for Adolescents (EHQA)
The overall score for the Eating Habits Questionnaire for Adolescents has been calculated. The score before the Psycho-educational programme is given and compared to the score after intervention has taken place.
Case Study D EHQA scores

<table>
<thead>
<tr>
<th>CLASSIFICATION</th>
<th>Good eating habits</th>
<th>Average eating habits</th>
<th>Bad eating habits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>64 – 120</td>
<td>121 - 147</td>
<td>148 - ∞</td>
</tr>
<tr>
<td>Before therapy</td>
<td></td>
<td></td>
<td>219</td>
</tr>
<tr>
<td>After therapy</td>
<td></td>
<td></td>
<td>200</td>
</tr>
</tbody>
</table>

The score of case study D has improved from 219 to 200 but remains within the bad eating habits range.

**Body Mass Index (BMI)**

The Body Mass Index of case study D has been calculated. The classification of weight before the Psycho-educational programme is given and compared to be Body Mass Index after intervention has taken place.

**Case study D Body Mass Index scores**

<table>
<thead>
<tr>
<th>CLASSIFICATION</th>
<th>Underweight</th>
<th>Normal range</th>
<th>Overweight</th>
</tr>
</thead>
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<td>&lt; 18,5 kg/m²</td>
<td>18,5 – 24,9 kg/ kg/m²</td>
<td>&gt; 25 kg/m²</td>
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<td>Before therapy</td>
<td>19</td>
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<td></td>
</tr>
<tr>
<td>After therapy</td>
<td>20</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Spud is 1,63m tall, weighed 51 kilograms at the start of the intervention programme and weighed 54 kilograms eight months after intervention. Her Body Mass Index score has changed from 19 kg/m² to 20 kg/m² but remains in the normal range.

**Emotions Profile Index (EPI)**

The Emotions Profile Index of case study D prior to the Psycho-educational programme is depicted on the diagram below.
Emotions Profile Index of case study D

A high score of 96 on the Trustful Dimension indicates that Spud tends to be accepting and trustful. A low score of 28 on the Dyscontrol Dimension indicates that she tends not to be impulsive and withdraws from social contacts. A percentile of 39 on the Depressed Dimension indicates that she tends to be satisfied with her style of life. A low score of 25 on the Controlled Dimension reveals that she tends to live her life on a day-to-day basis and she does not plan for the future. A high percentile of 99 on the Gregarious Dimension reveals that she tends to be friendly and affectionate.

Draw A Person (DAP)

With the consent of case study D, the researcher has provided the reader with the person drawn by the client.
The emotional indicators include: extensive colouring in indicates possible anxiety, shading of the face indicates a poor self-concept; the shading of arms indicates possible aggressive impulses; transparency of body through the dress may reveal immaturity; long arms which may indicate ambition for achievement or reaching out to others; feet in opposite directions may indicate a problem with her feelings towards her education situation or upbringing.

According to the Draw a Person questionnaire of Appendix H, Spud has presented a fourteen year old girl Riana who when she looks in the mirror sees a fat person. Riana is a skinny girl and if nobody could see her, the thing that she would like to do most would be to write letters. One day, Riana cried and went to bed because she does not want to “think about things” and she dreamt about her family and friends. If she could change anything it would be her whole body.
**Sentence Completion**

Significant responses to the Sentence Completion are as follows: **When I eat** “I am mostly bored”; **I want to change** “My top legs, they are very big”; **I wish** “my dad was still alive”; **I hate** “my mom sometimes and my little brother”; **My body** “is very long”; **Food** “is not really my favourite. I don’t like eating”.

From the above responses one can see that the theme of the responses revolve around a dissatisfaction with her body, missing her father and a negative attitude to food.

**Dietary Record**

Food recorded eaten by the client most frequently included: hamburgers, sweets, chocolates, milkshakes, chops, eggs and bacon. Activities while eating included: sitting outside, listening to music, watching television, lying down, sitting in a car. Thoughts while eating included: how much work she needs to catch up, wondering what her friends are doing. Feelings recorded while eating included: sadness, depression, confusion, being scared, anger and boredom. From the above it is evident that Spud often feels sad, confused and bored when eating. Her Dietary Record rarely includes sitting at a table when eating but rather watching TV or listening to music.

**Interview**

From the interview the therapist gained access to the clients achievements at primary school that included: swimming in the second team; playing netball in the first team; participating in cross country and horse riding. At high school she has played in the under fourteen hockey team and does tibo (self defense). Her hobbies include collecting spoons and miniature toys. She participates in both tibo and hockey at present. From therapy she expects to learn to stop wanting to change her body and to follow a healthier diet.

The information gleaned from the interview was used as ego-strengthening in hypnotherapy in session two (see 4.2.2) and in session five: transformation of self-concept (see 4.2.5). The information was also used in individualized gift-wrapping.
Gift-wrapping

According to the Ericksonian Diamond (see 3.4.4.1) the therapist’s goal was to communicate to the client that she must refrain from avoiding the reality of her physical appearance as well as fighting with her family and friends. She needs to accept herself as she is and to learn to appreciate others too.

Gift-wrapping, tailoring, processing and utilisation were used during the Psycho-educational programme as set out in section 3.4.4.1. Individualized gift-wrapping included a metaphor of: The man in the glass (anonymous) and 5 Juggler’s balls of life that the researcher modified (Dyson in Life-Line 1999:1).

After putting the client in hypnosis the therapist told the story of a girl:

who when she unwrapped her surprise present found a mirror that could speak to her ... with a voice very much like her fathers ... and it said ... “When you get what you want in your struggle for gain ... and the world makes you king for the day ... Go to the mirror and look at yourself ... And see what that man has to say ... You may be one who got a good break ... And think you’re a wonderful guy ... but the man in the glass says you’re only a fake ... If you can’t look him straight in the eye ... It isn’t your father, or mother, or wife ... Whose judgment ... upon you must pass ... For the one whose verdict counts most in your life ... is the one staring back in the glass ... You may fool the whole world down the pathway of years ... and get pats on the back as you pass ... But your final reward will be heartache and tears ... If you have cheated the man in the glass ... Imagine life as a game in which you are juggling some five balls in the air ... You name them school, family, health, friends, and spirit – and you’re keeping all of these in the air ... You will soon understand that school is a rubber ball. If you drop it, it will bounce back ... But the other four balls – family, health, friends and spirit are made of glass ... If you drop one of these, they will be irrevocably scuffed, marked, nicked, damaged or even shattered ... They will never be the same ... You must understand that and strive for balance in you life ... How? ... Don’t undermine your worth by comparing yourself with others ... It is because we are different that each of us is special ... Don’t set your goals by what other people deem important ... Only you know what is best for you ... Don’t take for granted the things closest to your heart ... Cling to them as you would your life,
for without them, life is meaningless ... Don’t let your life slip through your fingers by living in the past or for the future... By living your life one day at a time you live all the days of your life... Don’t give up when you still have something to give ... Nothing is really over until the moment you stop trying ... Don’t be afraid to admit that you are less than perfect ... It is this fragile thread that binds us to each other ... Don’t be afraid to encounter risks... It is by taking chances that we learn how to be brave ... Don’t shut love out of your life by saying it’s impossible to find ... The quickest way to receive love is to give it ... and the best way to keep love is to give it wings ... Don’t run through life so fast that you forget not only where you’ve been ... but also where you are going ... Don’t forget, a person’s greatest emotional need is to feel appreciated ... Don’t be afraid to learn ... Knowledge is weightless, a treasure you can always carry easily ... Don’t use time or words carelessly ... Neither can be retrieved ... Life is not a race ... but a journey to be savoured each step of the way ... Yesterday is history ... Tomorrow is a Mystery and Today is a gift ... which is why we call it ‘The Present’” ... and you can spoil yourself ... perhaps you can visualize yourself ... participating in swimming ... cross country ... running cross country ... doing tibo ... horse riding ... and riding your way to the new you ... and when you are ready ... you can re-orientate yourself ... to the here ... and the now.

The metaphor was used to help the client to accept herself and to realise how precious certain aspects namely: family, health and spirit are.

**Feedback from Adolescent D on therapy**

Spud reported that she benefited from cognitive-behaviour therapy in that she realised that it was irrational to think that she can change everything about her. It helped her to accept herself and the physical characteristics that she cannot change. The hypnotherapy gave her a chance to focus on her inner self and to spend time with her real self. The group therapy helped her to realise that people accept her and like her.

As a researcher she believes that irrational thoughts can hamper the way one behaves negatively. Her message to adolescents is to “stop wasting time wishing you were someone
else” and to “face the reality of accepting yourself as you are”. Her message to psychologists is that they must fully understand teenagers in order to help them.

CASE STUDY E

Background
Velvet a thirteen-year-old white female and is in grade 8. Her parents are divorced and she lives with her mother. She is the middle child of three children. The physical activity that she participates in is tap and modern dancing at a dancing school. The physical appearance of her parents is of normal weight. She obtains most of her information about nutrition from magazines.

Adolescent Self-concept Scale (ASCS)
The respective self-concept scores for Velvet have been calculated. The score before the Psycho-educational programme is given and compared to the score after intervention has taken place.

Case study E ASCS scores

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>Low self-concept</th>
<th>Medium self-concept</th>
<th>High self-concept</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>28 - 55</td>
<td>56 - 70</td>
<td>71 – 90</td>
</tr>
<tr>
<td>Before therapy</td>
<td>53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After therapy</td>
<td>63</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The lowest dimension of the self-concept was the Physical dimension. The overall self-concept score for case study E shows a significant improvement from 53 to 63. The client’s self-concept has changed from a low self-concept to a medium self-concept.
Eating Habits Questionnaire for Adolescents (EHQA)

The overall score for the Eating Habits Questionnaire for Adolescents has been calculated. The score before the Psycho-educational programme is given and compared to the score after intervention has taken place.

Case Study E  EHQA Scores

<table>
<thead>
<tr>
<th>CLASSIFICATION</th>
<th>Good eating habits</th>
<th>Average eating habits</th>
<th>Bad eating habits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before therapy</td>
<td></td>
<td></td>
<td>222</td>
</tr>
<tr>
<td>After therapy</td>
<td></td>
<td></td>
<td>210</td>
</tr>
</tbody>
</table>

The score of case study E has improved from 222 to 210 but remains within the bad eating habits range.

Body Mass Index (BMI)

The Body Mass Index of case study E has been calculated. The classification of weight before the Psycho-educational programme is given and compared to the Body Mass Index after intervention has taken place.

Case study E  BMI scores

<table>
<thead>
<tr>
<th>CLASSIFICATION</th>
<th>Underweight</th>
<th>Normal range</th>
<th>Overweight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before therapy</td>
<td></td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>After therapy</td>
<td></td>
<td>21</td>
<td></td>
</tr>
</tbody>
</table>
Velvet is 1.47m tall, weighed 42 kilograms at the start of the intervention programme and weighed 46 kilograms eight months after intervention. Her Body Mass Index score has changed from 19 kg/m\(^2\) to 21 kg/m\(^2\) but remains in the normal range.

**Emotions Profile Index (EPI)**

The Emotions Profile Index of case study E prior to the Psycho-educational programme is depicted on the diagram below.

![Emotions Profile Index of case study E](image)

**Emotions Profile Index of case study E**

A high score of 91 on the Trustful Dimension indicates that Velvet tends to be trustful, obedient and gullible. A percentile of 84 on the Dyscontrol Dimension reveals that she tends to be impulsive and likes to try new things and have new experiences.

A low score of 10 on the Depressed Dimension indicates that she tends to be satisfied with her style of life. A percentile of 35 on he Distrustful Dimension reveals that she tends to be uncritical and not rejecting. A low score of 26 on the Aggressive Dimension indicates that Velvet tends to be unaggressive and has very little anger or is reluctant to express it overtly. A percentile of 91 on the Gregarious Dimension reveals that she enjoys warm, friendly contacts and the Bias Dimension indicates that she tends to present herself positively in social situations.
**Draw A Person (DAP)**

With the consent of case study E, the researcher has provided the reader with the person drawn by the client.

![Draw A Person of case study E](image)

**Draw A Person of case study E**

According to Oster and Gould (1987:28) the portrait of a head without the inclusion of a body may indicate a fearfulness of thoughts concerning the body. According to the Draw A Person Questionnaire of Appendix H, Velvet has presented a thirteen-year-old girl, Nicole who would like to change her body and would like more than anything to be recognised. She enjoys being with friends and her favourite food is chips. She asks the fairy for the ability to be popular and to change her body.

**Sentence Completion**

Significant responses to the Sentence Completion are as follows: **When I eat** “I feel that I am getting fat”; **I need** “to lose weight and become thin”; **Most boys** “think that I am ugly”; **I want to change** “my body and face”; **I wish** “that I could be liked by boys”; **When I see models in magazines** “I wish that I could be like them”; **My body** “is the thing that I hate”; **Food** “is something that makes me upset”. From the above responses one can see that the theme of the responses revolve around a fear of getting fat, a need to change her body and a need to be accepted by others.
**Dietary Record**

Food eaten by the client most frequently included: Chelsea buns, hamburgers and pizza. Activities while eating included: walking around, sitting in a car, watching television. Thoughts while eating included: negative self-talk because of the junk food eaten. Feelings recorded while eating included: guilt about eating fast foods. From the above it is evident that Velvet eats fast food often and despite her awareness that the food she eats may not be considered to be healthy, she continues to follow an unbalanced diet.

**Interview**

From the interview the therapist gained access to the clients achievements at primary school that included: getting 100 percent for Maths, being acknowledged for her participation in swimming and dancing. At high school she has danced at the South African dancing championships. Her hobby is dancing and her participation in physical activities includes dancing and running around the block. From therapy she expects to learn how to accept herself, to stop buying friends and to refrain from lying to others about herself.

The information was used in session two: ego-strengthening (see 4.2.2) and in session five: transformation of self-concept (see 4.2.5). The information was also used in individualized gift-wrapping.

**Gift-wrapping**

According to the Ericksonian Diamond (see 3.4.4.1) the therapist's goal was to communicate to the client that she does not have to buy others presents in order to accept her and that she does not have to lie about situations in order to gain approval. The therapist further wanted to communicate that dancers can follow a healthy diet and do not have to be underweight in order to dance effectively.
Individualised gift-wrapping included a metaphor based on the story: The Velveteen Rabbit written by Margery Williams and was modified by the therapist.

After putting the client in hypnosis the therapist told the story of a velveteen rabbit...

“What is REAL?” asked the rabbit one day when they were lying side by side near the nursery fender... before Nana came to tidy the room... “Does it mean having things that buzz inside you and a stick-out handle?”... “Real isn’t how you are made” said the skin horse... “It’s a thing that happens to you... When a child loves you for a long... long time... not just to play with... but REALLY loves you, then you become REAL”... “Does it hurt?”... asked the rabbit... “Sometimes”... said the skin horse, for he was always truthful... “When you are Real... you don’t mind being hurt”... “Does it happen all at once... like being wound up”... rabbit asked “or bit by bit?”... “It doesn’t happen all at once”... said the skin horse “You become... it takes a long time... That’s why it doesn’t happen often to people who break easily... or have sharp edges... or have to be carefully kept... Generally by the time you are REAL... most of your hair has been loved off... and your eyes drop out... and you get loose... in the joints and very shabby... But these things don’t matter at all... because once you are REAL... you can’t be ugly... except to people who don’t understand”... and just like the rabbit... Velvet... you can... wind yourself up... and once you have accepted yourself... for who you are... and love yourself... for being special you... you can allow yourself... to dance in your own... velveteen... way... to the banquet... of life... and the truthful skin horse... will help to guide you... to follow a healthy... balanced diet... because real isn’t how you are made... it’s a thing that happens to you... because you are loved... and you can spoil yourself... perhaps you can visualize... getting an award for maths... receiving an award for swimming... and dancing... dancing your way to the rhythm of the new you... and when you are ready... you can re-orientate yourself... to the here... and the now.

The metaphor was used to help the client to realise that she is loveable just the way she is and that she can stop pretending to be someone else.
Feedback from Adolescent E on therapy

Velvet reported that she benefited from cognitive-behaviour therapy in that she is now able to reason with herself and “check my thoughts for a better view”. The hypnotherapy relieved her of her stress. The group therapy helped her to realise that people have different points of view and she got to know more people.

As a researcher she believes that by having a better knowledge about the nutritional value of food and by gaining more self-knowledge one can adopt healthier eating habits. Her message to adolescents is “never bring yourself down because of your weight. People must accept you for who you are and not your looks”. Her message to psychologists is to be gentle in therapy.

CASE STUDY F

Background

Lolly is a fifteen-year-old black female and is in grade 10. She lives with both parents and is the third of four children. The physical activity that she participates in is dancing. The physical appearance of her mother is thin and her father is of normal weight. She obtains most of her information about nutrition from television. She is deaf in one ear and has experimented with Marijuana.

Adolescent Self-concept Scale (ASCS)

The respective self-concept scores for Lolly have been calculated. The score before the Psycho-educational programme is given and compared to the score after intervention has taken place.
Case study F ASCS scores

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>Low self-concept</th>
<th>Medium self-concept</th>
<th>High self-concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before therapy</td>
<td>28 - 55</td>
<td>56 - 70</td>
<td>71 – 90</td>
</tr>
<tr>
<td>After therapy</td>
<td></td>
<td></td>
<td>72</td>
</tr>
</tbody>
</table>

The lowest dimension of the self-concept was the Values dimension. The overall self-concept score for case study F shows a significant improvement from 55 to 71. The client’s self-concept has changed from a low (negative) self-concept to a high (positive) self-concept.

Eating Habits Questionnaire for Adolescents (EHQA)

The overall score for the Eating Habits Questionnaire for Adolescents has been calculated. The score before the Psycho-educational programme is given and compared to the score after intervention has taken place.

Case Study F EHQA scores

<table>
<thead>
<tr>
<th>CLASSIFICATION</th>
<th>Good eating habits</th>
<th>Average eating habits</th>
<th>Bad eating habits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before therapy</td>
<td>64 - 120</td>
<td>121 - 147</td>
<td>148 - ∞</td>
</tr>
<tr>
<td>After therapy</td>
<td></td>
<td>191</td>
<td>189</td>
</tr>
</tbody>
</table>

The score of case study F has improved from 191 to 189 but remains within the bad eating habits range.
**Body Mass Index (BMI)**

The Body Mass Index of case study F has been calculated. The classification of weight before the Psycho-educational programme is given and compared to be Body Mass Index after intervention has taken place.

### Case study F BMI scores

<table>
<thead>
<tr>
<th>CLASSIFICATION</th>
<th>Underweight</th>
<th>Normal range</th>
<th>Overweight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt; 18.5 kg/m²</td>
<td>18.5 – 24.9 kg/m² kg/m²</td>
<td>&gt; 25 kg/m²</td>
</tr>
<tr>
<td>Before therapy</td>
<td></td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>After therapy</td>
<td></td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>

Lolly is 1.61m tall, weighed 50 kilograms at the start of the intervention programme and weighed 53 kilograms eight months after intervention. Her Body Mass Index score has changed from 19 kg/m² to 20 kg/m² but remains within the range for normal weight.

**Emotions Profile Index (EPI)**

The Emotions Profile Index of case study F prior to the Psycho-educational programme is depicted on the diagram below.

![Emotions Profile Index of case study F](Image)
A low score of 34 on the Trustful Dimension indicates that Lolly tends to be distrustful, disobedient and not very gullible. A high score of 95 on the Dyscontrol Dimension indicates that she tends to be impulsive and likes to try new things and have new experiences. A percentile of 37 on the Timid Dimension reveals that she tends to take risks and can easily get into trouble. It further indicates that she is less fearful than the average person. A percentile of 29 on the Depressed Dimension indicates that she tends to be satisfied with her style of life. A low score of 17 on the Control Dimension indicates that she tends to live her life on a day to day basis and does not plan for the future. A percentile of 35 on the Gregarious Dimension reveals that she tends to be unaffectionate and withdrawn. The Bias Dimension indicates that she tends to present herself negatively.

**Draw A Person (DAP)**

With the consent of case study F, the researcher has provided the reader with the person drawn by the client.
The emotional indicators included: arms behind her back which may indicate guilt; drawing in the middle of the page which may indicate tension and insecurity; extensive colouring in which indicates possible anxiety or hiding something; coloured in hair could indicate aggression; feet in opposite directions which may indicate a problem with her feelings towards her education or upbringing.

According to the Draw A Person questionnaire of Appendix H, Lolly has presented a twenty six year old girl, Olivia who when she looks in the mirror sees a perfect person. Olivia is a popular girl because she is very successful, independent and beautiful. If nobody could see her the thing that she would like to do most is impersonate other people. One day, Olivia cried and went to bed because someone said something ugly to her and because she is very lonely. She dreamt about paradise and wants to change her past.

**Sentence Completion**
Significant responses to the Sentence Completion are as follows: I **need** “to be a better person”; I **secretly** “impersonate other people and act out people when I’m alone”; I **want to change** “a lot about me”; **My greatest weakness** “is I’m curious, tempted and I can’t say no”. From the above responses one can see that the theme of the responses revolve around wanting to be someone else and the fact that she often succumbs to peer pressure.

**Dietary Record**
Food recorded eaten by the client most frequently included: cold drinks, Chelsea buns, biltong, chips, chocolates, toasted bacon and cheese. Activities while eating included: walking around, watching television. Thoughts while eating included: boredom, worried about getting friends a present, pleased that the week is over. Feelings recorded while eating included: boredom, tiredness, worry. From the above it is evident that Lolly frequently eats fast foods and that feelings of anxiety and boredom surround her eating habits.

**Interview**
From the interview the therapist gained access to the clients achievements at primary school which included: being a prefect; participation in drama and the choir; playing in the A side
netball team; participating in hurdles and she did scholar patrol. At high school she has played in the under fourteen-netball team in grade eight and sang in the choir. Her hobby includes reading and since the end of grade eight she has not participated in any physical activities. From therapy she expects to learn to accept that she can change her experimentation with drugs and that she can accept herself as she is.

The information gleaned from the interview was used as ego-strengthening in hypnotherapy in session two (see 4.2.2) and in session five: transformation of self-concept (see 4.2.5). The information was also used in individualized gift-wrapping.

**Gift-wrapping**

According to the Ericksonian Diamond (see 3.4.4.1) the therapist’s goal was to communicate to the client that she can forgive herself for having experimented with drugs and that by accepting that her self-image can change she can have fun in healthier ways.

Gift-wrapping, tailoring, processing and utilization were used during the Psycho-educational programme as set out in section 3.4.4.1. Individualized gift-wrapping included a metaphor based on two African stories: Grandfather and his dagga horse (Leah Motlhabane in Orgill 1996:16) and My father’s paint drum (Josephine Tau in Orgill 1996:12).

After putting the client in hypnosis the therapist told the story of:

*a girl named Lolly who was brought up by her grandparents ... in Maputo ... Her grandfather was an ex-soldier ... and she will never forget him ... He used to drink ‘bantu beer’ and ... smoke dagga ... He had a horse called ‘Whiskey’ ... and while he cleaned his uniform ... he would take a piece of cloth ... soaked in crushed ... dagga leaves ... and wrap this around ... the horse’s head ... The horse would suck the dagga ... juice ... from the cloth while the old man ... got ready ... for the journey ... When her grandfather was dressed ... in full army uniform ... he stood proud ... next to his horse ... and smoked his dagga ... Whiskey’s eyes were ... wild ... and red ... Then the two of them ... were on their way ... Much later in the night ... they returned ... and Lolly noticed that there was ... no more singing ... The horse was walking slowly ... with grandfather drunk and fast asleep on her back ... and Lolly*
watched ... sadly as the old man ... was carried into the house ... and Lolly went to bed ... and had a dream ... about her father ... who used to be a very ‘kwaai’ man ... He told her that if an adult sends her anywhere ... to buy something ... she must not hesitate ... she must go ... no matter how many kilometres it is ... Now her father has CHANGED ... He has a pension ... and sits all day ... and dreams ... about all the good ... things ... that Lolly will achieve ... One day he phoned her very late at night ... She asked him why he was phoning her ... He said that it is because she never phones him ... and he wonders why ... She said to him, “Now look father ... tomorrow you must take your ... 20 litre paint drum ... and sit in the sun ... from sunrise ... to sunset ... Tomorrow I will be busy ... Producing ... the ... new ... PRODUCTION ... I won’t see the sun ... I have changed father” ... “I have changed too” ... replied her father ... “I am no longer a kwaai man” ... he said ... He started laughing ... until he said his ribs were paining him ... and Lolly started laughing too ... having a ... new kind of fun ... in a healthy ... fun ... kind of way ... He said he was happy to hear her voice ... and she realised that ... Things can be ... changed ... for the better ... and maybe you can visualise ... being a prefect ... playing netball ... jumping over hurdles ... singing in the choir ... singing a song about the new you ... and when you are ready ... you can re-orientate yourself ... to the here ... and the now.

The metaphor was used to help the client to forgive herself for mistakes made previously and to build onto all her many talents.

Feedback from Adolescent F on therapy
Lolly reported that cognitive-behaviour therapy helped her to realise that one cannot please everyone and one has to be yourself. The hypnotherapy was “relaxing, a time to think of myself and nothing else in the world mattered”. The group therapy was experienced as a relief in knowing that there are others with similar problems and she realised that “to be unique does not mean that you are weird”.

As a researcher she believes that self-concept is linked to eating habits as a result of conforming to the norms of society, i.e. people strive to be picture perfect. Her message to adolescents is to “be yourself, cause you meet different people everyday and you can’t
always change to suit their needs because then you’ll end up losing your inner being”. Her message to psychologists is to be understanding and patient when working with teenagers.

CASE STUDY G

Background
Nomfundo is a sixteen-year-old black female and is in grade eleven. She lives with both parents and is the youngest of three children. She does not participate in any physical activities at present. The physical appearance of her mother is normal weight and the physical appearance of her father is overweight. She obtains most of her information about nutrition from television.

Adolescent Self-concept Scale (ASCS)
The respective self-concept scores for Nomfundo have been calculated. The score before the Psycho-educational programme is given and compared to the score after intervention has taken place. Although the client has a medium self-concept, the therapist felt that a score of 57 with a stanine of 4 was low enough to work with considering the client has unhealthy eating habits.

Case study G ASCS scores

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>Low self-concept</th>
<th>Medium self-concept</th>
<th>High self-concept</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>28 - 55</td>
<td>56 - 70</td>
<td>71 – 90</td>
</tr>
<tr>
<td>Before therapy</td>
<td></td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>After therapy</td>
<td></td>
<td></td>
<td>80</td>
</tr>
</tbody>
</table>

The lowest dimension of the self-concept was the Physical dimension. The overall self-concept score for case study G shows a significant improvement from 57 to 80. The client’s self-concept has changed from a medium self-concept to a high (positive) self-concept.
**Eating Habits Questionnaire for Adolescents (EHQA)**

The overall score for the Eating Habits Questionnaire for Adolescents has been calculated. The score before the Psycho-educational programme is given and compared to the score after intervention has taken place.

**Case Study G EHQA scores**

<table>
<thead>
<tr>
<th>CLASSIFICATION</th>
<th>Good eating habits</th>
<th>Average eating habits</th>
<th>Bad eating habits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>64 - 120</td>
<td>121 - 147</td>
<td>148 - ∞</td>
</tr>
<tr>
<td>Before therapy</td>
<td></td>
<td></td>
<td>206</td>
</tr>
<tr>
<td>After therapy</td>
<td></td>
<td></td>
<td>190</td>
</tr>
</tbody>
</table>

The score of case study G has improved from 206 to 190 but remains within the bad eating habits range.

**Body Mass Index (BMI)**

The Body Mass Index of case study G has been calculated. The classification of weight before the Psycho-educational programme is given and compared to be Body Mass Index after intervention has taken place.

**Case study G BMI scores**

<table>
<thead>
<tr>
<th>CLASSIFICATION</th>
<th>Underweight</th>
<th>Normal range</th>
<th>Overweight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt; 18,5 kg/m²</td>
<td>18,5 – 24,9 kg/ kg/m²</td>
<td>&gt; 25 kg/m²</td>
</tr>
<tr>
<td>Before therapy</td>
<td></td>
<td></td>
<td>36</td>
</tr>
<tr>
<td>After therapy</td>
<td></td>
<td></td>
<td>35,9</td>
</tr>
</tbody>
</table>
Nomfundo is 1.62m tall, weighed 96 kilograms at the start of the intervention programme and weighed 95 kilograms eight months after intervention. Her Body Mass Index score has changed from 36 kg/m² to 35.9 kg/m² but remains within the range for being overweight.

**Emotions Profile Index (EPI)**

The Emotions Profile Index of case study G prior to the Psycho-educational programme is depicted on the diagram below.

![Emotions Profile Index of case study G](image)

**Emotions Profile Index of case study G**

A high percentile of 70 on the Trustful Dimension indicates that Nomfundo tends to be accepting and trustful. A tendency towards being gullible is also indicated. A high score of 76 on the Dyscontrol Dimension reveals that she tends to be impulsive and likes to try out new things and to have new experiences. A low score of 18 on the Depressed Dimension reveals that she tends to be satisfied with her style of life. A percentile of 39 on the Aggressive Dimension indicates that she is not quarrelsome and is somewhat passive. A high percentile on the Gregarious Dimension indicates that she tends to be sociable, friendly and affectionate.
**Draw A Person (DAP)**

With the consent of case study G, the researcher has provided the reader with the person drawn by the client.

![Diagram of a person drawn by the client](image)

**Draw A Person of case study G**

The emotional indicators include: feet in opposite directions, which may indicate a problem with her feelings towards education situation or upbringing and big hands, which may indicate an acting-out behaviour. According to the Draw A Person questionnaire of Appendix H, Nomfundo has presented a fifteen year old girl Amelia, who when she looks in the mirror sees a sexy, beautiful girl. She is popular because she makes people laugh and if nobody could see her, the thing that she would like to do most is “dance and stuff”. One day Amelia, cried
and went to bed because people laughed at her and she dreamt about a perfect world where everyone was equal. The thing that she would most like to change is her body.

**Sentence Completion**

Significant responses to the Sentence Completion are as follows: **When I eat** “my goal is to be full and sometimes I question the amount I eat”; **My mind** “is something that tells my inner self what to do” **I need** “a lot of encouragement to make myself secure with my body”; **I want to change** “the way I look physically”; **I wish** “sometimes to be thin like my friends and I feel I would be a lot more comfortable with my self image”; **When I see models in magazines** “I sometimes wish to look like them”; **I hate** “being uncomfortable and thinking that someone will comment on my weight”; **My body** “I accept because I have no choice but I would trade it if I could”; **Food** “is something that I eat and sometimes it makes me guilty like I am the cause of my being overweight”; **A fat person** “is mostly unattractive to the opposite sex and is bound by his/her body”; **A thin person** “is attractive and is free to do as they want”. From the above responses one can see that the theme of the responses revolve around dissatisfaction with her body and a fear of people commenting on her weight.

**Dietary Record**

Food recorded eaten by the client most frequently included: hamburgers, cold drinks, chips, bread, chocolate and ice cream. Activities while eating included: chatting to friends, sitting on a bench, walking and sitting at a dining room table. Thoughts while eating included: thinking about how hungry she is, how nice the food tastes. Feelings recorded while eating included: guilty about eating too much, hunger, tiredness. From the above it is evident that Nomfundo feels tremendous guilt when eating. She is aware that she is overeating but continues to overeat. Continual feelings of being hungry and a need to feel full are reflected.

**Interview**

From the interview the therapist gained access to the clients achievements at primary school which included: singing a song about AIDS to the school, serving as a library monitor, receiving a prize for Afrikaans and being a prefect. At high school she plays in a brass band, she sings in the choir, plays chess and participates in Olympiads. Her hobbies include surfing
the internet and listening to the radio. She does not participate in any physical activities at present. From therapy she expects to learn to develop healthier eating habits and to gain a better understanding of herself.

The information gleaned from the interview was used as ego-strengthening in hypnotherapy in session two (see 4.2.2) and in session five: transformation of self-concept (see 4.2.5). The information was also used in individualized gift-wrapping.

**Gift-wrapping**

According to the Ericksonian Diamond (see 3.4.4.1) the therapists goal was to communicate to the client that she would have to take responsibility for her recovery from being overweight.

Gift-wrapping, tailoring, processing and utilization were used during the Psycho-educational programme as set out in section 3.4.4.1. Individualized gift-wrapping included a metaphor based on a metaphor taken from an Ericksonian technique of: The King who sought personal empowerment (Battino & South 1999:452)

After putting the client in hypnosis the therapist told the story of:

*once a king commanded his advisors to tell him something that would empower him, help him overcome obstacles in his life, ... help him to achieve goals, ... and energize him to move forward ... The advisors told him everything they knew, but he rejected it all, saying he had heard to all before. “Yes, yes,” said the king, “you’ve told me all these things already ... Tell me something new that will really empower me.” ... Finally the advisors told him about an old wise man ... who lived in a cave on top of a mountain on the other side of the world who knew everything and could answer his question ... The advisors cautioned the king that the journey to see the man was long, tiresome, and dangerous ... One had to travel across stormy ... turbulent oceans ... cross burning deserts ... tramp through snake-infested jungles ... cross rivers with piranhas and other man-eating creatures ... and finally climb a high mountain that even the guides refused to climb ... The king insisted that he still must go despite the advisors’ protestations ... So he went on the voyage ... traveled the oceans ... crossed the deserts ... tramped the jungles and rivers ... and climbed the mountain till he found the cave*
Inside, the king saw an old man with a white beard ... wearing only a loincloth, staring into the fire ... The king began to talk to the old man, but he stopped the king telling him he already knew why he was here and would soon answer the question ... After a long period of silence ... the old man looked at the king and said, “If you want to achieve your goals, overcome obstacles, empower yourself and move forward in your life ... everyday in the morning ... every night ... and several times during the day ... you must say this ... “IF IT’S TO BE ... IT’S UP TO ME. IF IT’S TO BE ... IT’S UP TO ME” ... and you can spoil yourself ... maybe you can visualise yourself ... singing a song about AIDS to an audience ... serving as a library monitor ... being a prefect ... singing in the choir ... playing in the brass band ... trumpeting a tune dedicated ... to the new you ... and when you are ready ... you can re-orientate yourself ... to the here ... and the now.

The metaphor was used to help the client to take responsibility for her eating habits and to encourage her to achieve her goals and to overcome the obstacles that may stand in her way.

Feedback from Adolescent G on therapy
Nomfundo reported that she benefited from cognitive-behaviour therapy and said “us teenagers tend to think irrationally without noticing it. I thought being thin meant that I would be accepted”. The hypnotherapy made her feel relaxed and resulted in her practicing self-hypnosis on her own. The group therapy was “Great. It was nice being with people with similar problems”.

As a researcher she believes that the self-concept plays a big role in behaviour. She said “The way I was feeling about myself was because of what I thought of myself. As soon as I changed my thinking I started to think better of myself”. Her message to adolescents is that they must not pay attention to messages and products promoted in magazines and on television. Her message to psychologists is that they need to fully understand how teenagers think in order to help them.