THE BODY IMAGE OF MIDDLE ADOLESCENT GIRLS

by

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SUPERVISOR: PROFESSOR E. WIECHERS

NOVEMBER 2001
WHAT MATTERS MOST IS HOW YOU SEE YOURSELF.
DECLARATION

"I declare that THE BODY IMAGE OF MIDDLE ADOLESCENT GIRLS is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references".

................................. ...................................
SIGNATURE DATE
Mrs J. G. Williams
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SUMMARY

The prevalence of dieting is alarmingly high amongst adolescents in South Africa. Dieting behaviour, influenced by the promotion of the thin ideal, poses one of the main risks for eating disorders, which have serious physical, psychological and social consequences, including death.

Treatment of eating disorders is a costly, difficult and long-term process, therefore preventative measures have been advocated. One of the shortcomings of existing school-based primary intervention programmes has been the failure to bring about significant changes in body image, a key defining feature of eating disorders.

This study evaluates the effectiveness of a modified version of Rosen’s body image programme with adolescents, with the view to exploring the idea of adding a body image component to existing preventative programmes. The modified version of Rosen’s programme proved to be effective in improving the body image of mid-adolescents.
TITLE OF THE THESIS:

THE BODY IMAGE OF MIDDLE ADOLESCENT GIRLS

KEY TERMS:

Body image; body image disturbance; eating disorders; intervention programme; primary prevention; cognitive-behavioural therapy; group counselling; adolescent development; self-esteem; depression; anxiety; peer relationships.
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CHAPTER ONE

THE BODY IMAGE OF MIDDLE ADOLESCENT GIRLS

1.1 INTRODUCTION

"Young women in western countries are increasingly becoming affected by the eating disorders, anorexia nervosa and bulimia nervosa. Over the past three decades the number of eating disorder patients has vastly increased. The sickly thin body ideal of the western countries drives young women to diet, which poses the main risk factor for eating disorders" (Charpentier 1998:65).

Are eating disorders in fact on the increase or is there merely a greater awareness? The prevalence of eating disorders is particularly difficult to assess and it is not surprising that prevalence statistics vary considerably. A possible explanation for this variance could be the issue of classification. While the criteria for full-blown eating disorders are relatively clear, the classification of eating disturbances is subjective, raising the question of where one draws the line between healthy and problematic eating attitudes and behaviour. In terms of eating behaviour, it is difficult to define "normal". The identification of eating disorders is further complicated by its very nature. Bulimics, for example, are often of average weight and cannot be identified externally. In addition, they are usually secretive about their eating habits, and do not readily seek help (Schlunt & Johnson 1990:3).

The researcher was unable to find prevalence statistics for full-blown eating disorders in South Africa. However, in a study in Johannesburg, Szabo (Szabo & Hollands 1997:527) found the prevalence of dieting amongst adolescent girls to be alarmingly high. His findings were similar to those of other Western countries.
In 1995, Szabo (1998:15) identified his first black patient with bulimia and, since then, the number of such patients has steadily increased in South Africa. The implications of this are enormous. Eating disorders can no longer be seen as a problem specific to the minority white population of South Africa, but one that is increasingly likely to affect the general South African population. South Africans cannot afford to sweep the problem of eating disorders under the carpet and the educational community cannot afford to remain uninvolved, considering the threat eating disorders pose to the psychological and physical well being of today's adolescents.

Defining a population "at risk" for eating disorders poses a great problem, since there is lack of clarity regarding the causes. While eating disorders have been clearly linked to various factors, such as body dissatisfaction and dieting (Killen et al. 1993:371), confusion remains as to whether these factors cause eating disorders or whether they exist as a result of the disorder. In addition, a need for further research seems necessary in order to understand the progression of eating disorders from simple dieting to full-blown anorexia or bulimia nervosa.

According to Treasure (1997:139), recovery from eating disorders is a slow and difficult process, the average recovery period being approximately five years. The recovery rate is more successful if treatment is started early in the illness. Relapses are common and some patients never fully recover. Bearing in mind the importance of early identification, it is not surprising that primary, school-based preventative programmes for eating disorders are being widely advocated. Primary prevention (Paxton 1996:340) involves the prevention of health risks that may develop into full-blown eating disorders. (Secondary and tertiary prevention will be explained in Section 1.6).

Although the primary prevention of eating disorders appears to be an attractive goal, existing programmes are far from ideal and further research is necessary in order to evaluate those programmes effectively and to improve upon the design (Carter et al. 1997:167).
1.2 ANALYSIS OF THE PROBLEM

1.2.1 Awareness of the problem

The researcher first gained insight into the “hell” experienced by eating disordered patients and their families five years ago. She was intimately involved with a family from Port Elizabeth who were devastated to learn that their daughter, who had been attending a well-known Port Elizabeth high school, had been diagnosed as having bulimia nervosa, already in an advanced stage.

The parents, whose family ironically come from a medical background, were devastated that neither they nor the teachers or the school psychologist had been equipped with the knowledge necessary to identify the disorder earlier. Their nightmare continued when they sought help. Unlike most of the bigger centres in the country, Port Elizabeth does not appear to have a specialised unit for dealing with eating disorders. The parents consulted a psychiatrist and various psychologists regarding their daughter. They received conflicting advice and were left feeling totally confused as to how to handle the situation. The daughter kept in regular contact with a dietician and attended a couple of sessions of individual psychotherapy. However, the latter soon came to an end as a result of the family’s medical aid funds running out. They then made inquiries concerning a support group, only to discover that a formal support group run by professionals did not exist. However, the family attended an informal support group run by one of the other desperate mothers for a short spell. The support group proved to be unsuccessful, as the members felt too inhibited to share their experiences.

Five years have elapsed and the daughter is at last showing signs of recovery, despite periodic relapses. A recent conversation with her mother is clearly demonstrative of the lack of awareness, facilities and support for eating disorder patients and their families in at least parts of South Africa. The mother commented: “I felt so isolated, helpless and desperate. If only
there had been the equivalent of Life Line that I could have contacted in order to get appropriate advice.”

While doing her internship at the Parkwood branch of The Family Life Centre in Johannesburg, the researcher counselled four bulimic teenagers and was struck by the secretive nature of the disorder. Three of the four teenagers had been purging for three to five years before either their school or their family became aware of the problem. In all four cases, it had been the friends of the bulimics who had alerted someone in authority about the problem.

The affordability of treatment appears to be an area of concern, due to inadequate medical aid coverage. Sorour-Morris (1998:66) quotes Graham Alexander, a psychologist who heads Cape Town’s Kennilworth Medicity Eating Disorders Unit, as follows:

“Some medical aids exclude treatment of eating disorders completely, others offer some cover, varying between 20 days and four months. Some of them don’t cover the treatment of eating disorders because, like a suicide attempt, they are seen as self-induced, which is ridiculous.”

Many researchers, such as Reas et al. (2000:433), have acknowledged the difficulty in the treatment of eating disorders and have recommended preventative measures. It is the belief of the researcher that the integration of a preventative programme into the school curriculum is feasible in the South African context.

1.2.2 Investigation of the problem

Eating behaviour can be viewed on a continuum ranging from “normal” eating behaviour to mild dieting, serious dieting, eating disturbances and, finally, full-blown eating disorders. Likewise, dissatisfaction with body shape and weight may range from mild concern to obsession. Mild dissatisfaction with body shape and weight and simple dieting is so widespread that it could
perhaps be viewed as the "normal" eating style for women (Bunnell et al. 1992:82).

The prevalence of adolescent girls on diet is alarming. Patton et al. (1997:299) estimate that between 30-60% of teenage girls in the United Kingdom are on diet at any given time, while Button (1990:408) estimates that, by middle school, 20-40% of American girls are dieting. Szabo (1997:529) conducted the Eating Attitude Test (EAT) among schoolgirls at private and government schools in Johannesburg. The results suggested that a fifth of the sample tested, which included both black and white girls, had abnormal attitudes to eating and were at risk for eating-related problems.

Dieting and eating disorders have serious psychological and social consequences, resulting in underachievement, as well as interpersonal and emotional difficulties. From a physical health perspective, the effects of eating disorders range from disturbed body metabolism, poor linear growth and delayed puberty, to death resulting from starvation or suicide. Psychologically, eating disorders are often linked with fatigue, anxiety, depression and low self-esteem (Griffiths & Farnill 1996:180). Compulsive behaviours and preoccupation with food may hamper concentration, attention, memory and problem solving. (The thinking process can become limited to black and white, resulting in the individual being unable to generate alternatives). In addition, preoccupation with food and weight loss may lead to loss of interest in general topics, loss of a sense of humour and, ultimately, loss of interest in friendships. The loss of social networks is made worse by the fact that the individual's maturational development is often delayed, resulting in a lack of interpersonal skills. Finally, the loss of sex hormones may result in the disappearance of the yearning for physical relationships (Treasure 1997:103).

The increase in eating disorders (anorexia nervosa and bulimia nervosa) and disturbed eating patterns among young people, especially girls (Dixey 1998:29), can be attributed to a number of factors. A significant factor is the
promotion of the "thin-ideal" image of womanhood by the media in Western cultures. Being thin is associated with beauty, wealth, power and success (Brouwers 1990:144-145).

While various preventative programmes have been developed, there has been little consensus regarding the appropriate content of the programme, which population group to target and the timing and duration of the programme (Huon et al. 1998:455).

Carter et al. (1997:167) studied the effectiveness of six school-based intervention programmes. The results were discouraging, in that the programmes all failed to bring about significant changes in body image disturbances, which is one of the main defining features in anorexia nervosa and bulimia nervosa. However, the programmes were all effective to some degree in increasing knowledge about nutrition and the nature and consequences of eating disorders.

With the HIV/AIDS epidemic in South Africa, the likelihood of receiving funds for the evaluation and development of preventative programmes for eating disorders is remote. While this is far from ideal, one could possibly try to draw aspects of existing programmes that have proven to be successful into the school curriculum. The "Outcome Based Education" system currently being used in South Africa is extremely flexible regarding the content of its syllabus and is designed to accommodate the specific needs of the individual school population (Department of Education Policy Document 1997:LO2-3).

James Rosen (as in Thompson 1996:432-436) is one of the researchers who has had some success in improving body image using a programme based on the cognitive-behavioural model. The main aim of this study is to evaluate the effectiveness of an adapted version of Rosen's programme (which was designed for college students and adults) in improving the body image of middle adolescent girls. Furthermore, the possibility of integrating
various aspects of Rosen's intervention programme as part of the Life Skills curriculum will be explored.

1.2.3 Statement of the Problem

As mentioned earlier, it appears that eating disorders are on the increase in South Africa, especially among young females. The treatment of eating disorders is a costly, difficult and long-term process, and a preventative approach appears to be a reasonable alternative. Although existing programmes have been successful in educating the general public with regard to healthy nutrition and the symptoms and behaviour associated with eating disorders, it seems that these programmes have been less successful in bringing about change regarding body image.

Abnormality of body image is one of the defining features of both anorexia and bulimia nervosa (APA 1994). Research has provided significant evidence that there is a link between body dissatisfaction, diet and eating disorders (Killen et al. 1993:271). However, some doubt still exists as to whether there is a direct causal relationship between body dissatisfaction and eating disorders.

For the purpose of this study, it is assumed that body dissatisfaction plays an integral role in the development of eating disorders and that, the more favourably the body is viewed, the less chance there is of the individual dieting excessively and developing an eating disorder. The problem investigated focuses on the exploration of a body image component that can possibly be included with other educational and skill-based components as a preventative measure for eating disorders and reads as follows:

What is the effect of a modified version of Rosen's body image programme on a group of middle adolescent girls?
1.2.4 Related Problems

The theoretical and practical issues connected to the implementation of a body image programme require a literary study in order to solve the following problems that come to mind:

Problems concerning eating disorders

- What are eating disorders?
- What is body image?
- What is body image disturbance and how is it linked to eating disorders?
- What is the general prevalence of eating disorders?
- What are the demographic characteristics of eating disorders?
- What are the causes of eating disorders?
- What are the environmental, emotional, behavioural, cognitive and physiological consequences of eating disorders?
- What is the prognosis of eating disorders?
- What treatment is used for eating disorders?

Problems concerning preventative programmes

- What content is recommended for a primary prevention programme?
- Who does one target and include in a primary prevention programme?
- How does one implement a primary prevention programme?
- What is the duration of a primary prevention programme?

Problems concerning the developmental stages and characteristics of middle adolescent females with and without eating disorders

- What are the normal developmental stages experienced by adolescents?
- How do adolescents with eating disorders differ from the non-eating disordered adolescents in terms of physical, psychological, social, moral and cognitive adjustment?
1.3 AIMS OF THE RESEARCH

1.3.1 General aim

The aims of this research are threefold. First, to adapt Rosen's body image programme to suit the cognitive level of middle adolescence; second, to implement the body image programme with a group of middle adolescent girls; third, to evaluate the effectiveness of the body image programme in terms of enhancing body image.

1.3.2 Specific aim

This study aims to determine the effect of a modified version of Rosen's body image programme in terms of assisting the adolescent in overcoming negative body image feelings, thoughts and behaviours and viewing her body more favourably. (The rationale behind this is that an individual with a positive body image is less likely to diet excessively and to develop eating disorders).

1.3.3 Related aims

Certain related aims arise from the specific aim. An empirical study is necessary in order to establish the effect of a modified version of Rosen's body image programme on adolescents in terms of the following:

- The enhancement of body image
- Self-esteem
- The development of interpersonal skills
- Reduction in anxiety levels
- The reduction of the level of depression
1.4 RESEARCH METHOD

This study is predominantly qualitative, but elements of quantitative methodology are present. It is a “trial” study and, thus, a small sample of subjects was used. Unfortunately, the sample size is too small to make significant deductions regarding the general population.

After various preventative programmes had been reviewed, the researcher came across a body image programme designed by Rosen and others, (Rosen as in Thompson 1996:436) which is based on a cognitive-behavioural model. The programme was designed for college students and adults, to be used both for primary intervention (where the focus is on the prevention of a health problem), as well as secondary intervention (where the aim is to treat a health problem). The programme had been used successfully with a group of obese women. Seventy percent of these women improved their body image after having completed the programme, while, on average, their weight remained unchanged. The subjects also benefited from the programme in terms of increased self-esteem.

The researcher was particularly interested in this programme, since it is her belief that a preventative programme for eating disorders should include a component designed specifically to improve body image and to boost self-esteem, over and above the educational and skill-related components.

The school counsellors from a private girls’ high school in Johannesburg welcomed the idea of research in the area of body image and self-esteem being done at their school. However, selecting an appropriate sample for the study was a sensitive issue. Although the counsellors were aware of a number of girls who had poor body image and self-esteem in the school, it was agreed that participation in the research study should be strictly voluntary.
The girls from this pressurised private Johannesburg school hailed mostly from middle to upper socio-economic backgrounds. These individuals could be viewed (to some extent) as at risk for eating disorders, based on the fact that, according to Omizo and Omizo (1992:217), eating disorders are most prevalent amongst Caucasian female adolescents from middle to upper socio-economic classes. Furthermore, the results of the Eating Attitude Test (EAT) Szabo (1997:529) conducted on a sample of girls in private and government schools in Johannesburg suggest that a fifth of the girls were found to have abnormal attitudes to eating and risked eating-related problems. If these results are representative of the general population, one could assume that the particular school targeted for research would be likely to have a large proportion of girls with abnormal attitudes to eating.

The researcher was given the opportunity of addressing the Grade 9 classes from the targeted private girls' high school in order to request volunteers to take part in the research study. The researcher informed the girls of her interest in the areas of body image and self-esteem and briefly defined each concept. She then requested volunteers to participate in the study, making it clear that, once the individuals had committed themselves, they were to follow through to the completion of the study.

Letters were given to the individuals who displayed interest in the research in order to gain permission from their parents to participate in the study. While 10 individuals returned positive consent letters, eight finally committed themselves to participation in the study. These eight individuals were randomly divided into two groups, the experimental group, which followed the adapted version of Rosen's intervention programme, and the control group, which followed a self-esteem programme based on Anita Naik's (1998) book called "Self Esteem: Learn to believe in yourself".

The researcher then set about modifying the programme designed for college students and adults to meet the cognitive level of middle adolescence. The following adaptations were made:
• The language to be used during the sessions was simplified;
• Additional and more age appropriate examples were used to illustrate various concepts;
• Time was allocated during the sessions in order to explain the homework exercises and to provide practice examples;
• The programme was extended for a longer period than advocated in Rosen's programme, so as not to overwhelm the girls with the amount of content to be covered during the sessions.

Prior to the commencement of the respective programmes, a brief unstructured interview was held with each subject, while a battery of standardised tests were administered in order to determine the levels of various areas linked to eating disorders, namely, self-esteem, body image, anxiety and depression. Tests used included:

- The Thematic Apperception Test (TAT)
- The Adolescent Self-Concept Scale (ASCS)
- The Beck Depression Inventory (BDI)
- The IPAT Anxiety Scale (IPAT)
- The Family Functioning in Adolescence Questionnaire (FFAQ)
- The Body Dysmorphic Disorder Examination (BDDE)

The programmes were run for a period of nine weeks. At the end of the nine-week period, the full battery of tests was once again implemented. The data from the test battery were then analysed both quantitatively and qualitatively, and comparisons between the experimental and control groups were made in order to ascertain the effectiveness of the experimental programme in terms of improving body image. The analysis of the respective information enabled the researcher to make deductions and to come to various conclusions.
1.5 DEMARCATION OF RESEARCH

As mentioned in Section 1.4, Omizo and Omizo (1992:217) suggest that eating disorders most commonly occur in Caucasian female adolescents with middle to upper socio-economic status. Bryan Dirks, who heads the Eating Disorders Clinic at Groote Schuur Hospital in Cape Town, has been reported as claiming that his black patients are either private-school pupils, university students or have lived overseas, where they have been exposed to Western culture (Sorour-Morris 1998:63). Bearing this in mind, it seemed appropriate that the research sample should come from a private girls' high school in the northern suburbs of Johannesburg, a school well known for its high academic and sporting achievements.

Whilst the majority of school-based preventative programmes have targeted middle or high school students, Attie and Brooks-Gunn (1989:71) suggest that the programmes should begin in the elementary school years, before negative eating attitudes and behaviours have been entrenched. While the researcher agrees with the above, Grade 9 girls with an average age of 15 were used in her study. The researcher considered the body image programme to be more suited to the cognitive development of the middle adolescent.

Ten girls from the Grade 9 classes volunteered to participate in the study, with the result that no further selection measures were necessary. Two individuals withdrew during the pre-testing phase. One found the testing "too personal", while the other, a provincial sportswoman, was unable to work around her sporting commitments. The sample was randomly divided into two groups, namely, the experimental, which was to follow the body image programme, and the control, which was to participate in a self-esteem programme. Post-testing took place at the end of the nine-week period.
1.6 CLARIFICATION OF CONCEPTS

The following are key concepts used throughout the study:

- **Self-concept**: "The overall image one has of oneself, including all the perceptions of "I" and "me", together with the feelings, beliefs, and values associated with them" (Atwater 1996:569).

- **Self-esteem**: Refers to the judgement about one's personal value, the degree to which the individual believes himself to be worthwhile (Perlman 1996:5).

- **Self-talk or intrapsychic dialogue**: Is the way an individual talks to himself about himself.

- **Identity**: "According to Erikson, the developmental task of adolescence in which the sense of self is redefined to incorporate one's uniqueness and self-chosen values" (Atwater 1996:565).

- **Sex role identity**: This encompasses the stereotypical behaviours of women and men respectively, as expected in terms of one's particular culture and society.

- **Gender identity confusion**: Refers to the confusion experienced by the child regarding identification with the male or female gender. As the individual grows up, sexual identify confusion may develop in terms of heterosexual, homosexual or bisexual sexual orientation.

- **Body image**: "The mental picture we have of our bodies, often including how we feel about our bodies" (Atwater 1996:562).

- **Body image attitudes**: "Could include dissatisfaction with physical appearance, perceived scrutiny and negative evaluation of appearance by others, and excessive importance given to physical appearance in self-evaluation. Body image behaviour might include excessive body checking and grooming rituals, camouflaging the body with clothes, avoidance of social situations that trigger physical self-consciousness, and avoidance of exposure of the body" (Rosen 1992:157).
• Distorted body image or body image disturbance: "The conceptual view of the body is inaccurate" (Brouwers 1990:144). For example, the anorexic patient feels fat "regardless of the degree of weight loss" (Vandereycken et al. 1992:403).

• Dissatisfaction with body image: "The emotional reaction toward the body is negative" (Brouwers 1990:144).

• Ideal self: "The self one would like to be" (Atwater 1996:565).

• Social selves: "The impressions one thinks others have of one, derived from one's social roles and interactions with others" (Atwater 1996:570).

• Eating disorder: "A strict definition of eating disorders includes only diseases such as anorexia nervosa, bulimia nervosa, and more recently, binge eating disorder" (Neumark-Sztainer 1996:64). Severe disturbances in eating behaviour, such as binge eating or the refusal to maintain minimal body weight (Atwater 1996:564). (The diagnostic criteria for anorexia and bulimia, as taken from the DSM IV (APA 1994) are included in Chapter Two).

• Eating disturbances: For the purpose of this study, eating disturbances include anorexic and bulimic behaviours, such as induced vomiting, laxative and diet pill use, cycles of binge eating and dieting, unhealthy dieting, which includes extreme caloric restriction, unhealthy eating behaviours, like high fat consumption or the skipping of meals, and obesity (Neumark-Sztainer 1996:64). "It includes any behaviours which reflect any unhealthy modification of food intake" (Gabel & Kearney 1998:32).

• Adolescence: "The period of rapid growth, both psychological and physical, between childhood and adulthood" (Atwater 1996:561).

• Early adolescence: "The early period of adolescent development, around the onset of puberty and afterward, about 10 to 13 years of age" (Atwater 1996:564).

• Middle adolescence: "The middle period of adolescence, involving the mid-teens, about 14 to 16 years of age" (Atwater 1996:567).
• **Late adolescence**: “The latter period of adolescence, the late teens and possibly the early 20s” (Atwater 1996:566).

• **Puberty**: “Technically, the attainment of sexual maturity or reproductive powers, more generally, the entire process of glandular and bodily changes accompanying sexual maturation” (Atwater 1996:568).

• **Amenorrhoea**: “The absence of menstruation” (Atwater 1996:561).

• **Menarche**: “The developmental onset of menstruation, or the girl’s first menstrual period” (Atwater 1996:567).

• **Group therapy**: Therapy where a leader meets with a group of individuals for therapy.

• **Cognitive-behavioural therapy**: “Focuses on thoughts and behaviour. The basic premise is that a person’s healthy functioning is adversely affected by negative reasoning or by distortions that occur in the mind (Stylianou & Havran 1998:47).

• **Qualitative methodology**: Is descriptive. The qualities or behaviours that are presented in the research are described, as well as the comments and remarks made orally as well as in the written form.

• **Primary prevention**: “Focuses on the prevention of uptake of health risk behaviours” (Paxton 1996:340).

• **Secondary prevention**: “Aims to identify and treat a health problem early in order to prevent its further development” (Paxton 1996:340).

• **Tertiary prevention**: “Involves actions to treat or reverse a health problem once developed” (Paxton 1996:340).

1.7  RESEARCH PROGRAMME

**Chapter One** presents an overview of the problems to be explored in the research study.

**Chapter Two** presents a literature review on eating disorders in order to gain a general understanding of the nature, demographics, causes and
consequences of eating disorders. Body image disturbance and the binge/purge cycle will also be explained.

Chapter Three includes literature dealing with the treatment and prognosis of eating disorders, as well as primary school-based preventative programmes and body image programmes. The content of Rosen's body image programme is explored, as well as the theory behind the cognitive-behavioural approach.

Chapter Four reviews what is considered normative of the middle adolescent in terms of her physical, psychological, cognitive, social and moral development. With this background, the researcher is better equipped to evaluate the effects of eating disorders in terms of development.

Chapter Five focuses on the empirical design of the research study and includes the general statement of the problem, the various hypotheses, the specific goals, the research methodology and the test media used.

Chapter Six includes the specific details of the research done with both the experimental and control groups. The qualitative and quantitative analysis of the data from both groups will be discussed, as well as any perceived differences.

Chapter Seven will provide the research findings, conclusions and recommendations. The feasibility of using a modified version of Rosen's body image programme in order to boost the body image of middle adolescent girls will be discussed. In addition, the feasibility of integrating various aspects of Rosen's body image programme into the Life Orientation curriculum of the particular school will be investigated.
1.8 SUMMARY

Eating disorders appear to be on the increase, and the adolescent female is particularly vulnerable in this regard. In the United States, eating disorders are ranked as the third most common chronic illness among adolescent females (Fisher et al. 1995:420).

Bearing in mind the disruption caused by eating disorders, the threat of mortality and the fact that treatment is more effective if started earlier in the disorder, the researcher believes that the pursuit of effective programmes should continue in order to help steer the “at risk” individuals away from eating disorder symptoms and to provide the symptomatic individuals with appropriate treatment.

The preventative programmes reviewed appeared to have met with success, in terms of bringing about greater awareness regarding nutrition and the facts concerning eating disorders, but were relatively ineffective in changing attitudes and behaviour concerning body image, dieting or the internalisation of the “thin ideal” (Martz & Bazzini 1999:40). The researcher believes that a component specifically designed to improve body image should be included as part of the preventative programme.
CHAPTER TWO
LITERATURE REVIEW

2. INTRODUCTION

This chapter presents a literature review on eating disorders in order to gain a general understanding of the nature, demographics, causes and consequences of eating disorders. Body image disturbance and the binge/purge cycle will also be explained.

2.1 DIAGNOSTIC CRITERIA FOR EATING DISORDERS

In 1994, the American Psychiatric Association published the fourth edition of the Diagnostic and statistical manual of mental disorders (DSM-IV, APA 1994), which includes changes in the diagnostic criteria for eating disorders. The classification of "eating disorders" no longer includes feeding disorders of children, but is restricted to anorexia nervosa and bulimia nervosa.

The diagnostic criteria as taken from the DSM-IV are listed below:

DSM-IV diagnostic criteria of anorexia nervosa (APA 1994):

A. Refusal to maintain a body weight over the minimal normal weight for age and height (e.g. weight loss leading to maintenance of body weight 15% below that expected; or failure to make expected weight gain during period of growth, leading to body weight 15% below that expected).

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance of the way in which one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or denial of the seriousness of current low body weight.
D. In females, absence of at least three consecutive menstrual cycles when expected to occur (primary or secondary amenorrhoea; a woman is considered to have amenorrhoea if menstruation occurs only following hormone administration, e.g. oestrogen).

The term “anorexia nervosa” means lack of appetite. This term is misleading, since the anorexic patient does not lose her/his appetite, but rather utilises control to override pangs of hunger and food cravings (Van den Broucke et al. 1997:2).

Two subtypes of anorexia are specified in the DSM-IV (APA 1994). The first is the classic or “restrictor” subtype, where the individual slims by restricting her/his food intake, especially foods high in carbohydrates and fats. The second is the “binge-eating/purging” subtype, where the individual resorts to self-induced vomiting, use of diet pills, laxatives, diuretics and extensive exercise over and above the reduction of food intake. In both types of anorexia, the rigid dieting results in amenorrhoea, the absence of at least three consecutive menstrual cycles (APA 1994). Individuals with the “pure” type of anorexia appear to have a better prognosis than individuals with the “binge-eating/purging” type (Van den Broucke et al. 1997:3).

Anorexics display an obsessive attitude towards food, nutrition, body weight and shape. A great deal of time is spent determining the caloric value of foods, drawing up menus and preparing food. It is common for anorexics to develop unusual eating rituals, such as hoarding or bingeing. Meals may become distressing occasions, accompanied by mixed emotions of panic, guilt and uncomfortable physical sensations. Anorexics often feel extremely self-conscious about eating in public, resulting in the avoidance of social situations where food is likely to be served (Mizes & Palermo as in Ammerman & Hersen 1997:573).
Furthermore, one of the defining features of anorexia nervosa is the disturbed perception of body weight and shape. Anorexics see themselves as being bigger than they are and perceive their ideal weight as being well below that regarded as medically acceptable. [Assessment of reasonable weight is often determined by using the body mass index. The BMI is weight in kilograms divided by height in metres squared. A BMI range of 20-25 is viewed as being healthy (Treasure 1997:115)]. The goal of becoming slim becomes all encompassing and the achievement and preservation of that goal is seen as self-mastery and a feat of self-control. The satisfaction of achieving the goal weight is short-lived, since the fear of gaining weight remains a constant threat and encourages the anorexic to continue with the slimming.

Although anorexia nervosa is the most visible eating disorder when in its advanced stages, it is not easy to identify initially. In the early stages, anorexics do well in order to keep up the front of being healthy. Academically, they are often model students, who work hard at achieving results and pleasing significant others. They are often hyperactive and work hard on the sports field. Initially, the anorexic is often unaware that help is required and, once the disease has progressed to the advanced stages, the eating behaviour and hyperactivity are often fiercely defended as being normal or healthy and assistance is rejected (Van den Broucke et al.1997:3).

How does one determine the seriousness of anorexia nervosa? When diagnosing anorexia nervosa, Van den Broucke et al. (1997:3) advocate that weight loss should be viewed from a relative perspective and that the focus should be on the speed of losing weight and the degree of preoccupation that the individual displays in terms of body image.

**DSM-IV diagnostic criteria of bulimia nervosa (APA 1994):**

A. Recurrent episodes of binge eating, characterised by both of the following:
(1) eating, in a discrete period of time (e.g. within any two hour period), an amount of food that is definitely larger than most people would eat during a similar period of time in similar circumstances; and

(2) a sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).

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

C. A minimum average of two episodes of binge eating and inappropriate compensatory behaviours per week for at least three months.

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

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

The word “bulimia” comes from the Greek words “bovine” and “hunger”. The translation, “ox hunger”, refers to the gluttony of binge-eating. This term is also misleading, as binge-eating is only one of the symptoms of bulimia nervosa and also occurs in many other somatic and mental disorders (Van den Broucke et al. 1997:2).

The bulimic is as preoccupied with weight and afraid of growing fat as the anorexic. However, while the anorexic utilises strict control to restrict her/his food intake in order to lose weight, the bulimic does not display the same control. She/he is unable to delay the binge and, once the binge has begun, eating will continue until the individual feels stuffed and bloated. “Bingeing” is specific to each individual, in terms of the frequency of episodes and their timing, as well as the quantity and type of food eaten. However, the feeling of being out of control is common (Schlundt & Johnson 1990:34).

In order for an individual to be classified as bulimic, the frequency of binge eating and inappropriate weight control behaviour, as defined by the DSM-IV (APA 1994), is twice a week for at least three consecutive months. Purging is not a
defining criterion for bulimia nervosa and, therefore, two subtypes of bulimia nervosa, the purging or the nonpurging type, are specified (APA 1994).

A binge involves eating food with an energy value of 2000 to 10 000 kilocalories (8400 to 42 000 kilojoules) within a relatively short time (e.g. within half an hour to an hour). After the binge the bulimic is often left feeling guilty, anxious, distressed, depressed and generally in a negative frame of mind (Van den Broucke et al. 1997:7).

The purging type of bulimic frequently plans to purge as a means of getting rid of the calories before the binge has begun. It is common for bulimic patients to have misconceptions about the effectiveness of other weight-reducing behavioural patterns, such as the extensive use of emetics (substances which induce vomiting), diuretics (substances which increase urination), appetite suppressants (pills which reduce the appetite by stimulating the sympathetic nervous system) and excessive exercise. While moderate exercise is extremely healthy (three to five times a week for a period between 20 and 60 minutes), excessive exercise is harmful to the body (Bulik 1994:123).

These weight-reducing behaviours temporarily reduce tension and the fear of increasing weight, and give the bulimic a sense of regaining self-control. The sad part is that the bulimic is actually losing control. The continual dieting inevitably leads to bingeing, which, in turn, results in purging, and so a vicious circle of self-destructive behaviour develops (Van den Broucke et al. 1997:5).

Bulimia nervosa is generally difficult to identify. It is not outwardly visible, since bulimics usually weigh within the normal range, although they can also be both underweight and overweight. They are secretive about their purging and weight control habits. In addition, most bulimic patients are reluctant to seek medical assistance, partly because their circumstances are not viewed as being life-
threatening and also because they often feel too guilty and ashamed to talk about their eating behaviour (Schlundt & Johnson 1990:3).

**Eating Disorder Not Otherwise Specified (NOS):**

The NOS classification was included in the DSM-IV in order to cater for eating and weight problems that do not precisely fit the criteria of anorexia and bulimia nervosa. Besides having two clusters of "near anorexics" and "near bulimics", the classification of *binge eating disorder (BED)* has been specified. The latter involves persistent and frequent binge eating that is not associated with the regular use of inappropriate compensatory behaviour, occurring at least two days per week over a period of six months (APA 1994). Individuals falling into this category consume large amounts of food and feel out of control in terms of their eating episodes. They are preoccupied with body shape, weight and dieting. Most individuals with binge eating disorder are obese and display difficulties with emotional and social problems (de Zwaan et al. 1994:311).

The addition of the *eating disorder not otherwise specified* classification is enormously helpful in classifying eating problems that do not quite fit the criteria for anorexia and bulimia nervosa. However, it is the opinion of the researcher that this is a vague classificatory category. It appears that an element of subjectivity exists in drawing the line between healthy and problematic eating attitudes and behaviour.

**2.2 UNDERSTANDING OF KEY DEFINING FEATURES:**

The purpose of this section is to foster an understanding of body image and disturbed body image, which is one of the core defining features of eating disorders. In addition, the binge-purge cycle typical of the bulimic will be discussed.
2.2.1 Body image

Body image may be described as the way one pictures body size, shape and form, the way one thinks and feels about one's physical characteristics and body parts, as well as the way one's behaviour is shaped according to the above beliefs (Kearney-Cooke & Striegei-Moore as in Garner & Garfinkel 1997:295).

Body image can be viewed from three perspectives, namely, the physiological, conceptual and emotional aspects. The physiological aspect refers to the brain's ability to detect weight, shape, size and form. The conceptual aspect is the mental picture of the body held by the individual, while the emotional aspect refers to the feelings the individual has about her/his body weight, shape and size (Brouwers 1990:144).

Fisher (as in Cash & Pruzinksky 1990:3) describes body image as the subjective sense of the body that develops both consciously and unconsciously. The individual's evaluation of her/his physical body and physical abilities contribute to the sense of the body, incorporating past as well as current body-related experiences. In addition, feedback from society regarding body appearance and socio-cultural values and ideals regarding the body influence has a significant impact on the individual's body image.

Cash (1991:1) suggests that body image is linked to body satisfaction and self-esteem and that a quarter to a third of self-esteem is based on the quality of one's body image. He highlights the significant role body image plays in determining one's social behaviour.

Kaslow and Eicher (1988:177) point out that, bearing in mind the link between body image and self-image, it is not surprising that eating-disordered individuals usually experience low self-esteem and feelings of ineffectiveness, and suggest
that treatment aimed at improving body image is likely to improve self-esteem as well.

Rosen (1996:340) refers to body image disturbance as a distressing problem, which precipitates eating disorders and which tends to remain a problem for the individual long after other symptoms have been controlled. Rosen has found that, given appropriate therapy, change in body image can take place without changing physical appearance.

Padesky (1994:267-268) describes body image in terms of body schemas. Schemas may be explained as cognitive structures within the system of the self, pockets of information regarding the physical appearance and attributes of the body. Padesky theorises that the mental representation of the body is "defended" and maintained by the selection of relevant information to reinforce the body schemas, and refers to the "Swiss cheese phenomenon", which can be explained as the tendency to hang on to negative comments while ignoring those that would have enhanced the body image.

2.2.2 Body image disturbance

Body image disturbance involves perceptual, psychological and behavioural features. *Perceptual disturbances* refer to inaccurate perceptions of bodily stimuli. Symptoms of perceptual disturbances include lack of awareness of stimuli like hunger, satiety and fatigue, as well as overestimation and distortion of body shape and size (Kaslow & Eicher: 1998:178).

While normal non-eating-disordered women tend to overestimate their body size, this phenomenon is particularly prevalent with anorexics (Thompson 1986:39). Anorexics suffer a great deal from body size disturbance and incorrectly perceive themselves as being heavier and bigger than they are. In addition, they
continually compare their bodies with others, developing an obsessive fear that others may be skinnier (Meyers & Biocca 1992:114).

The *psychological features* of body image disturbance refer to the negative attitudes and feelings attributed to the body. Individuals with a negative body image tend to devalue their appearance and to exaggerate perceived flaws. Feelings concerning one's appearance may range from self-consciousness to feelings of shame or embarrassment. An individual with disturbed body image tends to think that her/his appearance is constantly being scrutinised and evaluated negatively. In addition, excessive importance is given to physical appearance in self-evaluation, undermining feelings of adequacy and of being worthwhile as a person (Kaslow & Eicher 1988:178).

The way one feels about one's body is often influenced by one's cognitions about the body. *Automatic negative and irrational thoughts* about appearance and the self not only affect the way one thinks about one's appearance, but also the way one acts. The cognitive therapist thus strives to assist the eating disordered client to understand where ideas about her/his body originate, and seeks to challenge the cognitions. Current events or situations that resemble the original stress-evoking experience relating to physical appearance tend to trigger body image distress (Kearney-Cooke & Striegel-Moore as in Garner & Garfinkel 1997:295).

In an attempt to control feelings of intense self-consciousness and insecurity regarding appearance, certain *self-defeating behaviours* are apparent. The individual may dress in such a way as to *disguise* body shape and weight. In addition, the preoccupation with appearance may result in constant *grooming* (e.g. brushing hair or re-applying makeup) and *checking behaviour* (e.g. frequent weighing on a scale or excessive viewing in the mirror to see whether one's weight or appearance has deteriorated). The self-conscious individual with negative body image tends to *avoid* body exposure and social situations that may
attract attention and trigger negative feelings regarding appearance (Rosen 1995:23).

From an early age, the individual learns what is considered to be physically attractive from the media, society and the family. The ideal body currently portrayed by Western culture is unrealistically thin, to the extent that the majority of women feel dissatisfied with their bodies and moderate dieting in order to control weight appears to be "normal" behaviour for Western women. However, it is the degree of preoccupation with body image, weight and dieting that differentiates the behaviour of patients with eating disorders as being pathological (Gabel & Keamey 1998:32).

Various factors, called "critical experiences", that are viewed as being influential in the development of abnormally negative body image have been identified (Rosen et al. 1997:202). These factors will only be mentioned briefly, since they will be discussed in detail later in the chapter, when dealing with the causes of eating disorders.

Rosen et al. (1997:202) maintain that teasing concerning body weight and shape is one of the most significant "critical experiences" influencing excessive self-consciousness about physical appearance. Teasing relating to physical appearance is likely to make the individual more susceptible to media messages depicting cultural expectations of the "ideal body". Social comparison is thus encouraged, which results in the awareness of perceived physical shortcomings. Peer pressure to conform to certain standards of beauty is particularly strong amongst adolescents. Deviation from the norm, in terms of physical features or a stage of physical development, tends to promote feelings of being different and a sense of failure at not having met cultural expectations. Individuals who attach particular significance to physical appearance as a measure of self-worth, as well as those who have been abused or assaulted, are particularly vulnerable to developing a negative body image. Exposure to peers and parents who
model weight concern, body dissatisfaction and dieting is likely to influence preoccupation with physical appearance. Rosen et al. (1997:203) suggest that the higher the frequency of the above "critical experiences", the greater the chance of developing a negative body image.

Negative body image tends to be maintained predominantly in three ways. First, the repetition and rehearsal of negative dysfunctional thoughts (private body talk that reflects flaws and imperfections) results in the individual believing the thoughts, regardless of their validity. Second, the avoidance of situations where the individual is likely to feel self-conscious due to physical appearance prevents the individual from learning how to handle situations of this nature. Third, the compulsive checking of one's appearance tends to reinforce the preoccupation with appearance. Body checking (such as daily weighing, pinching fat, studying body parts in the mirror) tends to provide relief in the short term, but in the long term perpetuates the cycle of body image concern and preoccupation (Rosen 1995:6).

2.2.3 Understanding binge eating

Binges usually consist of four stages, namely, tension building, tension release, recovery and a new beginning.

2.2.3.1 Tension build-up

One of the most common triggers of tension build-up is restrictive dieting. The restriction of calories often results in negative feelings, such as hunger, fatigue, irritability and stress. Common emotional triggers for binge eating are boredom, loneliness, anger and anxiety. Stress may occur when individuals feel out of control and lacking in the skills and expertise necessary to cope with particular situations. In addition, the continual failure to meet one's own expectations or culturally defined standards may lead to the build-up of tension. The lack of willpower to maintain the restricting diet, as well as the anticipation involved in
planning a binge, also result in the build-up of tension. Eventually, the tension builds up to the point where relief is sought (Nash 1999:102).

2.2.3.2 Tension release
Binge-eating provides most individuals with a release from the tension and anxiety previously experienced, as well as with the letting go of negative thoughts. The binge serves as a distraction from problems and negative feelings, but the release of tension is short-lived. Panic concerning the gain of weight often follows, driving some individuals to vomit. Vomiting temporarily alleviates the guilt of bingeing and the fear of weight gain, but it leaves the individual feeling both physically and emotionally exhausted. In the long term, the vomiting tends to perpetuate hunger, due to the elimination of food but, in a sense, gives the individual permission to engage in binge eating (Abraham & Llewellyn-Jones 1992:117).

2.2.3.3 Recovery
The purging behaviour results in the individual feeling tired, lethargic and lacking in energy. Additional symptoms may include headaches, nausea, diarrhoea and abdominal discomfort. This phase is often referred to as a "binge hangover", since the individual is left feeling low. During this phase the individual gradually restores her/his strength (Nash 1999:103).

2.2.3.4 New beginning
The final stage is brief for many eating disorder sufferers. It is a period when the individual's hope is restored and resolutions are renewed. However, tension soon begins to build up, setting the scene for binge-eating and the initiation of a new cycle (Abraham & Llewellyn-Jones 1992:117).

In summary, it can be said that body image can be described as the mental picture one has of one's body, the way one thinks about or evaluates one's appearance and the way one behaves according to the above beliefs. Body
image disturbance involves body image distortion, body image dissatisfaction, and body image avoidance. Negative body images tend to be maintained by the rehearsal of self-defeating thoughts concerning physical appearance, the avoidance of stress-inducing situations relating to appearance and the compulsive checking of appearance. The way one feels about one's body is an important part of one's overall self-image. According to Rosen (1995), appropriate therapy may give one the ability to change body image without changing physical appearance.

The binge-purge cycle consists of four stages. Various factors result in the build-up of tension, to the point that relief is sought in the form of bingeing. The relief is short-lived, since feelings of guilt and panic concerning weight gain develop. Purging behaviour temporarily brings relief to these negative feelings, but then leaves the individual with a "binge-hangover", where the individual feels tired and lethargic. The individual gradually regains her/his energy and, for a brief period, hope is restored and resolutions are renewed. Tension soon begins to build up again, maintaining the binge-purge cycle.

2.3 FACTORS COMPLICATING DIAGNOSIS

Eating disorders may exist independently, but often co-exist with other conditions or disorders. Diagnosis of eating disorders may be complicated by the fact that the symptoms typical of eating disorders may also be symptomatic of other pathology. Various other conditions or disorders are often linked with eating disorders and it is therefore extremely difficult to distinguish cause from effect, particularly when the disorder is complex and chronic. Conditions often linked to eating disorders include depressive, anxiety and personality disorders, and substance abuse (Mizes & Palermo as in Ammerman & Hersen 1997:575).
2.3.1 Depression

Depression and the symptoms of eating disorders frequently present themselves simultaneously. It is difficult to determine whether the depression occurs as an independent clinical problem or whether it is connected to the eating disorder. In the latter case, the connection between depression, body dissatisfaction, self-esteem and eating disorders is far from clear, as will be demonstrated. Depending upon the particular case, it appears that depression may be one of the contributing factors leading to eating disorders or it may be one of the effects of the eating disorder, or both.

Dr Wynchank (as in Humes 2000:156) is one of the medical practitioners who believe that depression could be a direct result of the effects of starvation and weight loss in certain cases. Dieting may lead to the reduction of the neurotransmitter serotonin, a lack of which has been implicated in depressed mood. Garner (as in Garner & Garfinkel 1997:157) refers to the research of Keys et al. (1950), in which subjects who had been put on a calorie restricted diet for six months displayed mood swings and became depressed.

Cooper and Fairburn (1993:388) distinguish between dissatisfaction with body shape and overvalued ideas about shape and weight. Preoccupation with body shape and weight, which was closely related to the individual's self-esteem, was found to be a necessary diagnostic feature of eating disorders. Body shape dissatisfaction, although commonly found with eating disordered patients, was not necessarily present. Nevertheless, the degree of body shape dissatisfaction appeared to be closely associated with the level of depressed mood.

Rierdan and Koff (1997:620) refer to body dissatisfaction and preoccupation with body shape and weight as dimensions of body image. In their research with early adolescent girls, they identified a link between negative body image and negative self-evaluation, lowered self-esteem and depression.
Stice (1994:661) suggests that cultural pressures to be thin and the discrepancy perceived by the individual between the actual self and the internalised ideal self are precursors to body dissatisfaction. He believes that the individual's perception of failure to meet cultural standards of beauty leads to depressive mood, which potentially results in dieting and bulimia.

Veron-Guidry et al. (1997:24-25) studied the following risk factors in preadolescent girls, namely, body dissatisfaction, social pressure for thinness, low self-esteem and depression. Like Stice, they concluded that body dissatisfaction is a reaction to social pressures to be thin, which, in turn, may promote dieting and heighten the risk of eating disorders. The findings suggested that body dissatisfaction was neither the result of low self-esteem nor depression.

Graber and Brooks-Gunn (1996:76-78) found in their research that body dissatisfaction was high amongst preadolescent girls, particularly amongst those who had matured early and had experienced the increase of body fat earlier than their peers. Whilst body dissatisfaction seemed to taper off during mid-adolescence, it seems that more depression was experienced during this period than at any other time. Graber and Brooks-Gunn concluded that puberty, per se, was not related to depression, but rather the ability to cope with the challenges relating to the transition into adolescence, such as changes at school, higher academic requirements and new social demands. The latter refers to dating, the search for greater assertiveness, greater independence and increased freedom to make decisions within the family structure. Based on the above findings, it would appear that depression and body image problems should be viewed separately.

Joiner et al. (1995:353) conducted studies to determine the relationships between body dissatisfaction, depression and bulimia, and concluded the following:
"At the least, the results suggested that body dissatisfaction is independently associated with bulimic and depressed symptoms. At the most, the results may indicate that body dissatisfaction is more a feature of depression or of a mixed bulimia-depression syndrome than of pure bulimia."

2.3.2 Anxiety disorders

In a study of a French sample of bulimics and anorexics, Godart et al. (2000:41) confirmed the high prevalence of anxiety disorders. Prevalence of social phobia (excessive worry about being in social situations where one thinks one might be judged) among both anorectics and bulimics was particularly high, while panic disorder and separation anxiety were also found among the subjects. The findings showed that the anxiety disorder frequently exists before the onset of the eating disorder. According to Dr Dora Wynchank (in Humes 2000:169), approximately 10% of anorexics suffer from obsessive-compulsive disorder, where the individual has intrusive, recurrent "obsessive" thoughts that cause severe anxiety and/or where they are compelled to perform rituals that alleviate this anxiety.

2.3.3 Impulse control disorders

It is not uncommon for bulimia and impulse control disorder to co-exist. Once the eating problem has been established, many bulimics feel compelled to give in to their urge to binge and resort to stealing either food or the money to purchase food. In addition, bulimics may often display outbursts of anger (Van den Broucke et al. 1997:9). Favaro and Santonastaso (1998:157) support the findings of researchers like Parry-Jones and Parry-Jones (1993), which confirm the association between eating disorders and self-injurious behaviour.
2.3.4 Substance abuse

Whilst alcohol abuse frequently seems to concur with eating disorders, especially with bulimia, addiction to marijuana, amphetamines, tranquillisers, cocaine, barbiturates, hallucinogens, cigarettes, laxatives, diuretics and the emetic ipecac has also been reported to be found with bulimics (Mitchell et al. 1988:226).

2.3.5 Traumatisation (physical/sexual abuse)

It appears that traumatic experiences are reported more frequently by bulimics than by restricting anorexics, and researchers like Vanderlinden and Vandereycken view sexual abuse as a risk factor for eating disorders. In their study on traumatic experiences in eating disorders, they found the highest prevalence of sexual abuse in individuals who displayed symptoms of bulimia together with other morbidity. The morbidity included depression, alcohol abuse, kleptomania, promiscuity, automutilation, including severe dissociative symptoms, such as identity confusion, derealisation, depersonalisation and amnesia (Vanderlinden & Vandereycken as in Schwartz & Cohn 1996:18-19).

However, researchers like Pope and Hudson (1992:455), who reviewed the literature on sexual abuse and bulimia nervosa, question whether sexual abuse is, in fact, a cause for bulimia. (Further discussion regarding this subject will appear in Section 2.5 of this chapter).

2.3.6 Personality disorders

Eating disorders have been associated with the following personality disorders:

2.3.6.1 Borderline Personality Disorder

Those with borderline personality disorder have unstable, intense or chaotic relationships in which they tend to vacillate between idealising and devaluing the
person. The person may display a variety of symptoms, the most common being mood swings marked by anxiety, depression or inappropriate displays of anger (Nash 1999:39).

2.3.6.2 Histrionic Personality Disorder
Those with histrionic personality disorder have a persistent need for attention, acceptance and approval by others. They tend to become easily bored, frustrated or disappointed and are prone to mood swings (Nash 1999:41).

2.3.6.3 Avoidant Personality Disorder
The above disorder is closely linked to anorexia nervosa. The individuals tend to be shy and, although they desire relationships, they tend to avoid socialising in fear of disapproval and rejection (Nash 1999:41-42).

2.3.6.4 Dependent Personality Disorder
Those with a dependent personality feel inferior and helpless. They tend to be passive and submissive in relationships, focusing on pleasing others at their own expense. The fear of abandonment prevents them from expressing their anger appropriately (Nash 1999:43).

2.3.6.5 Obsessive-Compulsive Disorder
Restricting anorexics or anorexics who engage in excessive exercise often have an obsessive-compulsive personality organisation with displays of perfectionistic and rigid traits, and over-concern with orderliness and logic. They are often extremely conscientious, self-disciplined and responsible (Nash 1999:45).

In summary, it can be said that the diagnosis of eating disorders is complicated. Anorexia and bulimia nervosa seldom occur alone, and it is extremely difficult to distinguish cause from effect. Eating disorders may coexist with other conditions or disorders, such as substance abuse, traumatisation, depression, anxiety disorders and personality disorders. Personality disorders include borderline,
histrionic, avoidant, dependent and obsessive-compulsive disorders. The symptoms typical of anorexia and bulimia nervosa may be symptomatic of other pathology.

2.4 PREVALENCE AND DEMOGRAPHIC CHARACTERISTICS

It is not surprising that prevalence estimates of eating disorders are so varied. Most of the earlier epidemiological studies focused on college students and young women, while more recent studies include adolescents. In addition, the diagnostic criteria, as redefined in 1994, are more stringent, thus reducing the number of individuals who meet the criteria for "pure" eating disorders (Mizes & Palmermo as in Ammerman & Hersen 1997:576).

Lucas et al. (1991:917) performed a study in Minnesota over a period of 50 years (1935-1984) in order to determine the prevalence of anorexia in females. The study revealed that anorexia had become more widespread amongst females ranging from 15 to 20 years, while the incidence rates for women over 20 had remained constant.

Steiner and Lock (1998:353) reviewed various epidemiological studies done by Flament et al. (1991), Killen et al. (1986) and Lucas et al. (1991), and came to the conclusion that bulimia tends to occur in the latter part of adolescence, while eating disorders not otherwise specified appear to be more common in early adolescence. Mention was made of research done by Field et al. (1993), where 40-60% of high school girls in the United States were reported to be on diet at any given time. These figures are similar to those found by Patton et al. (1997:299) in the United Kingdom.

Pagsberg and Wang (1994:259) confirm that prevalence rates of eating disorders in the European countries and the United States of America are very similar. It
is the opinion of Szabo (1998:15) that South Africa appears to have followed the trend of Western countries regarding the epidemiology of eating disorders. While eating disorders are typically detected in young adult Caucasian females, usually of middle-to-upper class status and Western culture, eating disorders are no longer restricted to this group. They include females ranging in age from 12 to 20, as well as older females, men and individuals of all racial, cultural and socio-economic groups.

Studies of rural villages in countries like Italy have shown similar prevalence rates to those of urban settings (Rathner & Messner 1993:180), suggesting little or no effect of urbanisation on the development of eating disorders. It is the opinion of the researcher that bulimia in South Africa is more common in the sector of the population that has access to television. However, research is needed to confirm this.

A high incidence of eating disorders is found amongst athletes who participate in activities emphasising leanness, such as jockeys, dancers, gymnasts, figure skaters and runners. In addition, individuals who have high profile jobs that place a great deal of importance on appearance are at a greater risk for developing eating disorders than those in environments where the standards of appearance are more relaxed. These jobs include sales and marketing, retail, fashion merchandising, design, entertaining, dancing, modelling, television presenting and so forth (Nash 1999:33-35).

In summary, it may be said that the prevalence rates of eating disorders in South Africa appear to be similar to those in the European countries and the United States of America. Anorexia appears to be on the increase amongst adolescents, which is not surprising when it is reported that 20-40% of high school children in the United States of America have been on a calorie restricted diet. While eating disorders are found mostly in the young adult population, they may also be found amongst adolescents ranging from 12 to 20 years, as well as
among older adults. The majority of anorexic and bulimic patients are female, Caucasian, of Western culture and from middle-to-upper class. However, eating disorders also affect individuals of all races, cultures and socio-economic groups.

2.5 CAUSES OF EATING DISORDERS

Julia Buckroyd (1989: 14) is a British psychotherapist and counsellor who has worked with bulimics and anorexics for many years. She views eating disorders as responses to emotional problems, and says:

“It is probably true that there are some difficult things to be known or understood by the food misuser. There is something that needs attention, needs to be dealt with, some part of our experience, of our history, some unfinished business. It is unlikely to be very agreeable or very easy or we would not have needed to misuse food rather than let ourselves know about it.”

Oprah Winfrey, the popular American host presenter of talk shows was sexually abused as a child and has struggled with a weight problem most of her life. Miles and Allison (as in Thompson 1996:365) quote her as follows:

“My greatest failure was in believing that the weight issue was just about weight. It’s not... it’s about not handling stress properly. It’s about sexual abuse. It’s about all the things that cause other people to become alcoholics and drug addicts.”

Susie Orbach is a British psychotherapist and writer. In her book “Hunger Strike”, she writes about women’s relationships to eating problems and views the causes of anorexia from a feminist perspective. She says:

“On the one hand, anorexia is about being thin – very, very thin. It is an expression of a woman’s confusion about how much space she may take up in the world. On the other hand, her food denial is driven by the need to control her body, which is, for her, a symbol of emotional needs. If she can get control over her body, then perhaps she can similarly control her emotional neediness. Submitting her body to rigorous discipline is part of her attempt to deny an emotional life. The anorectic cannot tolerate feelings. She experiences her emotional life as an attack on herself, and she attempts to control it so that she will not be devoured by her emotions.
She tries to gain control over her body and her mind by creating an altogether new person out of herself. In other words, she negates who she is - needy, hungry, angry, yearning - and through the adoption of strenuous diet and exercise rituals turns herself into someone she finds more acceptable. In turn her submission to the rituals creates a boundary between herself and her needs. She gathers strength from the knowledge that she can ignore her needs and appetites" (Orbach 1993:xii).

Many researchers describe the causes of eating disorders in terms of predisposing, precipitating and perpetuating factors. The *predisposing* factors include issues that make the individual particularly vulnerable to eating disorders. They include genetic factors (e.g. pre-existing vulnerability to depression), psychological factors (e.g. all-pervasive sense of ineffectiveness), personal factors (e.g. social insecurity) and family factors (e.g. a family who is too close and too involved, without the necessary separation and individualisation).

The *precipitating* causes are factors that tend to trigger the eating disorder. They include situations in which the individual experiences distress and perceives a threat of loss of self-control or loss of self-worth. Examples of precipitating factors include loss of parents at an early age, divorce, serious illness of a close friend or a serious disappointment (Marx as in Alexander-Mott & Lumsden 1994:124-128).

The *perpetuating* causes include factors that maintain the eating disorder, such as the cultural pressure for extreme thinness, the craving for food and the likelihood of bingeing as a result of restrictive dieting, cognitive distortions, feelings of ineffectiveness and social withdrawal. Anorexics tend to withdraw socially because of their preoccupation with food and their fear of having to eat in public. However, the resulting feelings of alienation and the lack of support to cope with the general challenges of adolescence make the individual even more vulnerable to eating disorders. Perpetuating factors often include the short-term benefits of starving, bingeing and purging, which serve as a payoff and reinforce the behaviour (Marx as in Alexander-Mott & Lumsden 1994:128-129).
Despite a considerable amount of research in the past three decades, there is still confusion as to the exact causes of eating disorders. It appears that it is no one single factor, but a combination of many factors that contribute to producing a vulnerability to the development and maintenance of eating disorders. Identification of the factors causing anorexia or bulimia in individuals is a difficult task, since these factors are unique in each case. Various risk factors for developing eating disorders have been identified, but it is unclear why only some individuals exposed to these risk factors develop eating disorders and not others. Connors and Johnson (as in Smolak et al. 1996:299) developed a two-component model of eating disorders in order to describe the “at risk” factors, as can be seen in Figure 1.

![Figure 1: A two-component model of eating disorders](image)

The reasoning behind the model made great sense to the researcher, who has used the model as a framework for the discussion of the causes of eating disorders. The rationale behind the model is that eating disorders may be the result of a combination of two components of experience. One component
results in body dissatisfaction, which could lead to dieting and eating disturbance, while the other component may predispose interpersonal and self-regulatory difficulties. According to the model, socio-cultural, physical and developmental factors have been identified as risk factors for body dissatisfaction. Furthermore, the individual who experiences body dissatisfaction without having emotional disturbance or self-regulatory difficulties is likely to follow the path of normal dieting. The model explains temperamental, familial and traumatic factors as predisposing factors for affective dysregulation, which could lead to a range of psychopathology. Should psychological impairment exist without body dissatisfaction, the individual is likely to develop a non-eating-disordered psychopathology. Individuals who have both high levels of body dissatisfaction and major difficulties with affective regulation are the most vulnerable to developing anorexia nervosa or bulimia nervosa (Connors as in Smolak et al. 1996:298-299).

Connors, like most researchers, acknowledges the significant role genetics plays in the development of eating disorders. The area of genetics is discussed very superficially, not because it is less significant, but because of the limited understanding available at present. Brief mention of some of the theories proposed by various researchers will be made, but a scientific explanation of the respective theories is beyond the scope of this study.

2.5.1 Genetics and Heredity

Whilst it is extremely difficult to differentiate between environmental and genetic factors, Nash (1999:82-83) suggests that heredity plays some part in determining body weight and body mass as was indicated by the research done by Bouchard (1997). In addition, she refers to research done by Weinsier et al. (1998), suggesting that diet, metabolism and physical activity, which all have an impact on body weight, are influenced to some extent by genes. Although it is acknowledged that family and environmental factors have a significant influence
on food choice, a small part of energy intake is believed to be the result of hereditary factors. Variations in resting energy and the amount of energy used to process food are also believed to be partly a result of genetic makeup. Finally, the spontaneous activity level of the individual is considered to be genetic. It must be emphasised that body weight, mass and shape are seen as the result of the interaction between genetic susceptibility and environmental, social, behavioural, psychological and physical factors and differences in lifestyle.

Phelphs et al. (1994:284) mention the set-point theory, as proposed by Bouchard et al. (1990), and which is supported by a number of researchers. The theory suggests that the individual has a point at which the body weight is set and that metabolic changes occur in order to maintain the "ideal" body weight. This theory is supported by Keys et al. (1950), who performed a "starvation" study in Minnesota (Garner as in Garner & Garfinkel 1997:161). Details concerning this study will be discussed in Section 2.5.3, under the sub-heading "Teasing".

Muuss (1985:527) discusses the theory of hypothalamus disturbance, whereby malfunctioning of the satiety centre in the hypothalamus is thought to disrupt the regulation of food intake and affect eating behaviour. However, it is still unclear whether starvation is the result or cause of hypothalamic disturbances.

2.5.2 Media influences

Throughout history, people have tended to change their bodies in order to conform to the physical ideal of that era. During the 1960s and 1970s, the standard for ideal beauty became increasingly thinner, as could be seen at the beauty pageants and from the models depicted in magazines like "Playboy" (Gamer et al. 1980:484). It appears that media, family and peer influence play an enormous role in the internalisation of the individual's stereotypic beliefs. The degree to which the individual is susceptible to the thin ideal message is
influenced by factors such as self-esteem and identity confusion, body weight, modelling by family, peers and media, coping skills, impulsivity, simultaneous developmental transitions and exposure to the sub-culture of dieting (Berel & Irving 1998:421).

The media promote gender role expectations and the thin ideal via television, movies and magazines. Killian (1994:313) reflects on the work of Schwarz and Barrett (1988) and describes the gender expectations portrayed by the media as including the subordinate role played by women, a role of passivity, dependence and limited control. The woman's role encompasses being the nurturer and the caregiver, being self-sacrificing and focused on taking care of others, to the point of denying her own needs. Killian suggests that eating disorders may be the result of unmet needs. For some, eating disorders may indirectly represent the desired power and control, since nobody can force the individual to eat or to stop bingeing and purging.

Furthermore, media messages promote the idea that being thin and beautiful brings the rewards of popularity, friends, success, power and romantic relationships. Anti-fat prejudice is communicated, together with the message that to be fat is to be a failure, weak, out of control and possibly rejected. Even the health industry in America has launched campaigns to persuade the Americans to reduce fat intake, lose weight and exercise more. Advertisers of the cosmetic, diet and fashion industries constantly focus on body weight, shape and beauty. Any deviation from the ideal look is portrayed as a flaw and women are persuaded that they have the power to change their appearance with the aid of the advertised products (Nash 1999:64).

Research done by Stice and Shaw (1994:288) suggests that exposure to the thin ideal promotes awareness of the disparity between the individual's actual weight and the ideal. Comparison with those superior to the individual on a particular dimension leads to negative self-evaluation and negatively biased attitudes of
self-worth and value. This often results in depression, stress, guilt, shame, decreased confidence and body dissatisfaction. Thus, a link between negative affect, body dissatisfaction, the internalisation of the thin ideal and eating disorders was found.

Harrison and Cantor (1997:61) examined the relationship between media consumption and eating disorders. They found that body dissatisfaction appeared to be more strongly related to television viewing than magazine reading, while the drive for thinness was more strongly related to magazine reading. Harrison and Cantor explain the drive for thinness, demonstrated by restrictive dieting and excessive exercise, from a social learning perspective (Bandura 1977). The dieting behaviour is believed to be motivated by the anticipation of the reward of being thin and socially accepted.

It appears that some individuals are more susceptible to media influences than others and that women differ in their preferences and their reasons for viewing media. Various factors are also responsible for the way the individual responds to the media. For example, an individual with a higher body mass index than the average is likely to be more sensitive to diet-related media. Media is particularly hazardous for those who have lowered self-esteem and feel inadequate and who use the media as a means of measuring self-worth (Berel & Irving 1998:419). Levine et al. (1994:487) suggest that young adolescent girls actively select media that confirm the thinness schema established in childhood via the messages received from magazines, family and peers.

Tiggemann and Pickering (1996:202) found in their research that total television viewing time was not related to body dissatisfaction or drive for thinness, but rather the nature of the material viewed. A positive correlation was found between body dissatisfaction and the time spent viewing women in stereotyped roles in "soap operas", the viewing of music videos (which portrays images of the ideal young woman), certain movies and sports.
Hamilton and Waller (1993:837) examined the influence of exposure to photographs of idealised female bodies in women's fashion magazines. They found that eating-disordered women tended to overestimate their body size more after they had seen pictures of models as opposed to neutral objects, while the women without eating disorders were not affected. This confirmed the findings of Penner et al. (1991:91), who made an interesting observation regarding the sample of women without eating disorders. He found that the average sized women were unaffected by media exposure, while the extremely thin women tended to overestimate their actual size. The possible explanations that were offered included difficulties with perception or a tendency to try to maintain the perception of the body size as it was before their dramatic weight loss. Giles (1988:143) presented a case study of body image distortion. He suggested that body image distortion was the effect of an anxiety reaction and that the individual, via social feedback, learns to fear being overweight and the possibility of becoming overweight.

In summary, it can be said that the individual learns the cultural perspective of female beauty from the media, family and friends. In Western society, the thin ideal is associated with popularity, having friends, success, power and a romantic relationship. Advertisers of cosmetic, diet and fashion industries that focus on body weight, shape and beauty in their advertisements promote this concept. Women who are overweight, feel inadequate and have low self-esteem, are more susceptible to the influence of media messages about the value of leanness. For these women, exposure to the thin ideal is likely to bring about awareness of the disparity between their own bodies and the ideal body shape. Body dissatisfaction tends to motivate restrictive dieting, which places the individual at risk for eating disorders.
2.5.3 Teasing

Perceived pressure to lose weight from family, peers, friends and dating partners is a powerful contributing factor to eating disorders. Criticism and teasing concerning body weight and shape, particularly from family members, makes the individual even more vulnerable to media messages about the "ideal body". Teasing concerning body shape may result in the individual feeling ashamed about her/his body and sad at not being able to meet expectations. The more frequent and upsetting the teasing, the greater the likelihood that it will lead to body dissatisfaction, providing the catalyst for restrictive dieting (Levine et al. 1994:484).

For adolescents who already live in a culture of dieting, teasing may be the final motivating factor to diet. The process of dieting, per se, places the individual at risk for eating disorders. Not only does dieting and the deprivation of food trigger bingeing (Garner as in Garner & Garfinkel 1997:151-161), but the loss of weight also slows the metabolism, resulting in a need for more extreme methods of losing weight and maintaining weight loss.

Garner (as in Garner & Garfinkel 1997:151-161) refers to the research of Keys et al. (1950), where 36 young, healthy, psychologically normal men were put on a restrictive caloric diet for six months. The volunteers experienced similar symptoms to those of patients with eating disorders, namely, food preoccupation, loss of control of appetite during the refeeding period, depression, mood swings, anxiety and irritability, social withdrawal, reduction of sexual interests, impaired concentration and judgment, decreases in body temperature, heart rate, respiration and metabolic rate. Another interesting fact was that, after the eight-month refeeding period, the volunteers were approximately 110% of their original body weight, but had approximately 140% of their original body fat. They also reported feeling fat and flabby and had developed a fear of weight gain. Thus, it
appears that many of symptoms that might have been thought to be primary features of anorexia nervosa are, in fact, symptoms of starvation.

In summation, frequent, upsetting teasing concerning body weight and shape from significant others, especially family members, often leads to body shame and increased body dissatisfaction. Teasing becomes a motivating factor to diet. Restrictive dieting tends to upset the metabolism. When normal eating is resumed after having dieted, the individual tends not only to regain the lost weight, but also to gain further weight, in particular, body fat.

2.5.4 Peer influences

Peer influence plays an enormous role in the internalisation of the individual's values and norms. While negative comments and criticism may deter certain types of behaviour, others will be encouraged by the compliments and modelling of peers. The thin ideal is thus promoted via social reinforcement. Adolescents tend to be particularly intent upon conforming to the norm and achieving social acceptance and, thus, are particularly vulnerable to peer pressure to be thin (Stice 1994:647). Dieting at a young age could start merely as the result of peer pressure or as an attempt at practising the adult role in anticipation of being an adult (Hill 1993:92).

Various sub-cultures promote different forms of “acceptable” behaviour. Dyer and Tiggemann (1996:137) did some interesting research, in which two private schools were compared, one co-educational and the other single-sexed, of roughly equivalent socio-economic status. Despite the fact that the girls from the single-sexed school weighed less, they were more dissatisfied and preoccupied with their weight and body shape. In addition, there was greater emphasis on professional success. The results demonstrate the influence of the sub-culture of the school and suggest that girls from single-sexed schools may be at greater risk for eating disorders.
2.5.5 Family influences

The family is one of many influences that help to interpret society’s values and expectations for the young individual. Families of eating-disordered individuals tend to be focused on physical appearance as a means of evaluating self-worth and may encourage dieting in order to meet the societal expectation of slenderness, either overtly or indirectly, by criticising and teasing the individual (Stice 1994:645).

McNab (1983:428) describes anorexics as generally being high achievers with low self-esteem and perfectionist tendencies. He refers to the work of Hilde Bruch (1978), who suggests that parental expectations may play a role in the development of eating disorders. Individuals who perceive parental acceptance and support to be based on achievement may feel insecure and fear being unable to meet these expectations.

Kanakis and Thelen (1995:498-499) examined the parental influence on daughters with bulimia nervosa. Compared to the control group, the bulimic group reported greater distress at being teased by the family and greater maternal pressure to diet. However, no difference was found in terms of eating behaviour, dieting, self-esteem, body importance or body image, suggesting that the parental influence is limited. This was supported by Sanftner et al. (1996:157), who specifically examined maternal influences on daughters’ eating attitudes and behaviour. Contrary to these findings, Pike and Rodin (1991:198) found that the daughters tended to adopt maternal attitudes toward weight and to copy the mother’s eating habits.

Killian (1994:312) reviewed literature on family systems and found that the various research studies indicated a higher incidence of psychopathology in families of eating-disordered individuals. Anorexia is frequently found with first-degree relatives of anorexics (Strober & Humphrey 1987 as in Killian 1994:312),
while the chance of finding bulimia in sisters of the patient is four times greater than that found within the general population (Strober et al. 1990 as in Killian 1994:312). In addition, relatives of anorexics and bulimics demonstrated a higher incidence of affective disorder (Hudson & Pope 1988 as in Killian 1994:312), depression and alcoholism (Bulik 1987 as in Killian 1994:312) than normal controls. It is extremely difficult to determine whether genetics play a role in the above findings or whether certain family patterns make the individual vulnerable to developing eating disorders.

From the family system theorist's point of view, dysfunction within the family system is seen as a significant cause for eating disorders. Various family system theorists emphasise different characteristics as being significant. Bailey (1991:253-255) and Connors (as in Levine et al. 1996:292-295) both highlight four characteristics frequently mentioned in the literature, namely, dimensions of cohesion, communication and expression of feelings, control and autonomy and conflict resolution.

2.5.5.1 Cohesion dimension

A healthy cohesive family tends to reflect nurturance, support, helpfulness, warmth, empathy and understanding (Connors as in Levine et al. 1996:293). Excessive cohesion (enmeshment) and lack of cohesion (disengagement) can be seen as dysfunctional. Members of the enmeshed family are overprotected and are denied privacy and their individual identity. When enmeshment is combined with emotional hostility and overprotectiveness, the individual experiences great difficulty escaping from the family and developing a well-defined sense of self. The disengaged family, on the other hand, lacks cohesiveness and boundaries. Members of underinvolved families are less available, supportive, attentive and affectionate than healthy cohesive families (Bailey 1991:253-254).
2.5.5.2 Communication and expression of feelings dimension

The expression of feelings, thoughts and desires is encouraged in well-functioning families, while communication amongst family members is clear, honest, supportive and respectful (Nash 1999:72). When the individual is disallowed free and open expression, feelings tend to be expressed inappropriately through outbursts or through psychosomatic illnesses. Such individuals experience difficulty with the identification and expression of feelings and tend to have poor communication skills (Bailey 1991:254).

2.5.5.3 Control and autonomy dimension

In overcontrolled families, rules are rigidly enforced and self-sufficient behaviour is discouraged, while mixed messages concerning control and autonomy are often conveyed. This results in the individual developing all-or-nothing patterns of viewing the world, and stunts the development of autonomy, competence and the courage to risk activities outside the safety of the home (Bailey 1991:255).

2.5.5.4 Hostile/Conflict-Avoidant dimension

This dimension involves the way family members express their anger. Some families express their anger openly and in a manner that can be blaming, belittling and rejecting, creating an angry, hostile and chaotic atmosphere. Other families present strong facades of togetherness, stay in control and avoid conflict at all costs. This results in the stunting of the individual's negotiation and problem-solving skills and the development of "pleasing" behaviour, often at the expense of their own needs (Nash 1999:74).

Marx (as in Alexander-Mott & Lumsden 1994:127) reviews various theories of family dysfunction. He refers to the models of Selvini-Palazzoli (1988) and Minuchin (1978) regarding the causes of anorexia nervosa. Minuchin suggested
that the interaction of families of anorexic children shared five characteristics, namely; enmeshment, overprotectiveness, rigidity, lack of conflict resolution and involvement of the young anorexic in parental conflicts. Selvini-Palazzoli’s model was similar to that of Minuchin in terms of lack of conflict resolution and rigidity, but included aspects like unwillingness to take leadership, rejection of communication, blaming behaviour and the formation of secret alliances with various family members. However, researchers like Rostam and Gillberg (1991) found that family characteristics of non-eating-disordered families as well as anorexic groups were similar, suggesting little support for Minuchin’s model. It was acknowledged, however, that eating-disordered families have more disturbed interactions than normal families.

Killian (1994:314) reviews the literature on the role played by family systems’ interaction in anorexia and bulimia. He describes three major subtypes of bulimic families. The first type is the perfect family, where there is a strong emphasis on appearance, enmeshment, achievement and perfection. The second type is the overprotective family, where extreme enmeshment, overprotectiveness, lack of conflict resolution skills and lack of rules for age-appropriate behaviour is evident. The child from this family finds it difficult to develop independence and an identity of her/his own. The third type is the chaotic family, where there is an absence of rules and inconsistent discipline. Physical or sexual abuse, frequent emotional outbursts and expressions of anger may be present, as well as substance abuse.

Attachment theory, as described by Bowlby (1969), suggests that the early experiences of the infant are critical in terms of developing a relation with the caregiver. The quality of this relationship is likely to influence the child’s sense of security and ability to adapt to life circumstances in the future. In addition, the initial relationship with the caregiver and those experienced within the family serve as models for the development of future relationships outside the family (Isabella as in Smolak et al. 1996:177-178).
Johnson and Blouin (1998:239-240) look at bulimia from the theoretical perspective of attachment theory. They mention the work of Ryan and Lynch (1989), who suggest that the challenge of the adolescent is to maintain, but modify, the connection with parents. This will provide the individual with confidence to explore the environment, knowing that there is a safe haven to retreat to if necessary. Negative attachment is likely to breed insecurity and the unwillingness to separate from the family, which appears to be more prevalent amongst eating-disordered patients than normal adolescents. The eating-disordered individual may try to compensate for the lack of safe attachment by using the control of food and nurturance as a sense of security.

In summation, the family plays a significant role in interpreting cultural norms and values. While consensus on the degree of modelling is lacking, it is generally believed that mothers influence their daughters to some extent in terms of body dissatisfaction, dieting and other eating disturbances. A higher degree of psychopathology, such as anorexia, affective disorder, depression and alcoholism is found in families with eating disorders than in control groups.

Family system theorists view dysfunction within the family in terms of cohesion, communication and expression of feelings, control, autonomy and conflict resolution, as a cause for eating disorders. While there is little evidence to support the theory that families with eating disorders have distinctive characteristics, it seems that these families often have more disturbed interactions than normal. Insecurity and unwillingness to separate appears to be more prevalent amongst eating disordered adolescents and could be attributed to negative attachment. The eating disordered individual may try to compensate for the lack of safe attachment by relying on the use of food as a means of control and a sense of security.
2.5.6 Developmental influences

The transition to adolescence is a time of change. While these changes are generally perceived as being positive and as a normative step towards adulthood, some individuals appear more vulnerable to the transitional changes than others and struggle to adapt. Adolescents are expected to adapt to the physical changes of puberty, cognitive changes (resulting in better understanding of cause and effect) and relationship changes (whereby the individual becomes less dependent on the family and more involved with the peer group). In addition, the individual undergoes personality changes as cultural expectations are accommodated and self-identity develops. The changes may even include the change of schools, or, if not, a change from elementary to junior-high school (Graber & Brooks-Gunn 1996:77).

Smolak and Levine (as in Smolak et al. 1996:209) refer to Cytrynbaum’s model in their interpretation of why some individuals are more vulnerable to transitional changes. Two factors were deemed important, namely, personality characteristics and the nature of social support. Personality characteristics that are significant in terms of eating disorders include factors such as the internalisation of the thin ideal and identity development, high reactivity to stress or criticism, difficulty in differentiating emotional from physical sensations, perfectionism and low self-esteem. Swarr and Richards (1996:644) found in their study that the closer the girls felt to their mothers, the fewer concerns they had about weight and eating. While further research is necessary, it seems that close relationships with mothers and time-intensive relationships with parents play a role in enabling the individual to adapt positively to pubertal development.

A number of researchers (e.g. Brooks-Gunn 1987) have pointed to the timing of puberty (early versus on time) as one of the factors contributing to the increase of body dissatisfaction, dieting and eating disorders. Although this may be the case in the short term, Smolak et al. (1993:365-366) found in their longitudinal
study that the timing of menarche does not have long-term effects on attitude regarding body weight, shape and disturbed eating. However, those girls who reached menarche early and experienced other normative stressors simultaneously (within the same year) experienced more body dissatisfaction and negative eating-disordered attitudes than those who had not reached menarche.

Crisp (1997:249) views anorexia as a phobic avoidance disorder. The individual regresses to a premenarchal perception of sexual development in order to avoid the mature body shape and weight. Anorexia may act as an escape from having to deal with fears of not coping with the responsibilities of adulthood.

Cauffman and Steinberg (1996:249) investigated the influence menarche and socialising with the opposite sex had on dieting. They found that physical involvement with a boyfriend increased the likelihood of dieting and possible eating disorders. According to Abraham and Llewellyn-Jones (1992:40), the eating disorder may subconsciously serve as an escape from anxiety concerning dating and sex for the individual who is unsure of her sexuality and may be used to delay sexual encounters until the individual feels ready.

During adolescence the individual begins to develop a sense of self (Frederick & Grow 1996:218). A great deal of attention is focused on the self and the adolescent experiences heightened self-awareness. The sense of self encompasses having the freedom to determine one’s own actions (autonomy), power to make one’s own decisions without outside influence (self-determination) and the freedom to think one’s own thoughts and to feel one’s own feelings.

Frederick and Grow (1996:225) discuss the role that family influences, or the lack thereof, play in the promotion of autonomy. It is suggested that a supportive environment that promotes self-determination is likely to build general self-esteem, a sense of security and some perception of who the individual is. The individual from a controlling or less nurturant parental environment is likely to
base self-worth on the evaluation and approval of others, instead of acknowledging own abilities and characteristics. Such an individual tends to focus on pleasing others, at the expense of their own needs, interests and ambitions.

The individual who indulges in pleasing behaviour is often a high achiever with low self-esteem and high levels of anxiety. The individual typically lacks social confidence and focuses on presenting a positive public self. Behaviour is motivated by social expectations and does not necessarily reflect the real self. "Phoney" role-playing develops as a result and a false self is projected. This becomes problematic to the individual, since the self-identity becomes confused. The focus on food and weight may serve as a means of preserving the self. Social approval may be gained by the loss of weight, while the bingeing/purging behaviour may be helpful in dealing with anxiety and negative feelings. The irony is that social deficits are likely to be amplified as a consequence of the eating disorder (Striegel-Moore et al. 1993:297).

Individuals from homes where both parents work or who come from divorced homes tend to lose out on cultural interactions with the family and community, and thus are presented with "undiluted" media messages. The influence of the peer group in the redefining and acceptance of values and norms becomes even more significant. Media messages include the idea that beauty is a commodity to be pursued and that will provide self-worth and power. In addition, it gives exposure to a system of beliefs regarding gender and sexuality, the cultural stereotype of being a woman and the stereotyping of employment (Durham 1999:212). However, various ambiguities and mixed messages are portrayed. The superwoman ideal involves the cultural expectation of having women adopt a number of roles simultaneously (Heilman 1998:187). Gender expectations where the woman is encouraged to be passive with men but competitive with women are confusing. Many women experience conflict between their need for relationships and socio-economic status. Stress arises from the adoption of
cultural values which conflict with personal needs, such as autonomy and control (Nagel & Jones 1992:110).

Schupak-Neuberg and Nemeroff (1993:335-336) investigated the sense of self of bulimics. They came to the conclusion that disturbance in identity can largely be attributed to personality deficits, decreased personal effectiveness and difficulties with sexual and social relationships. They observed that bulimics tend to use the body to represent the inner identity structure and to use food as a means of emotional regulation. As mentioned previously, the focus on food during the binge period provides a temporary escape from self-awareness. After the binge, the negative feelings return. However, the bulimic then attributes food as the source of negative feelings and is thus motivated to purge. Schupak-Neuberg and Nemeroff question whether identity disturbance precedes bulimia nervosa or is a secondary effect.

In summary, according to Cytrynbaum's model, personality characteristics and the nature of social support (e.g. close relationships with parents) influence the ease with which adolescents adapt to pubertal changes. Early maturing girls (who are temporarily heavier than their peers) tend to have greater body dissatisfaction than the norm, when other normative stressors are experienced simultaneously (within the same year). Adolescent girls are more likely to diet when they begin to date and become physically involved with boyfriends. For the anorexic, amenorrhoea and the regression to a premenarchal perception of sexual development may serve as a means of delaying sexual encounters and of avoiding anxiety around dating and sex. The adolescent may experience confusion in terms of gender expectations, as well as self-identity. “Phoney role-playing” in order to please and seek approval may result in the individual feeling needy and disempowered. As a response to unmet needs, food may be used as a means of emotional regulation.
2.5.7 Personality traits

Hurlock (1978:525) defines personality traits as "[s]pecific qualities of behaviour or adjustive patterns, such as reactions to frustrations, ways of meeting problems, aggressive and defensive behaviour and outgoing or withdrawing behaviour in the presence of others. Traits are integrated with and influenced by the self-concept. Some are separate and distinct, while others are combined into syndromes or related patterns of behaviour."

Personality traits refer to individual forms of behaviour typical of the particular individual. In other words, the individual will display consistent behaviour in similar situations under similar conditions.

While temperament may be viewed as genetic in origin, both hereditary and environmental factors influence personality. "Personality traits evolve as a consequence of the temperament one is born with and the treatment he or she receives in the family and later from peers" (Nash 1999:38). Various researchers have highlighted personality traits considered to make the individual vulnerable to developing eating disorders. Some researchers have isolated differential personality profiles for anorexia and bulimia. However, since there is little consensus in this regard, the researcher will refrain from categorising these personality traits.

Most researchers consider low self-esteem as being a significant factor contributing to eating disorders. Low self-esteem implies self-hatred and, particularly in this context, refers to self-deprecating feelings about the body. The individual with low self-esteem is likely to be self-critical and to experience feelings of guilt, shame and general worthlessness. Lack of confidence, feelings of ineffectiveness and failure may also be experienced. In addition, the individual with low self-esteem may experience social anxiety, difficulty adjusting to social norms and relating to peers and others (van der Ham et al. 1998:83).
Ashby et al. (1998:263) refer to adaptive perfectionism as being the pursuit of high standards by someone with high self-esteem, while maladaptive perfectionism is viewed as being significantly related to low self-esteem. The maladaptive perfectionistic individual is likely to be over-concerned with performance and seeks to appear perfect in the eyes of others. The individual is, therefore, usually ambitious and sets high self-imposed expectations. Hewitt et al. (1995:318) suggest that the maladaptive perfectionist is so concerned about not making mistakes that there is a tendency to avoid engaging in novel situations for fear of not performing adequately. They refer to the three components of perfectionism, namely, "the need to appear perfect, the need to avoid appearing imperfect, and the need to avoid disclosure of imperfection" (Hewitt et al. 1995:318).

Treasure (1997:123) suggests that low self-esteem and fear of criticism motivate the maladaptive perfectionist to engage in pleasing behaviour in order to gain the approval of others.

Pryor and Wiederman (1998:297) differentiate between anorexics and bulimics, particularly in terms of their need for self-discipline. The anorexic is described as having obsessive-compulsive traits. As indicated earlier in the chapter, this implies that the individual is perfectionistic, rigid and predictable, conscientious and well organised. In addition, the anorexic is self-disciplined, rule-conscious and concerned about doing the right thing and pleasing others. The bulimic, on the other hand, is viewed as having a weaker impulse control, low frustration tolerance and a need for instant gratification. These traits can be likened to those of alcoholics and substance abusers, who appear to be lacking in self-discipline or control.

Dickstein (1989:110) describes eating-disordered individuals as having high and acute levels of dysphoria, which includes depression or minor affective disorders. Highly variable moods and high levels of anxiety and tension may be observed.
Eating-disordered individuals may react to situations with greater intensity than the norm and may be lacking in resilience to cope with stress. Nash (1999:79) mentions a variety of stresses that may be overwhelming for the individual and result in bulimic bingeing in order to regulate her/his mood. These are physical stresses like hunger, loneliness as a result of interpersonal conflict, feeling manipulated and needing freedom of choice and control over life and, lastly, being unable to relax and have fun.

Steinberg and Shaw (1997:700) consider the eating-disordered individual as lacking the capacity to self-sooth, which refers to the ability to manage the various states of tension and to maintain self-esteem. It is suggested that bulimics manage states of tension through the binge/purge process, as other self-soothing tools are unavailable.

Favaro and Santonastaso (1998:163) describe the difficulty experienced by eating-disordered individuals in terms of identifying and interpreting emotions and bodily sensations (i.e. hunger and satiety). Negative emotions may be interpreted as cravings to eat, while the purging behaviour may be a way of experiencing the body in an attempt to "seek a sense of reality and identity".

Bauer and Anderson (1989:416-419) explored the self-talk of individuals suffering from bulimia nervosa and found that they share a characteristic pattern of thinking. The researcher has quoted some of these common beliefs from Bauer and Anderson's article, since Rosen (1995:20) focuses a great deal on the role irrational thoughts play in distorting one's body image and influencing one's behaviour. (This will be discussed in more detail in the following chapter, when dealing with Rosen's body image programme).

The following are thoughts typical of the bulimic (Bauer & Anderson 1989:416-419):
• Being or becoming overweight is the worst thing that can happen to me. (Fat is disgusting and repulsive. To be fat is to be a failure.)

• Certain foods are good foods; other foods are bad foods. (Good foods are "diet" foods. Bad foods are fattening. Eating bad foods makes me a bad person, eating good food makes me a good person. Bad food is turned directly into body fat.)

• I must have control over all of my actions to feel safe. (Self-control is a sign of strength and discipline. Minor dietary indiscretions are indicative of a complete loss of self-control. Trying harder is the answer to my food problems.)

• I must do everything perfectly or what I do is worthless. (I hold myself to standards that I would never apply to another individual. I feel that, regardless of performance, I could have done even better if I had tried harder. I negate accomplishments and dwell on failures.)

• Everyone is aware of and interested in what I am doing. (If I hear people laughing, I know it is about me. Other people watch and are critical of what I eat and know if I have gained weight.)

• Everyone must love me and approve of what I do. (I must keep others happy regardless of the cost to me. I feel so unworthy of love that I attempt to buy it. I perceive rejection whether it is intended or not. I am basically a bad person.)

• External validation is everything. (Numbers are very important: calories, weight, grade point average, score on any type of competition. I take opinion polls every time I need to make a decision to be sure I am making the right choice.)

• As soon as I ......, I will be able to give up bulimia.

• To be successful, a woman must combine the traditional values of women with the aggressive career orientation of men. (I must be independent and subservient like my mother. I must be aggressive and competitive like my father. I must be attractive and feminine, but never sexual.)
Insight into the thought patterns of the bulimic is enormously useful for both the therapist and the patient in gaining an understanding of the needs of the bulimic. These thought patterns contribute to the development of the eating disorder and perpetuate its patterns, which makes treatment difficult.

As mentioned in Section 2.5, the eating disorders are not about food, but about unmet needs. The above thought patterns reflect the individual's unmet needs and highlight the areas that need to be worked on (Bauer & Anderson 1989:416-419):

- Change body image dissatisfaction
- Develop an accurate perception of body shape and weight
- Stop self-depreciation based on body appearance
- Resist societal pressures to be excessively thin in order to feel acceptable and successful
- Work through past teasing and rejection based on weight
- Develop acceptance of body shape and weight and, if necessary, more appropriate methods of reducing weight (low calorie diets which create hunger and feelings of deprivation from not eating the desired food perpetuate binges)
- Develop independence and autonomy (often found with individuals growing up in an enmeshed and overly involved family)
- Need for approval and to feel valued
- Replace binge-purge coping skill with healthier coping skills to deal with stress
- Expand friendship base to include those who can offer support
- Need for unconditional love, to feel valued for who the individual is regardless of accomplishments
- Resist parental expectations of high achievement (high expectations create competition/numbers represent ways of competing with the self)
- Learn to accept imperfection (flaws become highlighted, screening out positive feedback)
• Develop a positive self-identity (form own beliefs concerning gender identity and sexuality).

In summation, personality traits considered to make the individual vulnerable to the development of eating disorders include low self-esteem, dysfunctional and erroneous thinking associated with the body and appearance, maladaptive perfectionism, obsessive-compulsive tendencies, weak impulse control, low frustration tolerance and a need for instant gratification. Eating disordered individuals are likely to suffer from depression, variable moods, anxiety and tension. They tend to react intensely to situations and lack the capacity to self-soothe and to cope with stress. Furthermore, difficulty may be experienced in terms of identifying and interpreting emotions and bodily sensations. It is unclear whether the abovementioned symptoms precede eating disorders or manifest themselves as a result.

2.5.8 Traumatic experiences

As Nash (1999:67) pointed out, children of chaotic families are at a greater risk for traumatic experiences, like sexual and physical abuse. Bearing in mind that family dysfunction may be linked to eating disorders, as mentioned in Section 2.5.5, it is extremely difficult to determine the role played by sexual or physical abuse.

Pope and Hudson (1992:455) reviewed a number of studies linking sexual abuse to eating disorders. They found that, compared to the general population, sexual abuse does not occur any more frequently. They suggest that a linear causal link does not exist between sexual abuse in childhood and eating disorders.

Byram et al. (1995:510) reviewed literature suggesting that sexual abuse causes preoccupation with body shape and weight. A study was performed with a sample of non eating-disordered women in order to test this theory and to
determine the relationship between sexual abuse and body size overestimation. The findings suggest that sexual abuse influenced the development of body image distortion only in cases where unhealthy eating attitudes existed prior to the sexual abuse.

Childhood abuse may be associated with various types of psychopathology. Stermac et al. (1993:251) suggest that disturbances in the individual's experience of her/his body may result from sexual abuse. The disturbance may be expressed in many ways, namely, depression, suicide attempts, self-mutilation, substance abuse, eating disorders, dissociative phenomena or multiple identities (dissociative identity disorder).

Vanderlinden and Vanderreycken (as in Schwartz & Cohn 1996:20) support the idea that childhood sexual and/or physical abuse places adults at risk for developing psychiatric disorders, which include anorexia and, especially, bulimia.

Costin (as in Schwartz & Cohn 1996:111-112) suggests that sexually abused individuals tend to have a need to gain control over their body or to dissociate themselves from their body. For example, bingeing, purging, exercising excessively and starving may be helpful in blocking out traumatic events. Physical symptoms may be interpreted as sensations of hunger. Bingeing may be a form of self-soothing.

In summation, it appears that childhood sexual or physical abuse may place adults at risk for developing psychiatric disorders, which include anorexia and, especially, bulimia. Body image distortion may be a symptom of sexual abuse for those individuals who experienced unhealthy eating prior to the abuse. Preoccupation with food may be a way of distracting the individual from the traumatic events.
2.6 CONSEQUENCES OF EATING DISORDERS

It is a sad irony that those who undertake restrictive dieting and who strive for weight loss to improve self-esteem and to build up confidence, often end up with more problems than they started with. In the long run, starving, stuffing and purging often lead to negative physical, psychological, social and cognitive consequences, which far outweigh the short-term benefits of self-nurturing or avoiding unpleasant emotions (Nash 1999:53). In the following section, the environmental, emotional, behavioural, cognitive and physiological consequences of eating disorders will be discussed.

2.6.1 Environmental consequences

In the initial stages, restrictive dieting has many rewards for the anorexic. The loss of weight may attract attention and possibly envy from both family and friends, making the individual feel special and proud. Compliments from friends who share the fear of fat may be forthcoming. Approval and admiration for having the willpower to diet may be communicated (Schlundt & Johnson 1990:171).

However, as the anorexia and bulimia develop, the consequences exert a very negative effect on family and friends. The family is often deeply concerned and distressed about the patient, and frustrated at wanting to help, but not knowing how. Family members often feel guilt, due to the belief that they are in some way responsible, or they may feel anger and disgust at the patient's behaviour, which could result in family conflict. In addition, family members may be affected by the patient's preoccupation with dieting and weight in the sense that they eventually begin to develop "fat phobia" (Nash 1999:59).

Purging and other weight reducing behaviour is aesthetically unpleasant and socially unacceptable, resulting in the patient being secretive and deceitful, and
leading to the constant telling of lies. Not only does the lying lead to feelings of distrust from family and friends, but the individual also lives with the constant fear of her/his lies being found out. Eating disorders are often linked with depression, which may possibly be responsible for the individual losing her/his sense of humour, interest in general topics and desire to participate in social activities. Good relationships tend to go sour, while friends may become alienated. The individual is left with very little social support, which heightens feelings of alienation and distress (Schlundt & Johnson 1990:172).

One of the effects of excessive dieting is the loss of sex hormones. This results in the decrease of interest in physical contact, which may interfere with the development of healthy sexual relationships (Treasure 1997:103). Another consequence of eating disorders involves the stunting of social development due to the patient's isolation. The chosen isolation of the patient results in the denial of opportunities to develop interpersonal skills and to "practice" more adult behaviour. In addition, the patient misses out on valuable communication with peers that plays an important role in clarifying various concepts for the adolescent, as well as communicating the social skills expected from that particular sub-culture. Thus, social development may become stuck at whatever stage the individual was at when her/his illness became significant (Buckroyd 1996:17).

The eating disordered patient may experience discrimination in the workplace. Anorexia and bulimia may result in poor job performance, failure to advance in the workplace or, possibly, loss of the job. The cost of food can be financially draining for the bulimic. Therapy is likely to be long-term and costly. The financial costs incurred by the bulimic may destroy savings, ruin credit ratings and may even lead to shoplifting and transgression of the law (Schlundt & Johnson 1990:171-172).
Eating disorders provide the excuse not to have to face social anxiety and to take risks in interpersonal relationships, as well as the opportunity to escape from sexual commitments. In addition, the anorexic or bulimic individual is given an excuse for not progressing in terms of her/his career.

2.6.2 Emotional consequences

Bulimic behaviour produces both positive as well as negative emotions. Eating can be enormously satisfying for the bulimic and can temporarily reduce negative affect. Successful dieting, on the other hand, evokes a sense of satisfaction of being in control and the weight loss fills the bulimic with a sense of pride. Dieting can also produce feelings such as irritability, anxiety and depression. When dieting fails and binge eating follows, feelings of disappointment and failure are often experienced. While purging alleviates the guilt concerning the binge eating for a while, it is replaced with guilt concerning purging. Vomiting helps to reduce the fear of gaining weight only temporarily, for the fear of fat remains to haunt the individual. The bulimic behaviour may evoke feelings of being out of control and the individual may experience shame and hatred for the body, as well as for the self, often resulting in depression (Abraham & Llewellyn-Jones 1992:117).

Loss of electrolytes and digestive juices occurs as a result of the vomiting. The gastrointestinal disturbances often result in bloating and abdominal pain, while electrolyte abnormalities may result in the individual feeling weak, tired and constipated, and may exacerbate feelings of depression (Garner as in Garner & Garfinkel 1997:167-169).

Long-term bulimic behaviour leaves the individual feeling less confident about herself/himself and her/his body, and feeling out of control. The anorexic may become so preoccupied with food and body shape that she/he may lose her/his
sense of self. Self-worth may degenerate to the extent that the individual feels so hopeless that suicide is contemplated.

2.6.3 Behavioural consequences

The binge-purge behaviour provides the bulimic with the pleasure of being able to eat any food of her/his choice without gaining weight. However, the bad eating habits of the bulimic, ranging from skipping meals to bingeing, are detrimental to her/his health. As previously mentioned, one binge leads to another and it is extremely difficult to break the cycle. Bulimic behaviour is costly both in terms of money, time and health (Schlundt & Johnson 1990:172).

2.6.4 Cognitive consequences

The act of dieting and purging leads the individual to believe that she/he is in control of her/his weight. Bingeing serves as a distraction and allows the individual to forget about her/his problems for the moment. In addition, the purging and dieting enables the individual to avoid unpleasant thoughts about getting fat. When tension builds up to the point that the bulimic can no longer control the urge to eat forbidden food, bingeing often occurs. The individual then views herself/himself as being weak and out of control. Failure to stick to the diet results in negative expectations by the individual in terms of being able to maintain control of her/his eating. In addition, it leads to negative self-evaluation, which, in turn, contributes to a negative self-image. The more frequently the individual fails to stick to her/his diet, the more stringent the demands for dieting become (Schlundt & Johnson 1990:174).

For the anorexic and bulimic, thoughts concerning food, body shape and weight become obsessive and distorted beliefs develop. The unusual beliefs about weight and shape may contribute to the maintenance of the disturbed behaviour characteristic of eating disorders. These beliefs are highly significant to the individual and are dysfunctional because they are rigid and extreme. The preoccupation with food, fatigue and possibly the depressive mood hamper the concentration, attention, memory, learning and problem-solving of the eating disordered patient. In addition, complex thinking is impaired and difficulty in
making decisions is experienced (Treasure 1997:103).

Another significant consequence of eating disorders is the delay in moral and cognitive development. Many anorexics and bulimics continue to be egocentric. They struggle to think abstractly and to evaluate efficiently. This leads to a number of cognitive distortions, which include dichotomous or all-or-nothing reasoning, emotional thinking (if I feel fat, I must be fat) and overgeneralisation (Marx as in Alexander-Mott & Lumsden 1994:130).

2.6.5 Physiological consequences

Eating disorders have a detrimental effect on cells, tissues, organs and systems in the body. Very serious complications are common in anorexia nervosa, and patients can die as a result of complications due to starvation or electrolyte imbalances, or from suicide. Generally, the complications associated with bulimia nervosa are not particularly serious and complaints include fatigue, lethargy, weakness, bloating while eating, dizziness, faintness and puffy cheeks as a result of swollen glands in the neck (Mizes & Palermo as in Ammerman & Hersen 1997:580).

The binge-purge cycle often disrupts the functioning of the gastrointestinal system, resulting in problems with bloating, cramping, constipation, loss of bowel function through laxatives and irritable bowel syndrome. Vomiting, laxative and enema abuse frequently upset the electrolyte balance, including minerals such as potassium, magnesium and sodium, which are important for the overall functioning of most organs, including the heart, brain and kidneys. Electrolyte disturbances can cause muscle cramps, tiredness and depression. In some cases, it can lead to cardiac arrest (slowed heart rate and low blood pressure is also often found in anorexics). Vomiting, laxative and diuretic abuse can also lead to dehydration, which, in turn, can result in fluid retention. Significant and permanent loss of dental enamel occurs as a result of the gastric acid in the mouth after vomiting. Starvation results in the skin losing its elasticity and becoming dry, while the hair also becomes dry and brittle and may fall out. The growth of downy body hair (lanugo) may occur (Nash 1999:53-56).
Coldness in the hands and feet is common, due to the reduced body temperature. Lowered levels of sex hormones result in the failure to ovulate and menstruate. In addition, these lowered levels reduce interest in sexual activity and may cause fertility problems at a later stage. Hormone deficiencies can also lead to osteoporosis and fractures. With adolescents, growth may be stunted and puberty delayed. Kidney damage, liver damage and a weakened immune system have also been associated with eating disorders (Mizes & Palermo as in Ammerman & Hersen 1997:581).

In summation, eating disorders are traumatic for family members, who become consumed with concern and guilt. The patient gradually withdraws and isolates herself/himself from peers, resulting in a lack of support and heightened distress. The results of disordered eating behaviour undermine the individual's confidence and feelings of self-worth (often resulting in depression) to the extent that suicide may be contemplated. Dysfunctional, self-defeating thoughts tend to perpetuate eating disorders. Preoccupation with thoughts concerning food, body shape and weight and fatigue hampers concentration, attention, memory, learning, problem-solving and decision making. Anorexia and bulimia nervosa may result in the delay of moral and cognitive development, as well as the stunting of growth and the delay of puberty in adolescents. The patient may continue to be egocentric and may still battle with abstract reasoning, as well as with evaluating efficiently. Eating disorders result in poor performance at school or at work, possibly resulting in failure to advance or even the loss of the job. The cost of food for the bulimic can be financially draining and may even lead to shoplifting.

Disordered eating is a particularly serious pathology, since it is so detrimental to the individual's physical health. While the bulimic suffers from a great deal of discomfort, such as bloating, constipation and fatigue, the anorexic tends to suffer from more serious complications, which can lead to death due to complications from starving or electrolyte imbalance, or from suicide.

The following chapter looks at the treatment and prognosis of eating disorders. It also gives an overview of existing preventative programmes.
CHAPTER THREE

TREATMENT AND PREVENTATIVE MEASURES

3.1 TREATMENT

Eating disorders are extremely difficult to treat. One of the greatest obstacles is the patient's resistance to treatment, as they are often satisfied with the status quo and cannot be forced into having treatment once they are over the age of eighteen. Those who agree to treatment often drop out of the programme in the early stages (Mizes & Palermo as in Ammerman & Hersen 1997:583).

Claire Beeken (Beeken & Greenstreet 2000:195) reveals her struggle with anorexia nervosa in her autobiography. Her first visit to hospital for treatment was at the age of ten. It was only thirteen years later that she was finally able to break the vicious cycle of starvation, laxative abuse, binge-eating and vomiting, and attempted suicide, interspersed with periods in a psychiatric hospital. The breakthrough came when Claire finally experienced the will to get better. Claire writes:

"... but the combination of Lisa's letter and Caroline's article has somehow thrown a switch in my mind. I feel so different. As I settle down to sleep, an unfamiliar sense of peace runs through me. From now on, I think to myself, 'everything's going to be okay.'"

Claire explains that the letter from her sister pleading her not to give up on life, and the article about Caroline, who was dying from anorexia, jolted her will to want to recover. From that moment on, she responded amazingly well to treatment. In her epilogue, she says the following:

"Looking at the last paragraph I wrote when the book was first published in 1997, I said, 'I would be lying if I said I didn't have the odd anorexic
thought, but I now understand why those thoughts happen and how to
deal with them.' Three years on I can honestly say that is no longer the
case" (Beeken & Greenstreet 2000: 233).

When the health of the anorexic has reached crisis point, the patient is usually
hospitalised in order for feeding to be controlled. Despite the use of contracts
and reward systems, long-term effectiveness is poor. The treatment of eating
disorders is time consuming and costly. Many patients are forced to cut corners
in terms of their treatment due to limited financial resources. This frequently
leads to relapse and a revisiting of the treatment process (Goldner & Birmingham

According to Mizes and Palermo (in Ammerman & Hersen 1997:588), most
therapists treating eating disorders aim firstly to restore nutrition and weight and
then to deal with the psychological needs. The methods employed in
accomplishing these goals vary. It seems that there is little consensus regarding
the most appropriate method of treatment. Most programmes are tailored
according to the individual's unique needs. Some of the more popular
psychological therapies used to treat eating disorders are cognitive behavioural
therapy, psychodynamic therapy, family therapy and interpersonal therapy. In
addition, a variety of pharmacological treatments have been used. Sokol et al.
(1999:233) mention the usefulness of psychotherapy and antidepressant
medication (methylphenidate) for treating patients with bulimia nervosa.

Eating disordered patients who choose individual psychotherapy can expect to
work on building up their ego strength in order to improve their poor self-esteem
and to reduce their perfectionism and feelings of ineffectiveness. According to
Goldner and Birmingham (as in Alexander-Mott & Lumsden 1994:146), other
areas tackled in therapy may include:

- Individuation from the family
- Social skills training to improve peer relationships and family conflict
- Training in coping skills
• Assertiveness training
• Relaxation techniques
• School and occupational issues
• Identification of own needs
• Assistance with identity confusion resulting from the struggle to integrate adopted gender roles with societal and cultural inequities
• Sexuality

Psychodynamic theorists would tend to focus on the perfectionism, extreme self-criticism and self-doubt displayed by the patient, and the belief that self-worth is dependent on approval from others. The interpersonal theorist, on the other hand, would highlight the coping strategies used for current life situations, such as interpersonal conflicts, losses, role transitions and interpersonal deficits. The cognitive-behavioural approach aims at changing maladaptive attitudes and beliefs concerning the rigid regulation of food and weight. Cues that precipitate body dissatisfaction are examined and irrational thoughts are challenged. The individual is also encouraged to develop strategies to prevent relapse (Mizes & Palermo as in Ammerman & Hersen 1997:589).

In addition to individual therapy, group therapy may be of great benefit in providing mutual support and decreasing isolation. It can also be a place where the family can bring their questions and concerns, and where education can take place. The group also provides the opportunity for the development of interpersonal skills (Weiss & Orysh 1994:487).

Family therapy, where the opportunity is provided for concerns to be expressed and problems to be resolved, is particularly useful for the younger patient. By strengthening their relations with the individual outside the issues of food and weight, the family can contribute enormously to the patient's recovery. Together with the assistance of the medical team, which may include a general practitioner, psychiatrist, psychologist and dietician, the individual is encouraged
to take responsibility for the control of food and weight (Goldner & Birmingham as in Alexander-Mott & Lumsden 1994:149).

For Claire Beeken, (Beeken & Greenstreet 2000:211) and many others, the support group proved to be of great comfort, serving to reduce her isolation and alienation and providing her with a community where there was acceptance and understanding of shared pain and similar experience. For Claire, hospitalisation was unsuccessful. She advocates seeking community support, arguing that hospitalisation should be a last resort. As previously mentioned, eating disordered patients differ in their needs and respond to different types of treatment.

3.2 PROGNOSIS

van der Ham et al. (1998:79) reviewed various sources on factors predictive of poor outcome of eating disorders in adolescents and then conducted a four year follow-up study on 49 eating disordered adolescent patients to test the respective hypotheses. The following variables were commonly found to be predictive of poor outcome for eating disordered adolescents, namely, extreme loss of weight, bulimia, disturbed body image, poor family relations, social isolation, neurotic problems, low self-esteem, obsessive-compulsive or personality disturbances and alcohol abuse.

The results of the research by van der Ham et al. (1998:83) revealed that psychological characteristics have a higher predictive value than behavioural variables. They found that maturity fears, together with immature sexual attitudes and difficulty with family emancipation, played a significant role in predicting the poor outcome of eating disorders in adolescence. More specifically, anorexia nervosa was seen as a way of dealing with a maturation crisis, where the individual felt insecure and insufficiently prepared to cope with
the demands of adulthood. For the bulimic, lack of self-esteem (together with lack of self-confidence and feelings of worthlessness and anxiety) and feelings of ineffectiveness (both in terms of social anxiety and poor academic progress) were found to be significant factors. Negative self-beliefs of bulimics appeared to be more centred on and in the body than those of anorexics (van der Ham et al. 1998:83).

There is no quick fix for eating disorders and the co-operation of the patient concerning treatment and general support from the family play a significant role in the prognosis of the eating disorder. There are various reasons why the patient feels ambivalent about treatment. From a social perspective, the eating disordered patient has a lot to lose by giving up the disorder. The strong willpower displayed by the rigid dieting may have made the anorexic feel special, while others may have enjoyed shelter from demands and special treatment from their family and friends. Refocusing from family to peers could be intimidating, particularly for those who feel embarrassment in facing their peers again (Treasure 1997:46).

The return of libido and menstruation may be threatening for those who have negative reactions to sexuality and maturation, while eating regular meals could result in physical discomfort, including the feeling of being bloated. The re-emergence of hunger heightens both the fear of regaining weight and the concern with body shape (Schlundt & Johnson 1990:91).

Psychologically, the patient may fear getting back in touch with negative feelings, and reverting back to feeling bad and emotionally distressed. Relinquishing the eating disorder would require giving up the control of restrictive eating. Giving up the starvation would mean giving up the illusion of coping with stress, and the increase in stress could possibly result in an increase in rituals and compulsive actions. Some adolescents perceive their agreement to treatment as a giving in to parents, while others fear pressure from the family regarding regaining weight.
Being unable to deal with the welling up of emotions is also a very real fear for some patients. For older patients, being allowed to return to their careers as a result of having given up their eating disorder can be particularly frightening for those who lack confidence and doubt their ability to cope (Treasure 1997:46).

Recovery rates for eating disorders vary considerably, as does the definition of "recovered". Herzog et al. (1999:829) conducted a study in which they assessed the course and outcome of anorexia and bulimia nervosa over a period of approximately 90 months. The full recovery rate of women with bulimia was found to be significantly higher than those with anorexia. Seventy-four percent of the bulimics and 33% of the anorexics recovered fully, while 83% of the anorexics and 99% of the bulimics reached partial recovery after the 90 months. Approximately a third of anorexics and bulimics relapsed after full recovery. The full recovery rate is supported by the findings of Reas et al. (2000:428), who investigated the prognosis of a sample of bulimics over a period of nine years. Reas et al. stress the importance of early identification in preventing chronic eating disorders.

It appears that some patients live with symptoms of eating disorders for the rest of their lives. Relapse is a frequent problem, with the result that the patient can be haunted by the illness for years. The average duration of anorexia is estimated to be five years, while about a quarter of the cases last 10 years. Death occurs in extreme cases, either due to complications or from suicide (Treasure 1997:80).

The researcher interviewed Mary (fictitious name), who has battled with bulimia for the past 20 years. Mary, an only child, grew up in a loving and secure home in Holland. She was blessed with good looks, intelligence and an excellent sporting ability. Competitive by nature, Mary worked hard at her swimming and eventually became a national swimmer. She perceived her family as being extremely supportive throughout her childhood and in no way felt pressurised to
perform, either generally or in her swimming. Mary’s self-esteem was low, despite her talents and achievements, and she was sensitive to the criticism of others. She over-reacted to the teasing of a couple of boys in her class, who felt that she was becoming stocky. Mary began dieting and, when she was unable to control her appetite, she tended to binge. Purging followed the binge episodes in an attempt to alleviate the guilt associated with the consumption of vast amounts of calories. Mary married and immigrated to South Africa. The situation worsened, as she was faced with even more stressors to contend with. It was only when Mary fell pregnant with her first child that she had any desire to want to control her bulimic behaviour.

Mary has lived with her secret for most of her life and confided in her husband only two years ago. For years she has lived with the stress evoked by having to hide her bulimic behaviour and “the guilt at having to live a lie.” Mary is now in therapy and is in the process of discovering the cues that trigger her bulimic behaviour. She believes that, although she can control her bulimia, she will never recover from it. Mary claims that she is addicted to food and that she no longer experiences the sensation of satiety. Resisting the temptation to overeat and purge is exhausting for Mary, while the fear of becoming fat still haunts her. Mary is, at present, studying psychology and wishes to dedicate the rest of her working years to the prevention of eating disorders. It took a great deal of courage for Mary to share her story and it is accepted with gratitude. Mary’s experience supports the literature researched and highlights the poor prognosis for some individuals who have eating disorders.

3.3 **PREVENTATIVE MEASURES**

While a number of preventative programmes for eating disorders have been designed for college students and young adults, this study focuses on school-based designs. In the following section, difficulties faced by researchers in
terms of designing intervention programmes for eating disorders will be explored, followed by a review of various existing preventative programmes. In addition, appraisals, comments and recommendations concerning existing preventative programmes will be discussed in order to explore appropriate content, target group and method of implementation, as well as the timing and duration of the implementation of a comprehensive school-based programme aimed at the primary prevention of eating disturbances.

3.3.1 Difficulties regarding preventative programmes

Paxton (1993:44) points out that the causal criteria for eating disorders are still unclear. While there is increasing recognition that eating disorders are caused by a combination of factors, the course of the illness cannot be seen to progress in a linear fashion. There is little understanding of the way in which initial concern about the body develops into an intense preoccupation with body shape and weight, or of the process whereby the desire to lose weight develops into a full-blown eating disorder. Bearing this in mind, one cannot be certain that reducing dieting behaviour and preoccupation with body shape and weight will, in fact, prevent eating disorders. Accurate information concerning the causes of eating disorders is critical in order to determine the appropriate content for a preventative programme for eating disorders and to be able to identify “at risk” candidates.

Huon et al. (1998:456) suggest that it is virtually impossible to change some of the socio-cultural factors that promote concerns with body shape and weight. Special reference is made to the media influences that promote the internalisation of the thin ideal and to family systems that may result in unhealthy coping strategies related to the control of food. Huon et al. mention the difficulty of drawing the line between healthy and disturbed eating behaviour. Restrictive dieting has become so normative and acceptable that there is little societal pressure to change weight-reducing behaviour.
Griffiths and Farnill (1996:187) highlight the enormous financial gains made by the media from the fashion and weight loss industries. These powerful political and economic forces create obstacles in the drive towards the prevention of eating disorders. It is of concern to Griffiths and Farnill that education concerning the negative effects of unhealthy methods of reducing caloric intake may, in some instances, promote the idea of unhealthy weight-control practices. However, they question whether it would be more harmful to the public to withhold the relevant information.

Miles and Palermo (as in Ammerman & Hersen 1997:585) are sceptical about the feasibility of running preventative programmes in schools, believing schools to be already overburdened by numerous educational and societal issues. Killen (as in Smolak et al. 1996:336) feels that it is unlikely that preventative programmes will ever be cost effective and that the prevention of eating disorders should be limited to the more serious “at risk” candidates.

3.3.2 Review of various programmes


Most of the school-based preventative programmes reviewed overlapped a great deal, having the common goal of reducing precursors to eating disorders, particularly dieting. While the core content of the respective programmes is reasonably similar, various researchers emphasise different components, such as factual information, skills training, direct and indirect approaches to developing self-esteem, cognitive-behavioural training and focus on systemic changes.
3.3.2.1 Focus on educational information and skill training

According to Paxton (1993:44), the content of most of the earlier programmes was based on the recommendations made by Shisslak et al. (1987), Crisp (1988) and Rosen (1989) in their respective papers. Recommended content for school-based interventions included the following (Paxton 1993:44):

- Information regarding: female physiology
  - changes in body composition
  - awareness of body needs

- Information regarding: nutrition
  - body weight regulation
  - binge eating
  - healthy and unhealthy dieting

- Guided decision making regarding the appropriateness of attempts to lose or gain weight

- Awareness of body image and modification of negative body image

- Exploration and discussion of: the ideal body concept
  - media influences
  - stereotyping of women
  - women's role in society

- Exploration of the connection between eating and emotion

- Skills training regarding: communication with parents and peers
  - assertiveness
  - problem-solving

The following researchers designed programmes that include some or all of the above components, namely, Shisslak et al. (1990), Killen et al. (1993), Moreno and Thelen (1993), Paxton (1993) and Huon (1994). The general aim of these programmes is to provide information concerning the nature and consequences of eating disorders. In addition, the programmes aim to provide the necessary
life skills in order to cope effectively with environmental demands and to be able to resist social pressures to diet.

Shisslak et al. (1990:103) emphasised information concerning eating disorders, such as identification signs, characteristics, risks factors and methods of treatment for anorexia and bulimia nervosa. One of the five components of Paxton's programme (1993:46) included the exploration of body size and shape determinants, such as heredity, early experience and metabolic and set-point influences. She also emphasised the importance of exploring the relationship between emotions and physical sensations, as well as the relationship between emotions and eating.

Moreno and Thelen (1993:113), Killen (as in Smolak et al. 1993:317) and Huon (1994:397) stressed the importance of developing skills to enable the individual to resist pressure to conform to the thin ideal from the media, friends and family, and to learn to value individuality. Killen (as in Smolak et al. 1993:321), Nagel and Jones (1993:54) and Huon (1994:397) advocate stress management in their programmes, arguing that the risk of using food in order to deal with stress would be minimised if effective alternative methods of stress management were put in place.

While Huon (1994:397) emphasises the importance of developing self-confidence, Nagel and Jones (1993:55) emphasise the importance of increasing self-acceptance and view body image as a critical component of primary prevention. In addition, Nagel and Jones recommend training in decision-making skills as well as in the ability to express feelings and deal with negative criticism.

Generally, the programmes discussed above were successful in terms of increasing knowledge and awareness of eating disorders, improving nutritional practices and weight regulation, as well as improving physical fitness in some
instances. However, the programmes failed to change negative body image and the internalisation of the thin ideal (Shisslak et al. as in Smolak et al. 1996:343).

3.3.2.2 Focus on the development of self-esteem

As a result of the association between low self-esteem and eating disorders, a number of researchers have included a component aimed at improving self-esteem in their programmes. The motivation for this is the belief that eating disorders may be prevented if individuals feel effective and good about themselves. While some programmes focus on enhancing self-esteem directly, others use indirect approaches, such as participation in sport, media literacy training and body image enhancement (Shisslak et al. 1998:107).

(i) Direct approaches to enhancing self-esteem

Rhyne-Winkler and Hubbard (1994:196) developed a framework for a wellness programme and allocated one of the six lesson topics to the enhancement of body-esteem and self-esteem. Carter et al. (1997:168-172) allocated one of the eight sessions of his prevention programme specifically to the development of self-esteem. The programme also included cognitive-behavioural procedures, in which participants were encouraged to identify problematic thoughts and beliefs concerning body shape and weight and were challenged to modify their irrational thoughts and unhealthy eating habits.

Friedman (1998:219) designed "The Girls in the 90s" gender-based model for eating disorder prevention aimed at pre- and early-adolescent girls. The programme involves group discussions, role-playing, dance and art, and aims to increase girls' awareness of the process of growing up female in a male world, providing an understanding of the societal pressures they face. The girls are encouraged to identify situations in which their self-esteem is lowered and they feel fat, and are also encouraged to look at the history behind these events. The
programme includes the promotion of healthy eating and a positive sense of self, as well as the provision of empowerment and support.

Shisslak et al. (1998:107) refer to two additional programmes designed by Outwater (1991) and Neumark-Sztainer et al. (1995), which incorporate a component aimed at developing self-esteem and body-image. Both these programmes, as well as those of Rhyne-Winkler and Hubbard (1994), Carter et al. (1997) and Friedman (1998), were effective to some degree in preventing the onset of unhealthy eating and weight control behaviours, but failed to bring about any significant change regarding body image and self-esteem.

(ii) Indirect approaches to enhancing self-esteem

The rationale behind encouraging participation in sport, media literacy training and body image enhancement is the belief that self-esteem is developed by experiencing mastery and success in areas of one’s life that are valued by the individual and that are also believed to be valued by those important to the individual. It is for this reason that Shisslak et al. (1998:111) stress the importance of having an adult mentor who is able to give personal attention to individuals and the prospect of structuring opportunities to experience success in specific areas that may be perceived as valuable.

(iia) Participation in Sport

Phelphs et al. (1999:100) advocate that activities should be designed to increase physical self-esteem and feelings of competence. The activities should focus on developing physical fitness, agility, general health and athleticism, resulting in an appreciation of how the body functions, as opposed to only focusing on physical appearance. Phelphs et al. also recommend that individuals should be helped to develop internal locus of control, resulting in feelings of empowerment and the belief that individuals have some control over their environment. However, in terms of physical appearance, guidance may be necessary in order to assist individuals in distinguishing between physical aspects that are able to be
changed and those features which are to be accepted. It is the belief of Phelphs et al. that the development of a more positive body image and feelings of physical and social competence is likely to enhance general self-esteem, which, in turn, is likely to decrease the possibility of developing eating disorders (Phelphs et al. 1999:99-101).

Shisslak et al. (1998:108) refer to various researchers, such as Pipher (1994) and Fredrickson and Roberts (1997), who have recommended participation in sport as a means of enhancing feelings of mastery and general self-esteem. However, mastery in the field of sport is likely to increase self-esteem only if the individual values sporting ability.

(iib) Media Literacy Training

A number of researchers have highlighted the role played by the media in promoting the unrealistic standards of beauty, body dissatisfaction and dieting which may lead to eating disorders. Shisslak et al. (1998:109) refer to a number of researchers, such as Stice (1994), Levine et al. (1996) and Adair and Purcell (1996), who have recommended media literacy training. The purpose of this training is to equip individuals with the necessary skills to interpret appearance-related media more critically, thereby reducing the creditability of persuasive media messages. While the media literacy programmes were effective in terms of helping individuals to be more critical of media messages, they failed to help individuals to be more accepting of their bodies and themselves in general.

Berel and Irving (1998:421) studied the association between media and disturbed eating and have highlighted factors viewed as being likely to contribute to the degree to which individuals may be influenced by media messages. These factors include self-esteem, impulsivity, available coping skills, body weight, exposure to weight concerns from family, peers and media, exposure to a subculture of dieting and experience of simultaneous developmental transitions, such as the onset of menstruation, dating and academic stress. Berel and Irving
explain how individuals who use the media to measure self-worth are likely to actively select, interpret and respond to specific media messages.

In terms of designing preventative programmes for eating disorders, Berel and Irving (1998:427) emphasise the importance of helping individuals to become aware of their own vulnerabilities to media messages, as well as to develop skills to process media messages more critically. They propose that existing media literacy programmes could be improved by including a feminist therapy approach, which would encourage individuals to challenge gender roles and to judge self-worth in terms of internal factors, as opposed to appearance.

(iic) Emphasis on body image

A number of techniques have been used in an attempt to correct distortions in body image and to encourage individuals to accept their bodies more readily. These techniques include positive affirmations, cognitive strategies that challenge irrational and negative body image thoughts, mirror work, imagery, drawing, moving to music and group discussions (Shisslak et al. 1998:109).

As mentioned in the section on body image in Chapter Two, body satisfaction has been linked to self-esteem (Cash 1991:1). Based on this theory, treatment aimed at improving body image is believed to simultaneously improve self-esteem (Kaslow & Eichen 1988:177). Rosen (1996:340) suggests that body image disturbance precipitates eating disorders and therefore believes that the enhancement of body image is significant in terms of preventing eating disorders.

The manual for Rosen's cognitive behavioural body image therapy was written in 1987, while the first studies were performed by Rosen et al. (1989:397) in 1989. The initial cognitive behavioural programme aimed at improving negative body image included six treatment sessions, each lasting two hours. According to Rosen et al. (1989), Butters and Cash (1987) also began investigating the use of cognitive behavioural therapy in improving body image. Their programme
included "relaxation, desensitisation to a hierarchy of disturbing body parts, cognitive restructuring and assignments to engage in pleasurable physical activities" (Rosen et al. 1989:394). Both Rosen and Cash, with their respective associates, refined their programmes. In 1995, Rosen modified his programme to include eight sessions, as well as advocating the use of Cash's audio-tape series called "Body-image therapy: A programme for self-directed change" (Cash 1991) to reinforce the content focused on during the sessions.

In Rosen's cognitive behaviour therapy manual (1995), he emphasises that the manual is intended for a wide range of individuals with body image issues and that the programme should be adapted according to the needs of the particular group. Whilst the programme is designed for small groups, it may be used in individual therapy. The programme includes practicing attitude and behaviour change at home, as well as listening to Cash's audio-tapes and completing the exercises in the client workbook.

Following is a brief overview of the eight sessions in Rosen's programme.

**Session 1** involves a mini-lecture on and discussion about the definition of body image, the relationship between body image and appearance, the development of body image and its effect on self-esteem and other psychological and behavioural functioning.

**Session 2** involves a number of exercises designed to assist individuals to explore their vulnerabilities and assets in terms of body image. Individuals are guided to identify body parts that cause distress, situations in which the distress is experienced, automatic negative thoughts that trigger distress and feelings and behaviours that result from the distress.

**Session 3** introduces and teaches relaxation skills, which include progressive muscle relaxation and controlled breathing. In addition, it involves the use of
constructive imagery where individuals are expected to paint pleasant pictures in their minds. Once totally relaxed, individuals are expected to focus on their breathing, visualising the inhalation of "peace and calm" and the exhalation of "tension". Subjects are then encouraged to visualise a small centre of their favourite colour in the middle of their bodies. The centre represents contentment and satisfaction and individuals are encouraged to visualise the growth of the coloured centre each time inhalation and exhalation takes place, until the whole body is filled with "calm and content".

Session 4 involves the construction of two personal body-image hierarchies, one of body parts that cause distress and the other of distressing body-image situations. Thereafter, the individual is guided through body image desensitisation. While in a state of calm relaxation, subjects are expected to imagine looking at the naked body in front of a mirror and to focus on parts of the body that cause minor distress, graduating to body parts that cause major distress. As individuals practice seeing their respective body parts in their minds, so they gradually acquire the ability to tolerate distressing scenes in their imagination. The next step involves viewing the clothed body in a mirror, followed by the viewing of the unclothed body in a mirror, once again focusing on the body parts that cause distress.

Session 5 involves a mini lecture on the definition of self-defeating beliefs. Problematic or self-defeating beliefs (thoughts which are simply wrong, faulty, irrational or without proof) tend to be automatic and result in making individuals feel unnecessarily negative about themselves, which triggers a chain of events. The role that beliefs play in the development of body image is discussed. Individuals are then taught to identify and monitor dysfunctional thoughts, beliefs and self-statements about their appearance. The 12 specific cognitive errors (adapted from Cash, 1991) and appearance assumptions (adapted from Cash, 1995) are also discussed. Subjects are encouraged to challenge self-defeating beliefs and are guided through the process of "corrective thinking". In addition,
this session involves a discussion on coping with stereotypes and prejudice, the importance of inoculating oneself against negative responses by being prepared to handle situations in advance, as well as reasons besides body image that result in social discomfort.

Session 6 involves a mini lecture on the behavioural aspects of body image, with particular emphasis on avoidance and body checking behaviour. Individuals are then guided through the "facing it" exercise used to overcome avoidance behaviour and the "erase it" exercise to overcome body checking and reassurance behaviour. In addition, individuals are encouraged to identify and take part in physical or sensual experiences that give bodily pleasure in order to develop an appreciation of how their bodies function and to minimise the focus on physical appearance.

Session 7 involves the reinforcement of the above. Examples of recent negative body image experiences are explored using a problem solving approach. The purpose of this exercise is to explore the events that precede the negative body image experience, to determine what could have been done at the onset of the negative feeling or thought and to prevent a future negative body image experience. After a discussion on relapse prevention, individuals are encouraged to identify triggers for relapse and to develop strategies to cope with these situations in advance.

Session 8 is a consolidation session. Individuals are given the opportunity to evaluate the programme and their progress in terms of body image. Subjects are encouraged to make use of the tools learnt during the programme in order to continue the work of improving body image.

At the time of writing Rosen's body image therapy manual, 500 people had been treated with the body-image programme and approximately 75% had made
significant improvements in terms of body image enhancement at a four-and-a-half month follow-up.

Shisslak et al. (1998:110) believe that individuals who have positive global self-esteem are more likely to feel good about their bodies and are better able to resist destructive media messages. As a result, they feel that the focus of preventative measures should be on the building of positive global self-esteem, rather than on media literacy training and body image enhancement.

Shisslak et al. (1998:109) point out that, despite the many different forms of self-esteem enhancement programmes, none of the programmes have unequivocally demonstrated that improving self-esteem reduces the likelihood of the onset of eating disorders.

3.3.2.3 Inclusion of cognitive-behavioural component

Cooper et al. (1998:214-215) evaluated the theory behind cognitive therapy, largely based on the work of Fairburn et al. (1986) and Garner and Bemis (1982). In terms of this theory, individuals are thought to develop both positive and negative core beliefs about the self, based on developmental events and experiences from the past. Underlying beliefs manifest themselves in self-statements, automatic thoughts and assumptions. Dysfunctional beliefs (those that are rigid and extreme in nature) may lead to erroneous information processing, resulting in a distorted interpretation of events. The conjunction of negative self-beliefs and assumptions about weight, shape and eating are thought to play a significant role in the maintenance of disturbed eating behaviour found in eating disorders.

Cooper et al. (1998:227) refer to McGinn and Young (1996), who posit that core beliefs are maintained by "schema avoidance" or "schema compensation", which
refer to strategies used to avoid triggering core beliefs that evoke negative effects and strategies used to cope with traumatic early experiences.

In the research done by Cooper et al. (1998:226), they found that the negative core beliefs of eating disordered individuals were concerned with themes of ineffectiveness, failure, worthlessness, uselessness, inferiority, abandonment and loneliness. Cooper et al. (1998:227-228) made recommendations regarding therapy for anorexia and bulimia nervosa based on their research, which validates the strategies used by Rosen in Session 5 of his programme. The recommendations are:

- Identify core beliefs, particularly negative beliefs about the self
- Identify the role developmental factors or early experiences played in the formation of negative self-beliefs
- Identify assumptions made by the individual that link negative self-beliefs to disturbed eating behaviour
- Challenge the "erroneous" assumptions by gathering evidence for and against the assumption
- Explore the advantages/disadvantages of believing or acting upon the beliefs
- Reformulate the beliefs and develop alternative, more accurate self-statements

Cognitive-behavioural theorists assume that there is a link between thoughts and behaviour. The basic premise is that negative reasoning or distorted interpretations of events are likely to adversely affect healthy functioning. Thus, change in thought processing is likely to result in behaviour change (Stylianou & Havran 1998:47).
3.3.2.4 Emphasis on systemic change

Many researchers involved with preventative programmes for eating disorders, such as Huon et al. (1998:486), have referred to the problem of controlling socio-economic factors that promote concerns regarding body shape and weight.

Piran (1999:79-88) designed a programme for a residential ballet school in Canada and, in a sense, was able to change the sub-culture of a school to become more accepting of differences in shape and size. The programme differed from other school programmes in that it emphasised systemic changes. Ongoing monitoring of the school environment took place and regular meetings were held with the students. The aim was to change various aspects of the school environment that were viewed as having a negative effect on body esteem. The content of the programme included peer relations, as well as issues like sexual harassment, gender inequity and other prejudices around body image. One of the features of the programme was the encouragement of interaction between age groups resulting in the development of role models and the offering of advice to younger girls in order to avoid the negative experiences experienced by the older girls. School staff, as well as other students, provided support. After a period of ten years the programme was evaluated and was found to be successful in terms of reducing restrictive dieting and disturbed attitudes towards eating and weight. Although it was possible to change the attitude regarding physical appearance in the sub-culture of the ballet school, Piran claims that efforts from the Canadian newspapers and television stations to make the public more accepting of differences in shape and weight had no effect on the ballet world at large.

Generally, the above-mentioned programmes dealing with nutrition, skills training, self-esteem enhancement using direct or indirect approaches, cognitive approaches and programmes based on systemic change, were all successful to
some degree in achieving specific goals. However, none of them proved to be particularly successful in preventing eating disorders. Perhaps the causes of eating disorders differ too much for any one programme to be suitable for all individuals.

3.3.3 Recommendations for primary prevention

In conclusion, the researcher will summarise the above section on preventative measures and, at the same time, will respond to the various problems highlighted in Chapter One concerning the design of preventative programmes for eating disorders.

3.3.3.1 Recommended content for a primary prevention

(i) **Knowledge and attitudes regarding nutrition and weight loss behaviour**

Jensen-Scott and DeLucia-Waack (1993:113-116) developed a framework for a programme for eating disorders and weight management for Junior and Senior High Schools. They proposed that relevant information for preventing eating disorders should be integrated across the school syllabus and should include three components, namely, the nutritional, behavioural and cognitive sections. The content of the proposed nutritional component include the following activities (Jensen-Scott & DeLucia-Waack 1993:115):

- Provision of accurate information concerning:
  1. Basic nutritional principles and concepts - e.g. minimum caloric intake or the importance of body fat
  2. The consequences of restrictive dieting
  3. Dangers of excessive exercise
  4. Risks and dangers associated with eating disorders
- The keeping of food diaries in order to highlight the food choices of the family and the individual
• Identification of attitudes and behavioural cues that motivate unhealthy eating behaviours – e.g. eating on the run
• Methods of modifying eating habits
• Keeping a log to monitor the activity level
• Discussion of positive effects of moderate exercise and negative effects of excessive exercise

Rhyne-Winkler and Hubbard (1994:196) stressed the importance of assisting individuals to explore the connection between food and the emotions. Stice and Agras (1998:271) advocated that preventative programmes should examine the factors that maintain eating disorders. They believed that one of the key factors responsible for maintaining eating disorders is the expectancy that eating regulates negative affect.

Shisslak et al. (as in Smolak et al. 1996:346) recommended that preventative programmes should take into account developmental issues and the respective risk factors manifested at the various developmental stages. They highlighted the risk factors for early, middle and late adolescence, as well as early and older adulthood stages, and recommended the appropriate content and strategies for each stage (as in Smolak et al. 1996:346-358).

(ii) Self-esteem and body image
The majority of the researchers view the enhancement of self-esteem as a significant component in a preventative programme for eating disorders. However, there are differences of opinion as to whether the building of self-esteem should be tackled directly or indirectly. Direct approaches to building self-esteem include activities that promote the development of greater self-acceptance and confidence. Indirect approaches include the encouragement of participation in sport, focus on the enhancement of body image and media literacy training. The indirect approaches to building self-esteem are thought to equip individuals with resources to resist propaganda from the media, family and
peers concerning the importance of being thin and the necessity of dieting. The reasoning behind the promotion of direct approaches to building self-esteem is that positive global self-esteem would be sufficient to empower individuals to resist the above-mentioned pressures, without the necessity of specific training in developing media literacy skills and enhancing body image.

(iii) Skill acquisition

Jensen-Scott and DeLucia-Waack (1993:113) believed that the acquisition of skills would enhance feelings of competence and self-esteem. The activities proposed in the behavioural component of their programme include:

- Problem-solving skills
- Decision-making skills
- Assertiveness training
- Communication and social skills training
- Coping and adapting skills training
- Stress management
- Assessment of personal strengths and weaknesses other than body weight and shape

In the primary intervention section of Nagel and Jones's model (1993:55), they advocate that specific strategies should be taught in order to empower individuals to learn to express their feelings better and to be able to resist teasing concerning body shape and weight. Suggested strategies include media literacy training and the development of self-esteem and body image. This idea is supported by Smolak and Levine (1994:303), who advocate the teaching of new methods of evaluating people in order to promote the internal status of academic, personal and social characteristics, rather than to have self-esteem based purely on physical appearance.
(iv) **Cognitive training**

Self-defeating beliefs (thoughts that are incorrect, faulty, irrational or without proof) are thought to play a role in the development of disturbed eating behaviour. Cognitive therapy involves the identification of negative self-beliefs, the exploration of the origin of these beliefs, the identification of assumptions that are linked to disturbed eating behaviour, the challenging of the validity of the self-defeating beliefs and the formulation of more accurate self-beliefs. The premise of cognitive therapy is that thought and behaviour are linked and that change in the thought process is likely to result in a change in behaviour.

In the cognitive component of their programme, Jensen-Scott and DeLucia-Waack (1993:113-114) aim to identify irrational or unrealistic thoughts concerning weight-related issues, as well as to develop realistic expectations relating to both the body as well as other issues. Activities include:

- Keeping thought diaries to identify irrational thoughts
- Assessment of weight-related expectations
- Identification of maladaptive cognitions
- Elimination of irrational thoughts through “thought stopping”
- Cognitive restructuring, the modification and practice of thinking new thoughts
- The challenging of dichotomous thinking and the pursuit of the middle-ground
- Relapse prevention
- Choice awareness

(v) **Systemic change**

Influences from the individual’s sub-culture (from family, peers, school and society) play a significant role in terms of developing and maintaining eating disorders. While it is extremely difficult to control these environmental factors, Piran (1999:79-88) was successful in changing the sub-culture of a ballet school...
in order to bring about greater acceptance of the differences in body shape and weight, thus reducing the need to diet.

3.3.3.2 Who to include in a primary prevention programme

Griffiths and Famill (1996:187) recommend that a primary prevention programme should adopt an holistic approach, where the focus is not exclusively on the individual, but is inclusive of all influences within the individual's environment. They recommend that education regarding nutrition and eating disorders should not only be geared towards students, teachers, coaches and instructors, but should also extend to parents, relatives and friends. This notion is supported by Nagel and Jones (1993:55) and Huon (1998:457). Rhyne-Winkler and Hubbard (1994:196) recommend the provision of in-service training in order to equip teaching staff with the necessary information to identify pupils “at risk” for eating disorders and the distribution of brochures on eating disorders to students, teachers, parents, relatives and friends.

3.3.3.3 Who to target in a primary preventative programme

Many of the earlier preventative programmes were designed for adolescents but, gradually, more programmes included elementary children as well. Smolak and Levine (1994:294) believe that the "culture of thinness" and negative body image may be too well ingrained by the time adolescence is reached and, therefore, propose that preventative programmes for eating disorders should be designed for elementary school children. Shisslak et al. (as in Smolak et al. 1996:344) support the idea of focusing prevention programmes on elementary school children rather than adolescents. Berel and Irving (1993:425) recommend that children as young as Grade 2 and Grade 3 should be exposed to prevention programmes, before "attractiveness schema" and conceptions concerning female beauty develop. Paxton (1993:49) believes that educational programmes for the prevention of eating disorders would be more effective if they started earlier and
if the content was reinforced in an aspect of the curriculum throughout high school. Neumark-Sztainer (1996:65) believes that students of all ages, from preschool to college, including males, as well as the larger community, should be included in the programme.

3.3.3.4 Suggested methods of implementing the programme

Neumark-Sztainer (1996:66) advocates that the content of the programme should be integrated into the school curriculum and that the method of implementation should depend upon the severity of the problem within a particular school, as well as on the resources available. Secondary intervention, either in the form of group or individual therapy, is recommended for individuals with disturbed eating patterns. Intervention could range from a one-off classroom lecture to the implementation of a comprehensive school-based programme, with linkages within the school and between the school and the community.

Like Piran (1999:87), Paxton (1993:49) stressed the importance of peer support groups, which provide a safe place where girls may share their experiences and feel empowered to speak about incidences in which they may have been unfairly treated.

While the need for individual therapy for "at risk" individuals for eating disorders is acknowledged, Paxton (1993:49) emphasises the value of small groups, possibly led by peer facilitators. The small group is thought to be a good setting for discussions, problem-solving and co-operative exercises to take place. Paxton believes that talks from visiting experts and testimonies from recovered eating disordered individuals would have credibility with the students. Killen et al. (as in Smolak et al. 1996:321) advocated the use of discussion, video, slides, drama and guided imagery in order to assist individuals to adopt healthful weight regulation skills, as well as skills to resist social-environmental influences that promote dieting and over-concern with weight and body shape.
Duration of the primary preventative programme

Paxton (1993:49) and Neumark-Sztainer (1996:65) recommend that primary intervention should take place throughout the student's school career. It is recommended that information and certain concepts should be revisited periodically as the child develops and gains a better understanding.

3.3.3.6 Summary

Most of the programmes reviewed have the following goals in common: to impart educational information concerning nutrition and eating disorders, to develop skills to empower individuals to deal effectively with the challenges of the environment, to enhance body image and self-esteem and to develop strategies to resist societal pressures to diet in order to meet the expected thin standards of beauty. Some programmes include a cognitive component. Many of the programmes recommend that preventative programmes should be integrated into the school curriculum and should begin at elementary school level. The content is to be reinforced and expanded upon throughout the high school years. The value of small groups led by peer facilitators is highlighted, as well as the value of peer support groups.

Many of the programmes required further research in order to determine their success. Griffiths and Farnill (1996:187), as well Neumark-Sztainer (1996:69), highlight the need for further research in preventative measures, especially in terms of evaluating the effectiveness of the respective programmes, rather than merely describing the programmes and techniques used.

It is the opinion of the researcher that each school has its unique set of societal problems and that the prevention of eating disorders would be a high priority for some of the girls' schools in South Africa. The researcher believes that it is the
responsibility of the school, led by the school counsellor, to initiate some form of intervention to reach all individuals at various stages of their school career.

However, the funding for the research and evaluation of preventative programmes is not likely to be forthcoming in South Africa in the near future. It seems that, at present, South African schools are largely reliant on existing research and programmes, which may possibly be adapted to suit the needs of the individual school. It is the researcher's opinion that the teaching of life skills advocated in the respective programmes is worth pursuing in its own right and that it is feasible to integrate preventative measures for eating disorders into the school curriculum. However, in addition to this, the involvement of the family and the community at large is believed to be essential.

In the following chapter the various stages of mid-adolescent development will be discussed. Physical, cognitive, psycho-social and moral development will be looked at with regard to both eating disordered and non-eating disordered adolescents.
CHAPTER FOUR

FEMALE MID-ADOLESCENT DEVELOPMENT

4. INTRODUCTION

According to Atwater (1996:70), puberty technically refers to the biological process whereby sexual maturity is attained, which includes the maturation of the reproductive organs, the development of secondary sex characteristics and the ability to reproduce. Adolescence, on the other hand, refers to the social and personal experience that accompanies puberty (Pipher 1994:53). Golinko (1984:748) defines adolescence as a process of "growing into maturity", which refers to the stage of life "between puberty and maturity, occurring in the years twelve through to nineteen." This chapter specifically deals with the developmental stages of mid-adolescent girls between the ages of 14 and 16.

Many changes take place in adolescence, namely, physical, emotional, intellectual, academic, social and spiritual development. The onset of puberty is a gradual process. For most adolescents the sequence of growth at puberty is similar, while the age of onset, rate and duration of growth may vary (Atwater 1996:72). Although various changes occur simultaneously, their development does not always occur in tandem. For example, an individual who has reached the level of abstract thought may still have the emotions of a child (Pipher 1994:52).
4.1 PHYSICAL DEVELOPMENT

4.1.1 Physical changes

Significant physical changes occurring in female adolescence include: the growth spurt in height and weight (pubescence), skeletal and muscular changes, the enlargement and maturation of primary sex organs (ovaries, uterus and vagina), the development of secondary sex characteristics (physiological signs of sexual maturity that do not directly involve the reproductive organs) and menarche (first menstrual period) signalling the onset of menstruation.

4.1.1.1 Growth spurt

One of the earliest signs that puberty has begun is a spurt in physical growth. This usually occurs during the years between 10 and 14, and significant changes in height and weight, as well as in the skeletal and muscular dimensions, can be observed (Atwater 1996:77-79). Girls gain between 6 and 11 centimetres in height during the growth spurt (Tanner as in Muuss 1990:40).

Dramatic growth in the skeletal and muscular dimensions results in a noticeable change in the shoulder to hip ratio. With the widening of the pelvic outlet, the broadening of the hips and weight gain, which is primarily in the form of body fat, the adolescent begins to develop a more feminine shape (Atwater 1996:79).

4.1.1.2 Sexual development and secondary sex characteristics

Sexual development is largely due to the activities of the hypothalamus, which stimulates various glands to produce certain levels of hormones at various stages, which, in turn, play a role in triggering developmental changes. In females, the level of oestrogen increases dramatically, which triggers the development of breast buds and pubic hair, the enlargement of the ovaries,
uterus, vagina, labia and clitoris, culminating in sexual maturation at the onset of menstruation (Atwater 1996:80).

On average, girls take three to four years to develop to full breast size. Pubic hair appears at more or less at the same time as the breasts begin to bud. Hair also appears on other parts of the body, especially under the arms and on the legs (Atwater 1996:81). In addition, the increased activity of sebaceous glands may result in the outbreak of pimples, roughening of the skin and drying of the hair, while the pitch of the voice deepens (Tanner as in Muuss 1990:46).

4.1.1.3 Menarche

*Menarche* (first menstruation) occurs relatively late in the sequence of female development, usually after the peak of growth in height. The initial menstrual cycles tend to be irregular and may occur without ovulation. The adolescent is thus usually only fertile a year or two after menarche. In the United States, menarche occurs on average at 12.8 years (Atwater 1996:80-83). The timing of maturational events such as menarche may impact on the adolescent psychologically, as will be discussed shortly.

4.1.2 Psychological aspects of physical changes

The adolescent’s perception of, and reaction to, changes in the body become more important psychologically than the physical changes per se. While many individuals remain reasonably unaffected by the physical changes during puberty, others become anxious and struggle to integrate the bodily changes, feeling ambivalent about leaving childhood. A healthy adjustment to the physical changes during puberty is necessary for the development of a positive body image and strong self-esteem. The following section deals with hormonal change, increase in body fat, acne and the timing of menarche.
4.1.2.1 Hormonal change and depression

Brooks-Gunn and Warren (1989:50-51) investigated the role played by hormonal factors in the emotionality and moody behaviour often thought typical of the adolescent. It was found that many factors contribute to the development of depression and that changes in hormonal concentration may play only a small role. In the case of the eating disordered individual (as mentioned previously), the effects of starvation, dieting or binge-purge behaviour, negative body image and feelings of low self-esteem influence depression over and above the effects of hormonal changes.

4.1.2.2 Increase in body fat, acne and body image

With the onset of puberty, the female shape changes with the increase in body fat and the gradual broadening of the hips. As the body shape moves further away from the Western cultural ideal of female thinness, so the adolescent becomes increasingly dissatisfied with her appearance. Overestimation of fatness is typical of the adolescent female and her body dissatisfaction becomes a motivating force to diet. While only three to five percent of adolescent dieting develops into eating disorders, dieting in its own right is hazardous to one's health in that it may lead to weight cycling and binge-eating (Smolak et al. 1993:356).

While acne is more common in boys than girls, a number of girls suffer from blackheads and pimples (Tanner as in Muuss 1990:46). This is devastating for the already self-conscious adolescent, who is focused on her appearance and who tends to exaggerate every perceived flaw.
4.1.2.3 Timing of menarche, dating and lowered self-esteem

Pipher (1994:52) mentions that the tendency for girls to menstruate and date much earlier than in the 1950s has become apparent during the latter part of the twentieth century. The impact of this phenomenon is that girls today may be less mature emotionally and psychologically than in the past at the stage of dating and may not have had the opportunity to develop the necessary skills to cope adequately with dating.

Blyth et al. (1985:207) explored the impact of the time of onset of puberty on satisfaction with body image for girls within different school environments. They arrived at the conclusion that early or late pubertal onset, in isolation, did not necessarily have an impact on satisfaction with body image and on self-esteem, but that a combination of factors contributed to the development of a negative body image.

Levine et al. (1994:12) support the above. These researchers found that, while the early onset of menarche and early dating were instrumental in increasing body dissatisfaction, body dissatisfaction increased even more when these factors occurred simultaneously (within the same year). Body dissatisfaction was likely to increase even further when the following additional factors occurred at the same time, namely, a change of schools and exposure to family and peers who showed concern regarding body weight and shape. Levine et al. concluded that girls who experience early menarche and dating concurrently, and who have a thin body ideal, may be at risk for developing eating disorders.

Cauffman and Steinberg (1996:634) found that there was a link between the onset of menarche and interest in dating. They support the notion that dieting is likely to increase with the combination of recent menarche and dating, particularly when the adolescent has been physically involved with her boyfriend and is concerned with physical appearance. Some doubt exists as to whether
dieting or disordered eating precedes, accompanies or follows girls' involvement with dating. Cauffman and Steinberg also found a link between early dating, the lowering of self-esteem and depression, as did Rierdan and Koff (1991:420), but acknowledged the fact that early dating in isolation was not a significant factor causing depression.

In their study concerning pubertal timing, body image and self-esteem, Williams and Curry (2000:132) found that poor body image contributed to negative self-esteem regardless of pubertal timing. Negative experiences related to early or late maturation tended to increase the dissatisfaction with body shape and size for those who already had a poor body image. Support was found for both the deviant and the developmental stage termination hypotheses. The deviant hypothesis suggests that 'off time maturation' (early or late) may evoke feelings of being different, resulting in difficulty in adapting to circumstances. The developmental stage termination hypothesis suggests that early maturation puts the adolescent at risk for adopting behaviour (e.g. dating and sex) before the individual is psychologically ready.

4.1.3 Impact of eating disorders on physical development

One of the major consequences of eating disorders is the delay or temporary regression of pubertal development. Thus, eating disorders may serve as a temporary haven for those individuals who may not yet have developed the necessary skills to cope with the challenges and responsibilities of adult behaviour.

4.1.3.1 Stunted growth and delayed puberty

According to Adams et al. (1994:163) the individual is born with a hypothalamus that, with the assistance of the pituitary gland (master endocrine gland) and the gonads (sex glands), is capable of triggering pubertal change. However, an
inhibitory effect of the hypothalamus prevents pubertal change from taking place until certain conditions are met. Adams et al. refer to research done by Frisch and Revelle (1971) and Frisch (1983). Frisch and Revelle suggest that a weight of 48 kilograms needs to be reached before menarche can occur, while Frisch suggests that menstruation will only take place once the individual's total body weight includes approximately 17% fat.

Bearing the above in mind, one can assume that the anorexic who is excessively underweight and lacking in body fat would be vulnerable to delayed pubertal development as a result of the inhibitory effect of the hypothalamus. In addition (as was mentioned in Chapter Two), restrictive caloric intake (dieting) may result in disturbed body metabolism, which, in turn, may lead to stunted linear growth and delayed puberty (Griffith & Farnill 1996:180).

4.1.3.2 Loss of weight, sex hormones and amenorrhoea

According to Adams et al. (1994:164) loss of body weight (between 10-15% of normal weight for height) leads to a disruption of the menstruation cycle (amenorrhoea). It appears that a certain amount of body fat is necessary in order to provide the necessary caloric needs to maintain a fully functioning reproductive system, and, if impregnation takes place, to provide a foetus with adequate nourishment. Amenorrhoea can perhaps be seen as nature's way of preventing a baby from coming into the world in an environment that would be life threatening both to the mother and to the baby.

As was mentioned in Section 2.6.1, one of the consequences of eating disorders is the loss of sex hormones, which results in the disappearance of interest in physical relationships (Treasure 1997:103). Cauffman and Steinberg (1996:634) highlight the irony whereby the interest in sexual activity during early adolescence may contribute to eating disorders, as one of the consequences of
eating disorders is the loss of interest in sexual activity. This is the very activity that contributed to the disorder in the first place!

To conclude, the following extract from Pipher's *Reviving Ophelia* (1994:22) is quoted:

"Adolescent girls are saplings in a hurricane. They are young and vulnerable trees that blow with gale strength. Three factors make young women vulnerable to the hurricane. One is their developmental level. Everything is changing – body shape, hormones, skin and hair. Calmness is replaced by anxiety. Their way of thinking is changing. Far below the surface they are struggling with the most basic of human questions: What is my place in the universe, what is my meaning?"

The following section will deal with the changes that take place in adolescent thinking.

4.2 COGNITIVE DEVELOPMENT

As adolescents develop physically and sexually, they also experience important changes in their thinking. Thinking gradually becomes more hypothetical and rational, while the ability to solve problems develops. In this section Piaget's concept of formal reasoning, relativistic thinking, adolescent egocentrism, social perspective taking and cognitive errors will be discussed.

4.2.1 Piaget

Jean Piaget played a significant role in exploring the development of cognitive development and discovered that the process of thinking changes with maturation. He believed that cognitive development gradually develops as a result of the combination of biological and environmental factors (Atwater 1996:103).
According to Inhelder and Piaget (as in Adams et al. 1994:197), meaning is gained through one's thoughts, or cognitions. Exposure to experiences that conflict with known information results in a process whereby the individual tries to resolve the discrepancies and to adapt to the environment. New information which is reasonably similar to existing knowledge is changed to conform to the existing cognitive structure (assimilation). However, dissimilar information results in the individual either ignoring the information or changing the current way of thinking in order to accommodate the new information (accommodation). Thus, the individual learns to adapt to the changing environment through maintaining a functional balance (equilibration) between assimilation and accommodation (ibid.).

Piaget believed that cognitive development unfolds in a sequence of four stages. While the sequence of the stages has been shown to be regular, the rate at which one progresses through these stages varies (Piaget 1972:2). These stages are: the sensorimotor stage from birth to two years; the preoperational stage from two to seven years; the concrete operational stage from seven to 11 years and the formal operational stage from 11 to 12 years and up (Atwater 1996:105).

According to Brainerd (1978:204), Piaget posits that formal thinking is only fully established at the age of 15 and that the period between 11 and 15 years should be viewed as a period of preparation. This implies that the adolescent in the "preparation phase" may display both concrete thinking and crude formal thought. During the second sub-stage of thinking, from 15 years onwards, the individual's thought becomes more flexible and effective.

Atwater (1996:106-107) describes three features of thinking that emerge during the formal operational stage, according to Piaget's theory. First, hypothetical reasoning, or the ability to entertain assumptions and possibilities that may not exist in reality, develops. Second, the adolescent develops the ability to combine
and classify items in a more sophisticated manner. Third, the adolescent learns to use inductive and deductive reasoning in order to form hypotheses and to deduce possible consequences from them. Atwater (1996:107) defines inductive reasoning as “drawing inferences from particular observations or facts to create more general statements”, while deductive reasoning involves “drawing inferences from known general principles in order to formulate particular statements.”

The implications of the above features of formal thought are that the adolescent becomes increasingly able to deal with abstractions, to entertain the idea of possibilities and to test hypotheses. The ability to think about thoughts results in the possibility of introspection or self-examination. The development of formal thought enables the adolescent to think about the future and to explore topics such as religion, justice, morality and identity (Adams et al. 1994:199-200).

Various aspects of Piaget’s theory of cognitive development have been criticised. Adams et al. (1994:201) point out that adolescents may not reach the formal operational stage as early as proposed by Piaget. In addition, the individual may use formal thinking in specific situations and not in others, while some individuals may never present with formal operational thinking. Atwater (1996:109) mentions another consideration: while the adolescent may have attained formal thought, given a particular situation, the individual may choose to reason on a concrete level.

4.2.2 Relativistic thinking

Atwater (1996:113-114) refers to the relativistic thinking theory based on the work of Perry (1981) and Leadbeater (1991). The theory recognises the subjective characteristic of the individual, resulting in variance in the interpretation of facts, and posits that, during late adolescence, individuals’ thinking begins to change from simplistic dualistic to relativistic thinking. This
implies that mid-adolescents typically view the world dualistically. Dualistic thinking refers to the idea that learning is a matter of acquiring the right facts. Ideas and people are considered right or wrong, good or bad. When differences of opinion arise, the discrepancy is attributed to the other individual having the wrong facts. However, as individuals mature to the next stage of relativism, they come to realise that knowledge is based on the interpretation of facts and they learn to respect the viewpoints of others.

4.2.3 Adolescent Egocentrism

According to Elkind and Bowen (1979:15) adolescent egocentrism is more prevalent in females. The belief of being special and unique appears to increase during early adolescence and peaks at about 14 to 16 years of age (mid-adolescence) and then decreases during later adolescence.

With the emergence of formal operational thought, adolescents are able to think about their own thinking and that of others. As a result, they believe that others, especially peers, are preoccupied with their appearance, thoughts and behaviour. They feel as if they are constantly on stage, and that everyone is focused on them and is being as critical or admiring as the individual is of herself. The anticipation of the reactions of the imagined audience results in the individual feeling extremely self-conscious and has an impact on the adolescent's behaviour. For example, the adolescent's need for privacy and secrecy may be explained as a reaction to the feeling of being constantly scrutinised and criticised (Elkind as in Muuss 1990:83).

Adolescents are typically self-centred. They tend to think of themselves as being particularly special and exaggerate their own importance and uniqueness. They assume that, because they are preoccupied with thinking about themselves, others must be doing the same thing (Rycek et al. 1998:745). Adolescents are often convinced of their own immortality, displaying unnecessary
risk-taking and self-destructive behaviour as a result. Elkind refers to this exaggerated sense of personal uniqueness as the personal fable, which is a subjective story that the adolescent tells of herself (Elkind as in Muuss 1990:84).

4.2.4 Social Perspective Taking

Social perspective taking refers to the ability to understand and consider the viewpoints of others along with one's own in dealing with people. Selman (1980) proposed that the process of perspective taking occurs in a given sequence of stages throughout adulthood and childhood. While progression from one stage to another occurs with maturation, it is largely dependent on social stimulation and education (Atwater 1996:121).

During mid-adolescence, individuals are able to examine their own viewpoint, as well as the viewpoints of others, in an objective manner and to accept the perspective of a neutral third person. Some mid-adolescent individuals may be capable of more advanced perspective taking and may be able to examine the perspectives of many individuals in order to determine the societal perspective. The ability to determine group consensus results in more accurate communication and facilitates problem solving with others (Atwater 1996:123).

4.2.5 Cognitive errors

Atwater (1996:109) refers to the phenomenon of pseudostupidity, which results as a consequence of the emerging ability to think abstractly combined with lack of experience in the process. With the ability to consider all the possible viewpoints, the adolescent tends to generate all sorts of possible solutions, overlooking the obvious, simple, straightforward solution. Thus, analysing a problem too deeply may hamper decision-making, while attributing ulterior motives to other people's actions may hinder the understanding of others.
Pipher (1994:59), a clinical psychologist who has specialised in dealing with female adolescents, describes the cognitive errors typical of the cognitive development of adolescents, which result in a distorted view of reality. As mentioned previously, adolescents are so egocentric in their thinking that they tend to focus only on their own experiences, thus losing a realistic perspective of their own importance. The preoccupation with the smallest detail of their lives and the feeling of being continually observed and criticised lead to excessive self-consciousness, the tendency to exaggerate their perceived shortcomings, and an overreaction to situations. There is a tendency to read deep meanings into casual remarks and to overanalyse glances.

In her experience, Pipher has found that most early adolescents are unable to think abstractly, but are at the stage where some are beginning to move into formal operational thought. For the mid-adolescent female, thinking ranges from concrete to more abstract and flexible thought. As a result of concrete thinking, adolescents have the need to categorise others (e.g. nerds). They tend to be extremists, who view the world in terms of black-and-white and fail to see the shades of grey. Life is either "cool" or a disaster. This results in the confusion of thoughts and leads to a fluctuation in the sense of self. The tendency to overgeneralise one incident to all cases (e.g. "John hates fat girls, therefore all boys hate fat girls") and to reason emotionally that something must be true if one feels it to be true (e.g. "I feel fat, therefore I must be fat"), exacerbates the fluctuation of self-esteem. The adolescent may therefore feel good about herself one day and hate herself the next (Pipher 1994:60).

According to Pipher (1994:61), girls who operate from a "false self" and who wish to please in order to gain acceptance are particularly vulnerable to being swayed by their peers regarding decision-making. Furthermore, when girls become overwhelmed with painful thoughts, discrepant information and cognitive confusion, there is a temptation to avoid the work of integrating the experiences. Some individuals may choose to oversimplify issues and reduce all the
complexity in life to one small issue, thus distorting reality in order to make the world a more manageable place. For the anorexic, the focal issue becomes weight.

4.2.6 Influence of eating disorders on cognitive development

When analysing the cognition of the eating disordered patient, the thought process does not appear to be much different from the typical mid-adolescent female. The difference appears to be a matter of degree. Eating disordered individuals tend to be more rigid and concrete-bound than their peers. They tend to see the world in terms of black and white, while their peers may see a greater measure of grey. The lack of flexibility of the eating disordered individual results in greater difficulty with problem solving and decision-making. Preoccupation with the self is typical of the adolescent, but the focus on the self, particularly on appearance, becomes obsessive for the eating disordered individual to the extent that interest in other topics is minimal. Self-consciousness, which is already heightened during mid-adolescence, is excessive for the eating disordered individual, particularly in situations relating to food or appearance. The feeling of being watched is exaggerated for the individual, who is focused on hiding the disturbed eating behaviour that is perceived as being disgusting and embarrassing.

The cognitive distortions typical of the adolescent, as mentioned in Section 4.5, become instrumental in maintaining the negative body image of the eating disordered individual, which tends to perpetuate the eating disorder. Feelings of confusion and lack of control over the environment are greater for the eating disordered individual than for her peers. The confusion is so overwhelming that the eating disordered individual resorts to distorting the reality in order to make the world a more manageable place. Furthermore, the effects of starvation, such as lack of concentration and memory loss, and the constant invasion of
compulsive thoughts regarding food and appearance, exacerbate the feeling of being out of control.

In conclusion, it appears that there is some controversy concerning the age at which formal operational thought is attained. Nevertheless, there seems to be consensus that the mid-adolescent is in the process of moving from a place of being concretely-bound to formal operational thinking, which entails the ability to think more abstractly, hypothetically, logically and systematically. The mid-adolescent moves away from dualistic thinking and learns to examine the perspectives of others and to respect diversity of opinion. Whilst the adolescent becomes better able to think abstractly, the lack of experience of formal thought initially leads to cognitive errors. Mid-adolescence is a time during which the individual is at the peak of egocentrism and is particularly self-centred. For the eating disordered individual, cognitive development is somewhat delayed and the preoccupation with the self becomes obsessive.

4.3 PSYCHO-SOCIAL DEVELOPMENT

The physical, emotional and social changes that take place during adolescence, as well as the acquisition of greater self-consciousness and the ability to think abstractly, bring about changes in the self-concept. Adolescents become increasingly aware of who and what they are and explore the kind of person they want to be. They undergo a process of redefining themselves and various adjustments are made involving the affirmation of some self-images and the rejection of others (Atwater 1996:302).

Pipher's description of adolescents clearly illustrates their confusion of identity and the need to redefine themselves (1994:52).

"Adolescents are travellers, far from home with no native land, neither children nor adults. They are jet-setters who fly from one country to
another with amazing speed. Sometimes they are four years old, an hour later they are twenty-five. They don’t really fit anywhere. There’s a yearning for place, a search for solid ground.”

4.3.1. Self-concept and self-esteem

The *self-concept* can be defined as the "overall awareness we have of ourselves" (Atwater 1996:302), reflecting the way individuals evaluate themselves. Put another way, self-concept refers to the values, thoughts, feelings and opinions individuals have about themselves.

The self-concept consists of hundreds of self-perceptions or selves. Adolescents learn to differentiate between the various selves, such as the body image, self-image (the way the self is perceived), ideal self (the desired self) and the social self (the perception of how others view the self). They begin to see themselves in many different ways, depending on the particular situation, role or relationship (e.g. confident in acting, but shy in public speaking). During mid-adolescence individuals become aware of and concerned about the contradictions and inconsistencies within themselves. Gradually, with the development of formal operational thought, the inconsistencies of the self-images are integrated into a consistent view of the self. Adolescents thus develop a clearer sense of who they are and their behaviour becomes more consistent (Atwater 1996:303-304).

During early and mid-adolescence, individuals begin to separate and distance themselves from their parents, acquiring a greater sense of individuality and uniqueness. Whilst adolescents require greater freedom from their parents and space to discover who the "real self" is, they still need parental support and protection. It is only in late adolescence that a greater stability of the self-concept is achieved (Atwater 1996:305).
Self-esteem refers to the way individuals like, respect, evaluate and accept themselves. It reflects the extent of worthiness felt, based on the respective self-images (Adams et al. 1994:253). Nash (1999:189) views self-esteem as the product of a comparative process, whereby one's self-esteem can go up or down, depending on how close one perceives one to be to the standard of comparison. Naik (1998:10) suggests that a strong self-esteem is essential for self-belief and the confidence to be the authentic self.

Adams et al. (1994:258-261) identified a number of characteristics likely to result in low self-esteem, namely: identity confusion, preoccupation with the self, oversensitivity to criticism, an external locus of control (belief that outcomes are caused by external factors), the feeling of making little difference in society and difficulty in differentiating between the real and the false self. (Individuals who experience the real self are spontaneous and true to themselves and are able to identify and express what they really feel and know. Individuals who experience the false self tend to construct personae that are socially acceptable and behave in a manner to please others). As a result of their stage of development, adolescents may display some of these characteristics, increasing vulnerability to the development of a low self-esteem.

Pipher (1994:63) refers to the American Association of University Women (AAUW) study, in which girls were found to experience a drop in self-esteem during adolescence and to have a lower self-esteem during that time than boys. Martin (1996:2) was particularly concerned about this lowering of self-esteem, which will be discussed in Section 4.3.2.

4.3.2 Puberty, sexuality and self-esteem

Martin (1996:2) explored puberty and initial sex as a possible explanation for the drop in self-esteem found predominantly amongst adolescent girls. She came to the conclusion that adolescents are particularly vulnerable to developing negative
self-esteem due to the experience of puberty (as mentioned earlier) and the process of moving away from parents. In addition, she found that various socio-cultural factors played a significant role in shaping the adolescent's sense of self, including cultural emphasis on appearance, pressure to conform to gender norms, constant objectification of the body, the first sexual experience and the giving up of the authentic self.

4.3.2.1 Cultural norms regarding body image

During adolescence, the cultural norms concerning standards of beauty become more rigid and, in Western society, the pursuit of thinness is adopted in earnest. Feeling fat is equated with feeling bad and full of shame and a dislike for the self often increases as a result of the discrepancy between the real and ideal self, which is exacerbated by unrealistic appearance goals. In addition, the pressure to conform to appropriate dress, which includes having designer clothes and name-brands, increases. The "right look" is paramount to the adolescent, and peer popularity and status is correlated with clothing conformity. Some adolescents tend to become obsessed with dieting, exercise, make-up and expensive clothes (Martin 1996:35).

4.3.2.2 Gender related role expectations

Martin (1996:12) found that there was increased pressure to conform to the traditional views of femininity during adolescence. Peer pressure for the adolescent to behave more femininely increases. According to Pipher (1994:39), the rules of femininity include being an attractive lady, nice rather than honest, unselfish, of service and competent, especially in terms of relationships. The gender expectations include having to give up the parts of the self that are considered masculine and having to adopt submissive behaviour. The rules of femininity are confusing and often hold mixed messages. For example, females are expected to achieve, but not too much, to be polite, but to be true to
themselves. Unfortunately, girls become more self-conscious and less self-assured as they adopt the gender-related roles and gradually develop specialised interests, particularly regarding interpersonal relationships.

4.3.2.3 Socio-cultural expectations regarding sexuality

Adolescents are under enormous pressure to be beautiful and to participate in heterosexual dating. If the girl is too plain, she may be left out of social life, missing out on experiences necessary for social development. The girl who is too attractive is often seen primarily as a sex object. For many adolescents, being constantly watched and judged evokes feelings of being an object, resulting in heightened self-consciousness. Girls eventually learn to objectify their own bodies. They scrutinise and criticise their bodies, highlighting the smallest perceived flaw. In an attempt to act according to social norms, girls give up their authentic self and become pleasers, resulting in feelings of being disconnected and dissociated (Martin 1996:39-40).

Many adolescents struggle to integrate all the bodily changes. Cognitive or subjective knowledge is often lacking, with the result that they are ambivalent about leaving childhood. Some adolescents associate puberty and their emerging sexuality with danger. It seems that girls are often criticised regardless of their actions, and are often unkindly referred to as being a “slut” or “frigid”. Adolescents often feel that they have been pressurised into having sex, or that sex “just happened” to them without serious consideration on their behalf. This frequently leaves adolescents with feelings of regret, shame, hesitation, confusion, frustration and lowered self-esteem (Martin 1996:72).

4.3.3 Identity exploration

Identity refers to the core of the self that remains consistent. It is the integration of the past and the present self, the private and the public or social self, and the
present and the future self. It is the image individuals have of themselves, which is in agreement with the view others have of them (Atwater 1996:315).

Erikson defines the ego identity as the following (1980:94-95):

"The ego values accrued in childhood culminate in what I have called a sense of ego identity. The sense of ego identity, then, is the accrued confidence that one's ability to maintain inner sameness and continuity (one's ego in the psychological sense) is matched by the sameness and continuity of one's meaning for others. Thus, self-esteem, confirmed at the end of each major crisis, grows to be a conviction that one is learning effective steps towards a tangible future, that one is developing a defined personality within a social reality that one understands."

While identity formation is a life-long task, adolescents, and particularly late adolescents, are particularly involved with self-exploration in order to develop a personal identity. The process of seeking an identity may be gradual and unconscious for many adolescents, but for others it may evoke a great deal of anxiety and self-doubt (Atwater 1996:313).

When adolescents separate from their parents, dependency on the parents is initially replaced by dependency on the peer group. The latter serves as a role model for the adolescent, and also provides necessary social feedback. Gradually adolescents become less dependent on their peers, as they begin to "find themselves" and to know where they are going. However, adolescents who fail to identify who they are, where they are going, and what they are to become, are likely to experience self-doubt and role confusion (Muuss 1996:52).

Identity formation occurs through interaction with others. Falling in love, for example, presents adolescents with the opportunity of seeing themselves through the eyes of a loved one and assists individuals in redefining their sense of self (Muuss 1996:52).

The search for self-identify includes the search for a vocational identity. (At the stage of middle adolescence, individuals tend to glamorise and idealise
vocational roles and are therefore inclined to make unrealistic choices). Identity formation also involves the formation of a philosophy of life, which enables individuals to evaluate events from a particular perspective (Muuss 1996:54).

Erikson (as in Hamachek 1998:355) developed a theory on human development and devoted a great deal of attention to the period of adolescence and to the task of establishing an identity. A brief overview of Erikson’s theory will be given but, as this chapter focuses on mid-adolescence, only the stage of identity vs identity confusion will be discussed.

The passage to adulthood is viewed as a sequence of eight psychological stages. Each developmental stage presents an emotional conflict that needs to be successfully resolved in order to progress to the next stage. Failure to resolve conflict successfully results in growth being arrested, lack of direction and the hampering of further healthy ego development. The task of individuals is to acquire ego identity as they move from one stage to another. The first five psychological stages as defined by Erikson, each with its negative counterpart, are as follows (Hamachek 1988:355-356):

1. **Trust vs Mistrust** (birth – 18 months)
2. **Autonomy vs Shame and Doubt** (18 months – 3 years)
3. **Initiative vs Guilt** (3 – 6 years)
4. **Industry vs Inferiority** (6 – 12 years)
5. **Identity vs identity confusion** (12 – 20 years)

During the identity vs identity confusion stage, the consolidation of old and new identities takes place in order to form a new personal identity. This enables adolescents to know who they are and where they are going. Only when this identity is achieved, can adolescents face the crisis of intimacy versus isolation (Moore & Boldero 1991:522).
Hamachek (1988:356) describes some of the characteristics displayed by individuals who have a sense of identity:

"They have a stable self-concept, they have a clear sense of goals, they are less susceptible to peer pressure, they generally accept themselves, they are able to make decisions without vacillating, they assume a sense of responsibility for what happens to them, and they are able to be physically and emotionally close to selected individuals without losing themselves."

4.3.4 Personal relationships

According to Atwater (1996:172), two of the greatest gifts parents can give their offspring are roots and wings. The "roots" represent the close ties with family and friends that contribute to making the individual feel loved, accepted and secure enough to explore the environment. The "wings" refer to the attainment of the individual's independence. Presented with a favourable environment, adolescents' wings gradually grow, enabling them to "fly from their parents' nest" to join their peer group.

4.4.4.1 Relationship with parents

During adolescence, teenagers feel great pressure to distance themselves from their parents in order to become autonomous individuals. Autonomous behaviour implies that individuals feel sufficiently self-confident and competent to define goals, regulate their own behaviour and make their own decisions. Ironically, feelings of trust and closeness to significant others (attachment) tend to facilitate autonomy. Positive relations with parents provide the support and security for adolescents to feel good about themselves and to feel capable of responsible, independent action. Thus, it appears that separation and attachment are complementary dimensions (Noom et al. 1999:771).

A change in the relationship between parents and adolescents occurs during the process of separation. Adolescents spend more time with peers and begin to
resist family activities. They make more decisions on their own, become more assertive and are more likely to resist family rules. Feeling that they have moved up in status, they expect to be treated differently by their parents, which often results in conflict (Pipher 1994:65).

Communication between parents and adolescents is largely dependent on the degree of cohesion amongst family members and the degree to which parents encourage independent decision-making and responsibility for actions. The process of finding the balance between freedom and security is bound to lead to at least a limited amount of conflict. While adolescents push for more freedom and space to be their own person, parents generally try to encourage more togetherness. Adolescents continue to negotiate with their parents for greater equality and freedom. However, it appears that adolescents simultaneously need the support and protection of their parents and, very often, “disagreements” may be a way of connecting and staying close. A lack of conflict between parents and adolescents suggest that the latter may be particularly dependent, anxious about separation and possibly fearful of independence. On the other hand, excessive conflict may be detrimental to adolescent development (Atwater 1996:180).

Pipher (1994:67) suggests that parents who are high in control and high in acceptance (strict but loving) appear to have teenagers who are independent, socially responsible and confident. Authoritative parenting implies that the parents are warm and accepting and emotionally available to listen, support and guide, while at the same time assertive regarding rules, values and norms. Noom et al. (1999:773) explored the relationship between autonomy, attachment and psychosocial adjustment, and found that the combination of high autonomy and high attachment provided the most positive psychosocial adjustment. Beyers and Goossens (1999:753) found in their research that authoritativeness predicted positive social adjustment, while autonomy was associated with negative adjustment, except for self-reliance. Barber and Olsen (1997:310) and
Eccles et al. (1997:287-288) suggest that children “fare better when they experience positive emotional bonds with significant others like parents (connection), have fair and consistent limits placed on their behaviour (regulation) and are permitted to experience, value and express their own thoughts and emotions, leading to the development of a stable sense of self and identity (psychological autonomy).”

4.4.4.2 Relations with peers

As the adolescents gradually separate from their parents, they become more reliant on their peers for intimacy, companionship and moral support. Friendships with peers play a significant role in the development of self-cohesion, self-affirmation and self-knowledge (Updegraff & Obeidallah 1999:53). According to Hartup (1996:4) children who have friends tend to have stronger self-esteem and self-confidence, cope better with stress and are likely to be more sociable, co-operative and altruistic.

Friendships are based on attractiveness of personality, common interests and activities, similar school-related aspirations and achievement, and common attitudes and values. Friends tend to be similar to one another in terms of normative activities like smoking, drinking, drug use, antisocial behaviour and dating, as well as in sexual behaviour and attitudes (Hartup 1996:6).

During mid-adolescence, the focus of friendships gradually changes from being a source of self-definition to becoming more relationship-orientated. Individuals become more interested in the personal qualities of friends and look for someone in whom they can trust and confide. Friendships become increasingly stable and adolescents are likely to keep the same friends during the year. Most adolescents have a special friend, several close friends and a larger friendship group. The friendship group gradually becomes smaller, more cohesive and intimate (Degirmencioglu et al. 1998:316).
Peer relationships supplement parental influence and serve many roles. Relationships with peers may be useful in assisting individuals to redefine the sense of self. By talking to friends, individuals can gauge their reactions and gain feedback on how they are seen by others. In addition, relationships with peers allow adolescents the opportunity of comparing themselves with others, enabling them to discover various aspects about themselves, such as abilities and characteristics. Peers serve as models for age-appropriate behaviour and tend to reinforce cultural values and norms. Role models provide standards by which adolescents can judge their own experience and behaviour (Pipher 1994:67).

Peers play a significant role in providing emotional security and status at a time when adolescents are in the process of separating from significant others. They provide a supportive, accepting and nurturing environment in which individuals feel safe enough to share their feelings with one another, work through their conflicts regarding nurturance and autonomy and test their individuality. The intimate nature of the adolescent friendship affirms self-worth and provides the opportunity for learning social skills, such as self-disclosure, co-operation, compromise, reciprocity and mutual support (Moore & Boldero 1991:523-525).

The status of adolescents is largely determined by the degree of acceptance by peers, resulting in pressure to conform to group norms. Peer pressure is particularly strong during early adolescence, but tends to decline gradually as individuals mature and become less dependent on the approval of others. Whilst the emotional intensity of female adolescent friendships may provide much security, they may also be a source of tensions and jealousies, resulting in teasing and catty behaviour (Atwater 1996:219).

During the early stages of adolescence, individuals may be seen socialising in the proximity of the opposite sex. This is followed by group dating, which gradually develops into the pairing of couples. During mid-adolescence, dating
changes from being self-focused, where the emphasis is on recreation and gaining approval, to being more focused on intimacy and companionship. Adolescent dating serves as a training ground for the social and interpersonal skills needed for successful relationships with the opposite sex. It serves as an opportunity to experiment with sexuality within mutually acceptable limits (Atwater 1996:221).

Most adolescents continue to identify with their parents and to seek advice and support from them. However, as adolescents gradually move away from their parents, their peers play an increasingly important role in validating their decisions and supporting their new, independent selves (Pipher 1994:67).

4.3.5 Psychosocial development of eating disordered individuals

One of the characteristics of eating disorders is a negative body image. A poor body image affects self-esteem negatively to the extent that individuals base their self-worth on physical appearance. Whilst other factors, such as identity confusion, difficulty in differentiating between the real and the false self, oversensitivity to criticism and an external locus of control (Adams et al. 1994:258-261) may contribute to the low self-esteem of eating-disordered individuals, the process of dieting and disordered eating behaviour lowers the self-esteem further. Individuals with low self-esteem tend to be self-critical and lacking in confidence. They may feel worthless, ineffective and have difficulty adjusting to social norms and relating to peers (van der Ham et al. 1998:83).

Peers play a significant role in reinforcing cultural norms and in promoting the thinness ideal in Western society. Peers model the “right look” and express approval or disapproval through complimenting, criticising, teasing or making of suggestions. Teasing by peers provides a strong motivation for dieting, which may lead to an eating disorder. The need to conform to the peer group
depends a great deal on the need for acceptance and approval (Pipher 1994:67-68).

Whilst low self-esteem tends to hamper the development of social skills, the withdrawal and isolation from peers typical of eating disordered patients exacerbates the difficulty adjusting to social norms (Schlundt & Johnson 1990:172). Isolation from peers denies eating disordered individuals exposure to age-appropriate role models. It does not allow the adolescent the opportunity of self-discovery through feedback from peers, the opportunity of working through various conflicts with empathetic peers, the validation of decision-making, the opportunity for sexual experimentation and the opportunity of “practising” social skills in the safe environment of the peer group. In addition, eating disordered individuals seem to miss out on the warmth, acceptance and support experienced within intimate relationships (Atwater 1996:221-222).

Eating disordered patients may come from families where the dysfunctional parent-adolescent relationship could be a contributing cause to the disorder. It appears that intrusive concern, overprotection by parents and excessive power and control exerted by the mother, in particular, may inhibit separation from the family and result in the lack of self-confidence to explore the environment and to develop a sense of identity and independence (Bailey 1991:255). Anorexia, which involves the control of food intake, may be seen as a reaction against a general lack of control and feelings of ineffectiveness.

In conclusion, Pipher (1994:22) mentions three factors that make young women vulnerable today, namely, their developmental level, the American culture and the expectation of having to separate from significant others. She writes:

"American culture has always smacked girls on the head in early adolescence. This is when they move into a broader culture that is rife with girl-hurting "isms", such as sexism, capitalism and lookism, which is the evaluation of a person solely on the basis of appearance. [...] Third, American girls are expected to distance from parents just at the time when they most need their support. As they struggle with countless new
pressures, they must relinquish the protection and closeness they’ve felt with their families in childhood. They turn to their none-too-constant peers for support.”

4.4 MORAL DEVELOPMENT

Muuss (1996:176) distinguishes between moral judgment and moral behaviour. Moral judgment refers to the cognitive ability to “evaluate the goodness or rightness of a course of action in a hypothetical situation.” Moral behaviour refers to the ability to resist lying, stealing, cheating or committing immoral acts, as well as prosocial behaviour (helping others in various situations). The fact that individuals may be able to reason morally does not mean that they will necessarily behave according to moral principles.

4.4.1 Kohlberg

According to Kohlberg (1984), one of the best-known theorists of moral development, children and adolescents progress through a sequence of six distinctive stages of moral reasoning that are based on the individual's cognitive development. Like cognitive development, moral development gradually unfolds in a regular sequence, but the rate of development varies with each individual. Attainment of each successive stage is necessary before the individual can progress to the next stage (Atwater 1996:373).

The development of moral reasoning is not solely dependent on the cognitive development, but is also determined by the individual's learning experiences and social interactions. Schonert-Reichl (1999:270) highlights the importance of peer group and friendship relationships in the development of moral reasoning. Individuals are more likely to be challenged and exposed to cognitive conflict within the “safe” environment of a close friendship group. The process of resolving the conflict brings about moral development.
Kohlberg distinguishes three basic levels of moral development, namely, the level of preconventional morality, conventional morality and postconventional morality. Each level consists of two types of moral judgment, as demonstrated below (Kohlberg 1981:17-18):

**Level 1: Preconventional level**
Type 1: Punishment and obedience orientation - (Motivating factor: avoiding punishment by authorities).
Type 2: Instrumental relativist orientation - (Motivating factor: making fair deals, acting in one’s own interest).

**Level 2: Conventional level**
Type 3: The interpersonal Concordance or “Good Boy – Nice Girl” Orientation – (Motivating factor: gaining approval, avoiding disapproval).
Type 4: Society Maintaining Orientation – (Motivating factor: doing one’s duty in order to maintain social and legal order).

**Level 3: Postconventional Level**
Type 6: The Universal Ethical Principle Orientation – (Motivating factor: adhering to universal ethical principles).

During mid-adolescence, a large number of adolescents are in the early stages of conventional moral thinking (Stage 3), while there is a slow but gradual movement towards the thinking typical of Stage 4. During Stage 3, the individual is aware of shared feelings and mutual agreements and expectations, and will behave according to the expectations of others. During Stage 4, the individual takes into account the laws and regulations of the social system and acts accordingly (Kohlberg 1981:410-411).
4.4.2 Gilligan

Whilst both sexes are capable of moral reasoning, Gilligan suggests that girls tend to view moral dilemmas from an interpersonal point of view. Girls tend to be concerned with relationships with others and see it as their responsibility to meet the needs of others. Adolescents are faced with the dilemma of being selfish and remaining true to the self or displaying caring and pleasing behaviour. Gilligan suggests that individuals progress through three stages before they are able to resolve the dilemma. The first level (caring for the self – survival) corresponds with Kohlberg’s preconventional level, while the second level (caring for others – goodness) is similar to Kohlberg’s conventional stage of moral reasoning. Thus, mid-adolescents, who are intent on gaining approval, tend to adopt pleasing behaviour and take on the role of the false self. During adolescence, girls struggle to find their voice in a male-oriented society and struggle to find the balance between their own needs and that of others. These individuals eventually enter the final level (caring for self and others – truth) of the “care perspective” theory in order to resolve the dilemma (Atwater 1996:379-380).

4.4.3 Values

The separation from their parents and the acquisition of abstract thought results in a gradual change in values. Parental values that have been accepted uncritically in the past are re-evaluated. An inconsistency in parental and peer values may be experienced, which motivates the establishment of the individual’s own set of values (Atwater 1996:389).
4.4.4 Religion

During adolescence, individuals become curious as to who they are and also as to how they fit into the greater scheme of things. It is a time when girls actively search for meaning and order in the universe. It is also a time of considerable idealism, when individuals tend to involve themselves with matters such as environmental and animal rights or vegetarianism (Pipher 1994:71-72).

4.4.5 The moral development of eating disordered individuals

Since eating disordered individuals tend to experience a delay in cognitive development, it would be logical to expect a similar delay in moral development. The necessary interaction with peers that challenge moral dilemmas may be limited due to the isolation typical of eating disordered patients. The latter may be motivated by self-interest and survival to lie, steal and shoplift, resulting in the alienation of others.

The following quotation from Pipher (1994:72) sums up the phase of adolescence:

"Adolescence is an intense time of change. All kinds of development — physical, emotional, intellectual, academic, social and spiritual — are happening at once. Adolescence is the most formative time in the lives of women. Girls are making choices that will preserve their true selves or install false selves. These choices have many implications for the rest of their lives".

In conclusion, adolescence is a time of dramatic change. Physically, the body changes in size, shape and hormonal structure. Adolescents become highly critical of and preoccupied with their bodies. Emotions become extreme and changeable and the instability of feelings may lead to unpredictable behaviour. Most early adolescents are unable to think abstractly. They think in terms of black and white, tend to overgeneralise and are extremely egocentric. However, by mid-adolescence, there is a gradual move towards more abstract
and flexible thought and a greater ability to solve problems. Socially, adolescents struggle to find the ideal balance between freedom and security. Adolescents experience much pressure to have the “right look”, to behave more femininely and to separate and distance themselves from their parents. At the same time, they become more reliant on their peers for support, companionship and intimacy. Morally, adolescents tend to behave according to the expectations of others. According to Gilligan, girls tend to view moral dilemmas from an interpersonal point of view. A gradual change in values takes place as adolescents begin to re-evaluate the values passed down to them from their parents. Spiritually, adolescence is a time when girls actively search for meaning and order in the universe. It is also a time when individuals are idealistic and are often involved with fighting for some cause or another.

The empirical design will be discussed in the following chapter which includes a discussion on the qualitative and quantitative methodology.
CHAPTER FIVE

THE EMPIRICAL DESIGN

5.1 INTRODUCTION

Having reviewed the literature on eating disorders (Chapter Two), it appears that excessive dieting and eating disorders have become common problems amongst adolescents. Treatment is a costly and lengthy process. A number of individuals never recover totally, while death has occurred in some cases as a result of complications or suicide. Many researchers have recommended preventative measures as an alternative to treatment and a number of programmes have been designed with varying degrees of success (Chapter Three). Bearing in mind evidence linking body image to eating disorders (Killen et al. 1993:271), it seems appropriate that preventative measures for eating disorders should include a component designed to enhance body image. The rationale is that individuals with a positive body image are likely to be more resistant to external pressures to be thin, and are less likely to diet excessively and to develop eating disorders.

This study evaluates the effectiveness of Rosen’s cognitive-behavioural body image programme on mid-adolescent girls. Details of the empirical investigation used in this study and a summary of the research design will be provided.

5.2 GENERAL STATEMENT OF THE PROBLEM

The problem being investigated in this research study has been stated in Chapter One. The problem is formulated as follows:
What is the effect of a modified version of Rosen's body image programme on a group of middle adolescent girls? Will the programme assist the adolescents to overcome a negative body image and accept their bodies more favourably?

5.3 SPECIFIC GOALS

The specific goals of this study are to determine the effect of the modified version of Rosen's body image programme on adolescents in terms of the following:

- The enhancement of body image
- Self-esteem
- The development of interpersonal skills
- A reduction in anxiety levels
- The reduction in the level of depression

The goals, as specified above, will be explored when evaluating the effectiveness of the prevention programme. A discussion of the research methodology used in this study will follow.

5.4 RESEARCH METHODOLOGY

5.4.1 Introduction

As mentioned in Chapter One, Rosen's Body Image Programme (Rosen as in Thompson 1996:436) was designed for college students and adults. While the programme was tested and found to be successful in enhancing body image within the above-mentioned age group, the researcher wished to investigate the effect of the application of the programme on mid-adolescent girls. The researcher felt that adolescents (who tend to be particularly self-conscious and aware of their bodies [Chapter Four]) would benefit a great deal from body image enhancement, which would be significant in terms of
preventing excessive dieting and the possibility of developing eating disorders. In addition, the researcher wished to investigate the feasibility of integrating various aspects of Rosen's programme in the Life Skills curriculum at secondary school level.

De Vos (1998:152) describes research design as the plan, recipe or blueprint for investigation. The plan for this study is a deliberate combination of quantitative and qualitative methodologies, sometimes referred to as "triangulation" (De Vos 1998:359). Duffy (1993:143) offers the following guidelines pertaining to triangulation:

- Theoretical triangulation involves the use of several perspectives in the analysis of the same set of data;
- Data triangulation uses a variety of sampling strategies in order to gather observations, ensuring that a theory is tested in more than one way;
- Investigator triangulation makes use of many observers, coders, interviewers and analysts in a particular study;
- Methodological triangulation makes use of two or more methods of data collection procedures in one study.

While a combination of both qualitative and quantitative methodological approaches is viewed as being problematic by some researchers, Mouton and Marais (1990:169-170) point out that phenomena explored in the social sciences are so enmeshed that a combination of the quantitative and qualitative approaches of methodology is sometimes necessary.

King et al. (1994:5) suggest that qualitative and quantitative research styles each have their strengths and limitations and that some of the best research "often combines the features of each". Charles Ragin (1994:92) explains his view on the combination of qualitative and quantitative research methods as follows:

"The key features common to all qualitative methods can be seen when they are contrasted with quantitative methods. Most quantitative data techniques are data condensers. They condense data in order
to see the big picture ... Qualitative methods, by contrast, are best understood as data enhancers. When data are enhanced, it is possible to see key aspects of cases more clearly."

Although some quantitative elements are present (as will be discussed shortly), this research is essentially a qualitative study. A literature study was done in order to gain an overview of the significant details pertaining to eating disorders such as the diagnostic criteria, prevalence and demographic characteristics, causes with particular reference to disturbed body image, consequences, treatment, preventative measures and prognosis. In addition, existing preventative programmes and various recommendations made by researchers were explored.

An understanding of the nature of eating disorders and knowledge of the causes were viewed as essential in order to evaluate the content of a preventative programme. In addition, information concerning the prevalence and demographics of eating disorders was deemed necessary in order to determine the appropriate population group to target.

Reid and Smith (1981:89) describe qualitative research as a process of systematic inquiry. It implies that information is obtained first-hand and the collection of data and the holistic understanding of phenomena is shaped as the investigation proceeds. This suggests that new information may come to light which may reflect different ways of thinking, or new behaviours, and which may modify existing ideas.

In this study, information regarding the thoughts, feelings and behaviour of the respondents was obtained through the process of unstructured interviewing and the use of questionnaires and exercises performed either during the sessions or at home. The use of a battery of standardised tests provided additional information facilitating the creation of profiles of each respondent.
The elements of quantitative methodology used in this study (as previously mentioned) refer to the use of a battery of standardised tests. The tests were administered before and after the implementation of the body image and self-esteem programmes, thus providing pre- and post-test scores used to measure changes resulting from the respective programmes. However, statistical analysis could not be applied, since the sample was too small to make significant deductions regarding the general population.

According to Reid and Smith (1981:87-88), quantitative research implies that the researcher is an objective observer who focuses the study on specific hypotheses that usually remain constant throughout the investigation. The manner of data collection and method of measurement is determined in advance of the study and is applied in a standardised manner. Specific variables are quantified through rating scales, frequency counts and other means, allowing for objective measurement. Statistical methods are used to determine the associations or differences between variables.

In this particular study, many features of quantitative research were not present. For example, hypotheses were not made at the beginning of the study, but rather an understanding of the phenomena was shaped as the investigation proceeded. Whilst the battery of standardised tests administered provided some quantifiable data, which could be measured objectively, subjective information gained via observation was also included in the study. Statistical measures were not used to determine the associations or differences between variables, since the sample used was too small to provide significant deductions regarding the general population.

De Vos distinguishes between "programme evaluation" and "intervention research" (1998:364). Programme evaluation refers to the evaluation of an existing programme, while intervention research implies the use of pilot tests and field replications to test and refine the programme. This study cannot be classified as "programme evaluation", since the programme has been adapted, and nor can the study be referred to as "intervention research", 

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since there is no intention of refining the original programme. This is a “trial” study. It evaluates a modified version of an existing programme, which is to be implemented within a target group (mid-adolescent girls) differing from the intended target group of the original programme.

5.4.2 Group composition

Initially, 10 girls volunteered to participate in the research project. Due to the small size of the group, further selection measures were unnecessary. Two girls withdrew from the study during the pre-testing phase, leaving eight mid-adolescent girls to complete the research project. The small sample was suitable however, since this is a “trial” study.

The girls were in Grade 9 and ranged in age from 14 to 16. This age group was targeted since adolescents tend to be self-conscious and particularly aware of their bodies at this stage (Chapter Four). Although Attie and Brooks-Gunn (1989:71) advocate that elementary school children be targeted for preventative programmes for eating disorders, it would not have been appropriate for this particular programme, since formal operational thinking was required in order to cope with the exercises presented.

The members of the group were from a private girls' high school in the northern suburbs of Johannesburg, a school well known for its high academic and sporting achievements. The girls all came from upper-class socio-economic backgrounds, since research (Omizo & Omizo 1992:217) suggests that eating disorders are most commonly found in female adolescents from the middle to upper socio-economic class. Omizo and Omizo also suggest that eating disorders are more prevalent amongst Caucasians. However, Szabo (1998:15) reveals the steady increase of eating disorders amongst the black population in South Africa. This is particularly so amongst those who are either private-school pupils, university students or those who have lived overseas and have been exposed to the Western culture (Sorour-Morris
The fact that the sample of girls used in this study was white was simply a result of not having had any volunteers from the black population.

The eight girls were randomly divided into two groups, namely, the experimental group, who followed the body image programme, and the control group, who participated in a self-esteem programme.

5.5 METHOD OF INVESTIGATION

As indicated in Chapter One, the researcher was given the opportunity of addressing the Grade 9 classes from a private girls' high school in Johannesburg, in order to request volunteers to take part in the research study concerning body image and self-esteem, and to explain the administrative details. Letters were sent to the parents of the volunteers, requesting consent for their daughters to participate in the research study and to furnish them with administrative details.

Prior to the programme, the subjects were subjected to a battery of tests in order to determine existing levels of self-esteem, body image, anxiety, depression and family relationships, which are all areas that have been linked to eating disorders. In addition, a brief unstructured interview was held with each subject.

Once implemented, the programmes included in this “trial” study were run for a period of nine weeks. During the ninth session, subjects were expected to evaluate the programme and their own performance, and were invited to make recommendations. During the tenth week, the full battery of tests was once again applied.
5.6 THE MEASURING INSTRUMENTS

As part of the pre- and post-test evaluation procedure, various test media were implemented. The test battery included the Thematic Apperception Test (TAT), the Adolescent Self-Concept Scale (ASCS), the Body Dysmorphic Disorder Examination (BDDE), the IPAT-Anxiety Scale (IPAT) and the Family Functioning in Adolescence Questionnaire (FFAQ). The various tests will be described in terms of content, administration procedure, scoring and evaluation procedure, and their applicability to the particular research question.

5.6.1 The Body Dysmorphic Disorder Examination (BDDE)

5.6.1.1 Introduction

The BDDE is a semi-structured clinical interview designed by Rosen and Reiter (1994:1-12) to measure the cognitive and behavioural symptoms of body dysmorphic disorder and negative body image. It taps into preoccupation with, and negative evaluation of, appearance as well as self-consciousness and embarrassment, excessive importance given to appearance in self-evaluation, avoidance of activities, body camouflaging and body checking.

5.6.1.2 Content

Questions have been designed to explore the following areas:
- Description of perceived defect in physical appearance
- Negative evaluation due to the defect
- Preoccupation with the defect in public and in social situations
- Degree to which defect is noticed by others
- Degree of distress felt as a result of comments concerning defect
- Body checking
• Reassurance seeking
• Avoidance of public and social situations, physical contact or physical activity
• Camouflaging the body
• Altering body posture
• Inhibiting physical contact
• Avoidance of looking at the body
• Avoidance of others looking at the body
• Comparing self to other people
• Beautification remedies

5.6.1.3 Administration procedure
The subject is requested to discuss his or her adjustment over the past four weeks in terms of the above mentioned areas and is also requested to rate each response according to the appropriate specifications. (Items are rated 0 to 6, the higher scores being more negative). The subject is given a subject's rating form to follow the interview. Before each question is asked and discussed, the question number is read aloud while the subject locates the appropriate rating scale. After a detailed explanation of how the feature applies or does not apply to the subject, the subject is expected to rate the response.

5.6.1.4 Scoring and interpretation
The total score is the sum of ratings for all items except items one to three, 22, 33 and 34. This score will determine the level of body dissatisfaction. The test also provides BDD (Body Dysmorphic Disorder) diagnosis, which is irrelevant for the purposes of this particular study. A rating of four or higher on specific questions suggests Body Dysmorphic Disorder.

5.6.1.5 Reliability and validity
Psychometric studies with clinical and non-clinical samples (77 overweight men and women who requested treatment for negative body image at an
outpatient clinic) showed the BODE has acceptable test-retest reliability ($r = 0.86$), internal consistency ($r=0.88$ to $0.91$) and concurrent validity with other body image questionnaires ($r=0.37$ to $0.77$). Fifteen subjects were randomly selected from the sample of 77 overweight men and women for a second, independent interview. The inter-rater reliability was $r=0.86$ for the total score (Rosen et al. 1995:29).

5.6.1.6 Reason for administering the test

In order to evaluate the effectiveness of a body image programme, it is necessary to find a body image test that provides a score that may be compared in order to measure the amount of body dissatisfaction experienced before and after the implementation of the programme. The BODE not only provides a score that measures the amount of body dissatisfaction, but is also extremely useful in assisting the subject in the self-exploratory process in terms of physical appearance. The questions help to clarify the hierarchy of body parts that cause distress, situations in which distress is experienced, automatic negative thoughts that trigger distress and feelings and behaviours that occur as a result of the distress.

5.6.2 Beck’s Depression Inventory (BDI)

5.6.2.1 Introduction

Beck studied the characteristic attitudes and symptoms of his depressed patients in the course of his psychoanalytical psychotherapy and then, with the assistance of others, designed an inventory in 1961. The inventory consists of 21 categories of symptoms and attitudes, each consisting of four graded self-evaluative statements. Numerical values from 0 to 3 are assigned to each statement (Beck et al. 1961:54).
5.6.2.2 Content

The behavioural manifestations of depression as selected by Beck include:

- Mood (sadness)
- Pessimism
- Sense of failure
- Lack of satisfaction
- Guilty feeling
- Sense of punishment
- Self hate
- Self accusations
- Self-punitive wishes
- Crying spells
- Irritability
- Social withdrawal
- Indecisiveness
- Body image
- Work inhibition
- Sleep disturbance
- Fatigability
- Loss of appetite
- Weight loss
- Somatic preoccupation
- Loss of libido

5.6.2.3 Administration procedure

Subjects are requested to select the statement in each group that best describes the way the individual has been feeling in the past week, including the day of testing. The number adjacent to the selected statement is circled. The subject may circle more than one statement, should several statements in the group seem to apply equally well.
5.6.2.4 Scoring and interpretation

The total score is the sum of the numerical values that have been circled. The total score may be interpreted as follows (Branberry & Oliver 1978):

- 0-9 No Depression
- 10-15 Mild Depression
- 16-23 Moderate Depression
- 24-63 Severe Depression

5.6.2.5 Reason for administering the test

As mentioned in Section 2.3.1, there appears to be a link between depression and eating disorders, although the precise nature of the connection is unclear (Joiner et al. 1995:353). Nevertheless, one may conclude from the theory that there is a good chance of finding depression amongst subjects who are preoccupied with body shape, weight and dieting. The decision to administer the BDI was based on the above theory.

5.6.3 The IPAT-Anxiety Scale (IPAT)

5.6.3.1 Introduction

The IPAT Anxiety scale was designed by Raymond Cattell to measure levels of anxiety and has been adapted and standardised for use in South Africa by Madge (Human Sciences Research Council 1968). It may be applied to subjects from 14 years of age. The questionnaire is non-stressful and is very economical regarding administration and scoring time. It is, therefore, particularly useful for all kinds of research where mass screening is required and where limited time is available for assessment and diagnosis (Cattell et al. 1995:1).
The questionnaire consists of 40 questions dealing with difficulties that most people experience at one time or another and usually takes between five and 10 minutes to administer. The total score consists of the “overt” and “covert” sub-scales, which reflect the degree to which the test takers are or are not conscious of their anxiety. In addition, the items may further be divided into five components which are, however, less reliable than the total scores (Cattell et al. 1995:3).

The five components consist of the following (Cattell et al. 1995:5):

1. **Defective Integration, lack of self sentiment**
   Failure to integrate behaviour about a clear self-concept leads to symptoms of anxiety.

2. **Ego weakness, lack of ego strength**
   An insecure ego with many ego defences tends to generate anxiety.

3. **Suspiciousness or Paranoid Insecurity**
   Social difficulties caused by paranoid-type behaviour could result in isolation and anxiety. Anxiety could occur first and paranoid behaviour could develop as a defence against anxiety.

4. **Guilt Proneness**
   Feelings of unworthiness, depression and guilt are included in this component.

5. **Frustrative Tension or Id Pressure**
   This appears to be the largest component in anxiety. It represents the degree to which anxiety is generated by excited drives and unmet needs (id pressure). Sex drive excitation, need for recognition and situational fear are drives that are positively related to this component. The symptoms include emotionality, tension, irritability and “jitteriness”.
5.6.3.3 Administration procedure

The test taker is expected to respond to the questions by placing a cross in one of the three boxes adjacent to the respective questions. Two of the boxes represent a positive or negative response, while the third "in between" or "uncertain" box is used when the testee is unable to make a choice between A and B.

5.6.3.4 Scoring and interpretation

Stencils are used to mark the various questions. The tester decides whether a breakdown of the five sub-scores is required, or whether only the total score is needed. The test is marked accordingly. A table is provided in order to convert the total score (and sub-scores, if so desired) into stens (units on a standard ten point scale with a mean of 5.5). Norms are thus reported in stens. A higher sten score suggests greater anxiety.

<table>
<thead>
<tr>
<th>Stens</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2 or 3</td>
<td>Indicates stability, security and general mental health</td>
</tr>
<tr>
<td>4, 5, 6 and 7</td>
<td>Still in the &quot;normal range&quot;, no need for further inquiry unless other indications of psychological difficulty are evident.</td>
</tr>
<tr>
<td>8, 9 and 10</td>
<td>Definite psychological morbidity is indicated, which could have adverse effects on schoolwork and social-emotional adjustment.</td>
</tr>
</tbody>
</table>
5.6.3.5 Reason for administering the test

As was mentioned in Section 2.5.7, individuals who experience low self-esteem may also experience social anxiety (van der Ham et al. 1998:83). Dickstein (1989:110) describes eating-disordered individuals as having high and acute levels of dysphoria, where these individuals may display highly variable moods, high levels of anxiety and tension and may lack the resilience to cope with stress. The IPAT was considered a useful test for this study, considering the link between anxiety and eating disorders.

5.6.4 The Adolescent Self-concept Scale (ASCs)

5.6.4.1 Introduction

The self-concept scale for adolescents was designed to gauge the nature of the self-concept of adolescent youth. Vrey (1974:95 – translation) defines self-concept as follows:

"The self-concept refers to the configuration of convictions about myself and to attitudes towards myself which are dynamic and, of which I am or may become conscious."

According to Vrey and Venter (1983:2) knowledge about the self provides self-understanding, while self-acceptance is valuable in allowing individuals to remain true to themselves. Vrey and Venter (1983:1) suggest that knowledge about the self has practical value as well, in that there is evidence to show that a negative self-concept relates to personality disorders and behavioural problems, while a positive self-concept relates to exceptional achievement and perseverance.

The ASCS was based largely on the Tennessee Self-concept Scale designed by Fitts in 1965, as well as on Vrey’s own research on the ego, the self and the self-concept (Vrey & Venter 1983:2).
5.6.4.2 Content

A total of 100 different items are included in the self-concept scale, representing different components of the self-concept. Vrey (Vrey & Venter 1983:3) identified five dimensions of the self-concept, namely:

- The physical self – the self in relation to physical aspects
- The personal self – the self in its own psychological relationships
- The family self – the self in family relationships
- The social self – the self in social relationships
- The moral/ethical self - the self in relation to moral and religious norms and self-criticism

The nature of the self-concept within each dimension can be interpreted by comparing them with the average subtest scores (Vrey & Venter 1983:22).

5.6.4.3 Administration procedure

The testee is supplied with a pencil, eraser and test booklet, and is required to work as quickly as possible (although there is no time limit). Each questionnaire item requires the testee to read descriptions of two persons, A and B, and then to draw a cross on the character adjacent to the description that most closely resembles him or her. It is pointed out to the testee that A and B do not represent the same person in each item, with the result that the answer to one item should not influence the answer of another (Vrey & Venter 1983:15).

5.6.4.4 Scoring and Interpretation

A total score out of 100 will determine whether the individual has a high, medium or low self-concept. The norms for the English version of the ASCS are calculated as stanines (units on a standard nine point scale with a mean
of five and a standard deviation of two) and are as follows (Vrey & Venter 1983:23):

<table>
<thead>
<tr>
<th>Self-concept</th>
<th>Raw Score</th>
<th>Stanine</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW</td>
<td>35-44</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>45-48</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>49-52</td>
<td>3</td>
</tr>
<tr>
<td>MEDIUM</td>
<td>53-58</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>59-68</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>69-75</td>
<td>6</td>
</tr>
<tr>
<td>HIGH</td>
<td>76-80</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>81-83</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>84-95</td>
<td>9</td>
</tr>
</tbody>
</table>

5.6.4.5 Reason for administering the test

As mentioned in Section 2.2.1, eating-disordered individuals usually experience low self-esteem and feelings of ineffectiveness (Kaslow & Eicher 1988:177). Cash (1991:1) suggests that body image is linked to body satisfaction and self-esteem. Low self-esteem can therefore be seen as a risk factor for eating disorders and the assessment of the nature of self-esteem was deemed valuable.

5.6.5 The Family Functioning in Adolescence Questionnaire (FFAQ)

5.6.5.1 Introduction

The FFAQ is designed to assess the psychological health of the family as perceived by the adolescent. It is based on a model that integrates family systems research, as well as the developmental tasks of the adolescent.
The FFAQ focuses on the developmental tasks of the individual family members, as well as those of the family as a unit. The test is suitable for adolescents between 14 and 18 years (Langley 1994:1).

The balance between belonging and separateness changes as the child develops. When adolescence is reached, the cycle of family life changes in order to accommodate the adolescent’s need for greater autonomy. It appears that the family that is sensitive to the adolescent’s need for autonomy is likely to provide an environment conducive to high levels of psychological adjustment (Langley 1994:3).

5.6.5.2 Content

The family systems model consists of six dimensions that determine the healthy psychological functioning of the family. The six dimensions are as follows (Langley 1994:18):

- **Structure**
  *Structure* in the family refers to the existence of healthy models of adult authority concerning aspects such as a good marriage, a sound system of values, appropriate problem-solving strategies, self-control of anger and positive mother-adolescent and father-adolescent relationships.

- **Affect**
  *Affect* in the family refers to the way feelings are expressed. This dimension looks at whether it is acceptable to express both positive and negative feelings, as well as whether the family members are sensitive to, and supportive of, one another’s feelings. *Affect* in the family may also include aspects revolving around autonomy and connection and whether the needs of a sense of belonging, privacy, independence, trust and fair punishment are being fulfilled. Is the mother-adolescent relationship positive? Do the parents respect the adolescent’s relationships with the opposite sex? Are
they available to listen to the adolescent? Does the adolescent feel obliged to please his/her parents or is he/she free to choose the company of friends in risky situations?

• **Communication**

This dimension addresses patterns of family communication and whether messages are communicated directly and clearly and positive feedback is given. It also looks at the assertiveness levels of individuals and for evidence of appropriate problem solving.

• **Behaviour Control**

Both *inappropriate* and *democratic* behaviour controls are explored in the questionnaire. Inappropriate behaviour control refers to parenting that is either too lenient or too strict and where signs of independence from family are met with negative feedback. Democratic behaviour control refers to healthy independence from family in which participation in decision-making is encouraged and guidance regarding sexual issues and economic management is provided.

• **Value Transmission**

The way social values and ethical standards are transmitted from parents to children is explored in this dimension of the questionnaire, with special focus on *other people and religious-oriented* and *individual development-oriented* value transmission orientations. "*Other people*” values refer to respect and care for others and sensitivity to other people. “*Religious-oriented*” values refer to the development of religious values and moral behaviour. “*Individual development-oriented*” values refer to the development of abilities leading to adulthood to full potential. These abilities include both intellectual abilities and the attainment of qualifications.
• **External systems**

*External systems* refer to external boundaries of the family in its relationship with systems outside the family system. Are these external boundaries clear but permeable? Do the family members participate in sport, community life and church? Are they involved in future career planning?

5.6.5.3 **Administration procedure**

The questionnaire contains 42 statements concerning the individual and his/her family. The individual responds to each statement by selecting one of four options, namely, "almost always", "often", "sometimes" and "hardly ever", and marking the appropriate oval space on the answer form. The questionnaire takes 10 to 20 minutes to complete, but no time limit is set (Langley 1994:8).

5.6.5.4 **Scoring and interpretation**

The FFAQ is scored by means of a personal computer. The results (Langley 1994:12) can be interpreted ipsatively (intra-individually) or normatively (inter-individually). From the items of the questionnaire, six dimensions can be determined relating to one or more developmental tasks to be mastered during adolescence. A minimum score of seven and a maximum score of 28 may be obtained and stanines are determined for each of the six dimensions mentioned above. A high score indicates that the adolescent is experiencing a particular dimension of her/his family as positive (Langley 1994:32).

The stanines may be interpreted as follows (Langley 1994:41):

<table>
<thead>
<tr>
<th>Stanine score</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1, 2 or 3</td>
<td>Below average family functioning in a particular dimension</td>
</tr>
</tbody>
</table>
4, 5 or 6  Average family functioning in a particular dimension

7, 8 or 9  Above average family functioning in a particular dimension

5.6.5.5  Reason for administering the test

In Section 2.5.8, Nash (1999:67) was cited in the discussion of the link between family dysfunction and eating disorders. Other family influences that may promote the development of eating disorders include parenting that is too critical, controlling, disconnected and inconsistent, as mentioned by Killian (1994:314) in Section 2.5.5. The assessment of the psychological health of the family is likely to elicit significant information for the purpose of this study.

5.6.6  The Thematic Apperception Test (TAT)

5.6.6.1  Introduction

According to Holt (1951:182), the Thematic Apperception Test is one of the most widely used tests. The word thematic refers to the themes that the test elicits, while the word apperception refers to the perceptual-interpretative use of the pictures. Herbart (1972:15) defines apperception as “[t]he process by which new experience is assimilated to and transformed by the residuum of past experience of any individual to form a new whole. The residuum of past experience is called apperceptive mass.”

The TAT was developed by Murray and Morgan, and consists of a set of 20 black and white pictures designed to stimulate the imagination (Holt 1951:181). Each picture elicits “objective” perception, where the majority of subjects agree on the definition of a stimulus, as well as “subjective” perception that reflects the individual’s own thoughts, motives, relationships

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and wishes (Bellak & Abrams 1954:34). The perceptual reactions to the pictures give some indication of the individual's relationships and the way the world is viewed. The pictures also facilitate the exploration of specific areas of potential conflict (Holt 1951:182).

5.6.6.2 Content

The TAT explores the nature of the individual's view of the world and the various relationships, specifically with parents, other adults, children and objects. Insight is gained into the individual's characteristic interpersonal relationships (van Niekerk 1986:250).

5.6.6.3 Administration procedure

The instructions, as suggested by Murray, are as follows (Bellak & Adams, 1954:54):

"I am going to show you some pictures, one at a time; and your task will be to make up as dramatic a story as you can for each. Tell what has led up to the event shown in the picture, describe what is happening at the moment, what the characters are feeling and thinking, and then give the outcome. Speak your thoughts as they come to your mind."

Usually a standard sequence of 10 TAT cards is used, but the tester is at liberty to add additional cards deemed to be useful. As the test taker tells each story orally, so the examiner records the responses. The tester also records how long the individual takes to respond to the various pictures, whether the individual laughs or stutters and any other useful diagnostic information.

5.6.6.4 Scoring and interpretation

The tester performs an in-depth word and thematic analysis of the TAT responses and pays particular attention to various questions, as discussed by
du Toit and Piek (1974:21-24). The questions pertaining to the relevant cards for this study are as follows:

**CARD 1 – Stimulus Value – Relationship towards self**
- How is a new situation approached?
- Is the individual impulsive or reticent?
- Is it intellectual or emotional?
- Is it active or passive?
- Is the boy accepted? Are there any indications of the nature of the self-concept or of interpersonal relationships?
- Is the sex of the boy acknowledged?
- What is the individual’s attitude towards authority figures?
- How does the individual react to the demands of life?
- Is the instrument seen as a violin?
- Is success achieved?
- How is success achieved – in fantasy or reality?
- Are feelings of inadequacy evident?
- Are feelings of depression evident?

**CARD 2 – Stimulus Value – Interpersonal Relationships**
- Is the focus on interpersonal relationships, especially that of the family?
- How are interpersonal relationships between family members perceived?
- Is the environment perceived as supportive or isolating?
- Do sexual aspects come to the fore?
- Who does the individual identify with?
- Are there any indications of the nature of the self-concept?

**CARD 3 – Stimulus Value – Frustration and Aggression**
- Are there any indications of frustration or depression?
- How does the individual react to frustration?
- Is the individual aggressive or assertive?
- How does the individual perceive the revolver?
• Is there evidence of repressed aggression?
• Is aggression directed internally or externally?
• Is there evidence of preoccupation with sex?
• Are there sex role problems?

CARD 4 – Stimulus value – Male/Female Relationships
• How is the interaction between the male and female perceived?
• Is it regarded as protective or aggressive?
• Is there conflict or co-operation?
• Are themes of jealousy evident?

CARD 6GF – Stimulus value – The Father-Daughter Relationship
• What is the nature of the father-daughter relationship?
• What is the individual’s attitude towards figures of authority?

CARD 7GF – Stimulus value – The Mother-Daughter Relationship
• What is the nature of the mother-daughter relationship?
• Is the mother perceived as nurturing or critical?
• How is motherhood perceived?
• What is the individual’s attitude towards the feminine sex role?

CARD 13MF – Stimulus value – Sex Card
• What is the individual’s attitude towards male and female sexuality?
• Are sexual implications acknowledged?
• If so, how are they described?
• Are there feelings of guilt?
• Who carries the blame?
• Is there any indication of aggression toward the female figure?
5.6.6.5 Reason for administering the test

As was indicated in Section 2.3.1, Vernon-Guidry et al. (1997:24-25) identified body dissatisfaction, social pressure for thinness, low self-esteem and depression as risk factors for dieting and eating disorders. In Section 2.5.5, mention is made of the impact of family influences on developing the individual's vulnerability to eating disorders. These influences include the setting of unrealistically high expectations, over-protective or excessively controlling parenting and criticism and teasing pertaining to body shape and weight (Killian 1994:314). In Section 2.5.8, Nash (1999:67) mentions the link between family dysfunction and eating disorders, and points out that children from chaotic homes are at great risk for traumatic experiences, such as sexual and physical abuse.

Various TAT cards were thus selected in order to determine the individual's emotional state (e.g. depression, anxiety, feelings of competence), attitude regarding authority and control, interpersonal relationships within the family (especially the mother-daughter and father-daughter relationships), as well as the individual's attitude towards male and female sexuality.

5.6.7 Other Evaluation Media

During the course of the programme, various aspects of the subjects will be observed, including body language, tone of voice, attitudes and facial expressions. At the end of the programme, subjects will be requested to evaluate their own progress in terms of body image, as well as to critically evaluate the programme.
5.7 CONCLUSION

The media mentioned above will be used to determine the effectiveness of the modified version of Rosen's body image programme. Rosen's body image programme, the self-esteem programme and an analysis of the test results will be discussed in Chapter Six.
CHAPTER SIX

THE INTERVENTION PROGRAMMES AND THE PERSONAL IMAGES OF THE VARIOUS SUBJECTS

6.1 INTRODUCTION

As was mentioned in Chapter One, the researcher was given the opportunity of addressing the Grade 9 classes (aged between 14 and 16) from the targeted private girls' high school in Johannesburg. The girls were informed of the researcher's interest in body image and self-esteem, and these concepts were discussed briefly. Volunteers were requested to take part in the research study. Interested individuals were provided with letters requesting permission from their parents to participate in the study, and providing them with administrative details.

Eight individuals finally committed themselves to participating in the research study. As a result of the small number of volunteers, further measures of selection were not required. These individuals were divided at random into two groups, namely the experimental group which followed an adapted version of Rosen's intervention programme, and the control group which followed a self-esteem programme based on Anita Naik's (1998) book called "Self Esteem: Learn to believe in yourself".

The two groups met weekly for a period of nine weeks. Although the sessions were officially scheduled for a period of 1 1/2 hours, an additional half hour was provided weekly in order to discuss personal issues. This half hour took place after the official session in the case of the experimental group, and before the official session in the case of the control group.

A brief unstructured interview was held with each subject prior to the commencement of the programmes, while a battery of standardised tests was
completed. After the completion of the respective programmes, the same battery of tests was once again performed. In addition to a comparison between pre- and post-test scores, a comparison between the data of the experimental and control groups served to further clarify the effectiveness of the body image intervention programme.

While the progress of each group member of the experimental group will be discussed, the focus of the control group will be on the cumulative effect of the self-esteem programme on the group as a whole. This chapter will give a description of the nine-week body image and self-esteem programmes. It will be done in considerable detail in order to facilitate replication of the research. A personal image of each group member will follow, which will include the background history, pre- and post-test psychometric results, as well as a summary of the changes observed after the implementation of the programmes.

The pre- and post-test results of the experimental and control groups will be tabulated in order to identify both individual and cumulative effects on the groups as a whole. The comparison of the test results of the experimental and control groups will be plotted on various graphs in order to facilitate the analysis of the effect of the body image intervention programme. (Unfortunately the nature of the interpretation of the Thematic Apperception Test as applied in this research is not quantified, and therefore the comparison of test results will not include this test). Suppositions will then be tested and accepted or rejected according to the results of the respective tests.

The body image intervention programme will be discussed in the next section.
6.2 THE ADAPTED VERSION OF ROSEN'S BODY IMAGE INTERVENTION PROGRAMME

6.2.1 Changes made to Rosen's intervention programme

The various changes that were made to Rosen's intervention programme will be discussed in this section.

Rosen's body image programme was designed for college students and adults. As mentioned in Chapter Five, the researcher adapted the programme to accommodate the cognitive level of mid-adolescents. It was viewed as necessary to follow a slightly slower pace than advocated in the programme, which necessitated the inclusion of an additional session. The language used in the sessions was simplified, while additional and more age appropriate examples were used to illustrate various concepts. Greater guidance was given concerning homework exercises, and practice examples were provided.

6.2.2 Cash's (1991) audiotape series

This section will include a brief description of Cash's (1991) audiotape series.

Rosen recommends the use of an audiotape series called "Body image therapy: A programme for self-directed change" (Cash 1991), in order to supplement his programme. Cash's body image series consists of a client workbook as well as four two-sided cassettes.

The client workbook consists of exercises designed to assist the individual in self-discovery. The self-discovery exercises help to provide the necessary information required in order to complete the various activities included in Rosen's intervention programme. The exercises in the workbook also assist individuals to record their experiences and progress.
The audiotapes contain information regarding the various topics discussed in Rosen's sessions, as well as instructions pertaining to the exercises provided in his *client workbook*. Each side of Cash's audiotapes presents an overview of the information discussed in the various sessions of Rosen's programme, and thus serves as a means of reinforcing concepts and information provided during Rosen's sessions.

At the beginning of the intervention programme each member of the group was provided with Cash's *client workbook*, which was to be brought to the sessions regularly. The appropriate audiotapes that correlated with the homework exercises scheduled were issued to the subjects as the sessions progressed.

The general format of the sessions will be described in the following section.

### 6.2.3 Composition of a typical session

The duration of the sessions was an hour and a half and took place on Wednesday afternoons in the school library. Each session focussed on a specific issue. The session began with a review of the homework assignments pertaining to the work covered in the previous session. The four subjects broke up into dyads to discuss their homework assignments. The members of the dyad indicated what information they were happy to share with the group, and one of the members of each dyad reported back to the larger group.

Various topics were introduced by the researcher. The researcher posed various questions to the group in order to determine their existing knowledge. Discussion of the various issues was encouraged. The researcher then filled in the gaps or discussed misconceptions where necessary.

Various exercises in Cash's (1991) *client workbook* that were completed for homework were reviewed. Concepts and instructions were clarified, while practice examples were provided. The appropriate audiotape from Cash's
(1991) body image series was issued. Subjects were expected to listen to the required side of the tape at home, which reinforced the issues discussed during the session, and included instructions for the exercises in the client workbook.

Once the programme had commenced, it became apparent that the subjects felt the need to discuss various personal issues. Since there was a reasonable amount of material to cover during the sessions, half an hour after each session was allocated for “personal matters”. The subjects initially requested to speak to the researcher privately to discuss their problems. However, as the group members learnt to trust one another, the entire group remained for the additional half-hour. After listening to each subject’s story, the members of the group would offer their comments on that particular issue and many interesting discussions and debates materialised. The four girls in the experimental group are referred to as Subjects A – D.

6.2.4 Session 1

6.2.4.1 Goals
- Introduction of group – establishing a safe environment
- Ground rules for participation in the programme
- Introduction of the following topics:
  - Definition of body image
  - Relationship between physical appearance and body image
- Overview of exercises to be completed at home

6.2.4.2 Activities

a) Introduction of the group
Each member of the group introduced herself by coupling an adjective with her name that started with the same initial letter as her first name. Thereafter, the subject explained why she had chosen to participate in the programme, and discussed her expectations.
b) **Ground rules for participation in the programme** (Rosen 1995:3):

(i) Attendance of all sessions is essential.

(ii) Should a subject not be able to attend a particular session for any reason, then it is the responsibility of that individual to inform the rest of the group and to reschedule the session.

(iii) Practice of learnt concepts in-between sessions is required as well the completion of homework exercises.

(iv) Workbooks and diaries are to be brought to each session.

(v) All matters discussed in the group are to be kept confidential.

c) **Introduction of various topics**

The method used for discussing various topics (as mentioned in Section 6.2.3) applies to all sessions. After the introduction of the topics, the researcher posed various questions in order to determine the existing knowledge of the group. The researcher then aimed to fill in the gaps or to discuss misconceptions where necessary. Discussion of issues raised was encouraged. The topics that were discussed in the various sessions will be mentioned briefly.

The topics discussed in Session 1 include a definition of body image and the implications of poor body image, as well as the relationship between physical appearance and body image. The researcher also initiated a discussion on the social rewards for physical beauty as well as the health risks of obesity and extreme leanness (see Appendix (vi) for details).

d) **Overview of exercises to be completed at home**

Subjects were issued with the appropriate audiotape (as explained in Section 6.2.2), while the instructions for the respective exercises to be completed for homework were reviewed and clarified. The homework exercises included the following:

(i) *My body and body experiences* (Exercise 1 – see Appendix (ii))

This exercise involves the exploration of bodily characteristics and significant events and experiences related to the body that took place during the following periods of the individual's life:
• Early childhood (up to age seven)
• Later childhood (before puberty)
• Early adolescence (especially during puberty)
• Mid-adolescence (Rosen's programme includes further developmental phases)

(ii) *My body area satisfaction scale* (Exercise 2 – see Appendix (iii)).
Using a scale of 1 to 5, subjects are expected to indicate how satisfied they are with various body parts.

(iii) *The situational inventory of body-image distress* (Exercise 3 – see Appendix (iv)).
Subjects are to indicate how often they experience negative thoughts or feelings about their physical appearance in the various specified situations, using a scale from 0 to 4.

(iv) *Body-image automatic thought questionnaire* (Exercise 4 – see Appendix (v))
Subjects are expected to indicate how frequently various thoughts concerning personal appearance have popped into their heads over the previous week, having been prompted by various situations. Frequency is indicated along a scale from 0 to 4.

(v) *The body image self-monitoring diary* (Exercise 5)
The A-B-C sequence was explained to the group. Various examples were given in order to demonstrate how certain events and situations (antecedents) trigger various beliefs and thoughts, resulting in various emotions being experienced and influencing behaviour. The intensity of the emotion experienced was rated from 0 to 10.
6.2.4.3 Responses of individuals

The following responses include the adjectives chosen by the subjects to describe themselves. The names used are fictitious, but have similar initial letters as their real names. The responses also include the reasons for wishing to participate in the research study, as well as the feedback concerning the homework exercises 1 to 5, as reported in Session 2:

Subject A:

Chosen adjective:
Subject A referred to herself as “Bashful Bronwyn” and explained how self-conscious she was when having to address a large group of people.

Reasons for wanting to participate in the group:
Subject A indicated that she was extremely self-conscious about her big hips, buttocks and thighs, as well as her facial hair and acne. She was hoping that the programme would help her to be more accepting of herself, to be more outgoing and give her the confidence to attend pool parties.

Feedback concerning the homework exercises 1 to 5:
Example of a significant incident relating to physical appearance:
Rather than one specific event, Subject A explained how repeated negative comments from her grandmother (e.g. “I would not wear my skirt so short if I were you” or “Trousers do not become you”) initiated her examination of and preoccupation with her body.

Example of a situation that evokes bodily distress:
Comments from her brother concerning her bodily hair (e.g. “The moustache is coming on well, let me know when your voice breaks”) were hurtful and made her even more self-conscious.

Example of an automatic thought relating to personal appearance:
Subject A related how whenever she had to read a passage from the Bible at church, she would imagine that the whole congregation would be studying her legs and judging her lack of willpower to lose weight.

Example of behaviour as a result of the thought:
The thought would make her feel ashamed and anxious. Her stomach would turn and she would stutter and stumble over her words as she read.

**Subject B:**

*Chosen adjective:*

Subject B referred to herself as “Mini Mary” which obviously referred to her height.

*Reasons for wanting to participate in the group:*

Subject B is a late developer and complained about feeling different as a result of the delay in her breast development. She was also self-conscious about having to wear dental braces. Subject B hoped that the programme would help her to accept her body more and give her the confidence to be able to enjoy her rowing without having to wear a shirt to cover her “chest”.

*Feedback concerning the homework exercises 1 to 5:*

*Example of a significant incident relating to physical appearance:*

Over the past year or two, Subject B’s brother had teased her a great deal about being “flat-chested” (e.g. “I don’t know why you bother to wear the bikini top”).

*Example of a situation that evokes bodily distress:*

Matters came to a head when Subject B first became intimately involved with her boyfriend. She made the following comment, “I freaked when he tried to touch my breasts, mostly because I do not have any, and then I could not even kiss him properly with these horrid braces!”

*Example of an automatic thought relating to personal appearance:*

Subject B became anxious every time her boyfriend explored her body, fearing that he would be disappointed and put off by her perceived immaturity.

*Example of behaviour as a result of the thought:*

She would tense and grab onto her boyfriend’s hands, which was interpreted by him as a sign of rejection.

**Subject C:**

*Chosen adjective:*

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Subject C referred to herself as "Careless Carol", a nickname her mother had given her as a little girl when she frequently bumped into tables knocking things over.

Reasons for wanting to participate in the research study:
Subject C mentioned that she is extremely self-conscious about being overweight, and feels "larger than life". She hoped that after the completion of the programme that she would be able to walk down the street with her mother ("who is anorexic") and her sister ("who is like a bean-pole") without everybody turning to look. I imagine them thinking, "Where does she come from? Look at the difference in size!"

Feedback concerning the homework exercises 1 to 5:
Example of a significant incident relating to physical appearance:
Subject C complained that as a little girl her half-sister used to refer to her as the "fat rat", which was extremely hurtful.

Example of a situation that evokes bodily distress:
Subject C’s mother (who was diagnosed as being anorexic) would study her nude body in the mirror and comment on how fat and flabby she was. The situation would trigger the process of comparison. Subject C would compare her overweight body with her mother’s slim figure, which resulted in distress.

Example of an automatic thought relating to personal appearance:
Subject C made the following comment, "I used to think, well if she’s fat and flabby, I must be enormous and disgusting!"

Example of behaviour as a result of the thought:
The idea of being overweight would cause Subject C to feel upset and depressed about her appearance, resulting in withdrawal.

Subject D:

Chosen adjective:
Subject D referred to herself as "Flabby Fiona" and mentioned that her father constantly tried to lure her to the gym in order to firm up her body.

Reasons for wanting to participate in the research study:
Subject D indicated that she was terribly self-conscious about her big waistline and her "revolting, flabby stomach". She also "detested" her nose,
and couldn't wait until she was 18 so that she could have the bump removed that worried her so. Subject D hoped that after the completion of the programme she would have the confidence to wear "cropped tops" instead of wearing loose shirts over her trousers, and to be able to go to the beach.

Feedback concerning the homework exercises 1 to 5:

Example of a significant incident relating to physical appearance:
Subject D's brother and father constantly tease her about her "spare tyre" resulting in the development of self-consciousness regarding her weight.

Example of a situation that evokes bodily distress:
Subject D experienced bodily distress when exercising at the gym where she is surrounded by a high proportion of slim bodies.

Example of an automatic thought relating to personal appearance:
"When I look at all the slim bodies around me, I think 'wow, I'm fat and ugly'. Others must feel disgusted when they see my body."

Example of behaviour as a result of the thought:
Subject C tends to avoid going to the gym, beach and beach parties so as to avoid the distress triggered by these situations.

6.2.4.4 Evaluation of Session 1

The group members appeared to be particularly interested in the topics discussed. All members of the group participated in the discussions. However, they appeared to be reasonably inhibited when it came to talking about their own appearance and feelings. After the session, two girls approached the researcher and expressed their fears about being able to trust one of the group members. The researcher reassured the girls that intimate matters were discussed within the dyad, and that the individual had the opportunity to screen information that was to be reported back to the group as a whole.
6.2.5 Session 2

6.2.5.4 Goals

• Feedback on homework exercises
• Introduction of the following topics:
  Identifying body image disorder
  Factors contributing to body image problems
  Factors that maintain body image problems
  Issues pertaining to weight loss efforts
  Consequences of other appearance change efforts
• Goals of the programme
• Overview of exercises to be completed for homework

6.2.5.5 Activities

(a) Feedback of homework exercises
Subjects referred to their client workbooks and shared the following with the
group: an example of a significant incident relating to physical appearance,
one situation that evokes body-image distress, one example of an automatic
thought that frequently “pops” into their heads relating to personal
appearance, and an example of behaviour which results from the feelings of
distress. (These responses have been mentioned in Section 6.2.4.3).

(b) Introduction of various topics
The researcher discussed the following topics with the group, namely when
poor body image is to be viewed as a problem, factors that contribute to and
maintain body image problems, issues pertaining to weight loss efforts and
consequences of other appearance change efforts (see Appendix (vii) for
details).
(c) Goals of programme (Rosen 1995:3-8)
The researcher discussed the goals of the programme with the subjects. The goals are:

- To change the way one views oneself physically, no matter what one's physical reality may be;
- To identify negative self-defeating thoughts and beliefs that cause negative body image;
- To identify the events, situations or people that trigger negative self-talk;
- To identify the self-defeating behaviours that occur as a result of the negative self-talk;
- To challenge, dispute and correct negative self-talk and the beliefs that cause negative body feelings;
- To identify and correct cognitive errors in daily life;
- To change self-defeating behaviours (such as avoidance and preoccupied rituals). Skills necessary for this process include:
  (a) Relaxation techniques – the goal is to replace the state of distress associated with physical appearance with a state of relaxation
  (b) Systematic desensitisation skills – the goal is to minimise distress resulting from physical appearance;
- To replace negative attitudes towards the body with positive ones – to learn skills to enhance one's appearance, fitness, bodily sensory experiences and creative activities;
- To prevent relapse.

(The programme does not suggest that individuals need to "accept" being at their current weight forever, nor does it encourage or discourage weight reduction for health reasons. Individuals may choose to improve body image both from the inside and from the outside simultaneously).

(d) Overview of exercises to be completed for homework

(i) Body image hierarchies (Exercise 6)
Exercise 2 (body area satisfaction scale), Exercise 3 (situational inventory of body-image distress) and Exercise 5 (self-monitoring diary) are required in order to complete this exercise.

Subjects are expected to use the above in order to rank body areas that evoke distress in descending order.

Events or situations that are typically associated with negative body image are also to be ranked in descending order.

(ii) Body and mind relaxation log (Exercise 7)
The researcher demonstrated the relaxation exercise from Cash's (1991) audiotape series (Side 3) that teaches relaxation skills, which includes progressive muscle relaxation, controlled breathing, constructive imagery and verbal self-instruction. The relaxation exercise was to be practised twice daily for the remainder of the week. Subjects were expected to monitor and record the depth of their relaxation (see Appendix (viii) for details).

6.2.5.6 Responses of individuals

In the following session the subjects shared the details of the homework exercise (Exercise 6). The responses pertaining to the five areas of body dissatisfaction and five situations that trigger distress relating to appearance are:

Subject A:

Personal body-image hierarchy in descending order:
- Acne
- Big legs
- Body hair
- Big buttocks
- Big hips

Antecedent situations in descending order:
- Being in a bathing costume
- Standing in front of a crowd (e.g. congregation)
• Being in the company of boys
• Posing for photographs
• Attending physical education classes

**Subject B:**

*Personal body-image hierarchy in descending order:*
• Small breasts
• Dental braces
• Undefined hips
• Short height
• Funny toes

*Antecedent situations in descending order:*
• Being intimate with boyfriend
• Wearing tight-fitting clothes
• Sun-bathing
• Swimming galas
• Posing for photographs

**Subject C:**

*Personal body-image hierarchy in descending order:*
• Fat stomach
• Fat thighs
• Fat buttocks
• Freckles on face
• Frizzy hair

*Antecedent situations in descending order:*
• Being on the beach
• Standing in front of people in revealing clothes
• Looking in the mirror
• Eating in front of thin people
• A significant person focusing on my appearance
Subject D:

Personal body-image hierarchy in descending order:
- Flabby stomach
- Big hips
- Flabby arms at the back
- Crooked teeth
- Bump on nose

Antecedent situations in descending order:
- Gym
- Beach
- Pool parties
- Eating in front of people
- Standing in front of people

6.2.5.7 Evaluation of Session 2

The subjects were initially a little inhibited to talk about their body dissatisfaction, and required encouragement from the researcher. The individuals participated actively in the session, and were particularly excited about learning the relaxation exercise.

6.2.6 Session 3

6.2.6.4 Goals

- Feedback on homework exercises
- Introduction of various topics:
  - Explanation of desensitisation process
  - Body image perception and objective feedback about appearance
  - Role of beliefs in body image
- Demonstration of distorted perception of physical appearance
- Role play exercise dealing with the acceptance of compliments
- Review of exercises to be completed for homework
6.2.6.5 Activities

(a) Feedback on homework exercises
The homework exercises on the body image hierarchies (Exercise 6) and the body and mind relaxation exercise (Exercise 7) were reviewed. All subjects were able to complete the personal body image hierarchies successfully, and were all able to perform the relaxation exercise without requiring the assistance of the tape. (Responses to Exercise 6 are found in Section 6.2.5.3).

(b) Introduction of various topics
In order to understand why desensitisation skills were being taught, the theory behind the desensitisation process was briefly explained. The researcher also discussed body distortion and the role played by wrong, faulty or irrational (problematic) beliefs in triggering a chain of events (see Appendix (ix) for details).

(c) Demonstration of distorted perception of physical appearance
(Rosen 1995:15)
Various activities were performed in order to bring about awareness of distorted perception amongst the subjects. These include:
1. Members of the group being asked to estimate their size after which measurements were taken in order to reveal the distortion.
2. The actual weight of the individuals was compared with that of the weight norms used for insurance purposes to demonstrate over-emphasis on weight.
3. First impression exercise – members of the group were to reveal their initial impressions of one another. The tendency to view individuals as a whole instead of focusing on a particular feature was demonstrated.

(d) Role play exercise dealing with the acceptance of compliments
(Rosen 1995:14)
Group members were expected to be genuine and to compliment one another, while the recipients were encouraged to accept the compliment. In
order to assist individuals to believe the compliment, verbal acceptance of the compliment was encouraged. (The rehearsal of positive feedback is believed to be helpful in challenging negative beliefs).

(e) **Review of exercises to be completed at home**

(i) **Body and mind relaxation exercise**
Subjects were expected to practice the body and mind relaxation exercise until they were able to calm themselves successfully in a couple of minutes, using slow breathing, positive imagery and pleasant self-instruction.

(ii) **Desensitisation**
The researcher demonstrated the *imaginal desensitisation process to the group.* Subjects were then expected to listen to Side 4 of Cash's (1991) body image therapy tapes concerning the basic steps of desensitisation, and to complete the respective desensitisation exercises for homework, namely *imaginaal body areas desensitisation* (Exercise 8) and *mirror desensitisation* (Exercise 9 - see Appendix (x) for details).

6.2.6.6 **Responses of individuals**

Whilst performing the activities as described in Section 6.2.6.2 (c), the subjects identified examples of distorted perception. They are:

**Subject A:**
Subject A over-estimated the size of her hips and thighs a great deal. She imagined that she was much larger than Subject C, and was amazed to discover that their measurements were very similar.

**Subject B:**
Subject B was convinced that attention was directed at her "chest". The feedback from the group suggested that attention was directed at her body as a whole. The girls perceived her to be "compact and cute".

**Subject C:**
Subject C also over-estimated her size, especially that of her waist, hips and buttocks. Whilst the group acknowledged that they initially looked at her whole body, they soon found themselves focusing on her beautiful face.
Subject D:
Subject D was convinced that when individuals looked at her, their focus was on her nose. While two of the girls felt that Subject D’s nose had character and was in no way unattractive, the third girl felt that her attention was drawn to Subject D’s deep blue eyes and long eyelashes.

6.2.6.7 Evaluation of Session 3

The subjects grasped the process of desensitisation. The girls enjoyed challenging one another regarding over-estimation or distortion of body shape and weight, participating happily in the role-playing exercise concerning the acceptance of compliments. However, there was a tendency to discount positive feedback regardless of the counter arguments.

6.2.7 Session 4

6.2.7.4 Goals

• Feedback on homework exercises
• Introduction of the following topics:
  Overview of cognitive therapy
  The 12 types of cognitive errors (as discussed on Side 5 of Cash’s (1991)
  body image therapy tapes)
  Appearance assumptions
  The process of cognitive restructuring
• Review of exercises to be done for homework

6.2.7.5 Activities

(a) Feedback on homework exercises
All subjects reported having made progress in terms of the time taken to achieve deep relaxation. While no difficulties were experienced applying the desensitisation exercise for *imaginal body areas*, Subjects A and C both felt
extremely embarrassed performing the mirror desensitisation exercise, especially without clothes, even though they were alone. It was suggested that the subjects used props to carry out the exposure (e.g. brushing hair or performing some grooming behaviour while doing the mirror exposure. Having a reason to look in the mirror is likely to reduce the self-consciousness).

(b) Introduction of the following topics
The researcher gave a brief overview of the principles of cognitive therapy, and the techniques used by Rosen and Cash. She then explained the process of challenging problematic ideas and replacing the negative self-talk with positive thoughts (cognitive restructuring). These ideas appear to be a reworking of Aaron T. Beck's idea of cognitive distortions, and the principles of Ellis's rational-emotive therapy (RET). Twelve types of cognitive errors and various appearance assumptions were also discussed (see Appendix (xi) for details).

(c) Review of exercises to be done for homework
(i) Body and mind relaxation exercise
• Practise as needed.
• You are expected to be in a state of deep relaxation within five minutes simply by means of slow breathing, positive mental imagery, or pleasant self-instruction.

(ii) Mirror desensitisation with and without clothes
• Repeat the mirror desensitisation exercise once more (as indicated in Appendix (x)).

(iii) Body image desensitisation of antecedent situations (Exercise 12)
• Follow the desensitisation process (as described in Appendix (x)) with the hierarchy of antecedent situations as determined in Exercise 6 (see Session 1).
• Record the progress.
(iv) The cognitive errors worksheet (Exercise 10 – see Appendix (v))
- Listen to Side 5 of Cash's (1991) body image therapy tapes, where 12 scenarios are described which illustrate important cognitive errors in thinking concerning the body or appearance.
- Indicate how much the respective cognitive errors apply to you, using a scale from 0 to 4.

(v) Corrective thinking worksheet (Exercise 11 – see Appendix (v))
- The A-B-C-D process (as discussed in Appendix (xi)) was explained. The researcher provided a number of practice examples, before the subjects completed Exercise 11 orally during the session.
- The subjects were then requested to complete an example of the A-B-C-D process in their client workbook for homework (see Section 6.2.4.2 for the responses).

(vi) Corrective thinking diary (Exercise 13)
- The corrective thinking diary worksheet was used to complete another example of the A-B-C-D process.
- Individuals were requested to go one step further and to include the effects of corrective thinking on emotions (E – consequences of corrective thinking. See Section 6.2.7.3 for the responses as shared during the following session).
- Examples of self-defeating thoughts and corrected thinking were to be recorded in the diary on a daily basis, and examples brought to the next session.
- To get more out of the exercise, individuals were requested to tape themselves saying the corrective thoughts, and to listen to the tape-recording daily.

6.2.7.6 Responses of individuals
The following are examples of the A-B-C-D process, as provided by the subjects while completing Exercise 11, as well as the responses of the
homework exercise 13, concerning the consequences of the corrective thinking (E) as shared during the following session.

**Subject A:**

*Cognitive error type:* The Magnifying Glass / Mind Mis-reading / The Blame Game / Misfortune Telling / The Blind Mind

A – *Antecedents:* My brother’s friend studies my face.

B – *Beliefs:* My skin must be really bad and off-putting. If my skin is bad then I must look ugly. He won’t be interested in me because of my looks.

C – *Consequences:* I feel hurt and rejected. I withdraw.

D – *Disputing:* When someone studies my face it does not mean that they find me unattractive. When my skin is bad it does not mean that I am totally ugly. My skin is only part of my body. I have pretty eyes and other attractive features.

E – *Consequences of corrective thinking:* “I feel a little less self-conscious about my skin, and judged less by my appearance.”

**Subject B:**

*Cognitive error type:* Mind Mis-reading / Misfortune Telling / The Blame Game

A – *Antecedents:* At a party, a handsome boy asks my friend whether I am her little sister.

B – *Beliefs:* He has noticed my flat chest. He sees me as a little girl, unappealing. He will not be interested in dating me because I look like a little girl.

C – *Consequences:* I feel unattractive and unwanted.

D – *Disputing:* The suggestion that I look young for my age does not mean that the focus has been on my flat chest. Some boys may find tiny people attractive.

E – *Consequences of corrective thinking:* “My flat chest does not embarrass me as much. It is not such a big deal.”

**Subject C:**

*Cognitive error type:* Feeling ugly / Moody Mirror

A – *Antecedents:* My peers tease me about my weight.

B – *Beliefs:* I am ugly. I am fat. I have a disgusting stomach.
C – Consequences: I feel fat and revolting. I am disgusted with myself. I want to hide.

D – Disputing: In terms of attractiveness, I am above average. I am a healthy weight. I have a full stomach.

E – Consequences of corrective thinking: “I feel better about my looks and feel more self-assured.”

Subject D:

Cognitive error type: Beauty or Beast / Unfair to Compare / The Unreal Ideal / Feeling Ugly

A – Antecedents: I attend a gym class. The instructor is thin and beautiful and so are the girls around me.

B – Beliefs: I am grossly overweight. I am ugly. Everybody else is slim and attractive.


D – Disputing: Being extremely thin is not necessarily healthy. It is unfair to compare myself only with the beautifully groomed girls at the gym. I am not thin but that does not mean that I am grossly overweight.

E – Consequences of corrective thinking: “I do not feel so ugly and worthless when I compare myself to all the girls in my grade.”

6.2.7.7 Evaluation of Session 4

The subjects were able to follow the steps of the ABC process, and to establish which thoughts and beliefs determined the way they felt and acted. With the assistance of the group, they were able to dispute the beliefs or negative thoughts. The subjects required a great deal of guidance concerning the corrective thinking process.

The subjects reported that they found the discussion on the 12 types of cognitive errors extremely valuable, resulting in an awareness of various erroneous thinking processes. The discussion on the appearance assumptions enabled the subjects to identify their own assumptions. In
addition, the subjects found it comforting to discover that they all were guilty of making various appearance assumptions.

6.2.8 Session 5

6.2.8.4 Goals

- Feedback on homework exercises
- Lead discussion on various topics:
  - Stereotypes and prejudice
  - Stress inoculation
  - Other reasons for social discomfort
  - Positive appearance management, fitness and sensory activity
- Review exercises to be completed for homework

6.2.8.5 Activities

(a) Feedback on homework exercises
All subjects made progress regarding body and mind relaxation, and took less time to reach a state of relaxation. With regard to the mirror desensitisation, some of the subjects struggled to change the habit of focusing immediately on body areas that upset them, resulting in negative self-talk. The subjects were reassured that negative self-talk required over-rehearsal and would not disappear overnight. Negative statements should be viewed as cues to rehearse the neutral self-talk. Subjects were able to identify their negative self-talk and to construct appropriate alternate beliefs (as indicated in Section 6.2.7.3).

(b) Introduction of various topics:
(i) Stereotypes and prejudice (Rosen 1995:22)
Subjects were requested to give examples of stereotypes (e.g. obese people are often seen as being lazy and lacking in will power). They were then asked to give examples to counter the stereotype (e.g. a real life example of
an obese woman who is not only an efficient manager, but who also plays provincial squash). Subjects were encouraged to offer their own suggestions concerning how to deal with discrimination, and then to discuss the various suggestions offered by Rosen (see Appendix (xii) for details).

(ii) **Stress inoculation** (Rosen 1995:22)
The researcher discussed the importance of preparing oneself ahead of time with a strategy to counter the automatic thoughts and feelings that typically cause distress in certain situations. Subjects were encouraged to examine their records regarding situations that elicit negative thoughts and to determine the commonalities. Subjects provided an example of a situation that typically elicits body image distress. They then imagined the situation (taking note of the feelings experienced), and suggested appropriate corrective body talk considered helpful in minimising the discomfort.

(iii) **Other reasons for social discomfort** (Rosen 1995:22)
The researcher emphasised the importance of differentiating between physical discomfort and social discomfort. In certain instances, body image complaints may serve to detract from the real problems (such as lack of interpersonal skills). Careful consideration is necessary in order to determine whether the focus of the work should be on body image or interpersonal skills.

(iv) **Positive appearance management, fitness and sensory activity** (Cash 1991:Side 7)
The researcher explained that the physical body is far more than what one looks like. The body enables individuals to be creative, to perform various physical activities, and to experience various sensations (see Appendix (xii) for details). Individuals who are preoccupied with physical appearance tend to ignore or minimise the abovementioned activities where satisfaction and pleasure may be derived from the body.

The researcher discussed the benefits of grooming (through the use of clothes and cosmetics) in terms of producing both a sense of accomplishment and a sense of pleasure. She also described the characteristics of the three
types of groomers (see Appendix (xii) for details). The girls then identified which category of groomer they perceived themselves to fall into (see Section 6.3.5.3 for the responses).

(c) Review of exercises to be completed for homework

(i) Continue with "corrective thinking diary" everyday – rate believability of each disputing thought.

(ii) Listen to the tape-recording made the previous week regarding corrective thinking (see Section 6.2.7.2 c (vi)).

(iii) *Body-related activities inventory* (Exercise 14 – see Appendix (xiii))

- Listen to Side 7 of Cash’s body image therapy tapes.
- Complete the *body-related activities inventory* by indicating how often you have been engaged in the various activities mentioned in the questionnaire over the past month.
- Indicate whether feelings of mastery or pleasure were experienced.

(iv) *Body enhancement activity schedule* (Exercise 15).

- Plan a different body related activity that will enhance your bodily experience (of mastery or pleasure or both) for every day of the week.
- Include activities that are not normally performed.
- Choose activities that represent appearance, fitness and sensory enhancement fairly equally.
- Record the activities in the *body enhancement activity schedule*.
- Rate the level of mastery or pleasure on a scale from 0 to 4.

6.2.8.3 Responses of individuals

The subjects shared their perception of themselves in terms of grooming. They also discussed examples of activities that enhanced their bodily experiences.
Subject A:
Grooming category: Subject A explained that she was a “flexible” groomer on her good days, and would try to make the most of herself. However, when her skin was bad, she would do no more than wash her face and take her medication. “When I look at my skin, I feel so ugly that I think there’s no point using make-up or trying to do something special with my hair.” On “bad” days Subject A perceived herself as being an “avoidant” groomer.
Examples of body enhancing activities:
- Tennis
- Using perfume
- Rubbing her body with lotion

Subject B:
Grooming category: Subject B perceived herself as being both a “preoccupied” and “flexible” groomer. “I am always conscious of my flat chest. I wear loose tops to hide it instead of the fashionable tight cropped tops. I do make an effort to look my best.”
Examples of body enhancing activities:
- Rowing
- Playing the guitar
- Having a hot bubble-bath

Subject C:
Grooming category: Subject C identified herself as a “preoccupied” groomer. “It takes me forever to get ready when I go out. I keep changing my outfit, because nothing looks good on me.”
Examples of body enhancing activities:
- Walking the dog
- Wearing jewellery
- Wearing new clothes
Subject D:

*Grooming category:* Subject D felt that she was an “avoidant” groomer. “I try to justify to myself that it is the inside that counts. The truth is that I still feel ugly after having made an effort to look my best. It is depressing, so I try not to focus on my appearance.”

*Examples of body enhancing activities:*

- Being out in nature – e.g. watching a sunset
- Having my hair washed
- Soaking in a hot bath

**6.2.8.4 Evaluation of Session 5**

All subjects participated actively in the various discussions, providing suggestions to counter stereotypes. They were able to construct appropriate corrective body-talk in order to minimise the body-related distress. The exercises pertaining to *grooming* and *body-related activities* were useful in terms of self-discovery.

**6.2.9 Session 6**

**6.2.9.1 Goals**

- Feedback on homework exercises
- Introduce discussion on the following topics:
  
  Behavioural aspects of body image
  Consequences of avoidance and body checking
  Overcoming avoidance behaviours
  Overcoming body checking and reassurance seeking
- Defeating self-defeating body-image behaviours (Exercise 16)
- Review exercises to be completed at home
6.2.9.2 Activities

(a) Feedback on homework exercises
Subjects experienced no difficulty completing Exercise 14 (body-related activities inventory) and Exercise 15 (body enhancement activity schedule for appearance, fitness and sensory enhancement) as discussed in Section 6.2.8.2 (c) (iii) and (iv).

(b) Introduction of various topics:
The researcher explained how a negative attitude towards one's appearance affects one's behaviour. Various forms of behaviour determined by negative body image, particularly that of avoidance, body checking and reassurance seeking were discussed. The consequences of the abovementioned behaviours were highlighted, and methods to overcome avoidance, body checking and reassurance seeking were suggested (see Appendix (xiv) for details).

(c) Demonstration of “Defeating self-defeating body image behaviours”
The subjects were guided through the process of “facing it” and “erasing it” in preparation for the homework exercises.

(i) Avoidance behaviour (facing it) (Rosen 1995:24)
The researcher guided the subjects through the following steps:
• Take out the Defeating self-defeating body image behaviours worksheet (Exercise 16 – see Appendix (xv)).
• Write down two activities or situations avoided and two preoccupation rituals (including body checking and reassurance seeking) on your worksheets. (The subjects shared these responses, seen in Section 6.2.9.3).
• Follow the process of “imaginal rehearsal of exposure”. (The subjects were guided through this process as described in Appendix (x)).
• Close your eyes and imagine yourselves in one of the avoidance situations as recorded in the worksheet.
• Describe the automatic thoughts or behaviour that might normally occur.
• Construct a plan that will enable you to “face” the situation that was previously avoided.
• Record the plan (involving corrective thinking and change of behaviour) in your worksheet.
• Rehearse the plan.

(ii) Preoccupied compulsive rituals (erasing it) (Rosen 1995:24)
The researcher guided the subjects through the process of “erasing it”.
• Close your eyes and imagine an example of a repetitive body checking ritual as recorded in your worksheet. Take note of the thoughts, feelings and expected reactions.
• Create an appropriate strategy in order to prevent a ritual from starting or to interrupt it once it has begun.
• Rehearse this plan.

(iii) Instructions for homework exercise (Exercise 16 – see Appendix (xv))
• Execute the respective plans for “avoiding avoidance by facing it” and “preventing a body-image preoccupation ritual by erasing it” for homework.
• Record the results.
• Use the learnt relaxation skills (see Appendix (viii)) in order to minimise the distress experienced while “facing” or “erasing” various behaviours.
• Reward yourselves for your efforts.

(d) Review of exercises to be completed at home
(i) Corrective thinking
Continue with “corrective thinking”, trying to increase the believability of your positive adaptive beliefs. The aim is to prepare you with corrective thinking prior to encountering stressful body image situations.
(ii) **Body enhancement activities**
Continue to practice *body enhancement activities* and record the progress.

(iii) **Affirming activities**
Listen to Side 7 of Cash's (1991) body image therapy tapes in order to gain an overview of “affirming activities”.

(iv) **“Facing it” and “Erasing it”**
As mentioned in Section 6.2.9.2 (b), execute at least one “facing it” and one “erasing it” behaviour change plan, and record the results using the “Defeating self-defeating body image behaviours” worksheet (Exercise 16 – see Appendix (xv)).

6.2.9.3 **Responses of individuals**
The subjects shared examples of avoidance behaviour and preoccupation rituals in Section 6.2.9.2 (c). They are as follows:

**Subject A:**

*Examples of avoidance behaviour:*
- Avoid wearing a bathing costume in public
- Avoid standing in front of a group of people

*Examples of preoccupation rituals:*
- Adjust the peak of my cap in an attempt to hide my face
- Study my reflection in shop windows or mirrors

**Subject B:**

*Examples of avoidance behaviour:*
- Avoid wearing tight-fitting clothing
- Avoid posing for photographs

*Examples of preoccupation rituals:*
- Always lie on my stomach when I sun-bathe
- Twirl my hair when I am anxious
Subject C:

Examples of avoidance behaviour:
• Avoid wearing revealing clothes
• Avoid eating in front of thin people

Examples of preoccupation rituals:
• Continually ask the opinion of others concerning appearance
• Weigh myself compulsively

Subject D:

Examples of avoidance behaviour:
• Avoid going to the gym
• Avoid looking at myself in the mirror

Examples of preoccupation rituals:
• Compare myself with models in magazines
• Look down at my feet when having to walk past a group of boys

6.2.9.4 Evaluation of Session 6

Subjects participated actively in the discussion concerning the behavioural aspects of the body and ways to overcome behaviour avoidance, body checking and reassurance. The subjects grasped the process of “facing it” and “erasing it” which was to be completed for homework.

6.2.10 Session 7

6.2.10.1 Goals

• Feedback on homework exercises
• Discussion of the following topics:
  Ideas for controlling checking behaviour
  Seeking reassurance is self-defeating behaviour
  Debriefing of negative body-image experiences
  Introduction of affirming activities
• Review of exercises to be completed at home

6.2.10.2 Activities

(a) Feedback on homework exercises
Subjects reported that their positive, adaptive beliefs were becoming more believable with practice. They also reported that the "body enhancement activity" exercise brought about a greater awareness of the pleasures that their bodies could provide. The subjects were all able to devise coping strategies in order to help them through the exposure exercises and to control anxiety relating to their appearance.

(b) Discussion of various topics:
The researcher discussed the ideas suggested by Rosen (1995:24) to control "body checking" behaviour. The subjects were encouraged to generate further suggestions. The motives behind "seeking reassurance" behaviour were discussed, and the negative consequences were highlighted. The researcher discussed various activities suggested by Cash (1991:Side 7), which may be useful in fostering positive body image feelings (see Appendix (xvi) for details). Subjects were cautioned to have realistic expectations concerning the body image programme. It was pointed out that change is a gradual process and that lapses are to be expected.

(c) Review of exercises to be completed at home
(i) Body enhancement activities
Practice your body enhancement activities for appearance, fitness and sensory enhancement.

(ii) "Facing it" and "Erasing it" activities
Execute an additional plan for "facing it" and "erasing it". Record the progress using the Defeating self-defeating body image behaviours worksheet.
(iii) **Affirming activities**

Listen to Side 7 of Cash's (1991) body image therapy tapes and complete the affirming activities (Exercise 17, as discussed in Appendix (xvi)).

(iv) Listen to Side 8 of Cash's (1991) body image therapy tapes in order to gain an overview of preventative maintenance.

### 6.2.10.3 Responses of individuals

In the following session, subjects were requested to share a "facing it" or "erasing it" plan, as described in Section 6.2.10.2 (c) (ii). The responses are:

**Subject A:**

**PREVENTING A BODY-IMAGE PREOCCUPATION RITUAL BY ERASING IT**

- **Preoccupation ritual:** I cannot help studying myself in shop windows and mirrors.
- **Plan:** I will go shopping for a gift without looking at myself in the shop window.
- **Behaviour:** When I become aware of myself studying my reflection, I will say "STOP" and look the other way.
- **I will tell myself the following:**
  - I look good. My skin is O.K.
  - I do not have to check to see how noticeable my spots are.
  - Many teenagers have spots.
  - I am not ugly because I have spots.
  - People look at me as a whole – they do not focus only on my skin.
- **When I feel anxious** I will imagine myself sitting in a garden – looking at the beautiful coloured flowers, smelling the lovely perfume and listening to the birds that are so happy and filled with peace and calm.
- **I will reward myself for my courage and willpower by using some of my expensive perfume that I keep for special occasions.**
Subject B:

AVOIDING AVOIDANCE BY FACING IT

- Activity or situation avoided: I hide my chest by wearing baggy clothes or sunbathing on my stomach.
- Plan: I will walk around in my bathing costume at the following rowing event without wearing a shirt to cover myself.
- I will tell myself the following:
  I have a good figure.
  I am a late developer – my breasts will develop in time.
  Nobody is perfect.
  People are too vain to be focussing on my chest.
- When I feel anxious or self-conscious I will focus on my breathing exercise to relax me. I will tell myself that I am strong and that I can do this.
- I will reward myself for my courage and willpower by having my favourite ice cream.

Subject C:

AVOIDING AVOIDANCE BY FACING IT

- Activity or situation avoided: I avoid eating in public especially in front of thin women.
- Plan: I will invite two of my slim girlfriends to have lunch with me at a restaurant. I will eat a healthy meal but will allow myself to have a small milkshake.
- I will tell myself the following:
  People are too busy to study what I am eating.
  My friends are focusing on the topic of conversation and are not thinking, “Look what she is eating! No wonder she is fat.”
  I will not feel guilty for having a small milkshake – it will prevent me from stuffing myself with ice cream when I get home.
  I will restrict myself to the milkshake and will not think, “Since I’ve broken my diet I might as well go the whole hog.”
- When I feel anxious or self-conscious I will use my breathing skills to relax me.
• I will reward myself for my courage and willpower by skipping my turn to wash the dishes at home.

Subject D:
PREVENTING A BODY-IMAGE PREOCCUPATION RITUAL BY ERASING IT
• Preoccupation ritual: I continually compare my body to that of other thin women or models in magazines.
• Plan: I will go shopping and will not compare my figure with all the thin girls I pass. I will try not to compare myself with anyone at all.
• Behaviour: When I become aware that I am comparing myself with others, I will focus my attention on the faces of passers by.
• I will tell myself the following:
  I am unique.
  I am special, capable and successful.
  I am a healthy weight.
  My self-worth is not dependent on my physical appearance.
• When I feel anxious or self-conscious I will imagine that I am watching a beautiful sunset and feeling calm and relaxed.
• I will reward myself for my courage and willpower by telephoning my friend in Cape Town.

6.2.10.4 Evaluation of Session 7
Subjects participated actively in the discussion session, and offered ideas for controlling behaviour. The girls were able to design their own affirming activities as requested in Exercise 17. The subjects grasped the concept of “facing it” and “erasing it” behaviour.

6.2.11 Session 8

6.2.11.1 Goals
• Feedback on homework exercises
• Discussion on the following topics:
Relapse prevention
How to “neutralise” the input of troublesome people
How to deal with bad days
Accepting the self
• Review of exercises to be completed at home

6.2.11.2 Activities

(a) Feedback on homework exercises
The responses (found in Section 6.2.10.3) of the “facing it” and “erasing it” exercise (Exercise 16), indicate that the subjects have mastered the ability to create plans to overcome avoidance or compulsive behaviour patterns. The members of the group had no difficulty completing the “affirming activities for a better body image” exercise (Exercise 17 as discussed in Appendix (xvi) 3), and were able to create their own special affirming activities.

(b) Discussion on various topics:
The researcher once again highlighted the fact that behaviour change is a gradual process and that relapse is to be expected. It was recommended that individuals should prepare themselves in advance to cope with situations that are likely to produce negative feelings about their appearance. Four steps regarding relapse prevention were discussed (Rosen 1995:27). The researcher discussed the various suggestions offered by Cash (1991:Side 8) on how to “neutralise” the input of troublesome people, how to deal with bad days and how to accept the self (see Appendix (xvii) for details).

(c) Review of exercises to be completed at home
(i) Exercise on Preventative Maintenance (Exercise 18 – see Appendix (xviii))
Perform the following steps when preparing for challenging body image situations:
• Write down the situations likely to elicit negative feelings about appearance.
- Identify the skills necessary to combat these negative feelings.
- Write down a plan of action to fight these feelings.
- Rehearse the preparation in your imagination (imagine being in the situation and handling it by using the corrective body talk, and feeling more positive about your body in that situation).
- Write down how you will cope with the distress.
- Write down how you will reward yourself for confronting and coping with the challenging situation.

6.2.11.3 Responses of individuals

In the following session, the girls were requested to share their homework exercises regarding the preparation for challenging body image situations (Exercise 18). The responses include the situation identified as likely to cause distress, and the plan devised to minimise the distress.

Subject A:
- **Situation:** Addressing a group of people.
- **Plan:** I will tell myself the following:
  - People are focussing on what I am saying (not what I look like).
  - People are interested in what I have to say.
  - I am good at public speaking.
  
  *If I become anxious:* I will imagine myself sitting in a beautiful and peaceful garden, listening to the birds.

Subject B
- **Situation:** Posing for a photograph.
- **Plan:** I will tell myself the following:
  - The photographer is focussing on my whole face (not on my mouth).
  - The photographer is trying to take a good picture and is not studying my face.
  - I look good even with (dental) braces.
  
  *If I become anxious:* I will focus on my breathing exercise to relax me.
Subject C

- Situation: Shopping with my "skinny" sister and mother.
- Plan: I will tell myself the following:
  People are too preoccupied to notice passers by.
  If people take note of the three of us, they will focus on my sister and mother, and notice how "skinny" they are.
  If I become anxious: I will use my breathing skills to relax me.

Subject D

- Situation: Exercising at the gym.
- Plan: I will tell myself the following:
  I look healthy.
  I am supple and good at doing exercises.
  People are too busy exercising to notice me.
  If I become anxious: I will imagine that I am at the beach watching a beautiful sunset and feeling calm and relaxed.

6.2.11.4 Evaluation of Session 8

The subjects all participated actively in the discussions. They grasped the process of "relapse prevention" easily. The girls found the recommendations regarding "ways to neutralise troublesome people" particularly useful.

6.2.12 Session 9

6.2.12.1 Goals

- Feedback on homework exercise
- Discussion on life after the sessions
- Evaluation
- Outing for tea – closure
6.2.12.2 Activities

(a) Feedback on homework exercise
Subjects experienced no difficulty completing the “preventative maintenance” exercise as discussed in Section 6.2.11.2 (c) (i).

(b) Life after the sessions (Rosen 1995:28)
- Subjects were informed that their therapy was still to continue despite the termination of sessions
- Subjects were now all equipped with the skills in order to continue with their own work
- Subjects were required to describe the remaining changes they hoped to achieve
- They were to describe how they felt about ending the sessions

(c) Evaluation
- The subjects were requested to sum up what they had learnt in the sessions
- They were to comment on:
  - The content of the body image intervention programme – level of instruction
  - The value of Cash’s (1991) audiotapes
  - The administration of the programme
  - Aspects found to be most valuable
  - Limitations and recommendations

(d) Outing for tea
- The outing served as an opportunity to thank the subjects for their participation in the programme
- It also provided the group with the opportunity of saying goodbye and served as a means of closure
6.2.12.3 Responses of individuals

This section includes the responses of the individuals concerning the changes they still wished to achieve, and their feelings concerning the ending of the session. It also includes feedback concerning the programme, as requested in Section 6.2.12.2 (c).

Subject A:

Remaining aspects requiring work: Subject A hoped to gain further confidence, which would enable her to attend pool parties and to be able to wear trousers and mini skirts without any discomfort. Whilst progress was acknowledged, she hoped to overcome her self-consciousness fully concerning her skin problem.

Termination: Subject A was sad that the sessions were ending. She questioned whether she would have the willpower to continue with the exercises without the supervision and monitoring.

Evaluation: Subject A was impressed with the intervention programme and found Cash’s (1991) audio-tapes particularly useful in reinforcing instructions regarding the various exercises. She found the discussion groups most valuable, and felt comforted in discovering that she was not alone in feeling dissatisfied with her body. Subject A felt that the sessions should continue for a longer period in order to reinforce the learnt skills.

Subject B:

Remaining aspects requiring work: Whilst progress was acknowledged, Subject B hoped to build on her confidence to “face” situations that revealed the size of her breasts with even less discomfort.

Termination: Subject B felt confident about continuing the exercises on her own. However, she was sad that the sessions were being terminated and felt that she would miss the “comradeship” she had experienced.

Evaluation: Subject B felt that she had gained enormously from the programme, and that the thinking skills had been most useful. “I realised one day that my breasts would eventually grow, and that I would not be wearing dental braces for much longer. I was making myself unhappy.” She felt that
the subjects were all able to grasp the concepts introduced in the intervention programme. Subject B was happy to end the sessions, and felt confident that she could practise the various skills on her own.

Subject C:
Remaining aspects requiring work: Subject C hoped to improve her confidence in general even further. She hoped that she would eventually feel totally comfortable wearing a bathing costume and “cropped tops” in public.
Termination: Subject C experienced a tremendous sense of loss. She had enjoyed the support from the group, and had experienced a sense of belonging. In addition, she had enjoyed having the opportunity to chat about her personal issues after the sessions.
Evaluation: Subject C felt that Rosen’s programme had facilitated self-discovery in terms of her attitude towards her physical appearance. She was particularly impressed with the relaxation exercise demonstrated on Cash’s (1991) audiotapes. She felt very strongly that the sessions should continue for a longer period and was fearful that she would regress once the sessions had terminated.

Subject D:
Remaining aspects requiring work: Although Subject D was able to “face” going to the gym with her father, she hoped that she would be able to go to gym without any discomfort.
Termination: Subject D was also concerned about having the self-discipline to do the exercises on her own. “It was clear to me from the beginning that we needed to use the information from the homework exercises during the sessions. I felt that I would be letting everyone down if I did not do my homework, and that kept me going. Some days it was really an effort when I had a lot of my school homework to do, but it was worth it.”
Evaluation: Subject D felt that some of the issues discussed in the intervention programme appeared to be quite complex initially, but that they had all been grasped by the end of the session. She found Cash’s (1991) audiotapes to be most valuable in reinforcing the material covered in the sessions, as well as clarifying instructions regarding the homework exercises.
There were times when I skipped my exercises for a few days, and had forgotten what I was supposed to do. It was 'cool' to be able to listen to the tape to refresh my memory." Subject D found the relaxation skills the most useful. "I used the relaxation skills to calm myself before I wrote my exam. It was 'cool'!

6.2.12.4 Evaluation of Session 9

The session provided a sense of closure. The researcher found the session extremely useful in terms of getting feedback from the subjects in order to evaluate the success of the programme.

6.2.13 Summary of the Sessions of the Body Image Programme

Judging from the homework exercises, the subjects appeared to grasp the material presented in the body image programme. The subjects were initially inhibited in sharing their thoughts and feelings regarding their physical appearance, but a marked change in confidence and openness could be observed as the sessions progressed. It was extremely fortunate that the subjects related to each other so well, despite initial fears of some of the subjects concerning confidentiality. The subjects were very supportive of one another and provided much encouragement. Although practice of skills was not always done regularly, the workbook exercises were completed on time. Cash's (1991) audiotapes provided reinforcement of the material covered during the sessions, enabling the researcher to focus on new material in each session. The small group provided the subjects with a safe environment in which to talk about their personal issues. It was interesting that after the initial session or two, members of the group seldom requested privacy when discussing their personal issues with the researcher. Although most of the subjects acknowledged that there were still many areas that they wished to work on (as indicated in Section 6.2.12.3), they all felt that they had made progress in terms of their body image.
6.3 THE SELF-ESTEEM PROGRAMME (Naik 1998)

6.3.1 Composition of the control group

As was mentioned in Section 6.1, eight individuals aged 14 to 16 committed themselves to participating in the research study. These individuals were randomly divided into two groups. While the experimental group followed an adapted version of Rosen's intervention programme, the control group followed a self-esteem programme based on Anita Naik's (1998) book called "Self Esteem: Learn to believe in yourself". The four girls in the control group are referred to as Subjects 1 to 4.

6.3.2 Content of the self-esteem programme

Although not specifically stated, Naik's (1998) book is geared towards female adolescents. The book discusses various issues that are pertinent to adolescent females and offers advice on how to improve self-esteem. The researcher is aware of many shortcomings concerning the programme, but an evaluation of the programme is outside the scope of this study. The purpose of introducing the self-esteem programme was to provide a control group in order to evaluate the modified version of Rosen's body image programme more scientifically. Bearing this in mind, the content of the sessions will be discussed very briefly, the focus being on the cumulative effect of the self-esteem programme on the group as a whole.

The aim of the self-esteem programme is to enhance self-discovery and awareness of particular issues causing low self-esteem. Naik (1998) discusses various topics, and makes various recommendations regarding the enhancement of belief in oneself. The topics discussed include the following; an explanation of self-esteem (Session 1), causes of low self-esteem (Session 2), suggestions for changing low self-esteem (Session 3), relationships with the opposite sex (Session 4), body image (Session 5), difficulties at home (Session 6), difficulties at school (Session 7) and steps towards positive thinking (Session 8).
6.3.3 Researcher's own contribution

As was suggested in Section 6.4.1.2, the researcher was aware of the fact that the self-esteem programme would not meet all the needs of the subjects. The researcher therefore decided to adapt the programme according to the needs of the subjects when required. The contributions of the researcher included discussions on topics such as social expectations, sub-culture expectations, peer pressure (see Section 6.3.6.2 (c)) and communication (see Section 6.3.11.2 (c) (iv)). Although Naik (1998:122-125) discusses "assertiveness" very briefly the researcher elaborated on the topic.

6.3.4 Administrative details

Sessions for the control group were assigned weekly during the period allocated to Life Skills lessons. Each session was scheduled for a period of an hour and a half. However, it soon became apparent that there was a need to discuss personal issues with the researcher. After the first session, the researcher agreed to arrive at the session half an hour before the commencement of school in order to discuss any personal issues, and opportunity that was well utilised.

6.3.5 The composition of a typical session

A typical session commenced with feedback from the previous session. This was followed by a "mini lecture" on a particular topic. The researcher used various methods to introduce the different topics to the group. For example, the researcher requested a response to a contentious magazine article, a letter "of help" from a teen magazine and a poster of a supermodel (thin ideal). The topic on role models was introduced by requesting responses to pictures of the pop group "Shaggy", a poster of the cast of "Friends", a popular television programme, and pictures of Amanda Coetzer and Anna Kournikova (two attractive professional tennis players). The researcher referred to various scenes from movies, television programmes and books to highlight examples of both low self-esteem and confidence. After the introduction of a
particular topic, the researcher would present the group with various forms of information, and would then encourage discussion within the group, providing the subjects with the opportunity to express their own ideas and suggestions concerning the respective issues.

At times the subjects were expected to complete various questionnaires, or to participate in various exercises designed to promote self-discovery of the level of the individual's self-esteem, or to enhance self-esteem. Under these circumstances, the four subjects broke up into dyads and discussed the responses to the respective exercises with their partners. The members of the dyad indicated what information they were happy to share with the group, and one of the members of the dyad reported back to the larger group. (On occasions, the subjects spontaneously challenged individual's self-beliefs).

A typical session concluded with a discussion on the merit of recommendations made by Naik (1998) for enhancing self-belief. It was constantly stressed that the recommendations would not suit all the individuals, and alternative suggestions were encouraged. (Feedback on the discussion groups will not generally be personalised, except on occasions where a particular subject has played a dominant role in the discussion).

6.3.6 Session 1

6.3.6.1 Goals

- Introduction
- Setting of ground rules
- Giving an overview of the programme
- Introduction of the following topics:
  - An explanation of self-esteem
  - Being true to oneself
- Discussion on social expectations, sub-culture expectations and peer pressure
6.3.6.2 Activities

(a) Introduction of the group
Each member of the group had to introduce herself by coupling an adjective with her name that was to start with the same initial letter as her first name. The names used are fictitious but have similar initial letters to their real names. Thereafter, the subject explained why she had chosen to participate in the programme, and discussed her expectations.

(i) Responses of the group
Subject 1
Chosen adjective:
Subject 1 referred to herself as “Silly Suzanne” or “Silly Sis” (as her brothers call her). She explained that (in comparison to her brothers) she was uncoordinated as a child. Whenever she knocked anything over or made a mistake, her brothers would refer to her as “Silly Sis”. While Subject 1 knows cognitively that her brothers meant well, she claims that she feels hurt when they use that name since she really feels stupid.
Reasons for wanting to participate in the research study:
Subject 1 hoped that participation in the research study would result in the development of her confidence in general.

Subject 2
Chosen adjective:
Subject 2 referred to herself as “Caring Cara”. She felt that she was very caring towards her friends who meant a great deal to her.
Reasons for wanting to participate in the research study:
Subject 2 hoped that participation in the research study would result in feeling more positive about her physical appearance.

Subject 3
Chosen adjective:
Subject 3 referred to herself as “Lazy Lindy”. “My teachers and my parents are always telling me that I am lazy.”
Reasons for wanting to participate in the research study:
Subject 3 hoped that participation in the research study would result in her feeling better about herself in general.

Subject 4
Chosen adjective:
Subject 4 referred to herself as “Unlucky Ursula”. She complained that very often her friend would initiate a conversation with her during her lessons, and as she replied, the teacher would look up, catch her in the act and shout at her.

Reasons for wanting to participate in the research study:
Subject 4 hoped that by participating in the research study she would feel better about herself in general.

(b) Setting of ground rules and giving an overview of the programme
Subjects were reminded that all information pertaining to the sessions was confidential. All sessions were compulsory. Should a subject be unable to attend a session, the individual was to take the responsibility of informing the group members about the rescheduling of the session. Subjects were encouraged to show respect towards one another at all times, and were given an overview of the various topics that were to be explored during the sessions as mentioned in Section 6.3.2.

(c) Introduction of various topics
The method for discussing various topics (as set out in Section 6.3.5) applies to all sessions, and will not be discussed further. After the introduction of each topic, the researcher posed questions to the group in order to encourage discussion and the sharing of their ideas and suggestions on various matters. For the sake of brevity the topics that were discussed will be mentioned briefly.

(i) An explanation of self-esteem, the advantages of believing in oneself, and having the courage to be true to oneself
The researcher requested that subjects share their ideas of what self-esteem is all about, and to suggest advantages of being confident. The researcher supplemented these ideas with various points made by Naik (1998:8-10). The essence was that self-esteem enabled one to like, trust and to believe in oneself. Naik (1998:10) suggests that self-esteem enables one to respect and value oneself regardless of one's imperfections, to make one's own choices, to take risks and to achieve one's potential. The researcher informed the group of the various personas (Naik 1998:14) individuals present to the world, namely the "public self", "critical self" and "true self".

(ii) Spontaneous discussion on peer pressure
Discussion within the group on the difficulties of being the "true self" spontaneously developed into a discussion on peer pressure. The responses from the subjects indicated that they resented the competition experienced within the school, both academically and socially. They wished they had the confidence to be themselves and not to worry about the opinions of others, but feared rejection and isolation should they choose to deviate from the norm.

(iii) Social expectations
The researcher explained to the group how society dictates standards of acceptable behaviour, as well as standards of beauty. It was pointed out how standards of behaviour and beauty differ with different groups, and change with time.

(iv) Sub-culture expectations
The researcher initiated a discussion within the group concerning the expectations of their peers within the school. The subjects identified the following criteria as being valued by their peers:
- Being pretty, which implies being thin (having small hips, buttocks and medium sized breasts) and having straight blonde hair
- Being clever (despite having referred to the academic girls as "nerds")
• Having a boyfriend, particularly from their brother school (girls are seen walking over the field to meet their boyfriends during recess)
• Having clothing with particular name-brands
• Having a fairly up to date cellular telephone
• Their parents having various symbols of status:
  Four-by-four motor vehicles and various other models
  Having beach cottages or game farms
  Having vacations in foreign countries, particularly skiing vacations

6.3.6.3 Evaluation of Session 1
The subjects gained a good understanding and appreciation of the value of having self-esteem. The members of the group participated actively in the discussions with the exception for Subject 4, who remained quiet and passive. The discussion on “being true to oneself” enabled the subjects to share the pressure they experienced to conform to the standards set by their peers.

6.3.7 Session 2

6.3.7.1 Goals

• Discuss any issues relating to the previous session
• Complete questionnaire concerning characteristics of low self-esteem
• Break up into dyads and discuss examples of identified characteristics of low self-esteem
• Complete questionnaire dealing with the causes of low self-esteem
• Break up into dyads and discuss the perceived causes of low self-esteem
• Share responses with the group

6.3.7.2 Activities
(a) Discussion on issues relating to previous session
The subjects indicated that they had a clear idea of what the programme was about. One of the subjects had unrealistic expectations of what the
programme might do for her. It was stressed that the gaining of self-esteem was a gradual process.

(b) Questionnaire regarding the characteristics of low self-esteem

The questionnaire has been based on research done by Naik (1998:18-23).

Complete the questionnaire by ticking the items that are applicable to you:

1. You are unable to accept a compliment
2. You are envious of people you perceive as being prettier than yourself
3. You are envious of people you perceive as more intelligent than yourself
4. You are envious of people you perceive as more popular than yourself
5. You believe that you are unattractive and unappealing
6. You believe that no decent guy would fall for you
7. You believe that there must be something wrong with the guys that show an interest in you
8. You believe that you are the only person in the world that harbours nasty thoughts
9. You stand in front of the mirror and give yourself a hard time
10. You refrain from joining in a conversation because you believe that you have little to offer
11. You are afraid to take risks in case people ridicule you
12. You constantly seek the approval and opinion of others
13. You cannot forgive yourself when you fail at something
14. You cannot forgive yourself when things do not go according to plan

(i) Feedback on characteristics of low self-esteem

Subjects broke into dyads and discussed the results of the questionnaire. The three most common characteristics emanating from the questionnaire and the discussions were as follows:

1. Difficulty accepting compliments (4 out of 4 responses)
2. Critical of physical appearance (3 out of 4 responses)
3. Constantly seeking the approval and opinion of others (3 out of 4 responses)
Questionnaire regarding the causes of low self-esteem

The questionnaire was based on research done by Naik (1998:26-33).

*Complete the questionnaire by ticking the items you perceive as having a negative effect on your self-esteem.*

1. Put-downs from parents, teachers and other authority figures
2. Being compared with others – siblings, friends
3. Bottling up your emotions – hiding your true feelings as you feel nobody will understand what you are going through
4. Verbal abuse such as “you’re stupid”, “you’re fat”, “you’re clumsy”, “you will never amount to anything”
5. Being over-protected resulting in a loss of faith in one’s own ability
6. Suffering from neglect – not being adequately cared for, receiving the message of being unwanted
7. Physical or sexual abuse – resulting in self-hatred and feelings of worthlessness
8. Being bullied – resulting in feelings of loss of belief in oneself and the feeling that one has done something to deserve the hate
9. Negative criticism from significant others
10. Having expectations that are too high and then lead to failure
11. “Slippery slope of self-esteem” – the individual reacts to an incident which undermines the self-esteem resulting in the questioning of self-worth – thereafter these feelings begin to escalate

Feedback on causes for low self-esteem

The subjects broke up into dyads and shared issues identified as having a negative effect on their self-esteem.

The following responses were found to be common:

1. Bottling up emotions believing that nobody will understand (4 out of 4 responses)
2. Slippery slope – low self-esteem is triggered by a particular incident (3 out of 4 responses)
3. Verbal abuse from significant others (2 out of 4 responses)
4. Put-downs by parents (2 out of 4 responses)
5. Being compared with siblings or peers (2 out of 4 responses)
The subjects indicated that they perceived the following issues as playing a significant role in creating low self-esteem: poor academic performance (3 out of 4 responses), appearance (3 out of 4 responses) and home circumstances (2 out of 4 responses).

A discussion spontaneously developed concerning verbal abuse from parents. Subject 2 took the opportunity of venting her feelings about her father, whom she perceived as verbally abusive. Subject 4, who had been very introverted and quiet up until this point, shared her frustration with her parents whom she perceived as being critical and having unrealistic expectations.

6.3.7.3 Evaluation of Session 2

It was evident that some form of trust had developed among the group members. They appeared to be at ease and willing to share personal information with one another. The change was particularly evident with Subject 4, who no longer took the role of being a passive spectator, but interacted with the group members. The responses from the subjects suggested that they had gained some insight into the causes of their low self-esteem.

6.3.8 Session 3

6.3.8.1 Goals

- Discussion of any issues relating to the previous session
- Mini lecture on how to change low self-esteem
- Exercise to identify positive attributes
- Exercise to identify negative self-talk
- Discussion on role models
6.3.8.2 Activities

(a) Discussion of any issues relating to previous session
Subject 2 referred to the discussion on verbal abuse that spontaneously took place the previous week (Section 6.4.3.2 (c) (i)). She identified that she needed tools to deal with her father's verbal abuse. When she tried to ask her father to speak to her with more respect, she was grounded for being cheeky. Other members of the group felt that they were also in need of assertiveness skills.

(b) Spontaneous discussion on assertiveness
The researcher briefly explained the benefits of assertiveness and suggested the use of various techniques when asking for something. The following points were made:

- Assertiveness refers to the ability to express feelings and ask for what you want
- Assertiveness helps to make you feel good about yourself and increases the likelihood of having your goals met
- Bear the following points in mind when asking for something:
  - Be positive and respectful when asking for things
  - Be clear and direct about what you want
  - Avoid using statements beginning with "you", but rather use "I statements", e.g. "I enjoy playing golf with my parents, but I also want to spend more time playing golf with my friends."

(i) Role-play exercise - asking for things in an assertive manner
Subjects were divided into dyads in order to role-play various scenarios displaying assertive behaviour. The researcher spent some time with each pair monitoring the process.
(ii) Observation of the role-play exercise
The subjects were initially embarrassed to practice the task of requesting things they wanted in an assertive manner. With practice, they all mastered the technique of using "I" statements as explained in Section 6.3.7.2 (b).

(c) Mini lecture on "how to change low self-esteem" (Naik 1998:34-41)
The researcher gave a "mini lecture" regarding suggestions to change low self-esteem. The following points were emphasised:
- Accept yourself, both your positive as well as your negative attributes
- Identify the areas of low-esteem
- Take responsibility for your shortcomings
- Commit to changing the areas of low self-esteem

(i) Response to the mini lecture
The subjects felt that they were capable of identifying the areas of low self-esteem and were willing to do whatever it took to improve their self-esteem. However, they questioned how they were to learn to accept themselves.

(d) Exercise to identify positive attributes
- Subjects were informed that individuals sometimes believe things about themselves that are not true, or they become so focused on the negative aspects that they lose sight of the positive attributes.
- Subjects were to identify and share their positive attributes with one another.

(i) Observation of the "positive attributes" exercise
The subjects found the task of identifying their positive attributes difficult. They appeared to be embarrassed to acknowledge their strengths and needed much encouragement initially. (However, it was interesting to observe how easily they identified their negative beliefs in the following exercise).
(c) Exercise to identify negative self-talk (Naik 1998:42-45)

- The researcher explained how a particular negative event may impact on one's attitude towards oneself and one's self-esteem. Repetition of the negative event may lower the self-esteem further.
- Subjects were to identify negative thoughts about the self and to share them with their partner.
- The partner then challenged the individual concerning the negative thoughts by asking the following questions:
  - How did you come to believe this about yourself?
  - Who said it?
  - Why was it said?
  - How was the person feeling?
  - Was there a hidden agenda?
  - What evidence exists to confirm your belief?

(i) Response regarding the negative self-talk exercise
The above exercise evoked spontaneous sharing of negative beliefs with the group as a whole. The subjects appeared to be taken aback by some of the beliefs mentioned. They challenged one another and offered counter-arguments. The subjects appeared not to "hear" the counter-arguments and tended to defend their beliefs with conviction.

(d) Discussion on role models (Naik 1998:45-47)

- Pictures of various characters (as mentioned in Section 6.3.5) typically admired by adolescents were presented to the subjects. The researcher initiated a discussion as to the reasons why the various characters were admired.
- The subjects were then requested to describe their own role models.

(i) Responses regarding role models
- Three of the girls described various actresses as their role model, while Subject 1 perceived her grandmother as her role model.
• The researcher explored the reasons why Subject 1 had chosen her grandmother. Subject 1 admired her grandmother who had developed into a well-adjusted and successful businesswoman despite having been orphaned as a teenager. Subject 1 spoke of her grandmother as a great listener, who generally focussed on the positive attributes of the individual and made people feel good about themselves.

(ii) Criteria for choosing an appropriate role model
• The researcher introduced the criteria advocated by Naik (1998:45-47) for choosing a role model who would be able to offer support in the process of improving self-esteem. (In the interests of brevity, these criteria will not be discussed). The researcher then demonstrated how Subject 1's grandmother fitted these criteria.

6.3.8.3 Evaluation of Session 3

The subjects learnt various strategies to enable them to ask for things more assertively. The exercises designed to explore individuals' positive and negative attributes were found to be useful in terms of self-discovery. Subjects gained insight into which criteria to look for when choosing a role model who would be supportive of individuals who were in the process of improving self-esteem.

6.3.9 Session 4

6.3.9.1 Goals

• Review of issues discussed during the previous session
• Discussion of the following topics:
  Relationships and self-esteem
  Boyfriends
  Romance, love and sex
  Coping with rejection
6.3.9.2 Activities

(a) Review of issues discussed during the previous session
   • Subjects did not wish to discuss any matters from the previous week.

(b) Relationships and self-esteem
The researcher discussed the various advantages of having a high self-esteem in terms of relationships as proposed by Naik (1998:50). The advantages are:
   1. Liking and loving oneself
   2. Having the confidence to prevent others from taking advantage of one
   3. Having the courage to get out of bad relationships
   4. Being able to resist using sex to have a relationship
   5. Being able to be oneself and not constantly having to be a "pleaser".
   6. Having self-respect and demanding certain standards of behaviour acceptable to the individual

(i) Response to the discussion
The discussion of the points mentioned above provided the subjects with the insight that many of the difficulties that they were experiencing (e.g. getting out of a bad relationship) were as a result of low self-esteem.

(c) The need for a boyfriend
The following question was presented to the group: *Is it necessary to have a boyfriend in order to have a healthy self-esteem?*
The question provided the stimulus for a lively debate, as indicated in the following responses:
   • Three of the four subjects believed that having a boyfriend in their particular environment was a status symbol and definitely boosted the self-esteem
   • It was felt that the expression of love from boyfriends resulted in the individual feeling special and good about herself
Subject 2 argued that a healthy self-esteem comes from the inside and that it was not dependent on having a boyfriend.

She added that having a boyfriend does not necessarily solve one's problems, and can very often complicate issues and make circumstances worse.

**(d) Romance, love and sex (Naik 1998:50-64)**

The researcher introduced the discussion on "genuine love" and "attitudes regarding sex" by presenting the group with suggestions for comment from Naik (1998:50-64).

(i) **Evaluate the following considerations regarding the identification of genuine love proposed by Naik (1998:61):**

1. "Actions speak louder than words". Take note of how you are treated.

- *Does your boyfriend:*  
  - love and respect himself?  
  - respect you?  
  - show consideration for your needs?  
  - encourage you to do your best?  
  - forgive you when you have made a mistake?  
  - accept you for who you are?

**Responses regarding “genuine love”:**

The subjects agreed that love is an over-used and much-abused word. They came to the conclusion that there were many ways of expressing love other than through physical and verbal expression, such as showing consideration, making compromises, doing things for each other, and the giving of gifts. An inconsistency between the various expressions of love could possibly suggest lack of genuine love. Subject 1 felt that the boys are sometimes pressurised by their peers to be "cool" and to treat their girlfriends badly, despite caring a great deal. Subject 2 felt that genuine love was based on trust and respect, and that if one's boyfriend respected one, he would naturally be considerate, accepting of one and forgiving.
(ii) Evaluate the following list of sexual don’ts compiled by Naik (1998:63):

- Don’t let anyone tell you that sex is a must in a relationship
- Don’t have sex unless you feel ready, and you really want to
- Don’t have sex simply because everyone else is doing it
- Don’t have sex just because you are 16 and legally entitled
- Don’t have sex to save a relationship
- Don’t confuse having sex with being in love

Responses regarding the “sexual don’ts”:
The subjects all agreed with the above statements. They expressed their frustration at having to deal with the boys’ double standards regarding sex. If they had sex, they were referred to as sluts, and if they refrained from having sex they were called frigid.

Subject 4 inquired whether it was acceptable to ask for a test for HIV/AIDS before agreeing to have a sexual relationship. The group complained that many of the boys were too casual about contraception and the threat of HIV/AIDS, believing that they would never be infected with the disease. The girls felt very strongly that it would be both sensible and respectful for both the boys and the girls to be tested for HIV/AIDS before agreeing to a sexual relationship.

(e) Coping with rejection (Naik 1998:64-65)
The researcher discussed Naik’s idea of reframing in order to deal with rejection.

- While rejection is painful, knocks one’s confidence and tends to make one feel worthless, it does not mean that there is something wrong with you
- Relationships end for a number of reasons and it is rarely the fault of only one person
- Think of a relationship as being a good fit. An individual requires a pair of gloves. The fact that the pair of gloves is too small to fit the hand does not mean that there is something wrong with the hand!
Responses regarding “coping with rejection”:
The subjects liked the idea of looking at relationships as “good fits”. However, Subject 3 had the following to say, “Sometimes my head and my heart don’t agree on things. While I might believe that my relationship failed because of a “poor fit”, I still feel the pain!”

(f) Abusive boyfriends
The subjects were presented with the following scenario (Naik 1998:65):
My boyfriend calls me bad names and sometimes hits me. I put up with it because I love him, and I know that it is caused by something I’ve done. He’s always so sorry afterwards. I know he means it.

Subjects were requested to respond to the following questions:
1. Do you consider the boyfriend’s behaviour to be acceptable?
2. How do you think one should react in situations such as this one?
3. Why do you think girls stay with boys who hit them or abuse them in other ways?

Responses of the group:
1. The girls all agreed that the boyfriend’s behaviour was unacceptable.
2. Most of the girls suggested that the girl should leave the boyfriend and that she should tell somebody what had happened. Subject 2 suggested that it was necessary to obtain all the facts and to view the incident in context before she could comment. She added that it was not always easy to report an offender.
3. The following reasons were suggested for girls not wanting to leave their abusive boyfriends:
   - Fear of retaliation
   - Fear of being alone
   - Believing that they possibly deserve it
The researcher added that verbal or physical abuse tends to destroy self-esteem, and leave the individual feeling humiliated, ashamed and afraid to do anything about it.

6.3.9.3 Evaluation of Session 4

The session proved to be valuable in that it provided the opportunity to discuss issues relating to boyfriends. Subject 1 mentioned that it was comforting to discover that the other girls shared her view regarding sex and general behavioural expectations of the opposite sex. The discussion helped her to clarify various issues in her mind, and gave her the confidence to "stick to her guns".

6.3.10 Session 5

6.3.10.1 Goals

- Discussion of issues relating to the previous session
- Discussion on the importance of loving one's body
- Discussion on the key influences on body image
- Exercise pertaining to body dissatisfaction

6.3.10.2 Activities

(a) Discussion of issues relating to previous session
Subject 2 requested input from the group concerning the following dilemma. Subject 2 was constantly being criticised by her mother for taking the initiative in her relationships with her male friends. Her mother felt that "it was not the done thing" to telephone her male friends or to invite them out. Her mother suggested that Subject 2 would be unlikely to establish a meaningful relationship with a boyfriend if she continued to pursue males in that manner. The group were very supportive of Subject 2 and suggested that Subject 2's
behaviour was quite acceptable, and that it was Subject 2's mother who was experiencing difficulty adjusting to the present way of life.

(b) Discussion on the importance of loving one's body (Naik 1998:71)
The researcher discussed the benefits of loving one's body as suggested by Naik (1998:71). The following points were emphasised:

- Acceptance of one's uniqueness in terms of physical appearance is likely to discourage comparison with others, especially supermodels
- Acceptance of the body is likely to minimise negative mood swings triggered by negative body feelings
- Acceptance of the body is likely to result in the individual feeling more confident in social settings
- Individuals who accept their bodies are unlikely to involve themselves with "get-thin" fads

The researcher pointed out that most individuals tend to focus on the parts of the body that they do not like, and seem to exaggerate their "flaws". Naik (1998:70) suggests that individuals only truly respect themselves when they learn to respect their bodies as much as their mind, behaviour and attitudes.

(i) Response to the discussion on the "acceptance of one’s body"
Members of the group debated over the extent to which individuals were to accept their bodies. Two out of the four subjects suggested that it was the responsibility of individuals to make the most of their bodies, which included losing weight if necessary. Subject 1 suggested that in order to be attractive to the opposite sex, one had no option but to strive for the ideal body.

(b) Discussion on key influences of body image
- The researcher initiated a discussion of the influences of the media (magazines, television and movies), the diet industry and various people (such as one's parents, siblings, peers and boyfriends) on one's body image.
• In dyads, the subjects were then expected to identify and discuss the key influences that influenced their body image.

(i) Response to the exercise on “key influences on body image”
• Teasing and negative comments from siblings (especially brothers) appeared to have a significant impact on the girls’ body image.
• The media was viewed by all subjects as having the greatest impact on body image.
• Subject 4 made a very interesting comment, “Girls want to date and dream of going steady. They don’t care what it takes to be attractive and to make this happen. They will strive to be whatever society dictates as being beautiful, even if it means putting their health at risk.”

(c) Exercise pertaining to body dissatisfaction
Subjects were requested to respond to the following:
1. List the aspects of your body that cause dissatisfaction
2. Identify the aspects that one can change, and those that one cannot change

The researcher then referred to Naik’s (1998:85) recommendations concerning the “unchangeables”:
• Very few people are born with “perfect” bodies
• One has the choice to accept one’s “shortcomings”, or one can choose to let one’s “flaws” get one down
• Acceptance of one’s body does not mean that one will have instant happiness, but it is likely to minimize the blaming of “unchangeables” for one’s misfortunes

6.3.10.3 Evaluation of Session 5
Subjects reported that the session was useful in terms of identifying factors contributing to the negative feelings about the body, and which aspects of the
body could be changed. However, the session was not successful in terms of helping the individuals to accept their bodies more readily.

6.3.11 Session 6

6.3.11.1 Goals

- Review of previous session
- Exercise in order to identify areas of difficulty at home
- Feedback on exercise

6.3.11.2 Activities

(a) Review of previous session

- Whilst reviewing the issues from the previous session, a discussion developed concerning the "thin ideal" portrayed by the media and its influence on body image. The girls discussed the enormous pressure they experienced to be thin, and expressed their resentment at having to constantly monitor their weight and diet. The conversation then progressed to a discussion on eating disorders.

- Subject 3 was prompted to share her dilemma with the group. Her friend had confided in her that she had become obsessed about her weight and was vomiting after meals. Although Subject 3 did not wish to betray her friend's trust, she felt it would be responsible to inform her friend's mother of the problem.

- A debate arose over the issue of trust. The majority of the group felt that the betrayal of trust was justified under the circumstances, and that Subject 3 had no option but to inform her friend's mother about the problem.
(b) Questionnaire designed to identify areas of difficulty at home
(Naik 1998:101-107)

The subjects were to complete the following questionnaire, and were then requested to break up into dyads in order to discuss the results.

*It is particularly common for teenagers to experience some conflict at home. Tick the following items in order to help you to determine your areas of conflict:*

- My mother/father are overprotective
- My mother/father go overboard with criticism
- My mother/father compare me with my siblings
- My brother/sister/mother/father tease me
- My mother/father embarrass me
- My mother/father annoy me often
- I argue a great deal with my mother/father
- My mother/father are ordinary and boring
- My mother/father always comment on my body
- My mother/father always comment on what I wear
- My mother/father don't understand me
- My mother/father don't trust me
- When my mother/father have problems of their own, they tend to take their aggression out on me
- My mother/father still see me as a little girl without her own ideas and desires
- My mother/father expect too much from me
- My mother/father try to plan out my future without consulting me
- My mother/father/brother/sister pick on me
- I find it hard to accept that my family are different – it embarrasses me
- I find it hard to be proud of my parents and of myself
- I tend to copy the behaviour of my brother/sister in order to get into my parents' good books
- I find it hard to congratulate my siblings on their successes
Feedback on exercise

The girls complained mainly about two issues, namely, the need for greater freedom and difficulty communicating with their parents.

(i) Autonomy and freedom

- Three out of the four members of the group complained about lack of trust from their parents and felt that their parents were overprotective, too restrictive and failed to give them adequate privacy. As a result of this attitude, the girls tended to become rebellious (e.g. disregarded their parents' instructions by attending the forbidden nightclubs).

- Subject 1 shared how she had solved the problem with her parents. After visiting the popular clubs attended by the teenagers, Subject 1’s parents agreed on allowing their daughter to attend two specific clubs. Subject 1 promised to be honest with her parents and to tell them exactly where she went provided they in turn trusted her. In addition, Subject 1 agreed to be responsible by telling her parents where she went, leaving contact numbers, sticking to curfews and not doing anything reckless.

- After sharing this with the group, Subject 1 became the role model for the group in terms of relating to parents. During the following sessions the girls frequently asked advice from Subject 1 concerning issues relating to parents.

(ii) Communication

- Three out of the four subjects complained that their parents “simply did not understand them”, and were unwilling to look at issues from their point of view.

- A discussion developed concerning the practice of mutual respect when communicating. The researcher made various recommendations regarding the improvement of communication skills. They are:
  1. Listen actively to the speaker
  2. Do not interrupt
  3. Remain calm
  4. Refrain from blaming
5. Be assertive  
6. Making use of “I” statements (e.g. I feel ...)  
7. Be open – be prepared to view matters from other points of view  

6.3.11.3 Evaluation of Session 6

Subjects reported that they found the session particularly valuable. They found it comforting to hear that other subjects were experiencing similar difficulties with their parents, and appreciated hearing how others had successfully overcome various problems. Subject 2 made the following comment, “Talking to the other girls about my parents confirmed my belief that my parents are quite unreasonable!”

6.3.12 Session 7

6.3.12.1 Goals

- Discussion of issues relating to the previous session  
- Exercise in order to identify areas of difficulty at school  
- Feedback on exercise

6.3.12.2 Activities

(a) Discussion of issues relating to the previous session

Subject 4 shared the discussion she had had with her parents, where she had tried to be assertive and respectful. Subject 4 had been successful in persuading her parents to consider following a system similar to that adopted by Subject 1 (as discussed in Section 6.3.11.2 (c) (i)).
(b) Exercise in order to identify areas of difficulty at school (Naik 1998:87-100)

Subjects were expected to complete the following questionnaire in order to identify their particular difficulties at school, and then to break up into dyads to discuss the results.

School is life in miniature. If you can work your way through school, make friends, get on with your teachers, do your best in your work and exams, then you are better equipped for life. However, we all have our difficulties. Tick the following items in order to determine your particular areas of difficulty.

1. POOR ACHIEVEMENT
   - Not putting in enough
   - Have difficulty disciplining myself to prepare properly for examinations
   - Tend to leave things to the last minute
   - Find myself day-dreaming in class
   - Am not motivated to achieve academically
   - Often in trouble for not doing homework
   - Get into trouble for talking too much in class or for playing around
   - Enrolled in the wrong subjects
   - Find subject matter boring

2. SELF-ESTEEM
   - Do not believe that I am clever
   - Do not believe that I have special talents
   - Work is too hard
   - Give up on work I find hard
   - My work is never good enough for my parents
   - Afraid to be called “dumb”
   - Feel stupid if I don’t understand something
   - Find it hard to ask for help when I need it
   - Having a tutor to help me with my work makes me feel stupid
   - Am afraid to participate in classroom discussions
   - Remain silent as I am embarrassed and afraid of failing or making a fool of myself
• Am afraid of standing up for myself and my beliefs
• People tend to interrupt me or shout me down when I speak in class
• Find myself comparing myself and competing with the rest of the class
3. SPORT
• I am not good at sport and this makes me feel inferior
• I hate physical education because I am so clumsy
• I hate physical education because I am embarrassed to undress in front of my peers
• I hate physical education because my teacher/peers humiliate me
• I hate team sport because somebody tends to say something nasty to me
4. UNDERACHIEVEMENT
• Do not work too hard as I do not want to be classified as a “nerd” or a “boff”
• I want to be feminine and thus try to downplay my ability in maths and science
• Tend to hide my talents under a bushel as a way of getting back at my parents who tend to push me
• I am made to feel that school is a make or break situation – if I do not find my career goal and develop my potential at school, then I will never succeed in life
5. TEACHERS
• Teachers not giving me the attention I need
• Find teachers boring
• Teachers often shout at me
• Am unable to please the teachers
• Teachers do not value my opinion
• Teachers think that they know everything and are always right
• Teachers are not always supportive and understanding
• My teacher puts me down for poor performance
• My teacher is moody
• Teachers are not always encouraging
• I am doing my best but that is not good enough for my teacher
6. BULLIED

- I feel bullied at school
- I tend to believe what the bullies say about me
- It is no good telling anyone that I am being bullied or harassed sexually

(c) Feedback on exercise

Subject 1 revealed her lack of confidence in her academic ability. She felt that both her parents and teachers set expectations that were too high for her. All the subjects agreed that the academic standards were extremely high in their school, and that there was tremendous competition amongst the more able students to achieve academically.

Subjects 3 and 4 appeared to be constantly in trouble at school and to have great difficulty relating to the teachers. On further investigation it transpired that they both struggled a great deal with their work, particularly with their mathematics. Subject 1 confessed that she was having extra mathematics lessons and suggested that the other girls follow suit.

6.3.12.3 Evaluation of Session 7

The subjects appreciated having the opportunity to vent their frustrations regarding their teachers. Subject 2 felt that the questionnaire had been useful in transforming her perception of a general dislike for school to a focussed dislike for sport and physical education.

6.3.13 Session 8

6.3.13.1 Goals

- Discussion of issues relating to the previous session
- Discussion of “steps towards positive thinking”
- Discussion of “difficult feelings”
6.3.13.2 Activities

(a) Discussion of issues relating to previous session
- Subjects did not wish to discuss any matters from the previous week.

(b) Discussion of "steps towards positive thinking"
The researcher gave a "mini lecture" on the "steps towards positive thinking" as advocated by Naik (1998:115-116). After each section the researcher initiated discussion within the group. The following points were made:

(i) Be a positive person
- When you look in the mirror take care not to focus on the negative features
- When you talk about yourself take care not to neglect or ignore the positive aspects
- Listen to yourself and take note of phrases which are used repeatedly – the words used tend to influence one's feelings
- Using positive language is the first step towards positive thinking
- Take care not to let the actions or reactions of others get you down
- Try to see the positive side of a situation

Discussion:
Subject 4 suggested that it was extremely difficult not to be upset by false rumours about oneself circulating the school, since many people tended to believe the rumours and form an opinion based on these rumours. The researcher agreed that it was upsetting, but suggested reframing. The researcher suggested that the culprit could possibly be viewed as being jealous, insecure, or too concerned with the issues of others in order to divert focus from her own issues.

(ii) Do not be hard on oneself (Naik 1998:116-119)
- Acknowledge your talents and achievements
- Accept compliments
- Accept yourself as you are
- Do not exaggerate mistakes
• Have realistic goals – one cannot be perfect
• Forgive yourself if you make a mistake or fail to do something successfully
• Give yourself a pat on the back when you feel you deserve it
• Take care not to believe that others are always better

Discussion
Interestingly, all four subjects complained that their parents set expectations that were far too high for them. Subject 1 made the following comment, “My brothers all represent Gauteng for soccer, with the result that they expect me to be really good at some sport too. I work so hard at my squash, but when I play a match I get so nervous that I tend to mess up. I end up disappointing myself and my parents!”

(iii) Take care not to say mean things and to be over-critical (Naik 1998; 120-121)
• Criticising others reflects one’s own insecurities
• Focussing on the flaws of others may be a way of diverting the attention from one’s own shortcomings
• Those who are able to accept their own weaknesses are less likely to be concerned about the weaknesses of others
• Criticising others tends to make one feel guilty and results in further insecurity
• Criticism of ourselves and others is linked to our expectations
• Is it right that one should demand certain things from certain people?

Discussion
In response to the above question Subject 3 suggested that behaviour that harmed others, undermined self-esteem and showed lack of respect was not acceptable. The girls all agreed that individual differences should be accepted, but that this was unfortunately not the reality. A discussion followed on peer pressure to conform, which the subjects felt was particularly strong at their school.
(iv)  \textit{Take care not to revel in guilt or self-pity} (Naik 1998:115)
\begin{itemize}
\item Unwarranted feelings of guilt sap one's energy
\item Self-pity often evokes irritation in others instead of the desired sympathy
\end{itemize}

(v)  \textit{Be assertive but not aggressive} (Naik 1998:122-123)
\begin{itemize}
\item Politely insist that one's opinions be valued and responded to
\item Do not let people use you as a doormat
\item Do not use aggression, disrespect, rudeness or bossiness
\item Remember that one has the right:
  \begin{itemize}
  \item To be treated well
  \item To be listened to
  \item To privacy
  \item To make up one's own mind
  \item To be happy
  \item To be different
  \end{itemize}
\end{itemize}

\textit{Discussion}

Subject 2 vented her frustration at her father's reluctance to allow her to make her own decisions. Subject 1 suggested that Subject 2 should try to negotiate a deal with her father, where both parties were to compromise regarding freedom and independence. In return for greater freedom, Subject 2 was to offer more responsible behaviour.

(vi)  \textit{Do you stand up for yourself?} (Naik 1998:133-134)
\begin{itemize}
\item Are you always putting the needs of others before your own?
\item Are you always listening to the gripes of others?
\item Do you feel that others are not as willing to help you?
\item Are you particularly involved in the problems of others?
\item Do you expect a reward when you help someone?
\item According to Naik (1998:135) genuine people are honest, selective, assertive, refrain from talking about their good deeds and live their own lives. Which of these characteristics do you possess?
Discussion

Subject 1 shared her conflict with the group. The pursuit of her own goals conflicted with consideration for her friend. She felt guilty about challenging her best friend for a position in the squash team knowing how much it meant to her friend to be on the team. The girls empathised with Subject 1, but felt that the world operated on a basis of "survival of the fittest", and advised Subject 1 to challenge her friend.

(vii) Living in the future (Naik 1998:139)
- Plan for the future, but live the present day to the fullest
- Do not be obsessed about worrying about tomorrow
- Only worry about issues that are within your control
- Find a promising solution to the nagging problem
- Take care not to let the fear of change prevent you from making choices
- Learn from your mistakes, forgive yourself and carry on with life

Discussion

The subjects discussed the difficulty of finding the balance between preparing for the future and living for the present day. Subjects 3 and 4 suggested that they tended to live solely for the present day in order to avoid thinking about problems that would impact on their future.

(b) Discussion on “difficult feelings” (Naik 1998:125-129)
1. Anger
- Anger is a natural response to certain things – it is better to express it than to bottle it up
- Do not take your anger out on others
- Walk away, count to ten, have a quiet think, and work out an assertive plan of action.

Discussion

Subject 2 complained that she was never allowed to express her anger at home. However, when the issue was investigated, it appeared that anger was
being expressed inappropriately. Subjects made various recommendations on how anger might be expressed. The researcher suggested the use of breathing exercises in order to help individuals to calm down before embarking on various methods of expressing their anger.

2. Frustration
   • Frustration comes from being misunderstood, ignored or being unable to achieve one’s goals
   • Remember that long-term happiness and fulfilment come from within

Discussion
Subject 3 suggested that frustration and anger were very closely related, and that she often expressed anger inappropriately at home, due to the frustration she experienced academically and the restrictive attitude of her parents at home.

3. Disappointment
   • You are likely to be disappointed if you depend on people or events to improve or dramatically change your situation or feelings
   • Take responsibility for your own life - you alone can make changes in your life

Discussion
Subject 4 suggested that frequent disappointment from her parents and friends had destroyed her trust in people, resulting in her reluctance to share intimate details with others.

4. Possessiveness
   • Possessiveness and fear go hand-in-hand
   • Those who are afraid of losing a friend tend to be reluctant to share their friends
   • Love is not about owning someone
• Individuals who cling to people are usually afraid of being alone – they are lacking in self-esteem and do not love themselves sufficiently

Discussion
Subject 1 acknowledged that she was possessive over her boyfriend who was both attractive and popular. The subjects tried to reassure Subject 1 that her boyfriend really adored her, and that her insecurities were becoming her own worst enemy. The researcher suggested that while Subject 1 was intellectually aware of the facts mentioned by the group, her negative self-talk was possibly responsible for fuelling her insecurity.

5. Being courageous
• Those who take sensible risks are usually not afraid of failing
• Those who do not take risks will never know what their capabilities are
• Courage is not about being fearless, but about doing something despite feeling scared to death
• When taking a risk, weigh up the pros and cons first

Discussion
Subject 3 acknowledged that she tended to take “stupid risks” that frequently resulted in her getting into trouble. After exploring the situation, the subjects suggested that Subject 3's actions possibly stemmed from her attitude of living for the now, thus avoiding having to deal with her problems that impacted on her future.

6.3.13.3 Evaluation of Session 8

The subjects all participated actively in the discussion groups. They found the session helpful in terms of identifying various areas of difficulty and thus learning more about themselves.
6.3.14 Session 9

6.3.14.1 Goals

- Discussion of issues relating to the previous session
- Discussion on "respecting oneself"
- Evaluation of programme and recommendations
- Outing for breakfast

6.3.14.2 Activities

(a) Discussion of issues relating to the previous session
Subject 3 proudly shared an incident with the group in which her assertive behaviour had paid off. She acknowledged that her friend’s teasing concerning her bandy legs was hurtful, and requested that the teasing stop. The friend apologised and appears to have stopped the teasing.

(b) Introduction of topic on "respecting oneself"
The researcher discussed the points made by Naik (1998:141-142) regarding the ripple effect of improved self-esteem and self-respect with the group. Individuals with self-respect were described as being likely to treat themselves and others in the following ways:
- Refraining from judging too harshly
- Acting kindly
- Acting openly and honestly
- Allowing people to do things for you
- Acting calmly and in a relaxed fashion
- Refraining from being impatient and angry with yourself
- Believing in yourself without requiring outside approval
- Accepting that you will make mistakes and not being devastated when errors occur
- Boosting your confidence
- Accepting that you are loveable
The researcher concluded by reading an extract from Naik's book (1998:142). It reads as follows:

"Life is not a race, a contest or a competition. You don't have to do battle with anyone, nor compare yourself to others. You also don't have to go ballistic when things go wrong. This is life, it comes with ups and downs and there's nothing you can do about it. You can, however, make it easier for yourself by being respectful of who and what you are. It's time to be friends with a very special person. You."

(c) Evaluation of programme and recommendations

Subjects 1 and 2 reported that the programme provided the girls with the opportunity of discussing and clarifying various issues. They appreciated the recommendations made in response to the sharing of their respective problems. However, they both felt that the programme did little to make them feel better about their physical appearance.

Subject 3 made the following comment, "I appreciated the fact that when we asked your (the researcher's) opinion on things, you asked the group what they thought about the matter. Sometimes adults think they know it all. It was nice to hear what our peers thought about things."

Subject 4 was impressed that the members of the group had kept their word concerning confidentiality. She said the following, "Perhaps the most important thing I learned was that one can trust some people."

The subjects valued the small group concept, and expressed regret that the sessions were to end. They all agreed that the programme was a little rushed, and that some of the topics warranted more than one session.

The researcher felt that the programme provided a good overview of the various issues. However, she agreed with the subjects that additional time was necessary for further exploration of specific areas of difficulty. The researcher felt that insufficient opportunities were created to practice the various skills learnt.
(d) Outing for breakfast

The breakfast provided the researcher with the opportunity of saying farewell to the subjects, and provided a sense of closure. The researcher urged the girls to approach the school counsellors regarding the various issues discussed weekly prior to the sessions.

6.3.15 Summary of Sessions of Self-esteem Programme

Although Subject 4 was inhibited initially, the members of the group soon learnt to trust one another sufficiently to share intimate information with one another. Subject 2 tended to dominate the conversation at times, but all members of the group treated one another with respect and were given the opportunity to voice their opinions.

The programme was found to be useful in terms of learning more about the self and identifying various areas of difficulty. Recommendations regarding dealing with various problems were reported as being valuable. However, the researcher felt that more role-playing and practice of skills would have been beneficial. Subjects also reported that they would have liked more time in order to consolidate various issues. The post-test results show a small improvement in self-esteem.

Personal profiles of each subject will be provided in the following section, as well as the comparison of pre- and post-test results.

6.4 PERSONAL IMAGES OF SUBJECTS AND COMPARISON OF PRE- AND POST-TEST PSYCHOMETRIC RESULTS

At the end of the respective programmes, psychometric tests were repeated with both the experimental (body image) group as well as the control (self-esteem) group. These results will be discussed in this section. In addition, a summary of the personal image of each subject in both groups will be
provided, as well as the pedagogical observations made by the researcher during the group process.

6.4.1 Personal images of the experimental group (body image group)

The eight participants in the study were informed that two different programmes dealing with body image and self-esteem were going to be implemented. The subjects were not informed that the experimental programme focussed on the development of positive body image, while the control programme focussed on the enhancement of self-esteem in general. The subjects were randomly divided into two groups and thus had no choice as to who was to be included in which group, or as to which programme they followed. The four subjects in the experimental group are referred to as Subjects A to D.

6.4.1.1 Personal image of Subject A

6.4.1.1(a) Background History

Subject A was 14 years 9 months old at the time of the initial interview. She has a brother who is four years older, and who has just completed his schooling. Subject A perceives her brother as being particularly mean to her. He teases her continually about being overweight. The siblings tolerate one another, but the relationship is not good. Respondent A views her relationship with her mother as having its "ups and downs". Whilst she feels that she has very little in common with her mother, she views her mother as being nurturing. Subject A views her father as being "strict" and sometimes controlling. However, she enjoys his company, particularly his sense of humour. It was a huge shock for subject A when (three months prior to the initial interview) she learned that her father had been having an affair and was to move into a cottage with his girlfriend. Subject A had been aware of some conflict between her parents. Her mother had confided in her that their sex life was non-existent (which embarrassed her a great deal at the time). However, Subject A had no idea that divorce was a possibility. Subject A
enjoyed the company of her father’s girlfriend’s two sons. Had she been given the choice, she would have chosen to live with her father. Subject A was having difficulty adjusting to the divorce of her parents. She felt depressed and fragile.

Subject A perceives her body image as being very poor. She perceives herself as being overweight and unattractive. Subject A achieves very well academically, which boosts her self-esteem. While she perceives herself as lacking in sporting talent, she is a member of the rowing team at school. Subject A has a very close relationship with a particular friend, and is a member of a group of four girlfriends.

6.4.1.1(b) Reasons for Inclusion in the Group

Subject A hoped that by participating in the body image programme she might learn to feel better about her body, which would hopefully enhance her confidence and general quality of life.

6.4.1.1(c) Pre- and Post-test Psychometric Results

1. Pre-test Results

In this section the subjects’ pre- and post-test psychometric scores will be presented. A description of the psychometric tests used in this study may be found in Chapter Five. The sectional references provided in the first case study are to be used for the remaining cases.

Results from the psychometric tests revealed the following:

(i) **No Signs of Body Dysmorphic Disorder** - (see Section 5.5.3.1). A score of 103 out of a possible 156 was obtained on the BODE, providing a score for her “level of body image concern” for comparison purposes (see Table (i), pg. 280).

(ii) **Severe Depression** – (see Section 5.5.3.2). A score of 32 on Beck’s Depression Inventory indicates that Subject A is suffering from severe
depression (see Table (ii), pg. 281).

(iii) **High Anxiety Level** – (see Section 5.5.3.5). A sten score of 9 on the IPAT Anxiety Scale reveals that Subject A is in a state of high anxiety (see Table (iii), pg. 282).

(iv) **Medium Self-Concept** – (see Section 5.5.3.4). A score of 50 on the ASCS indicates that Subject A has a medium self-concept (see Table (iv), pg. 283).

(v) **Low Structure** – (see Section 5.5.3.6). A stanine score of 3 on the FFAQ reveals that Subject A is experiencing the structure in the family as below average (see Table (vi), pg. 285).

(vi) **Low Affect** – (see Section 5.5.3.6). A stanine score of 2 on the FFAQ indicates that Subject A rates both the quantity and the expression of affection in her family as very low (see Table (vi), pg. 285).

(vii) **Low Communication** – (see Section 5.5.3.6). A stanine score of 1 on the FFAQ indicates that Subject A experiences communication as below average in the family (see Table (vi), pg. 285).

(viii) **Low Behaviour Control** – (see Section 5.5.3.6). A stanine score of 1 on the FFAQ indicates that Subject A’s behaviour control is below average (see Table (vi), pg. 285).

(ix) **Low Value Transmission** – (see Section 5.5.3.6). A stanine score of 1 on the FFAQ reveals that Subject A does not identify positively with the value system of her parents (see Table (vi), pg. 285).

(x) **Low External Systems** – (see Section 5.5.3.6). A stanine of 3 on the FFAQ shows that Subject A does not participate in school-related activities and has below average interaction with other external systems (see Table (vi), pg. 285).

(xi) According to the TAT responses (see Section 5.5.3.3), elements of helplessness ("... cannot change the circumstances ..."), passivity ("... doesn't want to do anything about it ...") and sadness ("... "sad and lonely", ..."crying desperately...") are evident. While this may suggest depression, there are indications of hope ("... eventually he'll carry on with life ...", "... perhaps someone will eventually cheer her up..."). Feelings of rejection and isolation come to the fore ("... feels left out of

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the group or unloved ...", "... doesn't have a home or family to go to...", "... envies the woman who has found love...", "... he pushes her away..."). The response to card 7GF includes a girl holding a baby, which may suggest a need for love and nurturing. The TAT responses suggest that Subject A is troubled ("... lost and confused ...", "... the girl has her worries and is in another world ..."). A theme of infidelity is evident ("... the husband has moved on and found someone else ...", "... feels guilty that his wife was murdered while he was with his girlfriend..."). Significant figures are regarded as distant and authoritative ("... he is angry and is telling her what to do ...", "... her mother wants her to listen but she doesn’t connect with her daughter...").

In the following section the post-test results will be presented.

2. Post-test Results

Results from the psychometric tests reveal the following:

(i) **No Signs Of Body Dysmorphic Disorder** - (see Section 5.5.3.1). A score of 63 out of a possible 156 was obtained on the BODE, providing a score for her “level of body image concern” for comparison purposes (see Table (i), pg. 280).

(ii) **Moderate Depression** – (see Section 5.5.3.2). A score of 17 on Beck’s Depression Inventory indicates that Subject A is suffering from moderate depression (see Table (ii), pg. 281).

(v) **Average Anxiety Level** – (see Section 5.5.3.5). A sten score of 6 on the IPAT Anxiety Scale reveals that Subject A is functioning within the normal range of anxiety (see Table (iii), pg. 282).

(vi) **Medium Self-Concept** – (see Section 5.5.3.4). A score of 57 on the ASCS indicates that Subject A has a medium self-concept (see Table (v), pg. 283).

(vii) **Low Structure** – (see Section 5.5.3.6). A stanine score of 3 on the FFAQ reveals that Subject A is experiencing the structure in the family as below average (see Table (vii), pg. 285).
(viii) **Low Affect** – (see Section 5.5.3.6). A stanine score of 3 on the FFAQ indicates that Subject A rates both the quantity and the expression of affection in her family as very low (see Table (vii), pg. 285).

(ix) **Low Communication** – (see Section 5.5.3.6). A stanine score of 1 on the FFAQ indicates that Subject A experiences communication as below average in the family (see Table (vii), pg. 285).

(x) **Low Behaviour Control** – (see Section 5.5.3.6). A stanine score of 2 on the FFAQ indicates that Subject A’s behaviour control is below average (see Table (vii), pg. 285).

(xi) **Low Value Transmission** – (see Section 5.5.3.6). A stanine score of 2 on the FFAQ reveals that Subject A does not identify positively with the value system of her parents (see Table (vii), pg. 285).

(xii) **Average External Systems** – (see Section 5.5.3.6). A stanine of 4 on the FFAQ shows that Subject A participates in school-related activities and enjoys average interaction with other external systems (see Table (vii), pg. 285).

(xiii) Responses on the TAT (see Section 5.5.3.3) indicate feelings of hopelessness (“... given up ...”, “... doesn’t know what to do ...”), sadness (“... so upset and tired ...”) and loneliness (“... feels lonely ...”, “... she envies the woman because she has found love and is soon to have a baby ...”). There are some indications of depression, but this is coupled with feelings of hope (“... perhaps he can learn to play another instrument that will make him happy ...”, “... she chickened out of committing suicide possibly because she has some family to go to ...”, “... the wife will get on with her life ...”). The father figure is depicted as controlling (“...he is picking out a husband for his daughter ...”), while feelings of rebellion are evident (“... she will go against her father’s will ...”, “... she will be naughty again ...”).

6.4.1.1(d) **Summary of changes experienced by Subject A**

Subject A appeared to benefit a great deal from the body image programme. A significant decrease in body image dissatisfaction was noted with a drop...
from 103 to 63 on the BDDE. In addition, Subject A gained a great deal of support from the members of the group at a time when she was having great difficulty adjusting to her parents' divorce.

In the beginning of the programme, Subject A was suffering from severe depression (32 on BDI) and high anxiety (9 on IPAT). However, with time she became less depressed (17 on BDI) and less anxious (6 on IPAT). Whilst the score of the initial ASCS test revealed her self-concept to be adequate (medium – 50), some improvement was noted (57) in the post-test results.

Subject A improved by one stanine score on all sub-tests of the FFAQ, except for the Structure and Communication sub-tests. The lack of progress on the structure sub-test can possibly be attributed to the lack of cohesion in the family resulting from the divorce. It appeared that Subject A's father made all the major decisions without consulting the opinion of other family members. Subject A's mother (and the children) lacked the necessary assertiveness and problem-solving skills to stand up to her husband and to arrive at more appropriate solutions to problems.

The initial TAT responses revealed feelings of sadness, helplessness, passivity and depression. Feelings of rejection, isolation and a need for love and nurturing also came to the fore. Significant figures were portrayed as distant and authoritative. In the follow-up TAT, feelings of helplessness and sadness were also noted, but a strong sense of hope was evident. The father figure was still portrayed as being controlling, and feelings of rebellion came to the fore.

6.4.1.1(e) Pedagogical Observations

Subject A was very quiet at the beginning of the group intervention programme. She appeared to be depressed and distracted. However, with time she became an active participant in the discussion group, asking intelligent questions and providing valuable insights. Despite her difficult home situation, she proved to be a caring and sympathetic listener. Subject
A made use of the opportunity to discuss her personal issues with the researcher and later with the group, and gradually came to terms with her home situation.

6.4.1.2 Personal image of Subject B

6.4.1.2(a) Background History

At the time of the initial interview, Subject B was 14 years 7 months of age. She has an older brother who was 20 at the time. A year prior to the interview Subject B had came across a photo album of a little boy. She discovered that she had had an older brother who died when he was ten months old. Subject B was extremely hurt that her family had not shared this information with her and a sense of mistrust regarding her parents subsequently developed. She wonders “what other secrets they are keeping” from her. Subject B perceives her parents as warm but overprotective. She feels that she is given too little freedom compared to her peers, and that she has more than her share of chores to do. Subject B feels bullied by her brother, but has very little to do with him now that he has moved into a communal residence.

Subject B is a late developer and is extremely small for her age. She is the cox for the school’s rowing team, and plays hockey for her school. Academically, she is very able. Socially, Subject B feels inadequate at times. She is a member of a small group of friends, but does not have any special friends. Subject B perceives her friends as not being sufficiently trusting of her to share intimate information with her. Subject B has a reasonable amount of confidence, but feels different physically. She is extremely self-conscious about the fact that she has not yet started developing breasts.

6.4.1.2(b) Reasons for Inclusion in the Group

Subject B hoped that by participating in the body image programme she might become more accepting of her body and feel less self-conscious.
6.4.1.2(c) Pre- and Post-test Psychometric Results

1. Pre-test Results

Results from the psychometric tests revealed the following:

(i) **No Signs Of Body Dysmorphic Disorder** - A score of 86 out of a possible 156 was obtained on the BDDE, providing a score for her "level of body image concern" for comparison purposes (see Table (i), pg. 280).

(ii) **Mild Depression** – A score of 14 on Beck’s Depression Inventory indicates that Subject B is suffering from mild depression (see Table (ii), pg. 281).

(iii) **Average Anxiety Level** – A sten score of 7 on the IPAT Anxiety Scale reveals that Subject B is functioning within the normal range of anxiety (see Table (iii), pg. 282).

(iv) **Medium Self-Concept** – A score of 53 on the ASCS indicates that Subject B has a medium self-concept (see Table (iv), pg. 283).

(v) **Average Structure** – A stanine score of 4 on the FFAQ reveals that Subject B is experiencing the structure in the family as average (see Table (vi), pg. 285).

(vi) **Average Affect** – A stanine score of 4 on the FFAQ indicates that Subject B rates both the quantity and the expression of affection in her family as average (see Table (vi), pg. 285).

(vii) **Average Communication** – A stanine score of 4 on the FFAQ indicates that Subject B experiences communication as average in the family (see Table (vi), pg. 285).

(viii) **Low Behaviour Control** – A stanine score of 3 on the FFAQ indicates that Subject B’s behaviour control is below average (see Table (vi), pg. 285).

(ix) **Average Value Transmission** – A stanine score of 4 on the FFAQ reveals that Subject B identifies positively with the value system of her parents (see Table (vi), pg. 285).
(x) **Average External Systems** – A stanine of 4 on the FFAQ shows that Subject B participates in school-related activities and enjoys average interaction with other external systems (see Table (vi), pg. 285).

(xi) According to the TAT responses, elements of frustration ("... fed up and frustrated ..."); "... life is frustrating ..."); "... nothing has gone right ..."); and loneliness ("...lonely practising on his own ..."); "... wishes she had someone to play with ..."); are evident. The TAT responses suggest issues around trust ("... you can’t trust anyone ..."); "... it is killing her keeping it inside but she can’t trust anyone ..."); A theme of hope is revealed in the analysis of the responses ("... he will eventually succeed ..."); "... maybe things will start coming right ..."); "... she will adapt to the news ...").

In the following section the post-test results will be presented.

2. **Post-test Results**

Results from the psychometric tests reveal the following:

(i) **No Signs Of Body Dysmorphic Disorder** – A score of 42 out of a possible 156 was obtained on the BDDE, providing a score for her “level of body image concern” for comparison purposes (see Table (i), pg. 280).

(ii) **No Depression** – A score of 7 on Beck’s Depression Inventory indicates that Subject B is no longer suffering from depression (see Table (ii), pg. 281).

(iii) **Average Anxiety Level** – A sten score of 7 on the IPAT Anxiety Scale reveals that Subject B is functioning within the normal range of anxiety (see Table (iii), pg. 282).

(iv) **Medium Self-Concept** – A score of 60 on the ASCS indicates that Subject B has a medium self-concept (see Table (v), pg. 283).

(v) **Average Structure** – A stanine score of 5 on the FFAQ reveals that Subject B is experiencing the structure in the family as average (see Table (vii), pg. 285).
(vi) **Average Affect** – A stanine score of 5 on the FFAQ indicates that Subject B rates both the quantity and the expression of affection in her family as average (see Table (vii), pg. 285).

(vii) **Average Communication** – A stanine score of 5 on the FFAQ indicates that Subject B experiences communication as average in the family (see Table (vii), pg.285).

(viii) **Average Behaviour Control** – A stanine score of 4 on the FFAQ indicates that Subject B's behaviour control is average (see Table (vii), pg. 285).

(ix) **Average Value Transmission** – A stanine score of 5 on the FFAQ reveals that Subject B identifies positively with the value system of her parents (see Table (vii), pg. 285).

(x) **Average External Systems** – A stanine of 5 on the FFAQ shows that Subject B participates in school-related activities and enjoys average interaction with other external systems (see Table (vii), pg.285).

(xi) Responses on the TAT indicate elements of frustration ("... fed up and frustrated ... ", "... things don't want to come right ... "). As was the case in the previous TAT assessment, feelings of hope come to the fore ("... eventually he will succeed ... ", "... she will find the strength to start again ... "). Family relationships are perceived as being cohesive ("... the whole family pulls together ... "), but a suggestion of conflict between father and daughter is evident ("... they argue ... her dad doesn't trust her ... ").

6.4.1.2(d) **Summary of changes experienced by Subject B**

Subject B benefited the most from the body image programme. A significant drop in scores (86 to 42) on the BODE test was noted after the completion of the body image programme. Subject B suggested that the realisation that her dissatisfaction with her appearance was likely to be temporary was a significant turning point for her.

The pre-test BDI score suggested that Subject B was mildly depressed (14) at the beginning of the programme. However, the post-test results revealed a
drop on the BDI test to 7, which suggests no depression. The score of 7 on the IPAT test was unchanged with the post-testing, indicating average anxiety. The scores of both the pre- (53) and post-test (60) results of the ASCS, suggest an average self-concept, although some improvement in self-esteem is noted.

Subject B scored in the average range for all the sub-tests on the FFAQ in the initial testing. This indicates healthy psychosocial functioning of the family. A general improvement in all sub-tests of the FFAQ was noted in the post-testing. The perception of improved family relationships is possibly due to the development of a more positive view of the self.

The responses of the initial TAT indicated feelings of loneliness, frustration and lack of trust. These feelings were also revealed in the follow-up TAT responses, but a greater sense of hope was evident. In the latter TAT, the cohesiveness of the family was portrayed, but some conflict between father and daughter was evident.

6.4.1.2(e) Pedagogical Observations

Subject B found it difficult to trust the group with intimate information initially. However, with time she shared her thoughts and feelings. Interestingly enough, the members of the group were also wary of sharing personal issues with Subject B. While one of the members of the group feared that Subject B would be unable to keep the information confidential, another member felt that Subject B “simply would not understand”. As it turned out, Subject B proved to be a valuable member of the group. She was extremely enthusiastic about the programme, and continually encouraged other group members.
6.4.1.3 Personal image of Subject C

6.4.1.3(a) Background History

At the time of the interview Subject C was 15 years and 3 months. She has a half-sister (six years older) who was sexually abused by her mother's first husband. The sister has been deeply affected by the incident and, despite years of therapy, is very moody and depressive. She tends to take her moods out on Subject C, especially since she has returned to live at home having fallen pregnant.

Subject C's mother is an aerobics instructor and is fanatical about her exercise and diet. Subject C admires her mother's self-discipline and reports, "She is my role model, I try to follow her footsteps!" Subject C's mother was diagnosed as anorexic 20 years ago and has not yet recovered. She is reported to be depressive, and at times locks herself in her bedroom for days on end. Subject C's mother has difficulty maintaining relationships and has had three failed marriages. The third marriage was to Subject C's father, which ended in a divorce shortly after Subject C was born. Subject C's father provides for her financially and visits her occasionally.

Subject C has a low self-image. She views herself as being useless and a failure. She is a member of a small group of friends, but is not particularly close to anyone. While she is creative, she battles generally with her academics and is not well co-ordinated. Subject C is particularly self-conscious about being overweight, and has been on various calorie restricted diets for years. There are times when she feels desperately lonely and depressed.

6.4.1.3(b) Reasons for Inclusion in the Group

Subject C wishes to be more confident and less self-conscious. She hoped that by participating in the body image programme she would become more accepting of herself and generally happier.
6.4.1.3(c) Pre- and Post-test Psychometric Results

1. Pre-test Results

Results from the psychometric tests revealed the following:

(i) **No Signs Of Body Dysmorphic Disorder** - A score of 84 out of a possible 156 was obtained on the BDDE, providing a score for her "level of body image concern" for comparison purposes (see Table (i), pg. 280).

(ii) **Moderate Depression** – A score of 21 on Beck’s Depression Inventory indicates that Subject C is suffering from moderate depression (see Table (ii), pg. 281).

(iii) **High Anxiety Level** – A sten score of 9 on the IPAT Anxiety Scale reveals that Subject C is in a state of high anxiety (see Table (iii), pg. 282).

(iv) **Low Self-Concept** – A score of 45 on the ASCS indicates that Subject C has a low self-concept (see Table (iv), pg. 283).

(v) **Low Structure** – A stanine score of 2 on the FFAQ reveals that Subject C is experiencing the structure in the family as below average (see Table (vi), pg. 285).

(vi) **Average Affect** – A stanine score of 4 on the FFAQ indicates that Subject C rates both the quantity and the expression of affection in her family as very low (see Table (vi), pg. 285).

(vii) **Low Communication** – A stanine score of 3 on the FFAQ indicates that Subject C experiences communication as below average in the family (see Table (vi), pg. 285).

(viii) **Low Behaviour Control** – A stanine score of 2 on the FFAQ indicates that Subject C’s behaviour control is below average (see Table (vi), pg. 285).

(ix) **Low Value Transmission** – A stanine score of 2 on the FFAQ reveals that Subject C does not identify positively with the value system of her parents (see Table (vi), pg. 285).

(x) **Low External Systems** – A stanine of 3 on the FFAQ shows that Subject C does not participate in school-related activities and has
below average interaction with other external systems (see Table (vi), pg. 285).

(xi) According to the TAT responses, elements of sadness (the words “upset” and “sad” are used frequently), helplessness (“... he can’t do it so he will just quit ...”), worthlessness (“... he feels completely useless ...”) and depression (“... she doesn’t want anyone to see her ...”) are evident. Parental figures are perceived as controlling (“... he was forced to play the violin ...”) and critical (“... his parents told him he was not good enough ...”, “... her father told her that she was useless ...”, “... her mother told her that she was fat and ugly ...”). The TAT responses suggest sibling rivalry (“... the sisters argue ... she is jealous of her sister because she has a crush on the guy who has made her pregnant ... “). Indications of aggression and abuse towards the daughter are evident (“... she was hit by her father ...”, “... the father sexually abused the daughter ...”). After completing the response of Card 13MF, Subject 3 confessed that her mother’s first husband had in fact sexually abused her half-sister, resulting in her mother’s first divorce.

In the following section the post-test results will be presented.

2. Post-test Results

Results from the psychometric tests reveal the following:

(i) **No Signs Of Body Dysmorphic Disorder** - A score of 74 out of a possible 156 was obtained on the BDDE, providing a score for her “level of body image concern” for comparison purposes (see Table (i), pg. 280).

(ii) **Moderate Depression** – A score of 18 on Beck’s Depression Inventory indicates that Subject C is still suffering from moderate depression (see Table (ii), pg. 281).

(iii) **High Anxiety Level** – A sten score of 8 on the IPAT Anxiety Scale reveals that Subject C is in a state of high anxiety (see Table (iii), pg. 282).
Low Self-Concept – A score of 48 on the ASCS indicates that Subject C has a low self-concept (see Table (v), pg. 283).

Low Structure – A stanine score of 2 on the FFAQ reveals that Subject C is experiencing the structure in the family as below average (see Table (vii), pg 285).

Average Affect – A stanine score of 5 on the FFAQ indicates that Subject C rates both the quantity and the expression of affection in her family as average (see Table (vii), pg. 285).

Low Communication – A stanine score of 3 on the FFAQ indicates that Subject C experiences communication as below average in the family (see Table (vii), pg. 285).

Low Behaviour Control – A stanine score of 2 on the FFAQ indicates that Subject C’s behaviour control is below average (see Table (vii), pg. 285).

Low Value Transmission – A stanine score of 2 on the FFAQ reveals that Subject C does not identify positively with the value system of her parents (see Table (vii), pg. 285).

Low External Systems – A stanine of 3 on the FFAQ shows that Subject C does not participate in school-related activities and has below average interaction with other external systems (see Table (vii), pg. 285).

A theme of being a mother and nursing her children is revealed in the analysis of the TAT responses, possibly suggesting a need for warmth and nurturing. The maternal figure is perceived as having high expectations (“... he'll practise even harder until his mother is satisfied ... ”). The paternal figure is perceived as critical and demeaning (“... he tells her that she is ‘useless and worthless’, ‘that he never wanted a girl’, ‘that he doesn’t care what she does with her life’ ... ”). Anger and aggression is directed towards women (“... the husband was angry and beat up his wife ... ”, “... the
father sexually abused his daughter ... "). Indications of sibling rivalry (" ... the sisters argue ... ") are evident. Subject C’s interpretation of the content of Card 2 reflects the circumstances of Subject C’s half-sister, who is pregnant and is about to get married as a result. In Subject C’s response, concern is expressed that the marriage will end in divorce, resulting in the suffering of the child soon to be born. It is possible that Subject C is reflecting on her own suffering as a result of her parents’ divorce. According to the analysis of the TAT responses the future is presented as being uncertain. An element of ambition is present, but this is tentative (" ... perhaps she will get divorced, go out to study and become a doctor or lawyer and be successful ... "). There appears to be ambivalence concerning the pursuit of independence. While part of Subject C reflects ambition, another part lacks the confidence and chooses to be dependent (" ... she dreams of being a mom, raising her children and being a housewife who is dependent ... ").

6.4.1.3(d) Summary of changes experienced by Subject C

The responses of the initial TAT reveal feelings of sadness, helplessness, worthlessness and depression. Authority figures are portrayed as being critical, aggressive and controlling. Sibling rivalry is indicated. These issues are revealed once again in the follow-up TAT. In addition, there is a suggestion of high expectations from authority figures. While some ambition is indicated, there is also uncertainty about the future. Ambivalence concerning the pursuit of independence is indicated.

The depression indicated in the responses of the TAT is supported by the results of the BDI. Moderate depression was indicated in the pre-testing (21) as well as the post-testing (18). The high anxiety indicated in the initial IPAT (9), remained unchanged. (This could possibly be due to the stressful events that occurred during that time, namely, the return of her half-sister to the home as a result of her pregnancy).
All sub-tests on the FFAQ (except for affect) were found to be in the low range and remained constant. This suggests little or no change in the perception of unhealthy family relationships. The average score for affect was puzzling (not to mention the increase from 4 to 5 in this area), since Subject C had frequently described her loneliness and isolation.

The scores on the BDDE (84 to 74) show improvement in Subject C's dissatisfaction with her physical appearance. Whilst a slight improvement was noted on the ASCS (45 to 48), the scores still reveal a low self-concept.

6.4.1.3(e) Pedagogical Observations

Subject C presented as a sensitive and vulnerable girl. She burst into tears a number of times when matters regarding her home situation arose. She appeared to be needy and lacking in confidence. The members of the group were sensitive to her needs and provided her with a sense of belonging and support. Subject C was extremely disappointed when the sessions were terminated. The researcher felt that Subject C was particularly vulnerable to developing an eating disorder, and thus referred her to the school counsellor for individual therapy.

6.4.1.4 Personal image of Subject D

6.4.1.4(a) Background History

At the time of the initial interview Subject D was 15 years and 2 months old. Subject D has a brother (two years older) who teases her relentlessly about being overweight. Her father is "obsessed" about exercising at the gym and looking good, and encourages Subject D to join him. Subject D's parents have had difficulties for some years. They are at present having counselling after Subject D's mother discovered that her husband had been having an affair. The news of this event upset Subject D a great deal. She is reasonably close to both her parents and fears that her parents might get
divorced at some stage. She perceives her father as being very strong and aggressive at times, while her mother tends to be submissive.

Subject D moved to her new school at the beginning of Grade 8, and is still struggling to settle in. Although she performed well academically and on the sports field at her previous school, her performance in these areas is now only just adequate. Financially, she perceives her family as being less fortunate than the majority of the families at the school. Her parents cannot afford to give her the extras that her peers enjoy, which makes her feel different and inferior. Although she still socialises with friends from her previous school, she has made a couple of friends at her new school. Subject D is still hesitant about bringing her friends from her new school to her home, since she feels that her home is very humble in comparison to that of her classmates. Outside the school environment, Subject D feels reasonably confident, but is unhappy with her body, which she perceives as being overweight.

6.4.1.4(b) Reasons for Inclusion in the Group

Subject D hoped that by participating in the body image programme she would become more accepting of her body, and learn to feel less reserved in her new environment.

6.4.1.4(c) Pre- and Post-test Psychometric Results

1. Pre-test Results

Results from the psychometric tests revealed the following:

(i) **No Signs Of Body Dysmorphic Disorder** - A score of 66 out of a possible 156 was obtained on the BDDE, providing a score for her "level of body image concern" for comparison purposes (see Table (i), pg. 280).
(ii) **No Depression** – A score of 9 on Beck’s Depression Inventory indicates that Subject D is not suffering from depression (see Table (ii), pg. 281).

(iii) **Average Anxiety Level** – A sten score of 6 on the IPAT Anxiety Scale reveals that Subject D is functioning within the normal range of anxiety (see Table (iii), pg. 282).

(iv) **Medium Self-Concept** – A score of 54 on the ASCS indicates that Subject D has a medium self-concept (see Table (iv), pg. 283).

(v) **Average Structure** – A stanine score of 4 on the FFAQ reveals that Subject D is experiencing the structure in the family as below average (see Table (vi), pg. 285).

(vi) **Low Affect** – A stanine score of 2 on the FFAQ indicates that Subject D rates both the quantity and the expression of affection in her family as below average (see Table (vi), pg. 285).

(vii) **Low Communication** – A stanine score of 3 on the FFAQ indicates that Subject D experiences communication in the family as below average (see Table (vi), pg. 285).

(viii) **Low Behaviour Control** – A stanine score of 3 on the FFAQ indicates that Subject D’s behaviour control is below average (see Table (vi), pg. 285).

(ix) **Average Value Transmission** – A stanine score of 4 on the FFAQ reveals that Subject D identifies positively with the value system of her parents (see Table (vi), pg. 285).

(x) **Low External Systems** – A stanine of 3 on the FFAQ shows that Subject D does not participate in school-related activities and has below average interaction with other external systems (see Table (vi), pg. 285).

(xi) Responses on the TAT suggest low self-esteem (“... not good enough ...”, “... must accept he’s not talented ...”). Elements of pessimism and hopelessness (“... won’t get it right ...”, “... gives up ...”, “... there is no solution to the problem ...”) are evident. The responses to Card 2 indicate some conflict regarding autonomy. (The younger sister envies the commitment to her family of her older sister, while the older sister envies the freedom and independence of her younger
sister). Underlying themes of anger and aggression from the male figure ("... shouts at his wife ...", "... going to hit her ...", "... will get angry and throw things off the table ...") are evident throughout the responses. While the male figure is perceived as "powerful" and aggressive, the female figure is perceived as "weak" and "unreasonable". Suggestions of rebellion ("... the girl turns her head away as she does not agree with her mother...") are evident.

In the following section the post-test results will be presented.

2. Post-test Results

Results from the psychometric tests reveal the following:

(i) **No Signs Of Body Dysmorphic Disorder** - A score of 52 out of a possible 156 was obtained on the BODE, providing a score for her "level of body image concern" for comparison purposes (see Table (i), pg. 280).

(ii) **No Depression** – A score of 8 on Beck’s Depression Inventory indicates that Subject D is not suffering from depression (see Table (ii), pg. 281).

(iii) **Average Anxiety Level** – A sten score of 5 on the IPAT Anxiety Scale reveals that Subject D is functioning within a normal range of anxiety (see Table (iii), pg. 282).

(iv) **Medium Self-Concept** – A score of 60 on the ASCS indicates that Subject D has a medium self-concept (see Table (v), pg. 283).

(v) **Average Structure** – A stanine score of 4 on the FFAQ reveals that Subject D is experiencing the structure in the family as average (see Table (vii), pg. 285).

(vi) **Average Affect** – A stanine score of 4 on the FFAQ indicates that Subject D rates both the quantity and the expression of affection in her family as average (see Table (vii), pg. 285).

(vii) **Average Communication** – A stanine score of 5 on the FFAQ indicates that Subject D experiences communication as average in the family (see Table (vii), pg. 285).
Average Behaviour Control – A stanine score of 4 on the FFAQ indicates that Subject D’s behaviour control is average (see Table (vii), pg. 285).

Average Value Transmission – A stanine score of 4 on the FFAQ reveals that Subject D identifies positively with the value system of her parents (see Table (vii), pg. 285).

Average External Systems – A stanine of 4 on the FFAQ shows that Subject D participates in school-related activities and interacts with other external systems (see Table (vii), pg. 285).

The analysis of the TAT responses reveal that Subject D lacks confidence in her abilities (“... distressed because he can’t play the violin properly ...”) but is reasonably optimistic about long-term achievement (“... if he practices really hard, he will eventually succeed ...”). Envy of a steady relationship is expressed in the response to Card 2. This could suggest a need for warmth and security. A theme of infidelity (“... the man will cheat on his wife ...”, “... after the divorce, the husband marries his girlfriend ...”) is evident. Some of the responses on the TAT suggest rejection directed towards the female figure (“... after the fight her boyfriend told her to leave ...”, “... the husband doesn’t love his wife anymore and asks for a divorce ...”). The male figure is perceived as being aggressive (“... he screams and shouts at her ...”), while the female figure is depicted as authoritarian (“... the nanny won’t let her play outside ...”). An element of rebellion (“... the girl won’t listen to the nanny and will go outside ...”) is evident.

6.4.1.4(d) Summary of changes experienced by Subject D

The pre-test results suggest that Subject D had a reasonably good self-concept and experienced neither depression nor excessive anxiety. The post-test results, however, indicate some improvement in these areas. An increase was noted on the ASCS (54 to 60), which suggests an improvement in self-concept, while the decrease on the IPAT (6 to 5) indicates that Subject D is feeling less anxious. Whilst the pre-test score on the BDI (9) indicated
that Subject D was not suffering from depression, her score dropped even further (8) in the post-testing, indicating a positive state of mind.

Subject D felt that she had gained a great deal from the body image programme. The results of the BDDE indicate improvement of dissatisfaction of physical appearance (decrease from 66 to 52).

Subject D scored within the low range for all the sub-tests of the FFAQ (except for structure and value transmission) in the initial assessment. The average score for value transmission was not surprising as Subject D was a committed Christian and had adopted a sound system of moral and religious values. However, the average score for structure was surprising as Subject D's parents were having difficulties with their marriage. However, they were receiving counselling and were committed to sorting out their differences. Subject D improved in all areas of the FFAQ with the post-testing, except for structure and value transmission. The most significant improvement was found in the areas of communication and affect. This can possibly be attributed to the counselling received by Subject D's parents, where the emphasis was on communication skills and the appropriate expression of feelings and opinions. The children were occasionally included in the sessions.

The responses of the initial TAT suggest low self-esteem, contrary to the results of the ASCS. Feelings of hopelessness and pessimism came to the fore, as well as some conflict regarding autonomy and independence. The male figure was portrayed as powerful and aggressive, while the female figure was described as "weak and unreasonable". Feelings of rebellion were noted. The responses of the follow-up TAT also indicated a lack of confidence, but optimism concerning long-term achievement was expressed. The reference of infidelity noted in the responses may possibly refer to the circumstances of Subject D's parents. Once again, the male figure is portrayed as aggressive. However, the female is described as authoritarian, which conflicts with the previous description. Feelings of rebellion come to the fore once again.
6.4.1.4(e) Pedagogical Observations

Subject D was a leader amongst the group. She communicated difficulties or requests on behalf of the group. She appeared to be reasonably confident within the context of the group, and expressed her opinions and feelings freely. Subject D took the opportunity of sharing her personal issues both with the researcher and the group. The process provided her with the clarity to find her own solutions to her problems. She seemed comforted to discover that not all the girls at the school valued economic status. As time went on, Subject D began to question whether she was in fact so different from her peers after all.

6.4.2 Personal images of the control group (self-esteem group)

The four girls in the control group followed a programme that focussed on building general self-esteem. These four subjects are referred to as Subjects 1 to 4.

6.4.2.1 Personal image of Subject 1

6.4.2.1(a) Background History

At the time of the initial interview Subject 1 was 15 years and 4 months old. She has two older brothers and one younger one. Her brothers are particularly talented. They all represent Gauteng for some sport or other, and cope very well academically. While Subject 1 plays a reasonable game of squash, she is not particularly co-ordinated. She has struggled academically since Grade 1, and has had many years of remedial lessons. Her father is a particularly successful plastic surgeon. Subject 1 feels inferior to the other members of her family. Subject 1 perceives her family as close, and relates well to her parents and her siblings. She has a boyfriend who continually compliments her and has done much to boost her self-esteem. Despite
being attractive and slim, Subject 1 watches her diet very carefully and fears gaining weight.

6.4.2.1(b) Reasons for Inclusion in the Group

Subject I hoped that by participating in a self-esteem programme she would develop her confidence.

6.4.2.1(c) Pre- and Post-test Psychometric Results

1. Pre-test Results

Results from the psychometric tests revealed the following:

(i) **No Signs Of Body Dysmorphic Disorder** - A score of 59 out of a possible 156 was obtained on the BDDE, providing a score for her “level of body image concern” for comparison purposes (see Table (i), pg. 280).

(ii) **No Depression** – A score of 8 on Beck’s Depression Inventory indicates that Subject 1 is not suffering from depression (see Table (ii), pg. 281).

(iii) **Average Anxiety Level** – A sten score of 7 on the IPAT Anxiety Scale reveals that Subject 1 is functioning within the normal range of anxiety (see Table (iii), pg. 282).

(iv) **Medium Self-Concept** – A score of 54 on the ASCS indicates that Subject 1 has a medium self-concept (see Table (iv), pg. 283).

(v) **High Structure** – A stanine score of 7 on the FFAQ reveals that Subject 1 is experiencing the structure in the family as above average (see Table (vi), pg. 285).

(vi) **Average Affect** – A stanine score of 5 on the FFAQ indicates that Subject 1 rates both the quantity and the expression of affection in her family average (see Table (vi), pg. 285).

(vii) **Average Communication** – A stanine score of 6 on the FFAQ indicates that Subject 1 experiences communication as average in the family (see Table (vi), pg. 285).
(viii) **Average Behaviour Control** – A stanine score of 6 on the FFAQ indicates that Subject 1’s behaviour control is average (see Table (vi), pg. 285).

(ix) **High Value Transmission** – A stanine score of 9 on the FFAQ reveals that Subject 1 identifies very positively with the value system of her parents (see Table (vi), pg. 285).

(x) **High External Systems** – A stanine of 7 on the FFAQ shows that Subject 1 participates in school-related activities and enjoys above average interaction with other external systems (see Table (vi), pg. 285).

(xi) An analysis of the TAT responses indicates feelings of frustration (“... upset with his violin ...”, “... had enough ...”, “... feels like giving up ...”). However, an element of hope exists (“... he’ll probably master it in the end ...”). Family relationships are portrayed as positive and connected (“... they are all helping ...”, “... they are having fun ...”). The paternal role may possibly be interpreted as being protective (“... the father is angry that the teacher hurt his daughter and will speak to the headmistress ...”). Elements of hope for a happy and successful future feature in some of the responses (“... daydreaming about a happy future ...”, “... wants to be successful ...”, “... wants to be a mother with a family ...”).

In the following section the post-test results will be presented.

2. **Post-test Results**

Results from the psychometric tests reveal the following:

(i) **No Signs Of Body Dysmorphic Disorder** – A score of 54 out of a possible 156 was obtained on the BDDE, providing a score for her “level of body image concern” for comparison purposes (see Table (i), pg. 280).

(ii) **No Depression** – A score of 6 on Beck’s Depression Inventory indicates that Subject 1 is not suffering from depression (see Table (ii), pg. 281).
(iii) **Average Anxiety Level** – A stanine score of 6 on the IPAT Anxiety Scale reveals that Subject 1 is functioning within the normal range of anxiety (see Table (iii), pg. 282).

(iv) **Medium Self-Concept** – A score of 60 on the ASCS indicates that Subject 1 has a medium self-concept (see Table (v), pg. 283).

(v) **High Structure** – A stanine score of 8 on the FFAQ reveals that Subject 1 is experiencing the structure in the family as above average (see Table (vii), pg. 285).

(vi) **High Affect** – A stanine score of 7 on the FFAQ indicates that Subject 1 rates both the quantity and the expression of affection in her family as above average (see Table (vii), pg. 285).

(vii) **High Communication** – A stanine score of 8 on the FFAQ indicates that Subject 1 experiences communication as above average in the family (see Table (vii), pg. 285).

(viii) **High Behaviour Control** – A stanine score of 8 on the FFAQ indicates that Subject 1’s behaviour control is above average (see Table (vii), pg. 285).

(ix) **High Value Transmission** – A stanine score of 9 on the FFAQ reveals that Subject 1 identifies very positively with the value system of her parents (see Table (vii), pg. 285).

(x) **High External Systems** – A stanine of 8 on the FFAQ shows that Subject 1 participates in school-related activities and enjoys above average interaction with other external systems (see Table (vii), pg. 285).

(xi) Responses on the TAT indicate frustration, ("... tired and fed up ...", "... confused ...", "... had enough ...") anger ("... he broke the violin ...") and hard work ("... working hard ...", "... trying hard ...", "... trying to get the piece of music right ...", "... trying to decide ..."). (In the case of Subject 1, the frustration and lack of success can possibly be interpreted literally. [Subject 1 acknowledged her frustration with her academic performance and approached the researcher for assistance in this regard]. Subject 1 does not seem to have the tools to deal with her problems ("... doesn’t know how to fix it ...", "doesn’t seem to have an answer ..."). The word “little” is used
more than once in the responses, which possibly suggests a need for nurturing and protection. Once again, hope for a positive future is evident ("... she will be happily married with a family one day ... ", ", ... she will have the choice as to whether she wants to work ... ").

6.4.2.1(d) Summary of changes experienced by Subject 1

The results of the pre-testing suggested that Subject 1 had an average self-concept, and no depression or excessive anxiety was evident. However some improvement in these areas was noted with the post-testing. The scores of the ASCS increased from 54 to 60, which suggests an improvement in self-esteem. Whilst no depression was found with the pre-testing, a decrease on the BDI (8 to 6) indicates even less evidence of depression. A decrease on the IPAT (7 to 6) with the post-testing suggests that Subject 1 is feeling even less anxious. Some improvement was noted regarding dissatisfaction with physical appearance. The scores on the BDDE decreased from 59 to 54.

All the sub-tests on the FFAQ were found to be within the average or high range, indicating the perception of healthy family relationships. An improvement was noted in all sub-tests with the post-testing with the exception of value transmission, which was already high.

The responses of the initial TAT indicate a positive and connected family structure, which supports the results of the FFAQ. The paternal figure is portrayed as being protective. There are indications of frustration, and hope for a happy and successful future is expressed. The responses of the follow-up TAT continue to indicate feelings of anger and frustration, and difficulty in dealing with issues. Once again, hope for a positive future is expressed.

6.4.2.1(e) Pedagogical Observations

Subject 1 was initially shy and inhibited, but soon gained the confidence to express her opinions and feelings. When matters concerning relationships
with parents arose, members of the group asked Subject 1 for her opinion. Subject 1 realised that she had become the role model for the group in this area, which did much to boost her self-esteem. Subject 1 sought assistance from the researcher concerning academic issues, and extra lessons were organised with a tutor.

6.4.2.2 Personal image of Subject 2

6.4.2.2(a) Background History

At the time of the initial interview Subject 2 was 14 years 7 months old. She had a brother who was two years older. Both siblings perceive their father to be overly strict, verbally abusive and aggressive. They relied a great deal on one another for support. Frequent references to being overweight and unkind comments have done much to undermine Subject 2's self-esteem. (For example, Subject 2's father would tell her that he was ashamed to admit that she was his daughter).

Strangely enough, Subject 2's father appears to respect his wife, a wealthy businesswoman who holds a powerful and prestigious position. Aggression is therefore seldom directed towards her. Subject 2's mother is perceived as being nurturing, but is extremely busy and is not always physically or emotionally available.

Academically, Subject 2 copes adequately, but complains about a lack of encouragement from her teachers. She has been concerned about her weight problem for many years, and has tried a number of different calorie restricted diets.

6.4.2.2(b) Reasons for Inclusion in the Group

Subject 2 felt self-conscious about her body and hoped that by participating in the research study, she would learn to accept her body more readily and to develop her confidence. (Unfortunately for the individual, Subject 2 was

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6.4.2.2(c) Pre- and Post-test Psychometric Results

1. Pre-test Results

Results from the psychometric tests revealed the following:

(i) No Signs Of Body Dysmorphic Disorder - A score of 104 out of a possible 156 was obtained on the BDDE, providing a score for her "level of body image concern" for comparison purposes (see Table (i), pg. 280).

(ii) Moderate Depression – A score of 17 on Beck’s Depression Inventory indicates that Subject 2 is suffering from moderate depression (see Table (ii), pg. 281).

(iii) Average Anxiety Level – A sten score of 7 on the IPAT Anxiety Scale reveals that Subject 2 is functioning within the normal range of anxiety (see Table (iii), pg. 282).

(iv) Medium Self-Concept – A score of 54 on the ASCS indicates that Subject 2 has a medium self-concept (see Table (iv), pg. 283).

(v) Average Structure – A stanine score of 6 on the FFAQ reveals that Subject 2 is experiencing the structure in the family as average (see Table (vi), pg. 285).

(vi) Low Affect – A stanine score of 3 on the FFAQ indicates that Subject 2 rates both the quantity and the expression of affection in her family as very low (see Table (vi), pg. 285).

(vii) Average Communication – A stanine score of 4 on the FFAQ indicates that Subject 2 experiences communication as average in her family (see Table (vi), pg. 285).

(viii) Average Behaviour Control – A stanine score of 4 on the FFAQ indicates that Subject 2’s behaviour control is average (see Table (vi), pg. 285).
(ix) **Average Value Transmission** – A stanine score of 6 on the FFAQ reveals that Subject 2 identifies positively with the value system of her parents (see Table (vi), pg. 285).

(x) **High External Systems** – A stanine of 8 on the FFAQ shows that Subject 2 participates in school-related activities and enjoys above average interaction with other external systems (see Table (vi), pg. 285).

(xi) Responses on the TAT suggest that Subject 2 may be trying to live up to the expectations of the significant figures in her life ("... he feels that he is expected to give of his best ... ", "... now he is beginning to have high expectations of his own ..."). Indications of rebellion are evident ("... he feels so pressurised he rebels ...", "... he's just going to give up ...", "... she's not interested in what her mom is saying and will do her own thing"). Elements of helplessness ("... can't do it ...", "... stuff in her life that she can't control ...") and loneliness ("lonely", "alone") come to the fore. In the response to Card 7GF, the girl is holding a baby which may suggest a need for warmth and nurturing. The word “little” is used twice in the responses, which also suggests a need for nurturing. The significant male figure is portrayed as "evil" and aggressive ("... the lady is afraid as she is not sure whether the man will be violent ...", "... the girl is scared of the man ..."). Hope for a brighter future is evident in some of the responses ("... she dreams that she moves out of the situation ...", "... she can do so much better with her life ...").

In the following section the post-test results will be presented.

2. **Post-test Results**

Results from the psychometric tests reveal the following:

(i) **No Signs Of Body Dysmorphic Disorder** – A score of 96 out of a possible 156 was obtained on the BDDE, providing a score for her "level of body image concern" for comparison purposes (see Table (i), pg. 280).
(ii) **No Depression** – A score of 9 on Beck’s Depression Inventory indicates that Subject 2 is no longer suffering from depression (see Table (ii), pg. 281).

(iii) **Average Anxiety Level** – A sten score of 6 on the IPAT Anxiety Scale reveals that Subject 2 is functioning within the normal range of anxiety (see Table (iii), pg. 282).

(iv) **Medium Self-Concept** – A score of 61 on the ASCS indicates that Subject 2 has a medium self-concept (see Table (v), pg. 283).

(v) **Average Structure** – A stanine score of 6 on the FFAQ reveals that Subject 2 is experiencing the structure in the family as average (see Table (vii), pg. 285).

(vi) **Average Affect** – A stanine score of 4 on the FFAQ indicates that Subject 2 rates both the quantity and the expression of affection in her family as average (see Table (vii), pg. 285).

(vii) **Average Communication** – A stanine score of 5 on the FFAQ indicates that Subject 2 experiences communication as average in the family (see Table (vii), pg. 285).

(viii) **Average Behaviour Control** – A stanine score of 4 on the FFAQ indicates that Subject 2’s behaviour control is average (see Table (vii), pg. 285).

(ix) **High Value Transmission** – A stanine score of 7 on the FFAQ reveals that Subject 2 identifies very positively with the value system of her parents (see Table (vii), pg. 285).

(x) **High External Systems** – A stanine of 8 on the FFAQ shows that Subject 2 participates in school-related activities and enjoys above average interaction with other external systems (see Table (vii), pg. 285).

(xi) According to the TAT responses, elements of frustration (“upset”, “fed up”) and self-defeat (“can’t accomplish anything”, “too difficult”, “defeated”) are evident. Once again, the word “little” is used more than once in the responses suggesting a need for nurturing. The response to Card 7GF includes the holding of a baby, which reinforces the notion that Subject 2 may be in need of warmth and protection. The paternal figure is portrayed as evil (“... he is evil ...”) and
aggressive ("... she is scared of the man ... ", "... she has been hurt by him ..."). While Subject 2 described her father as being verbally abusive in the initial interview, the responses of the TAT suggest the possibility of physical abuse as well. In this assessment, the maternal figure is portrayed as being authoritative ("... her mom is forcing her ... "). Hope for a brighter future is evident in some of the responses ("... dreams of a better place, a better life ...", "... get out of the home ...", "... she can achieve more ...").

6.4.2.2(d) Summary of Subject 2

The responses of the initial TAT suggest that high expectations have been set for Subject 2. Feelings of loneliness, helplessness and rebellion are indicated, while the need for warmth and nurturing comes to the fore. Hope for a brighter future is expressed. The responses of the follow-up TAT reveal frustration and self-defeat. The need for nurturing is evident once again, as well as the hope for a brighter future.

The pre-test results indicated that Subject 2's self-concept falls into the average range. Some improvement was noted on the ASCS with the post-testing (increase from 54 to 61). A decrease on the BDDE was also noted (104 to 96), indicating some improvement regarding the dissatisfaction of physical appearance.

A decrease from 7 to 6 was noted on the IPAT with the post-testing, indicating a slight improvement with Subject 2's level of anxiety. Subject 2's scores on the BDI decreased from 17 (moderate depression) to 9 with the post-testing, indicating that Subject 2 no longer suffered from depression.

Contrary to expectations, Subject 2 scored within the average or high range in all sub-tests of the FFAQ (except for affect) in both the pre- and post-testing. This indicates that Subject 2 perceives her family relationships as being healthy. Perhaps Subject 2 has focused on the general picture of the family. While her relationships with her brother and mother are close, the issues with
her father are significant. With the post-testing, Subject 2 improved in the areas of affect and communication, as well as value transmission.

6.4.2.2(e) Pedagogical Observations

Subject 2 presented as being needy and frustrated, and tended to dominate the conversation with her issues concerning her father at times. It was frequently necessary for the researcher to intervene in order to give the others an opportunity to express their views. Subject 2 relied a great deal on Subject 1 for support, and a close relationship developed between the two. Subject 2 worked extremely hard at improving the communication with her parents.

6.4.2.3 Personal image of Subject 3

6.4.2.3(a) Background History

At the time of the initial interview Subject 3 was 14 years and 5 months old. Subject 3 has a sister who is two years older. A great deal of sibling rivalry exists. Subject 3 feels that she has very little in common with any of her family members, and chooses to spend most of her time with her small group of friends. Subject 3 perceives her mother as being insecure and weak, one who is constantly trying to please others in order to gain approval. She views her father as being "strict" and aggressive at times, but suggests that she has learnt to manipulate him in order to get her way.

Subject 3 perceives her sporting and academic abilities as deficient. She has struggled with her studies for many years, and becomes particularly anxious when writing examinations. Despite recommendations from various teachers, Subject 3 has not received the recommended assistance. Physically, Subject 3 acknowledges that she is slim, and perceives her shape as acceptable.
6.4.2.3(b) Reasons for Inclusion in the Group

Subject 3 viewed herself as lacking in general confidence. She hoped that participation in the research study would be helpful in developing this. Subject 3 was honest enough to confess that she disliked the school counsellor intensely, and that the idea of being able to avoid Life Skills classes was an additional motivating factor for her participation in the study.

6.4.2.3(c) Pre- and Post-test Psychometric Results

1. Pre-test Results

Results from the psychometric tests revealed the following:

(i) **No Signs Of Body Dysmorphic Disorder** – A score of 77 out of a possible 156 was obtained on the BDDE, providing a score for her “level of body image concern” for comparison purposes (see Table (i), pg. 280).

(ii) **Mild Depression** – A score of 13 on Beck's Depression Inventory indicates that Subject 3 is suffering from mild depression (see Table (ii), pg. 281).

(iii) **High Anxiety Level** – A sten score of 9 on the IPAT Anxiety Scale reveals that Subject 3 is in a state of high anxiety (see Table (iii), pg. 282).

(iv) **Low Self-Concept** – A score of 48 on the ASCS indicates that Subject 3 has a low self-concept (see Table (iv), pg. 283).

(v) **Low Structure** – A stanine score of 2 on the FFAQ reveals that Subject 3 is experiencing the structure in the family as below average (see Table (vi), pg. 285).

(vi) **Low Affect** – A stanine score of 3 on the FFAQ indicates that Subject 3 rates both the quantity and the expression of affection in her family as below average (see Table (vi), pg. 285).

(vii) **Low Communication** – A stanine score of 3 on the FFAQ indicates that Subject 3 experiences communication as below average in her family (see Table (vi), pg. 285).
Low Behaviour Control – A stanine score of 2 on the FFAQ indicates that Subject 3's behaviour control is below average (see Table (vi), pg. 285).

Average Value Transmission – A stanine score of 5 on the FFAQ reveals that Subject 3 identifies positively with the value system of her parents (see Table (vi), pg. 285).

High External Systems – A stanine of 7 on the FFAQ shows that Subject 3 participates in school-related activities and enjoys above average interaction with other external systems (see Table (vi), pg. 285).

The responses of the TAT suggest feelings of sadness ("... he is sad ...", "... she is upset ..."). It appears that Subject C experiences difficulty coping with the demands of life ("... he couldn't get the piece right ...") and feels powerless to resolve issues ("... doesn't know what to do ...", "... doesn't know how to persuade her father ..."). The significant male figure is portrayed as authoritative ("... he pushed him to continue ...", "... tried to force her to marry someone ...") and aggressive ("... argues with his daughter ...", "... beaten his wife ..."). In response to Card 2, Subject 3 identifies with the young girl whom she portrays as feeling isolated and different from her family ("... she is different ...", "... she cannot relate to her family ...").

In the following section the post-test results will be presented.

2. Post-test Results
Results from the psychometric tests reveal the following:

No Signs Of Body Dysmorphic Disorder - A score of 71 out of a possible 156 was obtained on the BDDE, providing a score for her "level of body image concern" for comparison purposes (see Table (i), pg. 280).

Mild Depression – A score of 10 on Beck's Depression Inventory indicates that Subject 3 is suffering from mild depression (see Table (ii), pg. 281).
(iii) **High Anxiety Level** – A sten score of 8 on the IPAT Anxiety Scale reveals that Subject 3 is in a state of high anxiety (see Table (iii), pg. 282).

(iv) **Medium Self-Concept** – A score of 54 on the ASCS indicates that Subject 3 has a medium self-concept (see Table (v), pg. 283).

(v) **Low Structure** – A stanine score of 3 on the FFAQ reveals that Subject 3 is experiencing the structure in the family as below average (see Table (vii), pg. 285).

(vi) **Low Affect** – A stanine score of 3 on the FFAQ indicates that Subject 3 rates both the quantity and the expression of affection in her family as below average (see Table (vii), pg. 285).

(vii) **Average Communication** – A stanine score of 4 on the FFAQ indicates that Subject 3 experiences communication as average in the family (see Table (vii), pg. 285).

(viii) **Low Behaviour Control** – A stanine score of 3 on the FFAQ indicates that Subject 3's behaviour control is below average (see Table (vii), pg. 285).

(ix) **Average Value Transmission** – A stanine score of 6 on the FFAQ reveals that Subject 3 identifies positively with the value system of her parents (see Table (vii), pg. 285).

(x) **High External Systems** – A stanine of 7 on the FFAQ shows that Subject 3 participates in school-related activities and enjoys above average interaction with other external systems (see Table (vii), pg. 285).

(xi) The responses on the TAT suggest that Subject C is not coping with the demands of life (“... he has messed up again ... “, “... it is too difficult for him ... “). Elements of sadness (“... very sad ... “) and loneliness (“... the little girl is lonely because she feels different from her family ... “, “... she doesn't relate ... “, “... the rich girl wants to be normal and do normal stuff with her friends ...”) are revealed in the responses. The paternal figure is portrayed as authoritarian and controlling (“... keeps pushing him ... “, “... he forces him to continue ... “, “... her father is strict ... “, “... she is not allowed to play outside ... “). Despite suggestions of conflict (“... going to have a huge fight ... “).
with her dad ... " , " ... she and her father will argue ... ") , some of the responses of the TAT suggest some connection and closeness between Subject 3 and her parents (" ... but he loves his daughter ... ", " ... even though she loves them ... "). Themes of loss of work (" ... he has been fired from his job ... ", " ... since he lost his job ... "), heavy drinking (" ... he's become a drunk ...", " ... being drinking too much at the bar ...", " ... girl's father is a drunk ... ") and aggression (" ... when the man is drunk he is abusive ...", " ... her father will be cross ...", " ... he beats his daughter ...", " ... he has taken it out on his wife ...") are evident throughout the responses of the TAT. (It has subsequently been confirmed that Subject C's father has been drinking heavily since he has lost his job, but there was no confirmation as to his aggressive behaviour). The maternal figure is portrayed as timid and submissive (" ... she doesn’t have the courage to leave him ...", " ... she just accepts it ...", " ... she doesn’t have the willpower to stand up to him or the courage to leave him ..."). Hope for a brighter future is evident in her responses (" ... she longs for more out of life ...", " ... eventually she will move out of the house, become independent and successful ...").

6.4.2.3(d) Summary of Subject 3

The responses of the initial TAT indicate sadness, isolation and difficulty coping with the demands of life. Hope for a brighter future is expressed. The paternal figure is portrayed as being authoritative and aggressive. The responses of the follow-up TAT also suggest sadness and lack of skills needed to deal with issues. While the paternal figure is portrayed as authoritative and controlling, the maternal figure is perceived as being timid and submissive. Connection as well as conflict is evident in the family environment. Themes of loss of work, excessive drinking and aggression come to the fore.

The results of the pre-testing suggest mild depression (13 on the BDI) and high anxiety (9 on the IPAT). In the post-testing, improvement was noted on
both the BDI (10) and IPAT (8) tests. A decrease was revealed on the BDDE (77 to 71), suggesting an improvement in the dissatisfaction of physical appearance. A low self-concept was indicated on the ASCS (48), but some improvement was noted with the post-testing (54).

The scores of the FFAQ with the pre-testing indicate low scores for all sub-tests except for value transmission (average) and external systems (high). These results indicate the perception of unhealthy relationships within the family. However, with the post-testing, improvement was noted in the areas of communication (average), structure (still low), behaviour control (still low), and value transmission (average).

6.4.2.3(e) Pedagogical Observations

Subject 3 presented as needy and lacking in confidence. Her need for approval from her peers was great. She was fickle and easily influenced by her peers as a result. Prior to the commencement of the programme, Subject 3 was frequently in trouble with the teachers, who found her resistant, uncooperative and unmotivated regarding her academics. During the course of the programme, Subject 3 demonstrated greater interest in her studies, but still experienced conflict with the teachers. The members of the group were extremely supportive during these times, offering both encouragement and assistance with her academics.

6.4.2.4 Personal image of Subject 4

6.4.2.4(a) Background History

At the time of the initial assessment Subject 4 was 14 years and 9 months old. She has a brother who is three years older. Subject 4 gets on well with her brother whom she perceives as being her only real friend besides her boyfriend. Subject 4 is exceptionally attractive in terms of Western standards, which appears to be both her blessing and her curse. It appears that her beauty evokes much jealousy amongst her girlfriends, who envy the
attention she receives. For many years Subject 4 has been on the receiving end of nasty comments. At times she has been excluded from social outings with her girlfriends, while untruthful rumours have been spread about her. She has learnt not to trust her peers, and seldom discloses any intimate information. Subject 4 has suffered from depression on and off for the past year and so, and her general practitioner has recommended that she takes an anti-depressant.

Subject 4 perceives her parents as being strict but at times inconsistent in terms of their discipline. She views their decision making as being unreasonable at times, and sees the level of independence granted dependent on the mood of her parents rather than on reason. While Subject 4 loves her parents and is sure that the love is mutual, she is not able to communicate effectively with them.

Academically, Subject 4 struggles a great deal, but believes that she can improve on her performance. She claims that she works hard when she is feeling good, but when her parents and the teachers are "on her back" about her studies, she becomes unmotivated.

She perceives the teachers as continually being "on her back", and feels that she is often blamed unfairly for looking for trouble. Despite her good looks, Subject 4 is overly concerned about her appearance, and lives in fear of putting on weight. She attends aerobic classes religiously and fasts once a week.

6.4.2.4(b) Reasons for Inclusion in the Group

Subject 4 feels that she lacks confidence. She hopes that by participating in the research study, she will gain confidence and feel more at ease socially.
6.4.2.4(c) Pre- and Post-test Psychometric Results

1. Pre-test Results

Results from the psychometric tests revealed the following:

(i) **No Signs Of Body Dysmorphic Disorder** - A score of 42 out of a possible 156 was obtained on the BDDE, providing a score for her "level of body image concern" for comparison purposes (see Table (i), pg. 280).

(ii) **Severe Depression** – A score of 26 on Beck’s Depression Inventory indicates that Subject 4 is suffering from severe depression (see Table (ii), pg. 281).

(iii) **Average Anxiety Level** – A sten score of 7 on the IPAT Anxiety Scale reveals that Subject 4 is functioning within the normal range of anxiety (see Table (iii), pg. 282).

(iv) **Medium Self-Concept** – A score of 53 on the ASCS indicates that Subject 4 has a medium self-concept (see Table (iv), pg. 283).

(v) **Average Structure** – A sten score of 4 on the FFAQ reveals that Subject 4 is experiencing the structure in the family as average (see Table (vi), pg. 285).

(vi) **Low Affect** – A sten score of 2 on the FFAQ indicates that Subject 4 rates both the quantity and the expression of affection in her family as below average (see Table (vi), pg. 285).

(vii) **Low Communication** – A sten score of 2 on the FFAQ indicates that Subject 4 experiences communication as below average in the family (see Table (vi), pg. 285).

(viii) **Low Behaviour Control** – A sten score of 3 on the FFAQ indicates that Subject 4’s behaviour control is below average (see Table (vi), pg. 285).

(ix) **Low Value Transmission** – A sten score of 2 on the FFAQ reveals that Subject 4 does not identify positively with the value system of her parents (see Table (vi), pg. 285).
Average External Systems – A stanine of 6 on the FFAQ shows that Subject 4 participates in school-related activities and has average interaction with other external systems (see Table (vi), pg. 285).

The responses on the TAT indicate elements of passivity ("... is sitting and thinking ...", "... is thinking what to do ..."), hopelessness ("... he's not successful and never will be ...", "... he'll never enjoy the violin ...") and depression ("sad", "disappointed", "unhappy", "... sad and depressed ..."). A theme of guilt runs through some of the responses of the TAT ("... he feels too guilty to stand up to his parents ...", "... she has done something bad ...", "... she's ashamed because she had a baby while still at school ...", "... she has done something wrong ..."). Family members are described as having very little connection ("... they all do their own thing ..."). Parental figures may be perceived as controlling ("... forced to play...") and critical ("... her father is shouting at her for doing something wrong ...", "... her father is angry with her for doing something bad...", "... her mother is giving her a lecture ..."). An element of rebellion comes to the fore ("... she rejects her mother and will not discuss the issue with her ...").

In the following section the post-test results will be presented.

2. Post-test Results

Results from the psychometric tests reveal the following:

(i) No Signs Of Body Dysmorphic Disorder – A score of 40 out of a possible 156 was obtained on the BODE, providing a score for her "level of body image concern" for comparison purposes (see Table (i), pg. 280).

(ii) Mild Depression – A score of 14 on Beck’s Depression Inventory indicates that Subject 4 is suffering from mild depression (see Table (ii), pg. 281).

(iii) Average Anxiety Level – A sten score of 6 on the IPAT Anxiety Scale reveals that Subject 4 is functioning within the normal range of anxiety (see Table (iii), pg. 282).
Medium Self-Concept – A score of 58 on the ASCS indicates that Subject 4 has a medium self-concept (see Table (v), pg. 283).

Average Structure – A stanine score of 4 on the FFAQ reveals that Subject 4 is experiencing the structure in the family as average (see Table (vii), pg. 285).

Low Affect – A stanine score of 3 on the FFAQ indicates that Subject 4 rates both the quantity and the expression of affection in her family as below average (see Table (vii), pg. 285).

Low Communication – A stanine score of 3 on the FFAQ indicates that Subject 4 experiences communication as below average in her family (see Table (vii), pg. 285).

Low Behaviour Control – A stanine score of 3 on the FFAQ indicates that Subject 4's behaviour control is below average (see Table (vii), pg. 285).

Low Value Transmission – A stanine score of 3 on the FFAQ reveals that Subject 4 does not identify positively with the value system of her parents (see Table (vii), pg. 285).

Average External Systems – A stanine of 6 on the FFAQ shows that Subject 4 participates in school-related activities and has average interaction with other external systems (see Table (vii), pg. 285).

Responses on the TAT reveal an attitude of passivity ("... sitting and thinking ...", "... he'll try to think of a plan ..."). Themes of concern ("... something has been bothering him ...", "... the girl looks very worried ...", "... needs to fix the problem ..."), guilt and fear of punishment ("... he has done something wrong ...", "... she has done something wrong and is going to be punished ...", "... she is afraid that her father will punish her because she did something bad ...") are evident throughout the responses of the TAT. The words "sad and depressed", "hurting" and "unhappy" are used a number of times throughout the responses of the TAT indicating possible depression. An unhappy family is identified ("... the family is unhappy ..."). Some conflict between husband and wife is suggested ("... the husband and wife are arguing again ... they both always want their own way ..."). The need for nurturing but at the same time for greater independence
is suggested ("... she rejects the maid's help ... ", "... she wants to hold the baby ... ", "... she will look after the baby her way ... ").

6.4.2.4(d) Summary of changes experienced by Subject 4

Subject 4 appeared to benefit from the intervention programme. Towards the end of the programme she was better able to drop her defences and to express her feelings more readily. The programme was particularly valuable for Subject 4 in that she learnt that other members of the group had similar issues with their parents. It was also comforting for her to discover that other members of the group also felt pressurised by the academic demands of the school.

A significant drop (26 to 14) from severe to mild depression was observed in the post-test scores. Some decrease in anxiety (7 to 6) was also found after the intervention of the programme.

Although the scores are still low, some progress is reflected in the affect (2 to 3) and communication scores (2 to 3) of the FFAQ, suggesting some improvement in Subject 4's ability to communicate with her family and to express her feelings. A positive change was also observed in the area of value transmission (2 to 3) suggesting that Subject C has developed a greater acceptance of the values and norms of her parents.

The post-test assessment reflects some positive change (increase of 53 to 58 points) regarding self-esteem, while a minimal positive change in body image (decrease of 42 to 40 points) can be observed.

6.4.2.4(e) Pedagogical Observations

Subject 4 initially presented as reserved and distant. In the beginning she chose to observe the sessions passively, and refrained from sharing anything of significance about herself with the group. The change came about during the fifth session, a day when Subject 4 had been "shadowed" by a member of staff. (It is the policy of the school for a member of staff to be assigned to

- 280 -
spend a day with a particular pupil whom the teachers are concerned about, in order to gain insight into their daily lives. The member of staff accompanies the child to every lesson for the day, and even observes them during recess). Subject 4 dominated the session by venting her frustration with the teachers and her parents. Thereafter Subject 4 slowly began to trust the members of her group and to share her feelings more. She expressed the greatest disappointment when the programme drew to an end despite her initial reticence, and also expressed amazement that the group had in fact kept their word and had kept her issues confidential.

In the next section the pre- and post-test psychometric results will be presented in tabulated form.

6.5 TABLES AND GRAPHS OF PSYCHOMETRIC RESULTS

This section includes the comparison of the pre- and post-test results of the members of both the body image (experimental) and the self-esteem (control) groups. These results have been represented in tabulated form. In addition, the average differences found between the pre- and post-test results of both groups have been plotted on a graph in order to highlight the difference between the experimental and control groups.

6.5.1 Comparison between pre- and post-test results
The comparison between the pre- and post-test results are presented in the following tables:
6.5.1.1 Body Dysmorphic Disorder Examination (BDDE)

A higher score suggests greater concern with body image

<table>
<thead>
<tr>
<th>EXPERIMENTAL</th>
<th>CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group Member</strong></td>
<td><strong>Before</strong></td>
</tr>
<tr>
<td>A</td>
<td>103</td>
</tr>
<tr>
<td>B</td>
<td>86</td>
</tr>
<tr>
<td>C</td>
<td>84</td>
</tr>
<tr>
<td>D</td>
<td>66</td>
</tr>
<tr>
<td>Total</td>
<td>339</td>
</tr>
</tbody>
</table>

6.5.1.1(a) Summary of the Pre- and Post-test Results on the BBDE

A 108 point difference on the pre- and post-test results on the BDDE is noted in the experimental group, while a 21 point difference in the control group is revealed. An overall improvement in body image is noted after exposure to both programmes, but a difference of 87 points is revealed in favour of the body image programme (experimental group), indicating the effectiveness of the programme. One of the specific goals of the empirical study (as mentioned in Section 5.3) is to determine the effect of the modified version of Rosen's body image programme on adolescents in terms of body image. The above results suggest that adolescents who are exposed to the modified version of Rosen's body image intervention programme, should develop a more positive attitude towards the body and a greater acceptance of physical appearance regardless of loss of weight.
6.5.1.2 Beck's Depression Inventory (BDI)

<table>
<thead>
<tr>
<th>Depression Level</th>
<th>Score Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Depression</td>
<td>0-9</td>
</tr>
<tr>
<td>Mild Depression</td>
<td>10-15</td>
</tr>
<tr>
<td>Moderate Depression</td>
<td>16-23</td>
</tr>
<tr>
<td>Severe Depression</td>
<td>24-63</td>
</tr>
</tbody>
</table>

Table (ii)

<table>
<thead>
<tr>
<th>EXPERIMENTAL</th>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Member</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>32</td>
<td>17</td>
</tr>
<tr>
<td>B</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>C</td>
<td>21</td>
<td>18</td>
</tr>
<tr>
<td>D</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>76</td>
<td>50</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONTROL</th>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Member</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>17</td>
<td>9</td>
</tr>
<tr>
<td>3</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>4</td>
<td>26</td>
<td>14</td>
</tr>
<tr>
<td>TOTAL</td>
<td>64</td>
<td>39</td>
</tr>
</tbody>
</table>

6.5.1.2(a) Summary of the Pre- and Post-test Results on the BDI

A 26 point difference on the pre- and post-test results on the BDI indicate an overall decrease in depression in the experimental group, while a difference of 25 points in the control group can be observed. This indicates that both the body image and the self-esteem programmes were effective in reducing depression. However, a very slight difference of 1 point can be noted in favour of the experimental group (body image programme). One of the specific goals of the empirical study (as mentioned in Section 5.3) is to determine the effect of the modified version of Rosen's body image programme on adolescents in terms of the reduction of the level of depression. The above results suggest that if depressive symptoms are evident in adolescents, exposure to the modified version of Rosen's body image programme should help to alleviate some of the symptoms.
### 6.5.1.3 The IPAT – Anxiety Scale (IPAT)

Indications of stability
- 1-3: Stability
- 4-7: Normal
- 8-10: High Anxiety

#### Table (iii)

<table>
<thead>
<tr>
<th>EXPERIMENTAL</th>
<th></th>
<th></th>
<th>CONTROL</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
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<td>Before</td>
<td>After</td>
<td>Group Member</td>
<td>Before</td>
<td>After</td>
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<tr>
<td>A</td>
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<td>6</td>
<td>1</td>
<td>7</td>
<td>6</td>
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<tr>
<td>B</td>
<td>7</td>
<td>7</td>
<td>2</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>C</td>
<td>9</td>
<td>8</td>
<td>3</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>D</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>31</td>
<td>26</td>
<td>30</td>
<td>26</td>
<td></td>
</tr>
</tbody>
</table>

#### 6.5.1.3(a) Summary of the Pre- and Post-test Results on the IPAT

A five point decrease in anxiety in the experimental group and a four point decrease in the control group is observed. This indicates that both the body image and self-esteem programmes were effective in reducing anxiety. A difference of 1 point in favour of the experimental group is revealed, suggesting that the experimental group benefited slightly more than the control group in terms of decreasing anxiety. One of the specific goals of the empirical study (as mentioned in Section 5.3) is to determine the effect of the modified version of Rosen’s body image programme on adolescents in terms of the reduction of the level of anxiety. The above results suggest that exposure to the modified version of Rosen’s body image intervention programme should relieve some of the anxiety experienced by adolescents.
### The Adolescent Self-Concept Scale (ASCS)

#### ASCS (Pre-Test)

<table>
<thead>
<tr>
<th>Group Member</th>
<th>Physical Self</th>
<th>Personal Self</th>
<th>Family Self</th>
<th>Social Self</th>
<th>Value Self</th>
<th>Self Criticism</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6</td>
<td>9</td>
<td>3</td>
<td>15</td>
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</tr>
<tr>
<td></td>
<td>12</td>
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<td>8</td>
<td>13</td>
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<td></td>
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<td>53</td>
<td>45</td>
<td>54</td>
<td>50.50</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>50</strong></td>
<td><strong>53</strong></td>
<td><strong>45</strong></td>
<td><strong>54</strong></td>
<td><strong>50.50</strong></td>
<td><strong>53</strong></td>
</tr>
</tbody>
</table>

#### ASCS - (Post-Test)

<table>
<thead>
<tr>
<th>Group Member</th>
<th>Physical Self</th>
<th>Personal Self</th>
<th>Family Self</th>
<th>Social Self</th>
<th>Value Self</th>
<th>Self Criticism</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7</td>
<td>10</td>
<td>5</td>
<td>15</td>
<td>10</td>
<td>8</td>
</tr>
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<td></td>
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<td>8</td>
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<td></td>
<td>9</td>
<td>8</td>
<td>3</td>
<td>9</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>10</td>
<td>10</td>
<td>12</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>57</strong></td>
<td><strong>60</strong></td>
<td><strong>48</strong></td>
<td><strong>60</strong></td>
<td><strong>56.25</strong></td>
<td><strong>58</strong></td>
</tr>
</tbody>
</table>

#### Total Scores
- Below Average: 35-52
- Average: 53-75
- Above Average: 76-95

---

(Table iv)

(Table v)
6.5.1.4(a) Summary of the Pre- and Post-test Results on the ASCS

An average increase of 5.75 points in the self-concept of the experimental group and an average increase of six points in the control group is noted. A difference of 0.25 points in favour of the control group is noted, suggesting that the self-esteem programme is slightly more effective in improving the self-concepts of the adolescents. One of the specific goals of the empirical study (as mentioned in Section 5.3) is to determine the effect of the modified version of Rosen's body image programme on adolescents in terms of self-esteem. The above results suggest that the adolescents' self-concepts should improve after exposure to the modified version of Rosen's body image intervention programme.
6.5.1.5  The Family Functioning In Adolescence Questionnaire (FFAQ)

FFAQ – (Pre-Test)

Below Average  1-3
Average       4-6
Above Average  7-9

<table>
<thead>
<tr>
<th>Group Member</th>
<th>EXPERIMENTAL</th>
<th>CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Structure</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Affect</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Communication</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Behaviour Control</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Value Transmission</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>External Systems</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Combined Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FFAQ – (Post-Test)

<table>
<thead>
<tr>
<th>Group Member</th>
<th>EXPERIMENTAL</th>
<th>CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Structure</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Affect</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Communication</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Behaviour Control</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Value Transmission</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>External Systems</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Combined Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Table vi)

(Table vii)
6.5.1.5(a) Summary of the Pre-and Post-test Results on the FFAQ

An average increase of 4.25 points on the FFAQ is observed both in the experimental as well as the control groups. This indicates that the body image and the self-esteem programmes were equally effective in improving the interpersonal relationships of the adolescents. One of the specific goals of the empirical study (as mentioned in Section 5.3) is to determine the effect of the modified version of Rosen's body image programme on adolescents in terms of the development of interpersonal skills. The above results suggest that the adolescents' interpersonal skills should improve after exposure to the modified version of Rosen's body image intervention programme.
6.5.1.6 The Thematic Apperception Test (TAT)

Individual differences observed on the pre- and post-test results of the TAT have been included in the respective profiles in Section 6.4. However, as a result of the diversity of the results of this test, and the fact that the TAT interpretation was not quantified, overall group differences between the experimental and control groups will not be discussed.

The differences between the pre- and post-test psychometric results of the experimental (body image programme) and control (self-esteem programme) groups will be presented in the next section in the form of graphs.

6.5.2 Comparison between experimental and control groups

The average difference between the pre- and post-test results of both the experimental and control groups have been plotted as graphs in order to facilitate comparison between the experimental and control groups regarding the various psychometric media used.

Figure 2: Comparison between Experimental and Control: IPAT, BDI and BDDE
In terms of improving body image, the results from the pre- and post-test analysis suggest that the modified version of Rosen's intervention programme (which focuses *specifically* on improving body image) is significantly more effective than a self-esteem programme (which may deal with body image *incidentally*).
The safe environment created by the small group provided individuals from both groups with the confidence to risk sharing intimate information. This proved to be a valuable spin-off of both programmes. A slight decrease in depression and anxiety, as well as a small improvement in interpersonal relationships and self-concept was found amongst both groups. Apart from body image, the variance of the psychometric results between the experimental and control groups was minimal.

The following chapter will deal with the résumé of findings, implications, recommendations and suggestions for future research.
CHAPTER SEVEN

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

In this chapter, a résumé of the research that was undertaken will be outlined. Conclusions, recommendations and suggestions for further research will follow.

7.2 The aims of the investigation and the extent to which these aims have been met

The main goal of this study was to evaluate the effectiveness of a modified version of Rosen's body image programme using a sample of mid-adolescent girls. The literature study provided an overview of eating disorders, preventative programmes for eating disorders and the developmental stages experienced by middle adolescent females.

In order to pursue the specific aims as mentioned in Chapter One (Section 1.3.2), a literature review was done in order to explore certain areas, while an empirical investigation was undertaken in order to verify certain suppositions. The respective areas researched and the suppositions are summarised below, while the outcomes of the research are tabulated in Tables (vii), (viii) and (ix).
Problems explored in the literature review pertaining to eating disorders as indicated in Chapter One (Section 1.2.4) include the following:

- What are eating disorders?
- What is body image?
- What is body image disturbance and how is it linked to eating disorders?
- What is the general prevalence of eating disorders?
- What are the demographic characteristics of eating disorders?
- What are the causes of eating disorders?
- What are the environmental, emotional, behavioural, cognitive and physiological consequences of eating disorders?
- What is the prognosis of eating disorders?
- What treatment is used for eating disorders?

Problems pertaining to preventative programmes include the following:

- What content is recommended for a primary prevention programme?
- Who does one include in a primary prevention programme?
- Who does one target in a primary prevention programme?
- How does one implement a primary prevention programme?
- What is the duration of a primary prevention programme?

Problems pertaining to developmental stages and characteristics of mid-adolescent females with and without eating disorders included the following:

- What are the normal developmental stages of mid-adolescent females?
- How do mid-adolescent females with eating disorders differ from the non-eating disordered adolescents in terms of physical, psychological, social, moral and cognitive adjustment?

The main aims of this literature review were therefore:

- To gain an understanding of the nature, causes (with particular reference to body image), consequences, treatment and prognosis of eating disorders
- To gain some knowledge of the nature of existing preventative programmes
• To identify how female adolescents with eating disorders differ from the non-eating disordered individuals in terms of physical, psychological, social, moral and cognitive adjustment.

**TABLE (vii) MAIN OBJECTIVES AND THE EXTENT TO WHICH THEY HAVE BEEN MET.**

<table>
<thead>
<tr>
<th>MAIN OBJECTIVE</th>
<th>THE EXTENT TO WHICH THESE OBJECTIVES HAVE BEEN MET</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To gain an understanding of the nature, causes (with particular reference to body image) and consequences of eating disorders.</td>
<td>The overview of eating disorders presented in Chapter Two suggests that success was achieved in gaining a general understanding of the nature, causes and consequences of eating disorders.</td>
</tr>
<tr>
<td>2. To gain knowledge of the treatment and prognosis, as well as the nature of existing preventative programmes for eating disorders.</td>
<td>The information provided in Chapter Three suggests that success was achieved in gaining knowledge of the treatment and prognosis of eating disorders, as well as the nature of existing preventative programmes.</td>
</tr>
<tr>
<td>3. To identify how female adolescents with eating disorders differ from non-eating disordered individuals in terms of physical, psychological, social, moral and cognitive adjustment.</td>
<td>The information provided in Chapter Four suggests that success was achieved in being able to determine the differences between eating disordered and non-eating disordered female adolescents in terms of physical, psychological, social, moral and cognitive adjustment.</td>
</tr>
<tr>
<td>4. To evaluate the effectiveness of the modified version of Rosen’s body image programme with mid-adolescent females.</td>
<td>The pre- and post-testing scores of a battery of standardised tests allowed for successful evaluation of the modified version of Rosen's body image programme with mid-adolescent females.</td>
</tr>
</tbody>
</table>
This research study was predominantly qualitative. The thoughts, feelings and behaviour of a small sample of subjects were observed. Unstructured interviewing and questionnaires were used to gain information. In addition, a battery of standardised tests was administered in order to gain pre-and post-test data, thus enabling the researcher to verify or refute the various suppositions made.

7.3 Findings from the literature review

In order to investigate the above research question, various books and articles in subject-related publications were studied.

TABLE (viii): FINDINGS FROM THE LITERATURE REVIEW

<table>
<thead>
<tr>
<th>PROBLEMS PERTAINING TO EATING DISORDERS</th>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Diagnostic criteria for eating disorders and factors complicating diagnosis.</td>
<td>Clearly defined criteria exist for diagnosing anorexia and bulimia nervosa (Diagnostic and statistical manual of mental disorders (APA 1994). NOS classification (eating disorder not otherwise specified) caters for eating and weight problems that do not fit the criteria of anorexia and bulimia exactly. Eating disorders often co-exist with other conditions or disorders – complicating diagnosis.</td>
</tr>
</tbody>
</table>
2. **Nature of body image**

Body image can be viewed from three perspectives. The physical aspect = brain’s ability to detect weight, shape, size and form. The conceptual aspect = mental picture of the body held by the individual. The emotional aspect = the feelings individuals have about their weight, shape and size.

3. **Nature of disturbed body image and its link to eating disorders**

Body image disturbance = symptoms of body dissatisfaction, and factors relating to it. These include: depression, low self-esteem and general psychological dysfunction. Eating behaviour is pathological depending on the degree of preoccupation with body image, weight and dieting. Abnormality of body image is one of the defining features of both anorexia and bulimia nervosa.

4. **General prevalence and demographic characteristics of eating disorders**

Prevalence estimates vary. Increase of eating disorders, especially amongst females ranging from 15 – 20 years. Abnormal attitudes to eating found in a fifth of sample of Johannesburg schoolgirls. Steady increase of South African black patients. Eating disorders most prevalent amongst Caucasian female adolescents from middle to upper socio-economic status.

5. **Causes of eating disorders**

The combination of a number of factors contributes to the vulnerability for the development and maintenance of eating disorders. These factors are: genetics, media influences regarding the promotion of the “thin ideal”, teasing about body shape and weight by significant others, disturbed interactions within families (e.g. psychopathology, excessive control,
enmeshment), poor adaptation to pubertal changes as a result of the experience of a number of stressors simultaneously, personality characteristics and the lack of social support, personality traits (e.g. low self-esteem, dysfunctional and erroneous thinking associated with physical appearance, maladaptive perfectionism, obsessive-compulsive tendencies), childhood sexual or physical abuse.

<table>
<thead>
<tr>
<th>6. Consequences of eating disorders</th>
<th>Negative consequences are: withdrawal, isolation, lack of support and heightened distress, degeneration of confidence and self-worth, possible depression, preoccupation with food, body shape and weight, degeneration of concentration, memory and problem-solving ability, delay of moral and cognitive development, stunted growth and delay of puberty in adolescents, possible financial drain for the bulimic, death due to complications with starving, electrolyte imbalance or from suicide.</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Treatment of eating disorders</td>
<td>Difficult to treat – patients often resist treatment. Relapse is common. Treatment is costly. Aim: restore nutrition and weight, and deal with psychological needs. Hospitalise when health is critical – often use contracts and reward system. Psychotherapy varies. Examples of popular therapies: cognitive-behavioural, psychodynamic, family and interpersonal therapy.</td>
</tr>
<tr>
<td>8. Prognosis of eating disorders</td>
<td>Relapse is frequent. Average duration of anorexia = five years – a quarter of cases last ten years. Some live with the symptoms for the rest of their lives. Death occurs in extreme cases. Early</td>
</tr>
</tbody>
</table>
Identification and treatment are beneficial.

<table>
<thead>
<tr>
<th>PROBLEMS PERTAINING TO PREVENTATIVE PROGRAMMES</th>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Recommended content for preventative programmes</strong></td>
<td>Most programmes have similar core-content - emphasis differs. The components include factual information, skills training (e.g. communication and social skills training, assertiveness, stress management, problem-solving, media literacy training), direct and indirect approaches to developing self-esteem, cognitive-behavioural training and systemic change.</td>
</tr>
<tr>
<td>2. <strong>Recommended individuals to be included in programme</strong></td>
<td>Information regarding nutrition and issues relating to eating disorders should be available to all individuals within the environment of the individual – students, teachers, coaches and instructors, parents, relatives and friends.</td>
</tr>
<tr>
<td>3. <strong>Recommended target group</strong></td>
<td>Earlier intervention programmes targeted adolescents. More recent programmes tend to target elementary school children as well. Some researchers recommend inclusion of students from pre-school to college. Males should also be included in the programme.</td>
</tr>
<tr>
<td>4. <strong>Recommended methods of implementation</strong></td>
<td>Methods depend on severity of problem and available resources. Could range from a one-off lecture to the implementation of a comprehensive school-based programme. Methods include: discussions within small groups, use of peer facilitators and peer support groups, having talks from visiting experts, use of the video, slides, drama, guided imagery.</td>
</tr>
<tr>
<td>5. <strong>Recommended duration of</strong></td>
<td>It is recommended that primary intervention</td>
</tr>
</tbody>
</table>

- 298 -
<table>
<thead>
<tr>
<th>programme</th>
<th>should take place throughout the student’s school career. Certain concepts should be revisited periodically as the student develops and gains better understanding.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROBLEMS PERTAINING TO DEVELOPMENTAL STAGES</strong></td>
<td><strong>OUTCOME</strong></td>
</tr>
</tbody>
</table>
| 1. What are the normal developmental stages of mid-adolescent females in terms of physical, cognitive, psycho-social and moral development. | **Physical**: Significant changes occur. These include the growth spurt in height and weight, skeletal and muscular changes, enlargement and maturation of primary sex organs, the development of secondary sex characteristics and the onset of menarche.  
**Cognitive**: Adolescents gradually move from concretely-bound to formal operational thought – able to think more abstractly, hypothetically, logically and systematically. They move away from dualistic thinking – black and white – and learn to examine the perspective of others and to respect diversity of opinion. Lack of experience leads to cognitive errors. Mid-adolescents are at the peak of egocentrism.  
**Psychosocial**: The self-concept changes – undergo a process of redefining themselves. *Identity vs identity confusion stage* – consolidation of old and new identities take place – learn who they are, where they are going. Particularly involved with self-exploration. Become particularly self-conscious – “right look” is paramount. Peer pressure is particularly strong. Increased pressure to conform to traditional views of femininity. Increased pressure to participate in heterosexual dating – group dating gradually develops into pairing of couples. Pressure to distance themselves from their parents – conflict between attachment and autonomy. Relationship between adolescents and parents change – |
move closer to peers. Friendships become increasingly stable.

**Moral:** Many mid-adolescents are in the stages of conventional moral thinking – aware of shared feelings, mutual agreements and expectations. Will behave according to the expectations of others. There is a gradual movement towards taking the laws and regulations of the social system into account. Parental values are re-evaluated – motivated to establish own set of values. Many adolescents actively search for meaning and order in the universe.

<table>
<thead>
<tr>
<th>2. <strong>The impact of eating disorders on the physical, cognitive, psycho-social and moral development of mid-adolescent females.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical: Loss of sex hormones. Delay or temporary regression of pubertal development. Stunted linear growth. <strong>Cognitive:</strong> More rigid and concrete-bound. World seen in terms of black and white. Lack flexibility – greater problems with problem-solving and decision-making. Preoccupation with self becomes obsessive. Excessive self-consciousness, particularly in situations relating to food or appearance. Greater feelings of confusion and lack of control over the environment. Lack of concentration and memory loss resulting from starvation. Constant invasion of compulsive thoughts, which implies that there could be a link with Obsessive-Compulsive Disorder. <strong>Psycho-social:</strong> Particularly negative body image. Self-worth is based on physical appearance. Process of dieting and disordered eating behaviour lowers self-esteem further. Tend to be self-critical - feel worthless and ineffective. Withdrawal and isolation from peers - difficulties adjusting to social norms.</td>
</tr>
</tbody>
</table>
7.4 Findings from the empirical research

Having completed the literature review, the researcher undertook an empirical study. Eight mid-adolescent girls were randomly divided into two groups. The experimental group followed an adapted version of Rosen's body image programme while the control group participated in a self-esteem programme. These programmes ran for a period of nine weeks. Prior to the programme subjects underwent a battery of standardised tests in order to evaluate their levels of self-esteem, body image, anxiety, depression and family relationships. In addition, the subjects underwent a brief unstructured interview. During the tenth week, the full battery of tests was once again implemented. Comparison of the pre- and post-test data took place. In addition, the comparison of the scores between the experimental and control groups enabled the researcher to come to various conclusions.

Specific goals pertaining to the empirical research as indicated in Chapter Five (Section 5.3) were to determine the effect of the modified version of Rosen's body image programme on adolescents in terms of:
- The enhancement of body image
- Self-esteem
- The development of interpersonal skills
- The reduction of the level of anxiety
- The reduction of the level of depression

**Moral**: Delay in moral development. Have limited opportunity of challenging moral dilemmas. Often resort to inappropriate moral behaviour (e.g. lying, stealing, shoplifting) - possibly motivated by self-interest and survival.
## TABLE (ix) THE AIMS OF THE EMPIRICAL STUDY AND OUTCOME

<table>
<thead>
<tr>
<th>SUPPOSITIONS</th>
<th>OUTCOMES OF THE RESEARCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>The modified version of Rosen's body image programme should:</td>
<td></td>
</tr>
<tr>
<td>1. <strong>Enhance the body image of adolescent females</strong></td>
<td>The pre- and post-test results of the BDDE support this supposition.</td>
</tr>
<tr>
<td>2. <strong>Improve the adolescents' self-esteem</strong></td>
<td>The pre- and post-test results of the ASCS support this supposition.</td>
</tr>
<tr>
<td>3. <strong>Improve the adolescents' interpersonal relationships</strong></td>
<td>The pre- and post-test results of the FFAQ appear to support this supposition.</td>
</tr>
<tr>
<td>4. <strong>Relieve some of the anxiety experienced by adolescents</strong></td>
<td>The pre- and post-test results of the IPAT support this supposition.</td>
</tr>
<tr>
<td>5. <strong>Alleviate depression should depressive symptoms be evident</strong></td>
<td>The pre- and post-test results of the BDI support this supposition.</td>
</tr>
</tbody>
</table>

### 7.5 Summary of the findings of the study

The results from the pre- and post-test analysis (as mentioned in Section 6.5.3) indicate that the body image of the experimental group (exposed to the body image programme) improved significantly more than that of the control group (exposed to the self-esteem intervention programme). The results therefore confirm the effectiveness of the modified version of Rosen's intervention programme.

However, the fact that the body image of the control group improved without exposure to the body image programme suggests the influence of the Hawthorne effect. Some of the improvement in body image can therefore be attributed to the fact that the attention bestowed on the individuals during the various programmes resulted in them feeling better about themselves. It also
reinforces the idea that there is a link between eating disorders and a weak self concept.

The small group environment proved to be a valuable spin-off of both programmes. The safe environment provided the subjects with the confidence to risk sharing intimate information. The possible catharsis experienced by sharing personal issues within the group may have had some influence on the results.

The pre- and post-test analyses reveal a slight decrease in depression and anxiety, as well as a slight improvement in interpersonal relationships and self-concept, amongst both the experimental and control groups. The variance of the psychometric results between the two groups was found to be minimal, apart from the body image.

7.6 Suggestions as to the implementation of the programme

This section will provide an overview of the various circumstances of the school where the research was performed. Suggestions regarding the implementation of the programme in this particular school will then be provided.

To some extent, all adolescent females are vulnerable to poor body image and the pressure of dieting, and therefore the programme as a whole could be integrated into the Life Skills programme for female students at school. In terms of the logistics of implementing the programme, methods will vary according the needs and facilities of the respective schools.

At the particular school where the research was done, resources are readily available, both in terms of finances as well as the availability of school and peer counsellors. Apart from basic core material that needs to be covered, the curriculum is relatively flexible, and is geared to accommodate the needs of the students. While the school is single-sexed, the boys from their brother school share various classes with them, such as French and Art. However,
in Grade 11, the girls and boys combine for English classes. The girls' junior and high schools share administrative facilities and work very closely together.

It may be possible to introduce various aspects of the programme (such as nutritional information, consequences of eating disorders, influences of body image and relaxation techniques) during the elementary phase. These topics may be revisited at various stages of the student's school career, and adapted according to the needs of the students and the respective cognitive levels.

It is suggested that the remaining aspects of the programme are accommodated in the Life Skills syllabus for Grade 9. Peer counsellors could be trained to lead the various discussion groups prior to the programme. With the assistance of peer counsellors in monitoring discussions within small groups, the school counsellor should be able to follow the programme within the classroom situation.

As indicated in Section 3.3.3.3, it has been recommended that males be included in the programme. This would not be feasible at this school, but it could be possible to introduce appropriate literature during the English lessons that would evoke discussion between the boys and girls on various issues such as beauty standards.

Further research would be necessary to explore the feasibility of implementing this programme within a classroom setting.

7.7 LIMITATIONS OF THE PROGRAMME AND RECOMMENDATIONS FOR FUTURE RESEARCH

The following recommendations are made pertaining to the implementation of the modified version of Rosen's body image programme with adolescents:
• Despite having added an additional session, the amount of information that was covered during each session was still not ideal. It is recommended that the programme be extended further in order to cut down on the amount of information presented during each session.

• The members of the group all happened to be white. It is recommended that the programme be evaluated with a group of children of different ethnicity and socio-economic status, in order to determine whether the programme accommodates the needs of children of diverse ethnic backgrounds.

• A very small sample was used. It is recommended that a larger sample of children be used for the research study in order to generalise the results to the greater population, and to make the results more significant.

• The modified version of Rosen's body image intervention programme has shown to be effective with adolescents in the short-term. It is recommended that long-term evaluations be made in order to determine whether the more positive feelings about physical appearance are sustainable, or whether follow-up sessions are necessary.

• During the programme the subjects were given the opportunity to discuss their personal issues. It became clear that many of the subjects required support and guidance to cope with their issues. It is recommended that the option of receiving additional support after the completion of the programme be made available.

7.8 CONCLUSIONS

As indicated in Section 3.3.2.1, various intervention programmes have reported success in terms of increasing knowledge and awareness of eating disorders, improving nutritional and weight regulation, as well as improving
physical fitness in some instances. However, the programmes have failed to change negative body image and the internalisation of the thin ideal.

The results of the research study suggest that the modified version of Rosen's body image intervention programme is effective in improving the body image of adolescents. Further research is necessary in order to design a school-based programme for the prevention of eating disorders, which includes a body image component, such as the modified version of Rosen's programme.

The aim of the existing school-based intervention programmes for eating disorders is to provided knowledge and skills in order to assist students to feel more comfortable with themselves as people, and with their physical appearance. It therefore seems fitting to conclude this research study with the Serenity Prayer (Anonymous):

\[ \text{God, give me the serenity to accept} \]
\[ \text{The things I cannot change,} \]
\[ \text{The courage to change the things I can} \]
\[ \text{And the wisdom to know the difference.} \]

_Serenity Prayer
Anonymous_
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Thompson, J.K. 1986. Many women see themselves as roundfaced and pudgy, even when no one else does. Psychology Today, April:39-44.


Dear Parents

I am currently studying for an M.Ed degree in Educational Psychology at the University of South Africa. I am particularly interested in the areas of body image and self-esteem, and will be investigating the effectiveness of two programmes dealing with these issues.

Your daughter, ........................................ has shown interest in taking part in the research study. The girls will be divided into two groups at random, and assigned to one of the two programmes. One of the programmes will take place during Life Skills lessons, while the other programme will take place after school at a time convenient for all. The programme involves 9 sessions, excluding pre- and post-testing, of one and a half hours duration.

If you are happy for your daughter to participate in the study, please complete the return slip below. Should you require further information, I can be contacted at the following number; 7839747.

Thank you for your support.

Yours sincerely

Gail Williams

---------------------------------------------------------------------------------------------------------------------------------

REPLY SLIP

I, parent/guardian of ........................................... (Pupil’s full name)

DO / DO NOT give my permission for my daughter to participate in the above research study.

Signed .......................... Date ..............................
MY BODY AND BODY EXPERIENCES: FROM THEN TO NOW

Describe your bodily characteristics and the important events and experiences related to your body that took place during the following periods of your life. Be sure to note experiences that were especially important influences on how you now feel about your body.

Early childhood (up to age 7)
My body:
Important events and experiences:

Later childhood (before puberty)
My body:
Important events and experiences:

Early adolescence (especially during puberty)
My body:
Important events and experiences:

Adolescent years (after puberty)
My body:
Important events and experiences:

Earlier adulthood
My body:
Important events and experiences:

Now
My body:
Important events and experiences:

THE BODY AREA SATISFACTION SCALE

Use this 1-5 scale to indicate how satisfied you are with each of the following areas of your body:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very dissatisfied</td>
<td>Mostly dissatisfied</td>
<td>Neither satisfied nor dissatisfied</td>
<td>Mostly satisfied</td>
<td>Very satisfied</td>
</tr>
</tbody>
</table>

1. Face (facial features, complexion).
2. Hair (colour, thickness, texture).
3. Lower torso (buttocks, hips, thighs, legs).
4. Mid torso (waist, stomach).
5. Upper torso (chest or breasts, shoulders, arms).
7. Weight.
8. Height.
10. Any other disliked aspect/feature of your body:
    Specify: 
    Specify: 
    Specify: 

Appendix (i)
THE SITUATIONAL INVENTORY OF BODY-IMAGE DISTRESS

Use this 0-4 scale to indicate how often you experience negative thoughts or feelings about your physical appearance in each of the following situations:

<table>
<thead>
<tr>
<th>Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
</tbody>
</table>

- Never
- Sometimes
- Moderately often
- Often
- Almost always

1. At social gatherings where I know few people.
2. When I look at myself in the mirror.
3. When I am the focus of social attention.
4. When people see me before I've "fixed up."
5. When I am with attractive persons of my sex.
6. When I am with attractive persons of the opposite sex.
7. When someone looks at parts of my appearance I dislike.
8. When I look at my nude body in the mirror.
9. When I am trying on new clothes at the store.
10. When I am exercising.
11. After I have eaten a full meal.
12. When people can see me from certain angles.
13. When I am wearing certain "revealing" clothes.
14. When I see attractive people on television or in magazines.
15. When someone compliments me on my appearance.
16. If I'm dressed differently than others at a social event.
17. When I get on the scale to weigh myself.
18. When I think someone has ignored or rejected me.
19. When anticipating or having sexual relations.
20. If my friend or partner doesn't notice when I'm "fixed up."
21. When I am already in a bad mood about something else.
22. When the topic of conversation pertains to appearance.
23. When I think about how I looked earlier in my life.
24. When I haven't exercised as much as usual.
25. When someone comments unfavourably on my appearance.
26. When my clothes don't fit just right.
27. When my partner sees me undressed.
28. When I see myself in a photograph or videotape.
29. When I think I have gained some weight.
30. When I think I have lost some weight.
31. When somebody else's appearance gets complimented and nothing is said about mine.
32. When I hear someone criticize another person's looks.
33. After I get a new haircut or hairstyle.
34. If my partner touches body areas that I dislike.
35. When I think about what I wish I looked like.
36. When I am not wearing any makeup.
37. When I recall any kidding or unkind things people have said about my appearance.
38. When I think about how I may look in the future.
39. When I have my photograph taken.
40. If my hair isn't fixed just right.
41. If my partner doesn't show sexual interest.
42. When I am with people who are talking about weight or dieting.
43. When I am with a certain person.
   (Specify whom:)
44. At particular times of the day or evening.
   (Specify when:)
45. During particular times of the month.
   (Specify when:)
46. During particular seasons of the year.
   (Specify when:)
47. During certain recreational activities.
   (Specify which:
48. When I eat certain foods.
   (Specify which:
49. Any other situations?
BODY-IMAGE AUTOMATIC THOUGHTS QUESTIONNAIRE

Listed below are a variety of thoughts about personal appearance that sometimes pop into people's heads in a variety of situations. Please read each thought and indicate how frequently, if at all, the thought occurred to you over the last week. Please read each item carefully and fill in the corresponding blank using the following scale as a guide.

0 1 2 3 4
Never Sometimes Moderately Often Very Often

NEGATIVE THOUGHTS:

1. I am so self-conscious about how I look.
2. I feel helpless to change my appearance.
3. My life is lousy because of how I look.
4. My looks make me a nobody.
5. I don't look good enough to be here.
6. Why can't I ever look good?
7. It's just not fair that I look like I do.
8. With my looks, nobody is ever going to love me.
9. I wish I were better looking.
10. I can tell that other people think I'm unattractive.
11. They think I look fat.
12. They're laughing about my looks.
13. Maybe I could look like him/her.
14. He/she won't sit by me because I'm not good-looking.
15. I wish I didn't care about how I look.
16. Other people notice "right off the bat" what's wrong with my body.
17. I wish I could look like someone else.
18. I think others won't like me because of how I look.
19. I'll never be attractive.
20. I hate my body.
21. Something about my looks has to change.
22. How I look ruins everything for me.
23. I can never look the way I want to.

POSITIVE THOUGHTS:

1. Other people think I'm good looking.
2. My appearance helps me to be more confident.
3. I am proud of my body.
4. My body has good proportions.
5. My looks seem to help me socially.
6. I like the way I look.
7. I still think I'm attractive even when I'm with people more attractive than I.
8. I'm at least as attractive as most people.
9. I don't mind people looking at me.
10. I'm comfortable with my appearance.
11. I look healthy.
12. I feel comfortable with the way I look in my bathing suit.
13. These clothes look good on me.
14. My body isn't perfect, but I think it's attractive.
15. I don't need to change the way I look.
THE COGNITIVE ERRORS WORKSHEET

On the "Private Body Talk" Tape (Tape Side 5), 12 scenarios are described to illustrate each of the following important cognitive errors in thinking about body or appearance. After listening to each scenario, use this 0 to 4 scale below to indicate how much each cognitive error matches your own thinking patterns:

<table>
<thead>
<tr>
<th>Type of cognitive error</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Beauty or The Beast</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. The Unreal Ideal</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Unfair to Compare</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. The Magnifying Glass</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. The Blind Mind</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Radiant Un-Beauty</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. The Blame Game</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Mind Mis-Reading</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Misfortune Telling</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. Beauty Bound</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Feeling Ugly</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Moody Mirror</td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

CORRECTIVE THINKING WORKSHEET

Cognitive error type: _______________________________

A – Antecedents (triggering situations and events):

B – Beliefs (and negative thoughts):

C – Consequences (emotional TIDE):

D – Disputing (with corrective thinking):

1. ____________________________________________
2. _______________________________________
3. ________________________________________
4. ___________________________________________
DETAILS OF TOPICS DISCUSSED IN SESSION 1 OF THE MODIFIED VERSION OF THE BODY IMAGE INTERVENTION PROGRAMME

1. **Definition of body image** (Rosen 1995:5)
   - Body image is the mental picture one has of the body
   - It is the way one thinks about or evaluates one’s appearance
   - The unhappiness experienced as a result of perceived negative appearance tends to affect behaviour in many ways
   - Body image is an important part of overall self-image

2. **The relationship between physical appearance and body image** (Rosen 1995:4)

   The researcher demonstrated how cultural norms for physical attractiveness change historically by presenting the subjects with pictures of various women ranging from the fifteenth to the twentieth century who were perceived as being beautiful at the time. In addition, pictures of women perceived as being beautiful in the third world (example: long necks or ear lobes, obesity) were contrasted with that of Western industrialized countries (example: slimness).

   A discussion followed highlighting the following points:

   - The role society plays in training women to become more concerned with their appearance
   - The role played by the media in determining the “ideal look”

3. The researcher also initiated a discussion on the **social rewards for physical beauty** as well as the **health risks of obesity and extreme leanness**.
DETAILS OF TOPICS DISCUSSED IN SESSION 2 OF THE MODIFIED VERSION OF THE BODY IMAGE INTERVENTION PROGRAMME

1. **Identifying body image disorder** (Rosen 1995:5)

   - It is normal to dislike some aspect of one’s appearance
   - It is of concern when body dissatisfaction interferes with feeling worthwhile as a person in general, or when it prevents one from engaging in the activities one would like to

2. **Factors contributing to body image problems** (Rosen 1995:5-6)

   (i) **Cultural factors**
   - Individuals tend to compare themselves with the ideal image of beauty internalised from the feedback from an appearance-, age- and fitness-conscious society
   - Families and peers reinforce ideas about physical appearance (e.g. nicknames, teasing, positive or negative feedback).

   (ii) **Physical development and self-consciousness**
   - Self-consciousness is at its height during mid-adolescence when physical and social development is rapid

   (iii) **Physical individuality**
   - Individuals become particularly self-conscious when they receive more than the usual amount of attention and interest in their appearance from other people (e.g. early or late onset of puberty)

   (iv) **Critical incidents**
   - Some individuals are exposed to especially negative or traumatic “critical incidents” which have an impact on their body image (e.g. teasing, being humiliated for looks)

3. **Factors that maintain body image problems** (Rosen 1995:6)

   (i) **Negative self-talk**
   - The repetition and rehearsal of negative and dysfunctional thoughts results in thoughts becoming automatic
   - One’s negative self-talk (private conversations with oneself) tends to maintain body image problems

   (ii) **The avoidance of situations that evoke anxiety**
   - The avoidance of situations which evoke anxiety due to appearance denies the individual the opportunity of learning to handle the anxiety

   (iii) **The Compulsive checking of one’s appearance**
   - Compulsive checking focuses the mind on the very thing one wishes one was not so preoccupied with (e.g. weighing daily, asking for reassurance).
   - Checking behaviour may be relieving in the short-term, but in the long-term, it perpetuates the cycle of body image worry and preoccupation.
4. **Issues pertaining to weight loss efforts** (Rosen 1995:7)

   (i) **The set point theory**
   - The theory suggests that one is biologically programmed to maintain a certain weight, and that the body will defend a set weight regardless of minor changes in food intake and exercise
   - The ability to lose weight is greatly affected by the genes

   (ii) **Unrealistic goals**
   - Most individuals are programmed to be average weight, but average weight is above that of the social ideal

   (iii) **Negative consequences of restrictive caloric dieting**
   - Most individuals regain the weight lost after dieting excessively and often gain even more weight
   - Dieters often personalize failure and suffer even lower self-esteem
   - Some dieters go too far and resort to measures such as fasting, vomiting after eating, laxative abuse and obsession with exercise
   - Binge eating often results from caloric restrictive dieting – the more the body is deprived of food, the more the body fights back and tries to make up for the deprivation
   - Loss of weight does not necessarily enhance body image

5. **Consequences of other appearance change efforts** (Rosen 1995:8)

   - This includes efforts like changes in hairstyle, dental work and cosmetic surgery
   - (Outward) change in appearance often fails to improve body image (on the inside)
BODY AND MIND RELAXATION EXERCISE (Cash 1991: side 3)

Instructions for the relaxation exercise are:

- Sit in a comfortable chair.
- Rate the level of anxiety before one commences with the exercise.
- Close the eyes.
- Take 3 slow deep breaths (taking twice as long to inhale as to exhale).
- Tense and relax the following body parts:
  - **Fists** (clench the fists of both hands)
  - **Biceps** (bringing the arms up)
  - **Triceps** (palms facing up)
  - **Shoulders** (put the hands up and pull the shoulders forward, then lean forward and push the shoulders forward)
  - **Neck** (push the neck forwards so that the chin pushes against the chest)
  - **Head** (sit forward and push the head back, then tilt the head to the left and then to the right)
  - **Face** (open the mouth as if yawning)
    - Push lips together as hard as possible
    - Press tongue against the roof of the mouth
    - Scrunch up the nose
    - Close the eyes tightly
    - Tense the muscles in the forehead by frowning
- Take 3 deep breaths (take twice as long to inhale as to exhale) and say “peaceful” when inhaling and “calm” when exhaling.
- Now tense and relax the following body parts:
  - **Stomach** (pull it in)
  - **Buttocks** (tighten the muscles in the buttocks)
  - **Legs – thighs** (inhale, raise the legs slightly and tense, exhale, lower the legs and relax)
  - **Calves** (flex the feet, exhale, relax)
  - **Toes** (point the toes towards the floor, relax)
- Take 3 or 4 deep breaths, making sure that the following body parts are all relaxed: arms, shoulders, neck, head, down the chest, through the mid section to the legs.
- Focus on one’s breathing. As one inhales, focus on breathing in peace, calmness and contentment. As one exhales, focus on breathing out tension.
- Imagine the tension to be like the mist, and watch it disappearing.
- Now use the imagination to paint a pleasant picture in the mind. It is a springtime scene at the beach, mountains, river or wherever.
  - One is safe, secluded and peaceful.
  - One can hear the melody of the birds.
  - One can see all the beautiful colours of the blossoms.
  - One can see nature all around one.
  - One feels the soothing warmth of the gentle sun.
  - One feels the comfort of a gentle breeze.
  - There is nothing to do but to relax.
- Picture a small centre of one’s favourite colour in the centre of one’s body (the centre is full of contentment and satisfaction).
- Make the centre grow as each breath is inhaled and exhaled, slowly increasing the amount of contentment and calm until it fills the entire body.
- Very gradually count back from 10 to 1, and then get up slowly and feel energised.
- Move the following body parts very gently: the arms, feet, legs and head.
- Open the eyes and rate the present experience for being totally calm and relaxed.
- Compare the present feeling to the feelings experienced in the beginning.
DETAILS OF TOPICS DISCUSSED IN SESSION 3 OF THE MODIFIED VERSION OF THE BODY IMAGE INTERVENTION PROGRAMME

1. **The desensitization process** (Rosen 1995:12)
   - Many individuals have been conditioned to experience anxiety, discomfort or disgust when thinking about aspects of their appearance or when viewing themselves in the mirror.
   - The connection between the antecedent situations and the negative emotions may have been present for so long that reactions almost become automatic, like a reflex action.
   - The goal of desensitization is to replace the negative feelings associated with physical appearance with more positive feelings.
   - The establishment of a connection between an individual's personal appearance and feelings of relaxation and contentment has been found to be effective in accomplishing counter conditioning. Feelings of distress and relaxation cannot be felt simultaneously.
   - Desensitization is a gradual process and requires active participation.

2. **Discussion on body image perception and objective feedback** (Rosen 1995:13)
   - Body image is the mental picture of how one looks
   - Perceptions may be quite different from the reality
   - Over-estimation of weight and shape may result in body distortion

3. **Role of beliefs in body image** (Rosen 1995:14)
   - Body image is greatly influenced by the beliefs one has about one's appearance, the way one evaluates oneself.
   - Appearance may become the very basis of one's self-esteem, minimizing factors like morals, social skills, personality traits.

4. **Problematic beliefs** (Rosen 1995:15)
   - Problematic beliefs include thoughts:
     That are wrong, faulty or irrational and which end up making one feel bad
     That tend to overemphasise one's imperfections
     That are automatic and no effort is made to question their validity
   - Self-defeating thoughts may be reflected in one's self talk.
   - Problematic beliefs may trigger a chain of events (e.g. "I look in the mirror. I feel fat and ugly. I feel anxious and depressed. I can't find something to wear to cover my hips. I don't want to go out. I cancel my date").
   - The goal of this programme is to challenge self-defeating beliefs and to replace them with automatic functional and accurate thoughts.
IMAGINAL BODY AREAS DESENSITIZATION (Cash 1991: side 4)

1. Details of the *Imaginal body areas desensitization* process (Exercise 8):
   - Sit in a quiet private place.
   - Close the eyes and spend 5-10 turning on body and mind relaxation.
   - Refer to the hierarchy of body areas evoking dissatisfaction identified in Exercise 6 (Responses are included in section 6.2.5.3).
   - Start with the body part that evokes the least amount of distress.
   - Picture that area of the body very clearly for approximately 15 seconds, and take note of the emotions experienced.
   - Return to relaxing for half a minute, using slow breathing, imagery of pleasant scenes, expanding the circle of contentment and the use of self-instructions to be calm, peaceful and relaxed.
   - Repeat the “imaginal” and “relaxing” procedure, gradually extending the time (30 seconds and then to 1 minute).
   - Picture the body part that evokes the second least distress as identified in Exercise 6 and follow the same procedure as for the first body part.
   - Identical steps are followed all the way up the hierarchy of body areas.
   - Relaxation skills are to be used when feelings of discomfort are experienced.
   - Move up the hierarchy only if you have been able to relax or have successfully reduced any distress evoked when imagining parts of the body lower in the hierarchy.
   - Stop after 30 minutes. (Most individuals require a number of sessions in order to reach the top).
   - End the session with 2 or 3 minutes of pleasurable body and mind relaxation, including imagery and expanding the “circle of contentment”.
   - Commence the following day with the last area you were able to imagine without experiencing distress.
   - Once the hierarchy has been mastered, have one more session going from the bottom to the top imagining each area for a full minute while actively maintaining one’s relaxation.
   - Record the experiences and the progress on the desensitization log found in the client workbook.

2. Details of the *Mirror desensitization* process (Exercise 9)
   - A full length mirror is placed in a private place.
   - Body and mind relaxation is to be turned on.
   - You are to stand approximately a metre from the mirror.
   - The same step by step procedure as the exercise above is followed, gradually moving up the hierarchy of body areas.
   - This procedure initially takes place clothed.
   - Thereafter the procedure is repeated in the nude (directly after a warm, relaxing bath is a good idea).
   - End the exercise with calming imagery and relaxed breathing.
   - Record feelings experienced on the desensitization log.
DETAILS OF TOPICS DISCUSSED IN SESSION 4 OF THE MODIFIED VERSION OF THE BODY IMAGE INTERVENTION PROGRAMME

1. Overview of cognitive therapy (Cash 1991: side 5)

- Cognitive therapy involves changing problematic areas of thought
- Methods are devised in order to explore and change illogical or faulty reasoning that evokes emotional distress
- Perceptions of events are often more important than the events themselves - individuals are largely disturbed by their views on matters, as opposed to the events themselves
- Events are interpreted automatically by means of self-talk – conversation in one's mind
- One's self-talk influences the way one feels emotionally
- Cash claims that there is evidence to suggest that cognitive interpretation of events precede one's emotions. (e.g. When the woman sees the auditor, she assumes that she is late with her tax returns and then begins to panic)
- Individuals tend to hold onto thoughts which perpetuate the emotions
- Awareness of self-talk is necessary in order to identify the cognition that may be faulty, distorted or illogical
- One can then challenge the thought processes and replace the negative self-talk with more positive thoughts, much as Ellis (RET) or Beck would do

2. The 12 types of cognitive errors (Rosen 1995:20)

The cognitive errors in thinking include the following:

- **Beauty or the Beast** – perceiving one's appearance in terms of extremes (black and white thinking, neglects all shades of grey)
- **The unreal ideal** – comparing oneself with the unrealistic societal standard of acceptable appearance
- **Unfair to compare** – bias lop-sided comparison – comparison only with people known to be more attractive
- **The magnifying glass** – focusing only on a disliked feature and exaggerating the significance of the feature
- **The blind mind** – ignoring the presence of features that make subjects feel good about themselves
- **Radiant un-beauty** – as one criticises one aspect of one's appearance, so the criticism gradually generalises to the whole body
- **The blame game** – blaming one's appearance for some unwanted event
- **Mind mis-reading** – individuals project their own feelings of unattractiveness. They erroneously assume that other people perceive their looks exactly as the individual does.
- **Misfortune telling** – individuals tend to predict how their appearance might bring about bad things to happen in the future
- **Beauty bound** – individuals believe that they are unable to do certain things because of their appearance
- **Feeling ugly** – individuals tend to reason on the basis of their emotions as opposed to logical reasoning
- **Moody mirror** – when individuals are upset or in a bad mood, they tend to view their appearance more negatively
3. Appearance assumptions (Rosen 1995:20)

- Rosen adapted the assumptions as compiled by Cash. They are:

1. I look defective and abnormal.
2. What I look like is an important part of who I am.
3. The first thing that people will notice about me is what's wrong with my appearance.
4. One's outward physical appearance is a sign of the inner person.
5. I can like me as long as I look the way I do. (I could lose a friend).
6. If I could look just as I wish, my life would be much happier/ unless I look the way I want to, I cannot be happy.
7. If people knew how I really look, they would like me less.
8. My appearance is responsible for much of what has happened to me in my life.
9. The only way I could ever like my appearance would be to change how I look.
10. If I learn to accept myself, I'll lose my motivation to look better.

4. The process of cognitive restructuring (Cash 1991:Side 5)

- The aim of cognitive restructuring is to change erroneous ways of thinking
- The following strategies are useful in challenging negative self-talk
  a) STOP and see the red flag - detect the cognitive errors in the self-talk
  b) LOOK and see what is happening - take note of how one feels and identify the beliefs that cause the feeling
  c) LISTEN and challenge and dispute the self-talk with counter arguments
  d) CORRECT and develop new positive statements or self-talk
  e) REHEARSE the new constructive ways of thinking
- The process advocated by Rosen of disputing negative thoughts and developing positive self-talk, is based on the ideas of Albert Ellis (RET) and involves the following:
  a) Analysis of the antecedent events (A = description of the situation about which you became upset - something which occurs that precedes the emotional reaction)
  b) Beliefs (B = description of your thoughts - aspects of self-talk that strongly determine one's responses to antecedent events)
  c) Consequences (C = description of your feelings - emotional consequences as a result of your thoughts)
  d) Disputing of cognitive errors (D = the challenge of your thinking with corrective thinking - the testing of reality and logic)
  e) Effects of corrective thinking on emotions (E)
DETAILS OF TOPICS DISCUSSED IN SESSION 5 OF THE MODIFIED VERSION OF THE
BODY IMAGE INTERVENTION PROGRAMME

DISCUSSION ON APPEARANCE MANAGEMENT, FITNESS AND SENSORY
ENHANCEMENT

1. Appearance management (Cash 1991:Side 7)

Grooming can produce a sense of accomplishment and a sense of pleasure. There are
three types of groomers, namely preoccupied, avoidance and flexible groomers.

(i) Preoccupied groomers tend to:
• spend hours trying to fix what they perceive as being wrong
• worry constantly and become upset by their appearance
• perform compulsive rituals frequently

(ii) Avoidance groomers tend to:
• dislike their appearance
• have little idea of how to go about changing their appearance
• groom very little and ignore or avoid focusing on their appearance
• avoid grooming in order to reduce or control body image anxiety

(iii) Flexible groomers:
• aim to enhance their looks in a way to demonstrate their individuality
• groom to have positive pleasurable experiences, and not to become perfect or
to try to hide various features
• are moderate, but open to try new looks from time to time
• have the confidence to wear clothes they enjoy. Their choice of clothing is not
dictated by fashion, or by styles which enable one to hide various “flaws”

Avoidance and compulsive rituals help to reduce anxiety in the short term, but reinforce
the behaviours in the long term. Both preoccupied groomers and avoidance groomers
focus on damage control. They try to hide or minimize flaws whether real or perceived.

2. Fitness enhancement (Cash 1991:Side 7)

The following themes featured in the discussion:

• The benefits and pleasure experienced from regular exercise (in terms of mental
  health and body image) were discussed
• The motives for exercising were discussed. These include exercising:
  (i) purely to look good
  (ii) to get fit
  (iii) as a means of controlling weight
  (iv) for pleasure
• Individuals who exercise purely to look good tend to overlook whether the activity is
  healthy or not

3. Sensory enhancement (Cash 1991:Side 7)

• The body contains specialised cells that enable individuals to experience the world
  around one with the various senses
• These experiences include the sense of sight, hearing, smell, taste, sensations
  reflecting temperature, the sensation of the body responding to the rhythm of music,
  the caring touch and embrace of a loved one and so forth
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DETAILS OF TOPICS DISCUSSED IN SESSION 6 OF THE MODIFIED VERSION OF THE BODY IMAGE INTERVENTION PROGRAMME

The following issues were discussed in Session 6:

1. **Behavioural aspects of body image** (Rosen 1995:23)

   - A negative attitude towards one's appearance affects one's behaviour
   - Behaviour can range from minor inhibitions to a whole lifestyle built around one's body image

   The researcher discussed various examples of behaviour determined by one's negative self-image. These include:

   (i) **Disguising or covering up one's appearance**

       Examples of "disguising" behaviour includes:
       - The wearing of baggy clothes
       - Being afraid to wear tight clothes or a bathing costume
       - Avoidance of physical intimacy as a result of embarrassment of one's body (not because of modesty or moral reasons)
       - Spending much time getting overly made up or dressed up
       - Holding one's posture in a certain position in order to hide a perceived "flaw"

   (ii) **Avoidance of various social situations**

       Examples of social situations avoided are:
       - Situations where food or weight are discussed
       - Situations where one feels that one is being scrutinized
       - Physical activities like running where one is likely to be the focus of attention

   (iii) **Eating restraint**

       This includes:
       - Going on an unnecessary restrictive caloric diet
       - Avoiding the consumption of certain types or amounts of food

   (iv) **Grooming**

       Examples of grooming behaviour include:
       - Looking in the mirror in order to check the body
       - Inspecting one's reflection in windows as one walks down the street
       - Frequent weighing
       - Comparing oneself to pictures of models in magazines

   (v) **Reassurance seeking**

       Examples of reassurance seeking behaviour where individuals repeatedly:
       - Seek reassurance that appearance is not as bad as perceived
       - Request advice as to whether they should lose weight
       - Seek feedback as to how others perceive their bodies
2. **Consequences of avoidance and body checking (Rosen 1995:23)**

- Body image avoidance is like a defense mechanism against situations that provoke negative feelings about oneself
- Avoidance results in focus on the self
- It creates an inhibited lifestyle
- The more frequently a situation is avoided, the greater the discomfort will be about the situation
- Hiding the body is a way of avoiding having to control one's insecurities concerning the body
- Checking behaviour (e.g. looking in the mirror) might result in immediate relief from concern about appearance, but the reassurance is not really believed


- The most successful way to overcome avoidance behaviours is to face the situations
- Individuals are likely to find that the distress experienced is not as bad as they imagined
- Self-consciousness gradually dissipates after repeatedly "facing" the situation that evokes body image distress
- Once one is convinced that one can handle a particular situation one's attitude begins to change
- The individual becomes less inhibited resulting in behavioural changes (e.g. wearing different clothes)


- Focus should be on developing self-confidence
- Self-confident individuals do not need to rely on external feedback in order to feel good
- Self-confident individuals do not rely on their physical appearance in order to determine their self-worth
### DEFEATING SELF-DEFECTING BODY-IMAGE BEHAVIOURS

**A. AVOIDING AVOIDANCE BY FACING IT:**

Activity or situation avoided: ____________________________________________________

Step-by-Step Plan for Facing It (include behaviours, cognitive and relaxation skills to prepare and manage, and self-rewards):

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Results: __________________________________________________________

**B. PREVENTING A BODY-IMAGE PREOCCUPATION RITUAL BY ERASING IT:**

Preoccupation ritual: ________________________________________________

Step-by-Step Plan for Erasing It (include behaviours, cognitive and relation skills to prepare and manage, and self-rewards):

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Results: __________________________________________________________

### AFFIRMING ACTIVITIES FOR A BETTER BODY IMAGE

1. Mirror affirmations:

   - ________________________________________________________________
   - ________________________________________________________________
   - ________________________________________________________________
   - ________________________________________________________________

2. "I am becoming" activity (description of body ideal):

   - ________________________________________________________________
   - ________________________________________________________________
   - ________________________________________________________________
   - ________________________________________________________________

3. "Writing wrongs" activity (notes for your letter):

   - ________________________________________________________________
   - ________________________________________________________________
   - ________________________________________________________________
   - ________________________________________________________________

4. "Feature attractions" activity (notes for your plans):

   - ________________________________________________________________
   - ________________________________________________________________
   - ________________________________________________________________
   - ________________________________________________________________

5. Create your own special affirming activity:

   - ________________________________________________________________
   - ________________________________________________________________
   - ________________________________________________________________
   - ________________________________________________________________
DETAILS OF TOPICS DISCUSSED IN SESSION 7 OF THE MODIFIED VERSION OF THE BODY IMAGE INTERVENTION PROGRAMME


   The following ideas were discussed with the subjects:

   - The compulsive weigher goes to the bathroom but refrains from weighing.
   - The compulsive weigher gets rid of the scales.
   - The individual is self-conscious about her hands tries on rings at the jewellery store.
   - The individual with a hair compulsion messes up her hair and refrain from brushing it.
   - A time limit for dressing is set for the individual who takes ages to dress.
   - Individuals who compulsively compare themselves with lean individuals, learn to compare themselves with all members of population. Gradually they learn to refrain from comparing at all. They may also refrain from buying magazines containing models that promote the "thin ideal".
   - Self-conscious individuals may be encouraged to exercise in front of the aerobics class.
   - Individuals who suffer from jealousy are encouraged to replace envy with appreciation of the person's beauty.

2. *Seeking reassurance is self-defeating (Rosen 1995:24):*

   The researcher highlighted the negative consequences of behaviour that seeking reassurance excessively. They are:

   - Seeking reassurance can become compulsive.
   - Individuals tend not to believe the reassurance.
   - Individuals are encouraged to focus even more on the feature one is self-conscious about.
   - The habit of constantly seeking reassurance can strain relationships with friends and partners.
   - Individuals need to learn not to rely too heavily on the opinions of others.
   - Individuals need to practice exposing themselves to anxiety provoking situations without trying to ask for feedback.

3. *Introduction of affirming activities (Cash 1991:Side 7)*

   Various activities can be done to foster positive body image feelings. Cash recommends the following activities:

   (i) *Mirror affirmations*

   It is suggested that subjects affirm themselves daily. The following steps are recommended:
• Stand in front of the mirror. While looking at your reflection, make positive statements about your body.
• Affirmation yourself aloud confidently and convincingly. Repeat this 4 or 5 times.
• The affirmations may be complimentary statements about your appearance, fitness or sensory experiences.
• The affirmations must be positive statements (e.g. “I am beautiful” rather than “I am not ugly”).
• Self-consciousness regarding mirror affirmations will gradually pass.

3.1 Be aware of the process of fulfilling one's potential in terms of appearance

• Have realistic goals when striving for your ideal appearance.
• Develop your own “unique” ideal, bearing in mind your potential.
• Imagine your “revised” ideal appearance, and see yourself as becoming that ideal.

3.2 Righting wrongs

• Think of your body as your friend and treat it accordingly.
• Write a letter to your body friend and apologise for abusing and mistreating it.
• Promise to make changes in your behaviour.
• Compliment your body friend for the things the body has given you.

3.3 Feature attractions

• Set aside time daily to give special treatment to some part of the body.
• Use mirror affirmations to give special recognition to the body part.
• Celebrate the special body part with body enhancement activities.
• Affirming attitudes result in the gradual loss of power of self-defeating attitudes.

3.4 Create your own special activity

• Design your own additional affirming activities.
• Record the particular affirming activities using the affirming activities for a better body image worksheet (Exercise 17 – see Appendix (xv)).
DETAILS OF TOPICS DISCUSSED IN SESSION 8 OF THE MODIFIED VERSION OF THE BODY IMAGE INTERVENTION PROGRAMME

1. Preventative maintenance (Rosen 1995:27)

- It is recommended that individuals should continue to execute the various skills learnt during the body image programme after the completion of the programme, in order to continue to progress and to prevent significant relapses.

2. Four steps in relapse prevention (Rosen 1995:27)

The 4 steps in relapse prevention are:

(i) PREPARE
- Identify situations likely to elicit negative feelings about appearance.
- Identify the skills necessary to combat these negative feelings.
- Develop a plan ahead of time to fight against these negative feelings.

(ii) CONFRONT
- Actively put oneself into the identified situation likely to evoke negative body image feelings.
- Do not try to avoid the situation.
- Practice dealing with the situation.

(iii) COPE
- Repeat the counter arguments to the self, and talk oneself through the difficult period.
- Make use of the relaxation and corrective thinking skills in order to help one through the situation.
- The goal is to "make it" through the situation and not to feel great.
- Be patient! The procedure will not work perfectly all the time.

(iv) REWARD
- Do something pleasurable for the self as a reward for having "faced" a difficult situation.
- Credit should be given for having had the courage to face a tough situation regardless of the outcome.
- Reward motivates one to continue trying

3. How to “neutralise" the input of troublesome people (Cash 1991:Side 8)

Cash’s suggestions concerning the dealing of troublesome people:

- Tell individuals in a pleasant way when their behaviour or words elicit bad feelings about your appearance.
- Ask these individuals to stop the unacceptable behaviour.
- Plan what you wish to communicate and which words you wish to use.
- Write the words down and rehearse them ahead of time.
- The rehearsal enables individuals to feel more equipped and confident when confronting people.
- If the assertive strategy does not work the first time, repeat it (some people need to be told 3 or 4 times before they respond).
- Guard against feeling intimidated or giving up.
- Don't take troublesome remarks personally.
4. How to deal with bad days (Cash 1991:Side 8)

- It is human to feel good about oneself on some days and not as good at other times.
- Guard against the "moody mirror" and "feeling ugly" errors when one is feeling down.
- Talk to the self and remind yourself that these negative feelings will soon pass.
- Don't berate yourself for feeling low.

5. Accepting yourself (Cash 1991:Side 8)

- Be aware of the powerful influence of society on one's internalised standard of beauty.
- Take care not to judge one's personal worth according to these standards.
- Be in charge of your own body standards.
- Individuals need to feel in control in order to feel good.
- Accept your body regardless of the size, shape or features.
- Continue to complete your personal image diaries as the diary reflects your self-talk (your struggles, victories, plans and progress).
PREVENTATIVE MAINTENANCE:
PREPARING FOR CHALLENGING BODY-IMAGE SITUATIONS

1. Prepare:
   What is the situation?

   What makes it challenging?

   What do I fear will happen?

2. Confront:
   What is my plan of action?

3. Cope:
   How will I manage (emotionally, cognitively, and behaviourally) any body-image distress or discomfort that could occur?

4. Reward:
   How will I reward myself for confronting and coping with the challenging situation?