EXPLORING THE INTERACTION OF EMOTIONAL INTELLIGENCE AND COPING IN THE DEVELOPMENT OF EATING DISORDERS

by

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CANDIDATE'S DECLARATION

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I, Yolanda Mitchell, hereby declare that this dissertation, Exploring the Interaction of Emotional Intelligence and Coping in the Development of Eating Disorders, 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.

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Signature   Date

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ABSTRACT

Eating disorders remain a phenomenon that escapes full comprehension, resulting in frustration for those who suffer from the disorders, their families, and their therapists. It is becoming increasingly necessary to describe the mechanism by which eating disorders develop, in order to effectively treat and prevent these disorders. The aim of this study was to illuminate factors that contributed to the development of eating disorders within the individual contexts of the lives of the participants, as well as how those factors interacted in context to culminate in the development of an eating disorder. This qualitative study was conducted from an interpretive perspective. The findings show how individual contextual factors interact to produce a marked fear of gaining weight, which is driven by fear of negative evaluation, and that the eating disorder behaviour serves specific functions that are related to coping with stress within the lives of the participants.

KEYWORDS:

ACKNOWLEDGEMENTS

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NOMENCLATURE

Anorexia nervosa: Anorexia nervosa is characterised by the persistent restriction of food intake or persistent behaviour that inhibits weight-gain, which causes significantly low body weight, accompanied by an intense fear of gaining weight and a distorted perception of one's own weight or shape (APA, 2013).

Bulimia nervosa: Bulimia nervosa is characterised by recurrent binge-eating episodes, followed by an inappropriate compensatory behaviour to prevent weight-gain, and accompanied by the undue influence of one's weight and shape on self-evaluation (APA, 2013).

Coping: The term 'coping' denotes a person's attempts to "...master, tolerate, or decrease the negative effects of a stressful situation" (Baron & Byrne, 2000, p. 548).

Eating disorders: The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5;* American Psychiatric Association [APA], 2013, p. 329) defines *feeding and eating disorders* (in this study referred to as eating disorders) as follows: "Feeding and eating disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning."

Emotional intelligence (EQ): Sternberg (2006) defines emotional intelligence as the ability to perceive, think about, understand and express emotion, and to regulate one's own emotion as well as the emotions of others.

Expression of emotion: In this study, expression of emotion refers to the ability of participants to verbally articulate and discuss their emotions with others.

Identification of emotions: In this study, identification of emotions refers to the ability of the participants to name and think about their emotions.

Perception of emotions: In this study, perception of emotions refers to the ability of the participants to acknowledge the experience of their emotions.

Psychological disorder: Barlow & Durand (2012, p. 1) define a psychological disorder as "a psychological dysfunction within an individual associated with distress or impairment in functioning and a response that is not typical or culturally expected."

Regulation of emotions: In this study, regulation of emotions refers to the ability of the participants to effectively deal with their emotions.

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1.1 INTRODUCTION

"We are dealing with a psychological mess [...] weight loss is merely a symptom." (Howard-Taylor, 2008, p. 11).

The author of the above quote describes her ordeal with anorexia nervosa as an internal war. As with every war a multitude of factors, events, and circumstances interact until they reach the climax; in this case, the onset of anorexia nervosa.

The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5;* American Psychiatric Association [APA], 2013, p. 329) defines *feeding and eating disorders* (in this dissertation referred to as *eating disorders*) as follows:

> "Feeding and eating disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning."

When I say that the devastation of an eating disorder is not limited to physical health and psychological well-being, I speak from experience. My own life was significantly affected by what was called *eating disorder not otherwise specified (EDNOS)*, according to *DSM-IV* (4th ed.; APA, 1994) diagnostic criteria. I became symptomatic at age 17, about midway through grade 11 of my schooling, and in my disordered state I wrecked my academic performance during grade 11 and grade 12 and ruined any chances I had of obtaining the bursary that I needed to pursue a tertiary qualification full-time. Thus, the development of an eating disorder is not only shaped by the context of one's past; in turn, it also shapes the context of one's future. It is the far-reaching consequences of eating disorders that necessitate a clearer understanding of their aetiology, the mechanism of their development, and by extension the efficacy of prevention and treatment programmes.

While researching the aetiology and development of eating disorders, I found myself 'ticking the boxes' of aetiological factors applicable to my own life, yet I could not find an answer to the question: "Why did I develop EDNOS?" I recall being socially 'awkward' from as early as I can remember, roughly around age three. I never quite 'fitted in', not even with the crowds of kids at the nursery school that I attended. I remember withdrawing from peers, unable to communicate with them. I am therefore inclined to think that the root of my eating disorder lies much deeper than issues of self-image, or wanting to comply with some unattainable standard of beauty as portrayed in the media. In fact, while I was growing up I never paid much attention to such media, and I still don't.

My greatest problem seemed to be that I had tremendous trouble expressing my feelings when I was angry or hurt. I simply did not know how to deal with these emotions and I could not even translate my feelings into thoughts, let alone into words. I could not communicate effectively. Moreover, I did not know how, or whom, to ask for help. I did not think that this mattered much in childhood, but during puberty and adolescence it became a serious stumbling block to my coping ability when faced with challenges. This led me to think about how my apparent lack of communication skills interacted with the other factors relevant to the development of my eating disorder.

Of particular interest to the development of eating disorders is the notion of specificity: Many of the factors involved in the development of eating disorders, such as low self-image, body image dissatisfaction, and anxiety, are present to some extent and in various combinations in the lives of 'normal' people as well as in people who display other psychological disorders (Polivy & Herman, 2002). Why then do some people *specifically* develop *eating* disorders? The answer may lie in how the factors implicated in the development of eating disorders interact with each other. That is, the specificity of the development of eating disorders may be linked to the mechanism by which these disorders develop.

Specific interactions between factors implicated in the development of eating disorders may be identifiable as patterns of behaviour. Recalling my personal

developmental journey, I recognised a persistent pattern of behaviour which I involuntarily revert to when confronted with great emotional distress and during times of uncertainty. I can identify this pattern when I recall the most stressful times in my life; it is characterised by social withdrawal, avoidance of taking cognisance of the problem, and distraction. Two individual factors can be distinguished in this behavioural pattern, namely emotional intelligence and coping style. Many studies on the aetiology of eating disorders have indeed focused on aspects of emotional intelligence (Polivy & Herman, 2002), and on coping style (Compas, 2009; Rueda & Rothbart, 2009). However, there is a paucity of research into the interaction of these factors within the context of individual lives. I therefore chose to explore the interaction of emotional intelligence (EQ) and coping with other aetiological factors within individual contexts, in order to contribute to filling the gap that I detected in the research literature.

1.1.1 What is emotional intelligence?

Sternberg (2006) defines emotional intelligence as the ability to perceive, think about, understand and express emotion, and to regulate one's own emotion as well as the emotions of others. The construct 'emotional intelligence' is difficult to investigate as a single construct, but based on Sternberg's (2006) definition, emotional intelligence can be split into four separate elements, that is: 1. Perception of emotion; 2. The ability to identify, understand, and reason about emotion; 3. Expression of emotion and; 4. Regulation of emotion. Based on my own experience, I postulated that individuals with eating disorders struggle with one or more of these components of emotional intelligence. This is not a novel idea. Researchers such as Costarelli, Demerzi & Stamou (2009) for example, have previously demonstrated that the young women with disordered eating attitudes in their study had lower levels of emotional intelligence than controls, in particular on the dimension of emotional self-awareness.

1.1.2 What do we understand by 'coping'?

The term 'coping' denotes a person's attempts to "...master, tolerate, or decrease the negative effects of a stressful situation" (Baron & Byrne, 2000, p. 548). A person can cope directly with the source of stress in a conscious and rational manner by using various coping strategies, or with the stress itself by engaging in defensive strategies

to defend themselves against the anxiety caused by stressful situations (Reber & Reber, 2001). The term 'coping style' is used in this study to denote the strategies that participants typically use when facing stress. Baron, Byrne & Branscombe (2006) distinguish between three types of coping styles. The first is *emotion-focused coping,* which is aimed at countering the negative emotions caused by stress. Emotion-focused coping strategies include avoidance of the situation; distraction from the situation by keeping busy; and denial of the situation. The second coping style is *problem-focused* coping, which targets the actual cause of stress when it is within the individual's ability to control the stressor. Examples of problem-focused coping strategies include actively seeking information to understand the problem; and evaluating different options for managing the problem. The third coping style is that of seeking social support from family and / or friends.

Persons with eating disorders may revert to using coping styles characterised by compensating for the component(s) of emotional intelligence that they have difficulty with. For instance, if an individual struggles to regulate their emotions, that person may revert to a coping style characterised by avoidance of emotional distress when his / her emotional load becomes unbearable and may employ methods of, for example, distraction from such distress. Tolan & Grant (2009, p. 62) state: "An essential feature of coping is that it is a response to stress." It is therefore possible that low emotional intelligence and ineffective coping with stress may interact directly with each other and with eating disorder behaviour in the development of an eating disorder. Specifically, an ineffective coping style may lead to the establishment of a pattern of using food, eating (or the avoidance thereof) and / or exercising excessively as a method of distraction, or as a direct coping mechanism, in times of stress and negative affect. Studies have shown for example, that eating disorder patients employ binge eating, starvation and compensatory behaviours in order to reduce negative affect (Barlow & Durand, 2012; Berman, 2006). Even in a non-clinical sample, persons who suffer from eating disorder symptoms display a lack of perceived control over eating when they experience negative affect, especially when they have access to a variety of food in large quantities (Berman, 2006). Likewise, there is support for the notion that psychological stress may provoke eating disorder behaviour. Freeman & Gill (2004) found that increased stress, rather than the level of depressed mood, predicted binge-eating behaviour in their sample of binge eating

college women, and Fryer, Waller & Kroese (1997) showed that the experience of events which impacted negatively on teenagers' lives was associated with disturbed eating behaviour.

An investigation into the persistent behavioural patterns in the lives of persons who suffer from eating disorders, may yield clues as to how the individual behaves when confronted with stressful situations, and in particular with emotional stress. If it can be shown that the eating disorder forms a part of such a behavioural pattern, then it may be possible to get a clearer picture of the development of the disorder within that individual's life. I particularly focused on patterns revolving around emotional intelligence and coping style, because emotional intelligence determines how emotions are managed. This ability, or inability as it may be, to manage one's emotions, determines how an individual will cope with high emotional stress.

Before beginning to explore how aetiological factors may interact in the process of the development of an eating disorder, it is necessary to take a closer look at what an eating disorder is. In the next section, I describe the classification; development; treatment; and prevention of these disorders.

1.2   UNDERSTANDING EATING DISORDERS

1.2.1 The classification of anorexia nervosa and bulimia nervosa as psychological disorders

Barlow & Durand (2012, p. 1) define a psychological disorder as "a psychological dysfunction within an individual associated with distress or impairment in functioning and a response that is not typical or culturally expected." Psychological disorders have been observed and recorded ever since human behaviour in general has been recorded, but the development of a *nosological* system (that is, a classification system that categorises medical or clinical phenomena) that is widely accepted as useful and reliable only took place during the second half of the twenty-first century (Barlow & Durand, 2012).

The *Diagnostic and Statistical Manual of Mental Disorders (DSM)* of the American Psychiatric Association contains the official classification system of psychological

disorders used in the United States of America, and today it is known and used as a diagnostic tool by clinicians worldwide (Barlow & Durand, 2012). The *DSM* was first published in 1952 and has since undergone a number of revisions, reflecting the evolution of the knowledge base of psychological disorders. According to Sunday, Peterson, Andreyka, Crow, Mitchell & Halmi (2001), the first two versions of the *DSM* lacked empirical reliability and did not include diagnostic criteria. The third revision, *DSM-III* (3rd ed.; APA, 1980) was the first to contain diagnostic criteria, including that for eating disorders. However, the criteria for the diagnosis of eating disorders, especially for bulimia, were very incomprehensive in comparison with later revisions of the *DSM*. Fairburn & Garner (1986) levelled critique at the *DSM-III* (APA, 1980) diagnostic criteria of what was then known simply as *bulimia*, as the criteria described only the binge-eating aspect of the disorder. These authors recognised that their patients shared other characteristics of the disorder, most importantly the overemphasis of body shape and weight in their patients' self-evaluations and the compensatory behaviour that patients use to counter weight gain. These criteria were included in the revised *DSM-III-R* (3rd ed., rev.; APA, 1987)*,* which also included the name *bulimia nervosa* for the first time (Garfinkel, 1992). The *DSM-III* (APA, 1980) diagnostic criteria for anorexia nervosa did not include the criterion for the absence of the menstrual cycle in females (amenorrhea), nor did it distinguish between the two subtypes of anorexia, namely restrictive type and binge-eating/purging type as it is known today. Amennorrhea was included in the *DSM-III-R* (APA, 1987) according to Garfinkel (1992), but the inclusion of the subtypes would only appear for the first time in *DSM-IV* (4th ed.; APA, 1994), where eating disorders were listed as a separate group of disorders (Barlow & Durand, 2012). In both the *DSM-IV* (APA, 1994) and its text revision form, the *DSM-IV-TR* (4th ed., text rev.; APA, 2000) only *anorexia nervosa* and *bulimia nervosa* were listed as clearly defined eating disorders (Barlow & Durand, 2012; 1995). The diagnostic criteria of both included the specification of sub-types, with the sub-types of bulimia distinguishing between patients who engage in purging behaviour and those who do not. The sub-types for bulimia were omitted in the subsequent fifth edition of the *DSM*, because it has proven difficult to define the *nonpurging* sub-type (Barlow & Durand, 2012). Additionally, in *DSM-IV* (APA, 1994) and *DSM-IV-TR* (APA, 2000)*,* variations of these two disorders were subsumed in a category labelled *eating disorder not otherwise specified (EDNOS)*, to describe eating disorders that do not meet the full

diagnostic criteria for either anorexia or bulimia. The following are examples of what would have been considered an EDNOS (Sue, Sue & Sue, 2003, p. 534):

- "A female who meets all the criteria for anorexia nervosa but has regular menses.
- An individual who meets all the criteria for anorexia nervosa and has lost a significant amount of weight but is in the normal weight range.
- An individual who engages in binge eating and compensatory activities less than twice a week or who has engaged in these behaviours for less than three months.
- An individual of normal weight who uses compensatory behaviours even after ingesting small amounts of food (vomiting after eating a candy bar).
- A person who chews or spits out large amounts of food without ingesting the food."

The latest version of the DSM, namely *DSM-5* (APA, 2013) lists the following eight disorders as *feeding and eating disorders*:

- Pica (eating of non-nutritive, non-food substances on a persistent basis)
- Rumination disorder (repeated regurgitation of food after eating or feeding)
- Avoidant / restrictive food intake disorder (in DSM-IV classified as *feeding disorder of infancy or early childhood*; characterised by the avoidance or restriction of food intake)
- Anorexia nervosa (persistent restriction of food intake or persistent behaviour that inhibits weight-gain, which causes significantly low body weight accompanied by an intense fear of gaining weight and a distorted perception of one's own weight or shape, which distinguishes anorexia nervosa from avoidant / restrictive food intake disorder)
- Bulimia nervosa (characterised by recurrent binge-eating, followed by an inappropriate compensatory behaviour to prevent weight-gain, and accompanied by the undue influence of one's weight and shape on self-evaluation)

- Binge-eating disorder (characterised by recurrent binge-eating; the absence of compensatory behaviour and of the undue influence of one's weight and shape on self-evaluation distinguishes binge-eating disorder from bulimia nervosa)

- Other specified feeding or eating disorder (disorders of which the symptoms are characteristic of a *feeding and eating disorder*, but which do not meet the full diagnostic criteria for the disorders listed above)

- Unspecified feeding or eating disorder (disorders of which the symptoms are characteristic of a *feeding and eating disorder*, but which do not meet the full diagnostic criteria for the disorders listed above; the clinician's choice not to specify a reason why full diagnostic criteria cannot be met distinguishes this disorder from *other specified feeding or eating disorder*).

In the *DSM-5* (APA, 2013), the criterion of amenorrhea has been omitted for anorexia, and Criterion A no longer specifies the maintenance of a body weight of 85% below the expected weight for an individual. Additions to the criteria for both anorexia and bulimia include the specification of the remission status and the severity of the disorder (APA, 2013).

The current diagnostic criteria for anorexia and bulimia are now presented below:

DSM-5 Diagnostic Criteria for Anorexia Nervosa (APA, 2013, pp. 338-345)

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. *Significantly low weight* is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.
B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

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

Specify whether:

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

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

Specify if:

In partial remission: After full criteria for anorexia nervosa were previously met, Criterion A (low body weight) has not been met for a sustained period, but either Criterion B (intense fear of gaining weight or becoming fat or behavior that interferes with weight gain) or Criterion C (disturbances in self-perception of weight and shape) is still met.

In full remission: After full criteria for anorexia nervosa were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

The minimum level of severity is based, for adults, on current body mass index (BMI) (see below) or, for children and adolescents, on BMI percentile. The ranges below are derived from World Health Organization categories for thinness in adults; for children and adolescents, corresponding BMI percentiles should be used. The level of severity may be increased to reflect clinical symptoms, the degree of functional disability, and the need for supervision.

> **DSM-5 Diagnostic Criteria for Anorexia Nervosa (APA, 2013, pp. 338-345) (continued)**
>
> **Mild:** BMI ≥ 17 kg/m²
> **Moderate:** BMI 16-16.99 kg/m²
> **Severe:** BMI 15-15.99 kg/m²
> **Extreme:** BMI < 15 kg/m²

Table 1.1: DSM-5 Diagnostic Criteria for Anorexia Nervosa (APA, 2013, pp. 338-345)

> **DSM-5 Diagnostic Criteria for Bulimia Nervosa (APA, 2013, pp. 345-350)**
>
> A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
>
>   1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
>   2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
>
> B. Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
> C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.
> D. Self-evaluation is unduly influenced by body shape and weight.
> E. The disturbance does not occur exclusively during episodes of anorexia nervosa.
>
> *Specify* if:
>
> **In partial remission:** After full criteria for bulimia nervosa were previously met, some, but not all, of the criteria have been met for a sustained period of time.
>
> **In full remission:** After full criteria for bulimia nervosa were previously met, none of the criteria have been met for a sustained period of time.

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DSM-5 Diagnostic Criteria for Bulimia Nervosa (APA, 2013, pp. 345-350) (continued)

Specify current severity:

The minimum level of severity is based on the frequency of inappropriate compensatory behaviors (see below). The level of severity may be increased to reflect other syptoms and the degree of functional disability.

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

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

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

Extreme: An average of 14 episodes of inappropriate compensatory behaviors per week.

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Table 1.2: DSM-5 Diagnostic Criteria for Bulimia Nervosa (APA, 2013, pp. 345-350)

1.2.2 Understanding research practices with regard to the aetiology and development of eating disorders

Anorexia-like phenomena have been observed and documented since at least the late 1600s, and the twenty-first century saw many attempts at explaining its origins and development (Andersen, 1983). Early theories centred around single aspects of the disorder, such as hypothalamic dysfunction and psychological conflicts within the individual. However, as the diagnostic criteria for anorexia were developed and elaborated upon, research into its origins became more scientifically based (Andersen, 1983), and it became clear that the development of anorexia could not be fully described by causal theories that focus narrowly on one contributory factor. The development of anorexia was then described from the perspective of the *biopsychosocial model*, an approach that demonstrates the interaction of biological, psychological, and social processes in the development of disease and disorders (Lucas, 1981; Suls & Rothman, 2004). By the time that bulimia was recognised as a

separate disorder in the late 1970s (Fairburn & Garner, 1986), researchers had begun to assert that eating disorders have their origins in the *interaction of multiple factors*, and that treatment should be individualised (Lucas, 1981). By the late 1970s, researchers also recognised the multidimensional nature of the psychopathology of anorexia, resulting in the development of the Eating Attitudes Test (Garner & Garfinkel, 1979) and of the Eating Disorders Inventory (Garner, Olmsted & Polivy, 1983). These two tests are still used widely today, to identify individuals at risk of developing eating disorders, and for diagnosing eating disorders.

Today, a literature search on the aetiology (the study of the causes of a disease or disorder) of eating disorders yields such an abundance of literature that one has to define narrow search parameters to even begin to make sense of it all, but one aspect clearly emerges: the aetiology of eating disorders is multi-factorial. However, given the relative infancy of eating disorders in the echelons of psychopathology research, many aetiological questions remain unanswered and the full complexity of the origins of these disorders still eludes description (Polivy & Herman, 2002). In researching eating disorders, issues such as sampling bias in the use of eating disorder patients as participants on the one hand, and difficulty in obtaining participants for empirical studies on the other hand, hamper the empirical testing of even the best theories on the development of eating disorders (Polivy & Herman, 2002; Striegel-Moore & Cachelin, 2001). Obtaining participants for this research study was therefore a very difficult process, which restricted this study to the degree that I could only obtain voluntary participation from four participants.

1.2.2.1 A multidimensional integrative approach to understanding psychological disorders

Barlow & Durand (1995) were the first authors to emphasise the interactions between aetiological factors in the *development of psychological disorders* in a textbook on psychopathology. Their *multidimensional integrative approach to psychopathology* embraces the multi-factorial nature of the aetiology of psychological disorders, with specific emphasis on the interaction between the factors that contribute to the development of a disorder. They explain that "[...] no one influence – biological, behavioural, cognitive, emotional, or social – ever occurs in isolation [...] our behaviour, both normal and abnormal, is the product of a

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continual interaction of psychological, biological, and social influences" (Barlow & Durand, 2005, p. 25). Barlow & Durand (2012) hold that the biological, psychological, emotional, social, interpersonal, and developmental dimensions of an individual's life interact with and are influenced by each other to cause psychopathology. Thus, an individual can be viewed as a system that operates within a unique environment, which includes the individual's biological, behavioural, cognitive, emotional, social, and cultural circumstances, that provides the context for the individual's psychopathology. The system receives multiple independent inputs from the environment. As these inputs are integrated into the whole system, they interact with other inputs and can therefore no longer be considered independent: every input must therefore be viewed in the context of the environment. Without consideration of this complex contextual interaction between information entering the system and the components of the system, psychopathology cannot be fully understood or described.

In this study, I used Barlow & Durand's (2012) multidimensional integrative approach to psychopathology as a point of departure from which to organise and discuss the multitude of factors that can contribute to the development of eating disorders. I then used this approach to make sense of the interactions of EQ and coping, to understand their role in the development of eating disorders in the lives of the four participants. I chose Barlow & Durand's (2012) multi-dimensional integrative approach to psychopathology because it accommodates the various factors described in the body of knowledge on the aetiology of eating disorders without forcing them into a narrow theoretical framework. The approach also acknowledges that individual factors do not cause eating disorders, but that every factor is inter-related with every other factor. Therefore, it provides scope for an exploration of the way in which the two specific factors under investigation interact with other factors in the development of eating disorders, within individual contexts.

1.2.3 Current treatment models for eating disorders

Anorexia is more resistant to treatment than bulimia, even though treatments for bulimia have only been developed since the 1980s (Barlow & Durand, 2012). Pharmacological, or drug treatments, have met with very limited success for both disorders, although drug treatments for depression and anxiety have been slightly

more effective in the short term for bulimia than for anorexia (Barlow & Durand, 2012).

Drug treatments alone have, however, not been proven to be effective for the long-term treatment of eating disorders; therefore the focus has shifted to psychological treatments. Three psychological treatments have been shown to be particularly effective in the treatment of eating disorders, namely *Cognitive-behavioural* Therapy; *Interpersonal Psychotherapy* and *Family-Based Treatment*. A fourth treatment model, *Emotion-Focused Family Therapy*, has recently been developed for the treatment of eating disorders.

1.2.3.1   Cognitive-behavioural Therapy

The current treatment modality of choice for both anorexia and bulimia is Cognitive-Behavioral Therapy (CBT), originally adapted by Christopher G. Fairburn in 1985 to treat patients with bulimia (Barlow & Durand, 2012). In the case of anorexia, the first priority is always to reduce the immediate health risks associated with the disorder by establishing weight gain to at least the minimum level considered to be healthy for the individual. In the case of bulimia, CBT focuses initially on educating the bulimic person about the adverse health effects of their disorder; the ineffectiveness of purging as a weight-control measure; and altering eating habits to include regular, small meals. Then the cognitive stages of treatment begin. This involves addressing dysfunctional thinking about body shape and weight, as well as the development of coping strategies aimed at (in the case of bulimia) improving impulse control, and (in the case of anorexia) reducing the anxiety associated with weight gain (Barlow & Durand, 2012).

Even though CBT has been the most effective treatment modality for eating disorders, specifically bulimia, to date, the original form of the treatment only led to remission in about 50% of bulimia patients, and hence it has undergone much development and improvement (Murphy, Straebler & Fairburn, 2010). The new *enhanced* form (CBT-E) focuses on addressing the salient trans-diagnostic psychopathological features – those features that share commonality across disorders rather than being unique to a specific disorder – of eating disorders; of which the over-emphasis on body shape and weight on the individual's self-

evaluation, together with the individual's efforts to control their shape and weight, is the most prominent. A second variant of CBT-E, the CBT-E *broad form* (CBT-Eb), also addresses aspects that maintain eating disorders in some cases, such as clinical perfectionism, low self-esteem, and interpersonal difficulties (Murphy *et al.,* 2010).

1.2.3.2   Interpersonal Psychotherapy

Interpersonal Psychotherapy (IPT) leads to remission rates that are comparable to that of CBT, but over a longer period (eight to twelve months) of time ((Murphy *et al.,* 2010). The focus of IPT is on the interaction of eating disorder psychopathology with interpersonal problems that the individual faces, and is characterised by the inclusion of

> "[...] a chronological review of the individual's significant life events, fluctuations in mood and self-esteem, and interpersonal processes in order to identify areas of social functioning associated with the development and maintenance of psychological symptoms" (Rieger, Van Buren, Bishop, Tanofsky-Kraff, Welch & Wilfley, 2010, p. 401).

IPT (originally designed for treatment outcome research on depression) is in the process of being adapted specifically for the treatment of eating disorders, with the new model, Interpersonal Psychotherapy for Eating Disorders (IPT-ED) emphasizing the interaction between an individual's social experiences and perceptions, and the psychological issues that perpetuate the eating disorder; in particular negative self-evaluation and ineffective emotion regulation (Rieger *et al.,* 2010).

1.2.3.3   Family-Based Treatment

The other treatment model that has been used with some success to treat eating disorders, particularly anorexia in adolescents, is Family-Based Treatment (FBT) (Hay, 2013). According to Loeb, Lock, Greif & le Grange (2012), a core feature of FBT is the inclusion of the whole nuclear family (including siblings in a supportive role) in the treatment of anorexia. In FBT, parents are assigned the role of active participants in the resolution of the problem, while absolving both the parents and the patient from blame and aiming to reduce criticism toward the patient. FBT is

foundationally atheoretical in terms of the developmental mechanisms of eating disorders, but Loeb *et al.* (2012) observed that the target interventions and the effectiveness of FBT suggests a trans-diagnostic model that emphasizes the influence of the eating disorder on the family-based factors that, in turn, maintain the disorder.

1.2.3.4   Emotion-Focused Family Therapy

Very recently, Robinson, Dolhanty & Greenberg (2013) introduced a family-based treatment model designed to target those individuals who do not respond adequately to the original form of FBT. In this new model, Emotion-Focused Family Therapy (EFFT), the principles of Emotion-Focused Therapy (a key focus of which is to support the development of emotional intelligence) are integrated into the FBT model. As Robinson *et al.* (2013) explain, in EFFT, the parents still fulfill responsibilities as per FBT, but they also become the patient's *emotion coaches*; a strategy that promotes the effective treatment of the behavioural problems as well as the emotional difficulties associated with eating disorders. Thus, the individual learns emotion regulation skills, thereby altering maladaptive emotional reactions and associated behaviour patterns. In this way, the need for the eating disorder as a coping mechanism is negated.

The treatment of eating disorders, and anorexia in particular, has been notoriously problematic in the past. Individuals who suffer from eating disorders are typically highly resistant to change and susceptible to relapse, which in turn leads to frustration for the individual, family, and clinicians alike. For this reason, there is an increasing focus on the development of programmes that are designed to prevent the onset of eating disorders (Barlow & Durand, 2012). I briefly touch on this trend in the following sub-section.

1.2.4   The prevention of eating disorders

Programmes that are designed to prevent the onset of eating disorders are typically targeted at a defined behaviour or at the core beliefs associated with eating disorders, such as concerns about body image. Prevention programmes are usually applied to young persons (either in early adolescence or in late adolescence at the

beginning of tertiary education) that have been screened by using measures to identify individuals at risk for developing an eating disorder (Barlow & Durand, 2012).

One of the strengths of such prevention programmes, is that they can be designed to be delivered on-line by using the internet, thereby extending their reach and limiting the cost associated with presenting programmes to groups in person. An example of such a programme is the *Student Bodies Program*, described by Winzelberg, Taylor, Sharpe, Eldredge, Dev & Constantinou (1998). These authors reported that the programme significantly decreased the drive for thinness in participants compared to controls.

Researchers such as Loth, Neumark-Sztainer & Croll (2009), have begun to investigate interpersonal family factors that may be targeted for prevention. They identified eight prevention recommendations for parents. Apart from those relating directly to body image, such as reducing the focus on weight and body image as drivers of self-esteem, their recommendations target increased parental support in the development of emotional intelligence and adequate coping mechanisms, as well as increased parental involvement and attention, particularly during times of transitions and stress for the young person at risk of developing an eating disorder.

An eating disorder, once developed, can have a severe and lasting impact on an individual's physical and psychological health and general well-being, which will be discussed in the next section. The ongoing design of effective prevention programmes is therefore needed, and the research that elucidates the development of eating disorders is vital for supporting this process (Striegel-Moore & Cachelin, 2001).

1.3 REASONS FOR EXPLORING THE DEVELOPMENT OF EATING DISORDERS

Eating disorders have been studied in depth since about the middle of the twentieth century. As such, one would think that there would be an abundance of accurate epidemiological data available regarding the trends in frequency and occurrence of these disorders and how these trends change over time. In reality however, the

statistical data pertaining to eating disorders vary widely in the literature, influenced by the inconsistent application of methodology, differences in the presentation of eating disorders, and differences in the application of diagnostic criteria of eating disorders (Smink, van Hoeken & Hoek, 2012). For example, many people suffer from some eating disorder symptoms, but not everyone fulfils the *DSM* diagnostic criteria for eating disorders and can therefore not be classified as having the condition. Moreover, it is difficult to obtain accurate statistics of eating disorders pertaining to the general population, as epidemiological community studies are costly and epidemiologists therefore tend to rely on medical or psychiatric records (Smink *et. al.,* 2012). Nevertheless, the available data seems to indicate that many people around the world are now at risk for developing eating disorders, rather than only those belonging to Westernised societies as previously believed. Thus, eating disorders are becoming a global phenomenon (Barlow & Durand, 2012).

The incidence and prevalence rates of eating disorders will be presented next, followed by their mortality rates and prognosis. Thereafter, I turn to the impact of eating disorders on psychological and physical health and well-being. Lastly in this section, I present a glance at eating disorders in the South African context.

1.3.1 The incidence and prevalence rates of eating disorders

Despite the broad occurrence of eating disorders across different countries, the portion of the population affected is still mostly young females. Females account for approximately 90% of severe cases. Both bulimia and anorexia usually sets in during adolescence. In females, the lifetime prevalence rate (the number of people that had been diagnosed with the disorder at any point in their lives) of bulimia is estimated at 1.5%, and that of anorexia is estimated at 0.9% (Barlow & Durand, 2012). Swanson, Crow, Le Grange, Swendsen & Merikangas (2011) estimated lifetime prevalence rates among adolescents to be 0.3% for anorexia, and 0.9% for bulimia, respectively. Machado, Machado, Gonçalves & Hoek (2007) conducted a prevalence study on a nationally representative sample of 1 834 Portuguese schoolgirls aged between 13 and 19 years and found prevalence rates of 0.39% for anorexia, 0.3% for bulimia, and 2.37% for EDNOS (which accounted for 77.4% of eating disorder diagnoses in that community). Their findings indicate that many women who seek clinical assistance did not meet the (then) current criteria for anorexia or bulimia. Makino,

Tsuboi & Dennerstein (2004) conducted a literature review comparing prevalence rates for non-Western and Western countries and found that prevalence rates in non-Western countries for bulimia ranged from 0.46% to 3.2% in female subjects. They did not report an average prevalence rate for anorexia in non-Western countries, although they did indicate that overall, these rates seem to be increasing.

Hoek (2006) in his evaluation of literature related to eating disorders, states that there has been a significant increase in the incidence (the number of new cases of a disorder during a specified period of time) rate of anorexia over the last three decades, particularly among women aged 15 to 24 years. Smink *et al.* (2012) similarly indicate an increased incidence rate of anorexia among 15 to 19 year old girls, but they state that it is not clear whether this rate reflects a decrease in age of onset, or whether it is increased due to earlier detection of cases. They further indicate that the incidence rate of bulimia seems to have decreased slightly since the 1990s. However, the influence of EDNOS on the reduced incidence rate of bulimia could not be determined, as epidemiological studies of EDNOS are scarce and their data is difficult to compare due to differences in definitions and study methods applied (Smink *et al.,* 2012).

On the face of it, eating disorders do not seem to be a huge problem in society based only on epidemiological statistics. After all, 0.3% of the population hardly seems like many people. So then, why is there such a fuss about eating disorders in research and clinical practice alike? The answer, simply, is because eating disorders are the most deadly of all psychological disorders, including depression (Barlow & Durand, 2012).

1.3.2 The mortality rate and prognosis of eating disorders

Sue, Sue & Sue (2010) concur with Barlow and Durand (2012) that eating disorders have the highest mortality rate of any major psychiatric disorder. According to Barlow & Durand (2012), anorexia results in the death of as many as 20% of persons diagnosed with this disorder, with suicide accounting for approximately half of these deaths. In a study among adolescents, Crow, Eisenberg, Story & Neumark-Sztainer (2008) found that suicide behaviour presents even in sub-syndromal eating disorders. Crow *et al.* (2009) found mortality rates for anorexia and bulimia to be

4.0% and 3.9% respectively. Additionally, they found elevated mortality rates due to suicide for both disorders.

As mentioned previously, the prognosis for eating disorders is generally poor, due to a high rate of relapse that makes treatment difficult and sometimes impossible. Both disorders are thought to be chronic if left untreated, although anorexia is deemed more resistant to treatment (Barlow & Durand, 2012). According to Keel and Brown (2010), remission rates for anorexia and bulimia ten or more years after treatment are 50% and 75%, respectively. Their findings are slightly more encouraging than those of Berkman, Lohr & Bulik (2007) who reported that according to studies with comparison groups conducted in New Zealand, only 30% of patients who were referred for anorexia were fully recovered when followed up after 12 years. A similar study conducted in the United States of America (USA) found that only 27% of patients referred for anorexia presented with no eating disorder diagnoses after ten years (Berkman *et al., 2007)*. The prognosis seemed to be slightly less dismal for bulimia sufferers. For example, a study with a comparison group conducted in Germany revealed that 67% of patients who had been referred for bulimia had no eating disorder diagnoses after a 12-year follow up (Berkman *et al., 2007)*.

A further reason for the drive to lessen the scourge of eating disorders in society is that, apart from their direct devastating effects, eating disorders have a far-reaching impact on an individual's psychological and physical well-being, which will be discussed below.

1.3.3 The impact of eating disorders on psychological and physical health and well-being

Eating disorders have many adverse physiological consequences, for instance electrolyte imbalance resulting from continued purging, which can cause potentially fatal conditions like cardiac arrhythmia and renal failure (Barlow & Durand, 2012). According to Derman & Szabo (2006), the exact causes of death in eating disorders, particularly anorexia, are unclear and warrant investigation and documentation. In a descriptive study, Herzog, Greenwood, Dorer, Flores, Ekeblad, Richards, Blais & Keller (2000) reported that 7 out of 136 anorectics had died during their longitudinal study (5.1% mortality rate), which was in its 11th year at the time of publication. Of

those seven, two had committed suicide by drug overdose, one had committed suicide by carbon monoxide poisoning, and one had died as a result of acute alcohol intoxication. The remaining three had died from multiple organ failure, cardiac arrhythmia and pneumonia respectively. Medical texts may be of relevance in the study of the causes of death in anorectics. Guyton & Hall (2000) for example, describe the mechanism of starvation and how acidosis (an increase in the acidity of the blood) and depletion of the body's fat and subsequently the body's protein stores, may result in organ failure and death. Death is the most extreme and unfortunate consequence, but numerous physical health effects of eating disorders impact negatively on the individual's quality of life. The more serious of these include conditions such as hypoglycaemia (low blood sugar levels), thyroid dysfunction, structural and functional brain changes, and gastrointestinal bleeding (Barlow & Durand, 2005).

1.3.4 Eating disorders in South Africa

Epidemiological data on eating disorders is rare in South Africa (Wassenaar, Le Grange, Winship & Lachenicht, 2000). This paucity of data is thought to be related to the secrecy associated with eating disorders, as sufferers seldom disclose their disordered status or fail to seek help for their disorder. Nevertheless, eating disorders do exist among the South African population. Senekal (2007), for example, found that approximately 13% of South African women surveyed in a study of 7000 women, aged between 15 and 65, met the criteria for an eating disorder. She reported that the incidence of eating disorders seems to be increasing, particularly among South African women of African descent.

Wassenaar *et al.* (2000) predicted that while South African women of African descent were previously thought to be protected from eating disorders by cultural norms that valued the fuller female figure, the prevalence of eating disorders among this group could be expected to increase due to urbanisation and acculturation. Recent research by Morris & Szabo (2013) seems to support this prediction. These authors found that black South African schoolgirls experienced pressure to be thin and had developed increased body image dissatisfaction as a result of social comparison with their white peers. Their findings further indicated that this experience was more pronounced among black South African girls in schools in

affluent communities where white South Africans represent the majority of the community. According to Mould, Grobler, Odendaal & De Jager (2011), research suggests that bulimic symptoms seem to be more prevalent than anorexic symptoms among black South Africans. Their own study indicated that black girls aged 13 – 15 years were significantly more likely than their white peers to engage in bulimic behaviour, such as episodes of uncontrolled eating, and purging in an attempt to curb weight gain.

1.4 RESEARCH QUESTIONS AND OBJECTIVES

In the discussions above, I illustrated the reasons for the global concern surrounding eating disorders from a clinical and research point of view. My own unresolved questions about my eating disorder provided the motivation to conduct this study. The purpose of this study is therefore to contribute to understanding the development of eating disorders, and to inform the prevention and treatment thereof.

The research questions that this study aims to address stem from the clinical and research needs, as well as from my own experience as an eating disorder sufferer. This research study aims to answer the following questions:

1. What persistent behavioural patterns, revolving around emotional intelligence and coping style, do individuals who suffer from an eating disorder display?

2. How do the factors identified in those patterns interact to contribute to the development of eating disorders within the context of individual lives?

The questions reflect a gap in the literature on the aetiology and development of eating disorders, which was neither addressed by my therapist at the time of my treatment, nor by exploring the available literature on the aetiology of eating disorders.

The objectives of this study are to:

1. Identify patterns of behaviour revolving around emotional intelligence and coping style within the context of individuals' lives with the aim of illuminating factors that contributed to the development of eating disorders; and to

2. Integrate those factors in terms of the multidimensional integrative approach to psychopathology (Barlow & Durand, 2012), to represent a limited view of the mechanism of development of an eating disorder in individual contexts.

1.5 CHAPTER OVERVIEW

Chapter 1 introduced and described various aspects relating to eating disorders, including my own interest and personal experience with an eating disorder.

Chapter 2 will present a broad review of what is known about eating disorders with specific reference to the factors implicated in their development.

Chapter 3 will provide details about the research design that guided this study; my chosen methods of data gathering, analysis, and presentation; ethical considerations; and the methodological challenges that I encountered.

The findings of this study will be presented in Chapter 4, and in Chapter 5 the findings will be discussed and then integrated by making use of the multidimensional integrative approach to psychopathology according to Barlow & Durand (2012).

Chapter 6 concludes this study by:

(1) Presenting the outcome of this exploration of the interaction of emotional intelligence and coping in the development of anorexia nervosa and bulimia nervosa

(2) Discussing the strengths and weaknesses of this research study

(3) Presenting recommendations for parents, teachers, therapists and counsellors, and

(4) Presenting recommendations for future research.

Appendices I, II, and III contain the interview guide; consent form; and indemnity form respectively.

2. EXPLORING THE AETIOLOGY OF EATING DISORDERS

2.1 INTRODUCTION

Research into the aetiology of eating disorders is confounded by the issue of causation, as it is difficult to establish whether observed characteristics of the disorder are the cause or the result of the disorder. An excellent example of this is an experiment conducted by the University of Minnesota towards the end of World War II, known as the Minnesota Semi-Starvation Experiment (Williamson, White, York-Crowe & Stewart, 2004). The experiment was conducted to provide information for post-war relief efforts as many people faced semi-starvation as a result of the war, but incidentally some of the observed effects of semi-starvation, such as depression; preoccupation with food; compulsive and rigid cognitive styles; and social withdrawal, are widely associated with the aetiology of eating disorders today. Thus, in the case of persons burdened with anorexia, the question arises whether those factors were present in the lives of those persons before the onset of the disorder; or whether those factors appeared as a consequence of the disorder.

Jacobi, Hayward, de Zwaan, Kraemer & Agras (2004), pointed out that the prospective and longitudinal research that is required to determine the causal risk factors for the development of eating disorders is costly and time consuming. For this reason, many of the factors associated with aetiology of eating disorders have seldom, if ever, been tested for causality. Risk factors are defined by Jacobi *et al.* (2004, p. 20) as "…a measurable characteristic of each subject in a specified population which precedes the outcome of interest and which can be shown to divide the population into two groups: a high- and a low-risk group." Other factors associated with the development of eating disorders can only be described as concomitant factors (factors that can precede or be a consequence of a disorder), or as correlates (factors that occur together with the disorder, but for which causality has not been established) of eating disorders.

However, according to Jacobi *et al.* (2004), the risk for developing eating disorders increases as the amount of factors that an individual is exposed to increases. Bulimics frequently indicate exposure to a combination of factors such as low self-

esteem, depression, anxiety, dysfunctional parenting, high parental expectations, physical and sexual abuse, and childhood obesity. Anorectics are likely to have been exposed to a combination of "…perfectionism, low self-esteem, severe personal health problems, a history of deliberate self-harm, major depression, premorbid drug abuse […] inadequate parenting, frequent house moves, high parental expectations, and parental history of AN or BN […] no close friends […] [and] physical and sexual abuse" (Striegel-Moore & Cachelin, 2001, p. 650). It is for this reason the Striegel-Moore & Cachelin (2001) emphasized the importance of delineating the mechanism of the development of eating disorders; that is, how individual factors interact with one another to contribute to the development of a disorder.

Despite the fact that the focus of this study is on the contribution of only two specific factors (EQ and coping style), their interactions must be described in relation to other factors implicated in the aetiology of eating disorders, according to the multidimensional integrative approach to psychopathology as described by Barlow & Durand (2012). I will now begin to discuss the factors that are generally associated with the aetiology of eating disorders, categorised according to the three dimensions delineated by Barlow & Durand (2012), namely the social dimension; the biological dimension; and the psychological dimension. Following this discussion, I will give special attention to literature concerning EQ and coping styles as they relate to the development of eating disorders.

2.2   AETIOLOGICAL DIMENSIONS OF EATING DISORDERS

According to Barlow & Durand (2012), the contribution of the social dimension to the aetiology of eating disorders outweighs that of the biological and psychological dimensions. This discussion therefore commences with the social factors that contribute to the aetiology of eating disorders, followed by the biological and psychological dimensions.

2.2.1   The social dimension

The social dimension of contributing factors may be divided into those that a person is exposed to within their core family environment (intra-familial factors), and those

that impact on an individual from within their cultural and / or societal environment (extra-familial factors).

2.2.1.1   Intra-familial factors

Jacobi *et al.* (2004) provide a good review of early discussions pertaining to family interaction patterns in the aetiology of eating disorders. According to Jacobi *et al.* (2004, p. 39):

> "…anorexic and bulimic patients describe different aspects of their family structure (e.g., interaction, communication, cohesion, affective expression) as more disturbed, conflictual, pathological, or dysfunctional than do controls across different family assessment measures."

In particular, Jacobi *et al.* (2004) report that high parental expectations; low parental contact; and parental critique about weight and shape were shown to be specific predictors for the development of bulimia. Barlow & Durand (2005, p. 272) note that families of anorectics are typically described as "…successful, hard-driving, concerned about external appearances, and eager to maintain harmony"; and early research described in Sue, Sue & Sue (2003) indicate that eating disorder patients' family relationships involve (an) over-controlling parent(s), emotional enmeshment, an inability to resolve conflict, rejection, and emotionally detached fathers.

Attachment disturbances were widely reported in the review of Jacobi *et al.* (2004). Tasca, Ritchie & Balfour (2011, p. 250) describe attachment as "[...] an inborn system that motivates an infant to seek proximity to a caregiving adult". The attachment styles of adults can be categorised as secure; preoccupied (anxious); or dismissing (avoidant). Together with these three attachment categories, a person who has suffered loss or trauma may be experiencing a disorganised (unresolved) state of attachment. Furthermore, attachment functioning within each of the categories is described concurrently with the respective attachment styles. Attachment functioning is measured on the dimensions of affect regulation; interpersonal style; coherence of mind; and reflective functioning (Tasca *et al.,* 2011). According to Tasca *et al.* (2011) women with eating disorders are more likely to have insecure attachment styles than women without eating disorders. Hooper &

Dallos (2012) explain that insecure attachment styles involve feelings of dependency and fear of rejection. Tasca *et al.* (2011) also state that attachment anxiety (characterised by dysfunctional affect regulation; dependent interpersonal style; low coherence of mind; and poor reflective functioning) was found to be related to the presentation of eating disorder symptoms as well as with poorer treatment outcomes across eating disorder diagnoses. Conversely, they found that when treatment for patients with binge-eating disorder included a focus on affect regulation and interpersonal problems, their treatment outcome improved. Similarly, attachment avoidance (characterised by avoidance of emotion expression; independent interpersonal style; poor coherence of mind; and limited reflective functioning) was associated with an increased drop-out rate from eating disorder treatment programmes Tasca *et al.* (2011).

Like eating disorders, a number of other psychiatric disorders, specifically mood disorders; anxiety disorders; substance abuse; obsessive-compulsive disorder (OCD); post-traumatic stress disorder (PTSD); and personality disorders have been shown to prevail in the families of persons with eating disorders. Jacobi *et al.* (2004) evaluated various family studies in which these factors were investigated and apart from methodological shortcomings like patient bias, their biggest concern is that most of the studies they reviewed did not establish whether psychiatric dysfunctions of family members preceded the onset of eating disorders.

2.2.1.2   *Extra-familial factors*

Western culture dictates that thin is good and fat is bad. While this may be a healthy outlook generally, it can quickly skew the perspective of the person who is at risk for developing an eating disorder. When the desire to be thin trumps the desire to be healthy, excessive dieting often results. This is widely considered to be the beginning of an eating disorder (Barlow & Durand, 2012; Jacobi *et al.*, 2004). Stewart, Williamson & White (2002) for instance, found that non-obese women who displayed a rigid approach to dieting were more prone to developing eating disorder symptoms than woman who dieted less strictly.

Much of the literature that describes factors that contribute to the development of eating disorders, such as Barlow & Durand (2012), Cramer & Steinwert (1998), and

Sue, Sue & Sue (2010) emphasize the role of the media – most prominently magazines and television - in perpetuating the message that attractiveness is directly related to thinness. Thompson & Stice (2001) for instance, found that women who internalise media messages that glorify thinness were at risk for developing eating disorders.

Polivy & Herman (2004) question the belief that societal pressure to be thin is to blame for the increasing incidence of eating disorders. They agree that many women internalise the media's messages and strive to be thin, but point out that only a few women go on to develop an eating disorder. In an earlier study, Stice (1998) indeed found that reinforcement from family and peers, rather than media buy-in, predicted the onset of eating disordered symptoms. Friendships may therefore be an important factor in determining, or conversely in protecting against, the development of eating disorders. Close friendship cliques play a large role in the shaping of the body image of individuals within the clique, as well as dictating the measures that individuals will take to improve their body image (Barlow & Durand, 2012). While close friends may criticise members of other groups, they are likely to be supportive of each other's physical appearance, providing a protective function against negative social comparisons (Krayer, Ingledew & Iphofen, 2008).

Participation in certain sports, such as gymnastics, athletics and ballet, was historically thought to be a risk factor for the development of eating disorders. On closer inspection however, it seems that while many elite female sportswomen develop eating disorder symptoms or sub-clinical eating disorders, most do not develop full syndrome eating disorders. Moreover, precedence of participation in sport prior to the onset of eating disorder symptoms was not established in the vast majority of this line of studies as reviewed by Jacobi *et al.* (2004). They hold therefore, that while participation in certain sports may correlate strongly with eating disorder symptoms, it cannot be said to be a risk factor for the development of eating disorders.

2.2.2 The biological dimension

The biological dimension includes the biological and genetic contributory factors in the aetiology of eating disorders, as well as aetiological factors that are related to human development.

2.2.2.1 Biological and genetic factors

Eating disorders often run in families (Barlow & Durand, 2012; Jacobi *et al.*, 2004; Striegel-Moore & Cachelin, 2001), therefore the possibility of a genetically inherited vulnerability cannot be ruled out. However, attempts at isolating the specific attribute that is inherited have yielded inconclusive results and questions pertaining to whether this component is truly hereditary or whether it is learned behaviour, remain unanswered (James, 2007; Polivy & Herman, 2002; Striegel-Moore & Cachelin, 2001). One likely possibility seems to be that a number of genes acting together and interacting with environmental factors may predispose certain individuals to the development of EDs, but Jacobi *et al.* (2004) hold that the results of family studies and twin studies which investigated this possibility are inconsistent and inconclusive. The field of gene mapping, which attempts to isolate genes linked to eating disorders, is developing rapidly but has met with limited success to date, as the results of studies that have found gene linkages have yet to be supported by further research (Jacobi *et al.*, 2004).

According to Polivy & Herman (2002), neurological functions have been implicated in the aetiology of eating disorders. In particular, the roles of the hypothalamus (a brain structure involved in the regulation and control of hunger) and of serotonin (a neurotransmitter important in the regulation of mood, anxiety and sleep) have enjoyed much attention in the research on eating disorders. However, Polivy & Herman (2002) found little evidence to suggest that problems with the hypothalamus causes eating disorders, as re-feeding in the case of anorexia has been shown to correct the hypothalamic dysfunction. As for the involvement of serotonin in the development of anorexia and bulimia, Polivy & Herman (2002) remark that the findings are equally inconclusive: Anorexia sufferers display increased serotonin levels, even after recovery; and conversely bulimia sufferers display decreased serotonin levels which persist after recovery. Polivy & Herman (2002) point out that this seems contradictory in the light of the overlap of the symptoms of the two

disorders, especially bulimia and binge-eating / purging anorexia, and that the role of a serotonin imbalance as a cause of the eating disorder is also questionable when one keeps in mind that many anorectics tend to become bulimics. Moreover, researchers have not as yet been able to establish whether biological dysfunctions associated with eating disorders are the cause or the result of the eating disorder (Barlow & Durand, 2012; Jacobi *et al.*, 2004). Many of the disruptions to the neuroendocrine system of an eating disorder patient may be the result of stress and / or starvation (Polivy & Herman, 2002).

The role of neural circuits in the aetiology and maintenance of eating disorders has also been investigated. Steinglass & Walsh (2006) for example, hypothesised that patients with anorexia may be predisposed to a disturbance in their implicit learning systems, mediated by the cortico-stratial-thalamo-cortical neural circuitry. Hilbert, Vögele, Tuschen-Caffier & Hartmann (2011) have recently investigated the effect of stress on psychophysiological responses in clinical samples. They noted that after exposure to stress (in particular interpersonal stress) only the bulimia group in their study showed an increase in desire to binge (psychological stress response) at follow-up, and that autonomic nervous system activity predicted lower recovery of the desire to binge, as well as changes in skin conductance levels and autonomic cardiac activity (physiological stress responses) in that group. Very recently, Schumacher, Kirschbaum, Fydrich & Ströhle (2013) suggested that autonomic nervous system dysregulation may be implicated in several mental disorders, including anorexia, and especially in the anxiety disorders. Research of this nature is however preliminary and causality remains to be established.

2.2.2.2 Developmental factors

Developmental factors, ranging from complications during the mother's pregnancy to pubertal changes within the body of the adolescent eating disordered individual, have been studied in relation to the development of eating disorders. In studies reviewed by Jacobi *et al.* (2004), preterm birth has been associated with elevated risk for anorexia; pregnancy complications have been associated with elevated risk for anorexia and bulimia; and birth trauma has been associated with increased risk for anorexia. Jacobi *et al.* (2004) also evaluated one study that investigated early childhood eating problems, such as pica; picky eating; feeding and digestive

problems; and difficulty at mealtimes, as risk factors for the development of eating disorders. They agreed that early childhood feeding and digestive problems do seem to correlate with later development of eating disorders, but emphasised that these factors were only examined in one study. Caution should therefore be exercised in generalising these findings.

The roles of childhood obesity; parental obesity; and high body mass index (BMI) in predicting later eating disorders have been investigated in a number of studies as reviewed by Jacobi *et al.* (2004). They refer in particular to case-controlled studies undertaken by Fairburn and colleagues, who found that both childhood obesity and parental obesity predicts the later development of eating disorders. However, Jacobi *et al.* (2004) point out that these results require verification by replication. Furthermore, they found that BMI could not be shown to be a predictor for the development of eating disorders, as those longitudinal studies which tested BMI as a predictor of eating disorders yielded conflicting results.

Jacobi *et al.* (2004) reviewed studies that investigated pubertal timing (the age at which puberty starts) as it relates to the development of an eating disorder, and concluded that pubertal timing was not consistently found to be a risk factor relating to eating disorder aetiology.

Developmental factors and cultural influences may interact to cause eating disorders (Barlow & Durand, 2005). During puberty, girls' bodies become plumper as weight is gained in fat tissue, thus deviating from the Western ideal of pre-pubertal thinness. By contrast, boys become more muscular and leaner, thus approaching the ideal body shape by Western standards. Their view seems to be supported by Krayer, Ingledew & Iphofen (2008), according to whom adolescents employ social comparison mechanisms to gain information about their social environment, and to evaluate their social standing accordingly. Negative evaluations may lead to self-criticism, and self-criticism correlates positively with eating disorder symptoms (Fennig, Hadas, Itzhaky, Roe, Apter & Shahar, 2008).

2.2.3 The psychological dimension

Psychological factors constitute the largest category of factors implicated in the development of eating disorders. These factors are usually studied in isolation and the interaction of these factors in the mechanism of development of eating disorders lacks clear description. There is also considerable overlap between individual factors as they relate to eating disorders and to disorders that occur co-morbidly with eating disorders, thus complicating the study of their individual and combined roles in the development of eating disorders.

2.2.3.1. *Body image and self-esteem*

Of all contributing factors in the development of eating disorders, distorted body image and low self-esteem are perhaps the most often mentioned. Numerous studies in which these factors were investigated were reviewed by Jacobi *et al.* (2004) and they found that persons suffering from bulimia and anorexia consistently had more negative self-concepts (as defined by body image and self-esteem) than control groups. However, they again mention that the time of onset (pre- or post-eating disorder) of the self-concept deficits was not established in most studies, as well as that these factors were not assessed independently of patients' depressive symptoms. Therefore the interrelation of the specific eating disorder with negative self-concept and depression remains unclear.

2.2.3.2 *Perfectionism*

Perfectionism, as it relates to eating disorders, is another factor that has been studied extensively. It is especially associated with anorexia patients, and to a lesser extent with bulimia patients (Jacobi *et al.*, 2004). Barlow & Durand (2012) concur that perfectionism is a contributing factor in the development of an eating disorder, but suggests that it may be moderated by body image and self-esteem. The combination of perfectionist tendencies and emphasis on the importance of physical appearance may lead vulnerable individuals to become overly concerned with their body shape and weight (Barlow and Durand, 2005).

2.2.3.3 *Control*

One of the most prominent schools of thought on the aetiology of eating disorders is that persons who suffer from eating disorders have a perceived lack of control over

their lives, including current circumstances and future aspirations. Those who espouse this school of thought believe that the eating disordered behaviour is a compensatory action for this lack of control. Thus, the extreme self-control displayed by anorectics on the one hand and the purging behaviour of bulimics on the other hand, is a form of expressing control over at least one aspect of their existence - food and the consumption thereof.

Dieting and weight loss may afford the individual at least some measure of control over his / her life (Sue, Sue & Sue, 2010). The term 'sovereignty' (an individual's sense of autonomy over his or her life) is perhaps a more descriptive term and one which seems to be a better fit if one considers other factors commonly associated with eating disorders, such as being raised in an authoritarian environment; the perceived lack of autonomy over one's life may be a contributor to the development of an eating disorder (Johnston, 1996). This idea corresponds with the suggestion by Barlow & Durand (2012) that a sense of loss of control over one's environment and a comparatively low level of confidence in one's own abilities manifests as low self-esteem. It is possible that, in the absence of autonomy, a person may not be given the opportunity to be exposed to significant challenges and therefore may not learn how to cope effectively and confidently under stressful circumstances.

2.2.3.4 Cognitive factors

Anorectics and bulimics have been found to display abnormal cognitive processes, such as obsessive thoughts centring on food and cognitive bias focused on weight and shape. Indeed, these thought patterns are the subject of most modes of treatment for eating disorders. Polivy & Herman (2002) hold that earlier studies failed to prove the presence of such cognitive aberrations in the aetiology of eating disorders and as such, these thought patterns may be the result of the eating disorder, rather than the cause thereof.

Persons suffering from eating disorders also seem to have a lack of interoceptive awareness. That is, they seem to lack the ability to accurately identify internal physiological sensations. This attribute has been described since at least as early as the 1960s (Bruch, 1962) and has become known as one of the three most consistent attributes of persons with eating disorders (Jacobi *et al.*, 2004), together with body

image disturbances and a sense of ineffectiveness. The notion that persons with eating disorders confuse emotional needs with physiological hunger, resulting in the 'comfort eating' associated with bingeing stems from this apparent lack of interoceptive awareness, according to Johnston (1996).

2.2.3.5 Co-morbidity

Individuals diagnosed with eating disorders frequently present with co-morbid psychological disorders, predominantly affective disorders, anxiety disorders (including childhood overanxious disorder), substance abuse, OCD, and Cluster B and C personality disorders. Díaz-Marsá, Carrasco & Sáiz (2000) for instance, indicate that 61.8% of their eating disorder participants presented with a co-morbid personality disorder, with avoidant personality type predominating among their anorexic participants while borderline personality type was most prominent among their bulimic participants. Anderluh, Tchanturia, Rabe-Hesketh, & Treasure (2003) found that personality traits associated with obsessive-compulsive personality disorder in childhood were predictive of the development of eating disorders, particularly anorexia, later in life. Westen & Harnden-Fischer (2001) point out that while there is considerable evidence of co-morbidity between personality disorders and eating disorders, the reported rates are very inconsistent (between 21% and 97%). Body dysmorphic disorder has also been shown to correlate with anorexia (Jacobi *et al.*, 2004). A number of early researchers suggested that other psychiatric disorders may in fact underlie eating disorders. Bulimia nervosa in particular was thought to be underpinned by mood disorders while obsessive-compulsive disorders were thought to underlie anorexia, but the majority of those studies did not investigate whether the co-morbid disorders preceded the eating disorders in onset (Jacobi *et al.*, 2004).

The co-morbidity of substance abuse with eating disorders has been documented extensively (Dawe & Loxton, 2004; Holderness, Brooks-Gunn & Warren, 1994; Wolfe & Maisto, 2000). Eating disorders and their symptoms have even been likened to addictions: bulimia sufferers are purported to have food cravings (likened to drug cravings) associated with repeated overeating, while anorexia sufferers are said to be addicted to opioids released by the body in response to excessive exercise. Polivy & Herman (2002) dismiss the addiction model based on failures thereof to

account for the characteristic aspects of eating disorders such as drive for thinness and low self-esteem.

In addition to full symptom disorders, certain clusters of symptoms have been shown to precede (they are therefore called prodromal symptoms) the onset of an eating disorder. Raffi, Rondini, Grandi & Fava (2000) found low self-esteem, depressed mood, anhedonia, irritability, impaired work performance, generalized anxiety, psycho-physiological reactivity, phobic avoidance, guilt, and strict dieting to be prodromal symptoms of bulimia, dating back to six months before the onset of the eating disorder.

2.2.3.6   Personality

Clinicians and researchers have long speculated about a link between eating disorders and personality types. Anorectics for example, often display personalities characterised by perfectionism, conformation and exemplary performance as students and / or athletes (Sue, Sue & Sue, 2003). In the last decade, research has shown that certain personality types may be associated with eating disorders generally and with eating disorder symptoms specifically. Westen & Harnden-Fischer (2001) found that they could distinguish three personality clusters among eating disorder patients. They labelled these the high-functioning / perfectionistic group; the constricted / overcontrolled group; and the dysregulated / undercontrolled group. The groups differed with regard to eating disorder symptoms and behaviour, suggesting that eating disorder phenotypes may correspond with specific personality types. Thompson-Brenner, Eddy, Franko, Dorer, Vashchenko & Herzog (2008) also differentiated between personality types in persons with eating disorders. Moreover, they found a positive association between substance abuse and one specific personality type, which they labelled the behaviourally dysregulated type.

2.2.3.7   Sexual abuse

Sexual abuse is an established risk factor for the development of eating disorders, but also for a host of other psychological disorders (Jacobi *et al.,* 2004). Sexual abuse may furthermore be associated with the severity and prognosis of eating disorders. Westen & Harnden-Fischer (2001) found that a history of sexual abuse was associated with greater disturbance among eating disorder individuals, and was

almost always found among eating disorder patients displaying the dysregulated / undercontrolled personality type.

2.2.3.8 Emotional factors

The occurrence of severely stressful life events, such as the death of a parent, prior to the onset of an eating disorder has been widely studied as it relates to eating disorders. Jacobi *et al.* (2004) agree that eating disordered persons have been found to have experienced stressful life events before the onset of their eating disorder, but they point out that this is true for psychiatric disorders in general, and is not limited to eating disorders. However, recent research has linked the loss of support (in combination with adverse life events) with presentation of bulimic symptoms (Bodell, Smith, Holm-Denoma, Gordon & Joiner, 2011).

It is possible that patients suffering from eating disorders do not necessarily experience more (referring to either quantity or severity) stressful events, but that they are less able to cope with such events than persons not prone to developing eating disorders. According to Sue, Sue & Sue (2003), bulimia often presents in persons that perceive events to be more stressful compared with the rest of the population. Barlow & Durand (2012) mention findings that some patients with eating disorder are altogether intolerant of negative emotions, which may lead to engaging in behaviours typically associated with eating disorders.

The next section focuses on the literature pertaining to the roles of emotional intelligence and coping style in the development of eating disorders.

2.3 EMOTIONAL INTELLIGENCE AND COPING STYLE AS POSSIBLE AETIOLOGICAL FACTORS OF EATING DISORDERS

The preceding section highlighted the multi-factorial and cumulative nature of the aetiology of eating disorders. In this section, I will organise the literature review pertaining to the concept of emotional intelligence, as it relates to eating disorders, according to the four elements in Sternberg's (2006) definition: 1. Perception of emotion, 2. The ability to identify, understand, and reason about emotion, 3. Expression of emotion, and 4. Regulation of emotion. I will then turn to the literature

pertaining to the concept of coping style; its relationship with eating disorder behaviour; as well as its relationship with emotional intelligence.

2.3.1 Emotional intelligence and the development of eating disorders

The role of emotional intelligence (EQ) in the development of eating disorders is under-researched, according to Markey & Vander Wal (2007). They find this surprising, because EQ aids in successful coping with everyday stress and challenges. Low EQ may therefore be expected to influence how one copes with factors that have long been correlated with eating disorders, such as emotional stress and difficult relationships. Low EQ may be directly related to the development of eating disorders, according to Markey & Vander Wal (2007), who found that bulimic symptoms are related to low emotional intelligence. Costarelli, Demerzi & Stamou (2009) also found lower levels of emotional intelligence in their sample of women with disordered eating attitudes. However, these studies do not give any indication as to whether low EQ was present before the onset of the eating disorder symptoms and therefore the role of EQ in the development of eating disorders cannot be inferred from them.

Research pertaining specifically to the different elements of emotional intelligence as they relate to eating disorders, is discussed in the next four sub-sections. I begin with the perception of emotion and how it is linked to eating disorders.

2.3.1.1 *Perception of emotion*

The ability of anorexia or bulimia patients to perceive emotions in others, or their subjective experience of emotion when exposed to emotionally-laden stimuli, has been the subject of a number of studies (Harvey, Troop, Treasure & Murphy, 2002; Kessler, Schwarze, Filipic, Traue & von Wietersheim, 2006; Troop, Treasure & Serpell, 2002). Harvey *et al.* (2002) demonstrated that a non-clinical sample with abnormal eating attitudes showed increased sensitivity to fear and to disgust; .and Troop *et al.* (2002) found that their sample of patients with eating disorders were prone to be sensitive to disgust. In a study that focused on the recognition of emotion in facial expressions, Kessler *et al.* (2006) failed to find a significant distinction in the performance of eating disordered patients compared with controls.

Joos, Cabrillac, Hartmann, Wirsching & Zeeck (2009) found that patients with the restrictive type of anorexia experienced less happiness than controls, but thought that this finding may be related to latent depression and anxiety among their anorexic participants. They found no difference between eating disorder patients and controls in the experience of fear when exposed to fear inducing stimuli. Furthermore, their study shows that anorexia and bulimia patients experience less anger than controls, but they report that this finding failed to reach the level of statistical significance. Interestingly, they found that anorexic patients displayed increased levels of fear when confronted with anger stimuli. Their explanation for this finding is that anorectics tend to be conflict avoidant; suppressing their anger or turning it in on themselves, rather than to express anger outwardly toward the source of their anger, as patients with bulimia tend to do. Joos *et al.* (2009) concluded that eating disorder persons do not display any fundamental deficits in the perception of emotion in others compared to controls. They did however highlight their finding that patients with anorexia react differently than patients with bulimia to anger inducing stimuli, and they draw the reader's attention to the role that depression may play in attenuating and masking fear among anorexic patients.

Regarding perception of own emotions, Oldershaw, Hambrook, Tchanturia, Treasure & Schmidt (2010) compared currently ill anorectics with recovered anorectics and found that currently ill patients fared worse than recovered patients in determining their own emotions. They postulated that this impairment facilitates emotional avoidance in currently ill patients, and in turn, that current illness diminishes the ability to recognise emotions by affecting the patient's brain functions, notably intelligence; attention span; memory; and executive brain functions.

According to the research described in this subsection, persons with eating disorders may be more sensitive to certain negative emotions (such as fear and disgust). Additionally, an eating disorder may affect a person's ability to perceive their own emotions correctly. However, I could not find any literature that examined the perception of emotion prior to the onset of eating disorders. It is therefore unclear whether this element of EQ (perceiving emotions acurately) is related to the development of eating disorders. The second element of EQ, that is, the ability to identify, understand, and reason about emotion, is explored in the next subsection.

2.3.1.2 Ability to identify, understand, and reason about emotion

The inability to identify, understand, and reason about one's emotions is defined by Reber & Reber (2001, p. 22) as alexithymia, which according to them includes "[...] a disruption in both *affective* and *cognitive* processes", such that "[...] typically the alexithymic person has relatively undifferentiated emotions and his or her thinking tends to dwell excessively on the mundane." In less abstract terms, this means that the alexithymic person lacks understanding of his or her emotional states, and is therefore unable to name and describe his or her emotions (Reber & Reber, 2001). Symptoms furthermore include "...a preference for attending to the details of one's physical symptoms or environment rather than introspecting; and limited symbolism, creativity, fantasy, and daydreaming" (Lumley, Mader, Gramzow & Papineau, 1996, p. 211).

Cochrane, Brewerton, Wilson & Hodges (1992) conducted a study on the presence of alexithymia in persons with anorexia and bulimia, and they identified high levels of alexithymia in their clinical sample. They hold that their finding may be relevant to the treatment of eating disorders, as the inability to identify and describe emotions may cause patients to express their feelings in the form of body image distortion. More recently, Bydlowski, Corcos, Jeammet, Paterniti, Berthoz, Laurier, Chambry & Consoli (2005) found that their sample of eating disorder patients were not only unable to identify their own emotions, they were also unable to adequately describe others' emotional experiences.

Dysfunctional parenting styles may influence the individual's emotional expression, according to Kooiman, van Rees Vellinga, Spinhoven, Draijer, Trijsburg & Rooimans (2004). They hypothesised that since children increasingly learn to identify, name and react appropriately to their emotions with the help of their parents, inadequate parenting would contribute to the development of alexithymia during childhood. Their findings supported their hypothesis, in that perceived lack of affection and perceived overprotection correlated with alexithymia in their sample, although not very strongly. Moreover, they found that optimal parenting by one parent had a buffering effect on the development of alexithymia. Their findings support those of Lumley *et al.* (1996), who found that differential expressions of alexithymia (impaired communication,

externally oriented thinking, or limited creativity) correlated with specific dysfunctions in parenting style: impaired communication was linked to parental over- or under-involvement; externally oriented thinking was linked to deficient rules governing behaviour within the family; and limited creativity was linked to poor problem solving ability within the family unit.

Since dysfunctional parenting has been linked to the development of alexithymia (Kooiman *et al., 2004)*, alexithymia could play a role in the aetiology of eating disorders, although this was not established in the research reviewed in this section. The following section will deal with the inability of eating disordered persons to effectively and appropriately express their emotions.

2.3.1.3   Expression of emotion

Persons who suffer from eating disorders have difficulty in expressing their emotions effectively, according to Polivy & Herman (2002) and Williamson *et al.* (2004). In particular, a tendency to suppress anger has been identified in anorexic patients. Zaitsoff, Geller & Srikameswaran (2002) measured to what extent adolescent females express anger and found that those participants who display comparatively high levels of eating disorder symptoms were more likely to inhibit negative feelings, although they found no difference between the groups in the expression of anger. In a later study, Ioannou & Fox (2009) found a negative correlation between the expression of emotions and perceived threat from anger.

The tendency to suppress anger is often accompanied by an interpersonal style focused on meeting the needs of others instead of the self (Geller, Cockell, Hewitt, Goldner, & Flett, 2000). Hambrook *et al.* (2011) found that among the anorexic patients in their study maladaptive beliefs about the expression of emotion, particularly in relation to the establishment of attachments to others, was associated with an elevation in eating disorder symptoms. Furthermore Meyer, Leung, Barry & De Feo (2010) discovered that, in their non-clinical sample, the women with eating, body shape and weight concerns were likely to believe that a display of emotion is a sign of weakness; that it may lead to rejection from others; or that it may harm others.

The last focal area of EQ as it relates to eating disorders is the area of emotion regulation, which is discussed next.

2.3.1.4 Regulation of emotion

The notion that eating disorder symptoms, particularly bingeing and purging, serve to regulate negative affect has been investigated in much of the literature on the aetiology of eating disorders. The theory that persons who suffer from eating disorders engage in these behaviours as a method to cope with emotional distress is well known according to Polivy & Herman (2002). Support for this theory has also been found indirectly through the application of dialectical behaviour therapy (DBT) which aims to reduce binge eating in binge eating disorder, although the researchers (Telch, Agras & Linehan, 2001) state that they do not know by what mechanism symptom reduction was achieved and that due to limitations of the study, it was not possible to claim that DBT, rather than nonspecific factors related to treatment, caused the observed symptom reduction. However, their results provide cause for further investigation of the possibilities. Their adaptation of the treatment for binge eating disorder focused on teaching patients mindfulness skills, emotion regulation skills and distress tolerance skills, and they achieved an 89% rate of abstinence from binge eating at least four weeks prior to the end of treatment. In more recent research, Markey & Vander Wal (2007) support the notion that emotional dysregulation (defined as an emotional response that is not well controlled) plays a role in the development and maintenance of eating disorders, as they found a significant association between bulimic symptoms in particular and a person's (in)ability to regulate their emotions.

The preceding sections make it clear that poor EQ has not been identified as a definite risk factor for the development of eating disorders, albeit only because it was not the aim of these research studies to explore the role of EQ in the aetiology of eating disorders.

In the next section, I explore whether coping ability is related to the development of eating disorders, as well as how this ability is related to emotional intelligence.

2.3.2 Coping ability and the development of eating disorders

The development of coping strategies takes places on intrapersonal as well as interpersonal levels: Compas (2009), Eisenberg, Valiente & Sulik (2009) as well as Rueda & Rothbart (2009) all argue that coping strategies develop in relation to emotion regulation abilities, and that the development of both are influenced by individual neurobiology (particularly those structures relating to the perception of and response to novelty, reward, challenge and threat), temperament, and individual context, including experiences of stress and emotions beginning in early childhood.

Compas, Connor-Smith, Saltzman, Harding Thomsen & Wadsworth (2001, p. 87) state that the construct of coping with stress includes "[…] the ways in which individuals manage their emotions, think constructively, regulate and direct their behavior, control their autonomic arousal, and act on the social and nonsocial environments to alter or decrease sources of stress." According to these authors, coping is an adaptive process that changes in response to changing demands of stressful situations as an individual matures. They assert that the two-dimensional model of problem focused coping (directed at resolving stress between self and environment) versus emotion focused coping (directed towards the reduction of negative affect) is inadequate to describe coping during childhood and adolescence, and they go on to provide support for a multidimensional model of coping, which involves voluntary and involuntary responses to stress. This model includes, but is not limited to, the categories of active coping (control over environment and emotions), adaptation (by reframing, acceptance or distraction) and avoidance (by disengaging from the stressor or stressful emotions). Compas *et al.* (2001) therefore hold that the coping skills that individuals adopt during childhood and adolescence set the trend for coping in adulthood. This may be particularly relevant to the development of eating disorders, because if a young person forms a habit of avoiding emotional distress, or distracting herself from emotional distress by eating, this habit may persist into later developmental years.

According to Markey & Vander Wal (2007), women with bulimic symptoms tend to use emotion-focused or avoidance coping in response to stress. A number of authors have found avoidance or escape-avoidance strategies to be prevalent in their studies of eating disordered individuals (Ghaderi & Scott, 2000; Corstorphine,

Mountford, Tomlinson, Waller & Meyer, 2005; Soukup, Beiler & Terrell, 1990). Ghaderi & Scott (2000) found escape-avoidance coping and perceived lack of social support to be prospective risk factors for the development of eating disorders, while Spoor, Bekker, van Strien & van Heck (2006) found that emotion-oriented coping as well as distraction-avoidance to be related to emotional eating. Soukup *et al.* (1990) furthermore found that both the anorectics and bulimics in their sample had a lack of confidence in their abilities to solve problems.

Denisoff & Endler (2000) examined the factors that contribute to excessive preoccupation with weight and found that participants' coping style, particularly emotion-oriented coping, served as a predictor for preoccupation with their weight. Williamson *et al.* (2004) reviewed a number of studies which support the notion that negative affect precedes binge eating and that the eating provides distraction (thus allowing the individual to avoid dealing with the stressful situation) or as a means of self-nurturance (thus providing comfort). Paradoxically, these studies also show that the binge eating did not provide comfort in the long run, but instead worsened the negative emotions.

Maladaptive coping has also been associated with low emotional intelligence. In fact, some researchers believe that effective coping is a practical application of high emotional intelligence, since effective coping is underscored by the ability to accurately identify one's own and others' emotional states, together with appropriate expression and regulation of emotion (Markey & Vander Wal, 2007). More specifically, maladaptive coping seems to be associated with alexithymia. For instance, Parker, Taylor & Bagby (2003) found that alexithymia is related to a maladaptive pattern of coping, characterised by low problem focus, high emotion focus and avoidance or distraction.

The research in this section on coping ability and the development of eating disorders seems to indicate that ineffective coping styles are potentially a risk factor in the aetiology of eating disorders. Furthermore, coping ability may be an expression of emotional intelligence (Markey & Vander Wal, 2007). The interactions between coping style and emotional intelligence in the development of eating disorders, however, were not established in the literature.

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2.4 CONCLUSION

The above presentation of the relevant literature pertaining broadly to the aetiology of eating disorders, highlighted the multi-factorial and cumulative nature of the development of anorexia and bulimia. The roles of emotional intelligence and coping style in eating disorders was discussed in more detail, emphasizing their interrelatedness with each other and with contextual factors such as family relationships. However, the interactions between potential aetiological factors, specifically emotional intelligence and coping, in the developmental mechanism of eating disorders could not be ascertained.

In Chapter 3, I will present the methodology of this study.

3. METHODOLOGY

3.1 INTRODUCTION

If research is to be useful, it must be grounded in solid epistemological, philosophical, and methodological foundations. According to Ponterotto (2005), the research methodology of a study encapsulates the process that is followed by the researcher in conducting the research project, and the procedures that are applied in this process. According to Terre Blanche & Durrheim (2006), a research design is a guiding framework for the planning and execution of research that depends on the consideration of four aspects of the research study, namely: 1. the purpose; 2. the paradigm; 3. the research context; and 4. the method. The research design thus reflects the steps that the researcher followed in the planning and execution of the research to ensure that the research questions are answered and that the research objectives are met. The research design that governed the present study will be presented as follows: 1. the research question and the purpose of this study; 2. the three major research paradigms and; 3. my reasons for choosing the interpretive paradigm for this study; 4. the philosophical underpinnings of the interpretive paradigm; 5. the research context; 6. the research method; 7. the ethics of the study and lastly; 8. the conclusion.

3.2 RESEARCH DESIGN

3.2.1 The research questions and purpose of this study

The research questions that this study aims to address stem from my own experience as an eating disorder sufferer. The questions are:

1. What persistent behavioural patterns, revolving around emotional intelligence and coping style, do individuals who suffer from an eating disorder display?

2. How do the factors identified in those patterns interact to contribute to the development of eating disorders within the context of individual lives?

The two questions above reflect a gap in the available literature on the aetiology of eating disorders. They also reflect the two aspects that were not addressed by my therapist during the time of my treatment.

By possibly discovering persistent behavioural patterns in the lives of persons who suffer from eating disorders, clues may be found as to how the individual behaves when confronted with stressful situations, and in particular with emotional stress. If it can be shown that the eating disorder forms a part of such a behavioural pattern, it may be possible to get a clearer picture of the development of the disorder within that individual's life.

Based on my own experience as well as the available literature on emotional intelligence and coping style with regard to eating disorders, individuals with eating disorders tend to struggle with one or more of the components of emotional intelligence as defined by Sternberg (2006), namely: 1. Perception of emotion, 2. The ability to identify, understand, and reason about emotion, 3. Expression of emotion, and 4. Regulation of emotion. In addition, individuals who have been diagnosed with an eating disorder revert to coping styles that compensate for the component that they are struggling with.

The purpose of this research project is thus to contribute to understanding the development of eating disorders, and in turn to inform the prevention and treatment thereof.

The second consideration in the research design is the research paradigm. I will now present the three major research paradigms and my reasons for choosing the interpretive paradigm for this project, followed by the philosophical underpinnings of the interpretive paradigm.

3.2.2 The research paradigm

The research paradigm is the meta-framework that defines what I propose to explore, and the process that I have followed in conducting this explorative study. According to Durrheim (2006, p. 40) "Paradigms act as perspectives that provide a rationale for the research and commit the researcher to particular methods of data

collection, observation, and interpretation." The research paradigm guides the researcher in choosing which philosophical assumptions to adhere to; how to gather, analyse and describe data; and ultimately what to do with the insights gained from the study (Ponterotto, 2005).

Terre Blanche & Durrheim (2006) distinguish between three major research paradigms, namely the positivist paradigm; the constructionist paradigm; and the interpretive paradigm. According to Ponterotto (2005), each paradigm is grounded in its own specific ontology (the nature of reality), epistemology (the relationship between the research participant as the 'knower' of reality, and the researcher as investigator of reality), axiology (how the researcher's own values impact on the research process), and methodology (the practical steps that the researcher takes to study reality).

3.2.2.1   The positivist paradigm

The positivist paradigm is underscored by an ontology that Ponterotto   (2005) refers to as 'naïve realism', which views reality as being stable and measurable. Ponterotto (2005) further describes positivism as operating from an epistemological basis of objectivism, advocating that a phenomenon can be studied objectively, and of dualism, asserting that research can be conducted in such a manner that the researcher and research participants do not influence one another by applying rigorous scientific procedures. Additionally, positivists maintain the axiological standpoint that the researcher can and should isolate his / her values from the research process, by remaining emotionally detached from the research and by using standardised, systematic methods of inquiry (Ponterotto, 2005). Positivist research aims to explain, predict and control phenomena, therefore positivists typically employ hypothetico-deductive methods in conducting research, the quality of which is judged according to stringent standards (Ponterotto, 2005).

3.2.2.2   The constructionist paradigm

Researchers that espouse constructionism advocate the ontological viewpoint that an individual's reality is fluid; it is influenced by the individual's social-historical context (Ponterotto, 2005). However, constructionists take a more critical, politicised epistomological stance than interpretivists (Terre Blanche & Durrheim, 2006). For

this reason, Houston (2001) refers to this paradigm as critical realism, and Ponterotto (2005) calls it the critical-ideological paradigm. Constructionism is based on the assumption that a person's social world is constructed through a process of interaction between people in a society, and that our understanding of the social world is context specific, or limited to our cultural (setting) and historical (time) boundaries. Therefore our knowledge of the world is perspectival, and our (limited) view of our social world dictates our actions (Houston, 2001). According to Houston (2001), the researcher's account of a phenomenon under investigation is subjectively experienced and similarly influenced by culture. It should therefore be viewed with skepticism (Houston, 2001). From an axiological point of view, criticalists not only acknowledge that their own values affect the outcome of the research process; they embrace this effect in the hope of exposing oppressive structures and of empowering participants to liberate themselves from those structures (Houston, 2001; Ponterotto, 2005). According to Terre Blanche & Durrheim (2006), studies that make use of methods such as discourse analysis and that focus on power imbalances, are typically underpinned by constructionist assumptions.

3.2.2.3 The interpretive paradigm

Proponents of the interpretive paradigm take a relativist ontological stance; they believe that every individual views reality in a unique, subjective way because s/he experiences the world inimitably (Ponterotto, 2005). Interpretivists hold the epistemological view that one understands a phenomenon subjectively; influenced by one's social environment, experiences, and interpersonal interactions, and that different descriptions of the phenomenon under investigation may all be valid, as the particular vantage point from which the phenomenon is being viewed differs. Hence, a phenomenon can never be studied objectively, because it is continually influenced by both the participant in the study as well as by the researcher in the situational context (Ponterotto, 2005). As such, a person's reality cannot be separated from that person's lived context, and the phenomenon being studied must be investigated subject to that context. According to Terre Blanche & Durrheim (2006), the researcher should particularly value an individual participant's subjective experiences of the phenomenon as each participant's circumstances, and their experience of those circumstances, are unique and distinguishable from that of other participants. As Terre Blanche & Durrheim (2006, p. 7) put it, the interpretive

approach "...aims to explain the subjective reasons and meanings that lie behind social action." Furthermore, interpretivists maintain the axiological perspective that the values and experiences of the researcher should not be eliminated, but should rather be acknowledged and described as part of the research process (Ponterotto, 2005). In fact, the researcher may empathise or identify with the participant. The researcher may discuss his or her experiences and biases openly with the participant to enhance rapport, and will typically acknowledge and describe these in the research report. According to Ponterotto (2005), bearing in mind the interdependent relationship between the researcher and the participant, the researcher's biases can at best be 'bracketed', or set aside temporarily. Terre Blanche, Durrheim & Kelly (2006) describe bracketing as the researcher's attempt to temporarily forget about what s/he knows (or feels) about a phenomenon, for the purpose of allowing the phenomenon to 'show itself'.

The goal of interpretive research is to understand participants' experience of phenomena from the point of view of participants' day-to-day lives (Ponterotto, 2005). When it comes to research methodology therefore, the interpretive paradigm has a number of distinguishing traits that are underscored by the defining interpretive characteristic, namely that each person's version of reality is unique, true, and valid for that person (Hunt, 2009; Ponterotto, 2005; Ponterotto & Grieger, 2007; Sandelowski, 2000; Walsham, 2006). First, interpretive inquiries are usually qualitative in design, making use of techniques such as in-depth, face-to-face interviews and participant observations to gather data, and endeavour to incorporate as much context as possible into the research (Kelly, 2006). Second, interpretive researchers do not usually ascribe to traditional means of verification of their analysed data. For example, according to Ponterotto (2005), peer consensus is a moot exercise because the researcher's interpretation of the analysed data is as unique as the participant's own interpretation of his / her experiences. Instead, the interpretive researcher relies on the interdependent participant-researcher relationship itself for verification of the researcher's interpretation of the data. By interacting and dialoguing with one another during the process of analysing and describing the data, *both* should reach a point of deeper, modified understanding of the research topic. Third, according to Ponterotto (2005, p. 132) the rhetoric of the presentation of the results from an interpretive inquiry is usually:

"[...] in the first person and is often personalised. The researcher's own experience, expectations, biases, and values are detailed comprehensively. Furthermore, the impact of the research process on the emotional and intellectual life of the researcher is reflected upon and discussed openly."

3.2.2.4 Choosing an appropriate research paradigm for exploring the interaction of emotional intelligence and coping in the development of eating disorders

My interest in eating disorders as a topic for this dissertation started in 2008, and I spent approximately three years gradually sifting through the literature on eating disorders in an attempt to refine my research question. In doing so, I did not try to adhere to a fixed epistemological or ontological foundation. Instead, I focused on what I really wanted to know. Hence, in designing this study, the challenge became one of 'goodness of fit', or matching the research that I wanted to do with a paradigm that is known, discussed and accepted in the current literature. Since the focus of this study is directed at the behaviour of individuals within their unique contexts, but is not intended to be a critical discussion, the only logical choice for a guiding meta-framework was the interpretive paradigm as it is the most fitting framework for achieving this purpose.

3.2.2.5 Philosophical underpinnings of the interpretive paradigm

The philosophical assumptions of phenomenology and hermeneutics, or hermeneutic phenomenology as Larkin, Watts & Clifton (2006) call it, underlie the interpretive paradigm. As noted above, interpretive inquiry focuses on the subjective meanings that drive our actions. This idea stems from the work of Husserl who pioneered phenomenology, which "[...] came to mean the study of phenomena as they appear through the consciousness" (Koch, 1995, p. 828). Husserl coined the terms 'life-world' and 'lived experience' to encompass the notion that one can only know what one has experienced. Following Husserlian phenomenology, a study would focus on describing a phenomenon in such a way that the underlying structures, or 'essences', of the human consciousness and perception may be exposed. A further assumption of phenomenology is that the researcher is able to eliminate all preconceived notions of a phenomenon under investigation through a

process of 'bracketing' (Koch, 1995). In this way, phenomenologists attempt to ensure that scientific rigour is maintained in their studies.

Whereas phenomenology centres around the procedure of understanding or 'meaning making' by giving predominance to the role of conscious thought, hermeneutics or Heideggerian phenomenology highlights the circumstances under which understanding occurs. Heidegger, Husserl's student, built upon his mentor's philosophy to include the notion that a person's background, as handed down culturally, precludes what a person may perceive as reality and how that person understands this reality. He used the term 'pre-understanding' to denote his conviction that a person is born with a certain framework for understanding his or her world, which cannot be bracketed out of the person's perception of reality, because it is already part of that person's 'being in the world'. Thus, person and world 'co-constitute' one another: while the world provides the framework for one's understanding, one continually expands this framework through experience (Koch, 1995). Therefore, every experience is filtered by a process of interpretation in which one's background is fundamental, hence the 'hermeneutic circle': "All claims to understanding are... made from a given set of fore-structures which cannot be eliminated, but only corrected and modified" (Koch, 1995, p. 832). This process of co-constitution and interpretation is the source of the fluidity of reality that is a hallmark of interpretive reasoning. As Larkin *et al.* (2006) explain, we as human beings are functions of our involvement in the world, which is in turn a function of our involvement with it. This concept is the essence of Heidegger's *Dasein*, which means 'there being' or 'being there', and implies that we are inseparable from our meaningful contexts.

Barlow & Durand's (2012) multi-dimensional integrative model of psychopathology seems to espouse hermeneutic underpinnings, because it emphasises the interrelatedness of all factors that contribute to the development of a psychological disorder, as well as the importance of an individual person's meaningful living context. Therefore, this model provides scope for an exploration of the way in which emotional intelligence and coping style interact within individual contexts to contribute to the development of eating disorders.

The third factor to consider in designing a research study is the research context, which is the topic of the next section.

3.2.3 Research context

Kelly (2006) emphasises that conducting research in context, that is, investigating a phenomenon as it occurs in the 'real world' or in its natural setting, is a central axiom of qualitative research. This study aims to explore the role that emotional intelligence and coping style may play in the development of an eating disorder. However, according to a number of researchers (Compas, 2009; Eisenberg *et al.,* 2009; Kooiman *et al.,* 2004; Lumley *et al.,* 1996; Rueda & Rothbart, 2009) emotional intelligence and coping style is also influenced by the context of an individual's life. For the purpose of this study, I therefore placed particular emphasis on the possible influence of three contextual factors in the development of the participants' emotional intelligence and coping styles: 1. Whether the relationships between individuals and their immediate family members, as well as relationships among family members, affected the development of the participant's emotional intelligence; 2. Whether support from friends affected the participants' emotional intelligence and / or their ability to cope with stress, and; 3. What significant life events preceded the onset of eating disorder symptoms, and what impact those events may have had on the participants' emotional intelligence and / or their ability to cope with stress. Finally, I explored how the eating disorder became a part of the participants' lives, and what possible role it played within the context of the life of each individual participant.

The fourth factor to consider in research design is which practical techniques to use in the research procedures. This aspect is covered in the next section, in which I discuss the research method employed in this study. The research method comprises the steps of choosing between quantitative and qualitative research; determining whom to include in the study; gathering of the data; analysis and description of the data; and evaluating the quality of the research study.

3.2.4 Research method

3.2.4.1 Numbers or words?

The first methodological step in research design is that of choosing between conducting a quantitative or a qualitative study. This choice depends largely on the purpose of the research (Durrheim, 2006). As the aim of this study was to investigate the phenomenon of eating disorders from unique, individual contexts, the option of conducting a quantitative study was ruled out, because it was unfeasible to describe individually contextualised experiences quantitatively. I therefore chose to conduct a qualitative study.

3.2.4.2 Population and sampling

The population under investigation was persons who had recovered from an eating disorder. This population is difficult to research as access to participants is limited for several reasons: 1. Unless persons with eating disorders seek treatment, there is no record of their disorder and thus no record of recovery; 2. Persons who seek treatment for eating disorders do not always reach remission status; 3. Clinical samples are difficult to access as an 'outsider', that is, as a non-clinician without any affiliations to treatment facilities. I therefore approached two in-patient facilities specialising in eating disorders for assistance in accessing participants. I requested that the relevant therapists identify participants whom they consider likely to partake in the study, and contact them on my behalf to request their participation, because client confidentiality prevents therapists from giving out patient details for research purposes. The therapists thus acted as gate-keepers, selecting participants according to three criteria: 1. Participants must have completed therapy; 2. Participants should be in full or near-full remission and; 3. Participants must have been weaned off all psycho-pharmaceutical medicine. I specified these criteria because I specifically required retrospective information. Therefore, I needed participants who were not in the acute stages of the disorder, as I feared that the effects of the disorder (such as depression and memory loss) would interfere with participants' ability to discuss retrospective data. Furthermore, I feared that if I interviewed participants in acute stages of their disorders, I risked causing trauma. I aimed to include eight to twelve participants in the study, guided by the principle of sampling to redundancy (Durrheim, 2006). That is, I aimed to interview enough people to ensure that no new information could reasonably be obtained by including more participants in the study. Sampling was therefore purposive and non-random.

Accessing participants turned out to be a tremendous stumbling block in this study, because: 1. The therapists at the relevant clinics generally did not follow up on their clients post treatment; 2. Very few of their clients ever recovered fully, and 3. Those who did reach remission status refused to be included in this study due to research fatigue. That is, they maintained that as in-patients they were submitted to so much research that, when given a choice to refuse participation, they did not hesitate to do so.

Failing to obtain sufficient access to participants via therapists at the in-patient clinics I contacted thirteen other practitioners, including clinical psychologists, counselling psychologists, dieticians and a pastoral counsellor (all of whom regularly treated clients with eating disorders) with the same request for assistance with access to participants. Of those whom I approached for help, three said that they do not get involved in research at all, and eight referred me to other therapists or to in-patient facilities as they did not have any clients that fulfilled the research criteria. One dietician contacted three potential participants, all of whom refused participation due to research fatigue, having formerly been in-patients at a clinic. Only the pastoral counsellor was able to locate two participants for this study.

During five months of searching for participants for this study, I only succeeded in obtaining four participants. One participant was a referral from an in-patient facility; two were referred by the pastoral counsellor; and the fourth was a referral by a personal acquaintance. Due to time constraints, I had to forego the search for more participants. All of the participants were white females, aged 47, 38, 32, and 25 years. Their socio-economic status ranged from middle to high income, and they were all living in respectable suburbs of metropolitan cities in South Africa. Three of the participants had recovered from bulimia, and one was in remission from anorexia, having successfully maintained a healthy weight for two years.

3.2.4.3 Data gathering

The participant-researcher interaction is central to interpretive research, as both must work together to reach a shared understanding of the research problem, and thus dialogue and reflection are key components of the interpretive process (Ponterotto, 2005). Stressing the participant-researcher interaction in the co-creation

of research data, the interpretive paradigm requires that the researcher spends as much time as possible with the participant in an effort to maximise understanding of the research topic. Triangulation of data gathering techniques is considered prudent so as to gain insight into the topic from different perspectives and to guard against researcher bias (Hunt, 2009). That is, interpretive researchers should ideally employ three different data gathering techniques, such as interviews, participant observations, and the use of questionnaires, in one study.

The participants of this study were interviewed retrospectively after they had recovered. They were asked to recall the required information from their childhood, adolescence, and early adulthood. For this reason, data gathering through observation and participation was not possible. Moreover, given the level of detail already required by the face-to-face interviews with the participants, the retrospective focus on their experiences, and the limited resources I had at my disposal for this study, I chose not to include interviews with family members. For the same reasons, focus group interviews were not considered. Furthermore, I chose not to use questionnaires in this study, because the research was exploratory in nature and as such I wanted the participants to be forthcoming with information, rather than to obtain answers to preconceived questions. Therefore, the only data gathering option available was to conduct a single long face-to-face interview with each participant in order to gather as much information as possible while limiting my intrusion (Yeh & Inman, 2007). Hence, although my research design fits well within the interpretive paradigm, it has a flaw that makes for what Thorne, Reimer Kirkham & O'Flynn-Magee (2004) calls 'method slurring' because I only made use of a single data gathering technique.

3.2.4.3.1 The research instrument and data gathering procedure

Data was obtained by conducting semi-structured interviews with the four participants. That is, I entered each interview with an interview guide (see Appendix I) consisting of open-ended questions. This technique allowed participants to provide as much information as they felt comfortable with, while providing me with the opportunity to engage with participants openly and empathically (Kelly, 2006). Participants were questioned about their unique contexts, focusing on their

relationships, patterns of behaviour that revolve around emotional intelligence and coping style, and their experiences with the eating disorder itself.

Upon making an appointment with each participant, I specified that I required approximately two hours of their time for the interview. Interviews were 1 hour 33 minutes, 2 hours 7 minutes, 1 hour 22 minutes, and 3 hours 13 minutes in duration respectively. I asked each participant to choose a venue that they felt comfortable with where the interview would take place. One participant was interviewed in her office at her place of work, while the others were all interviewed in coffee shops. I was initially afraid that being interviewed in a public setting might limit the participants' willingness to disclose certain details about their experiences with their disorders. However, I felt that they were very forthcoming with necessary information, despite the potential awkwardness of the situation. The interviews were recorded on a good quality digital voice recorder with voice identification capability, thus maximising the quality of the recordings even in a public setting with background noise.

I began each interview by introducing myself and then explained the purpose of my research. I also explained that my research interest in the topic stems from my own experience with an eating disorder. This may have helped to establish rapport with the participants, but even if it did not, I wanted them to understand that I had empathy with their experiences, although I emphasised that I valued their experiences as being unique. I then proceeded to gather information, as follows:

> Question 1: I explained what a genogram (visual representation of family genealogy) is, and asked participants to tell me about each of their family members, starting with their grandparents, and working down to their siblings. I also asked the participants to describe the relationships between their parents and grandparents; parents and parents' siblings; grandparents and themselves; parents and themselves; and themselves and their siblings.

This first question provided an important indication of the extent to which family members usually communicate with each other.

Question 2: I asked the participants to describe their school careers to me, focussing specifically on their friendships and significant events, such as transferring to a new school.

This question provided me with information about participants' social support structures beyond their nuclear families.

Question 3: I narrowed in on incidents that participants had mentioned in the conversation up to that point, such as traumatic experiences, and asked them to describe their emotions at the time, as well as what they did to cope and to whom they spoke about those experiences.

This exploration provided me with information related to their emotional intelligence and coping behaviour.

Question 4: I asked them to describe a typical day during specific life stages, such as when they were in primary school (before significant trauma); when they were young adolescents just entering high school; when they were in their senior high school years, and so forth. In so doing, I obtained information relating to the habits that they had formed. Eventually, this information became specifically related to their eating disorders, and I asked them to elaborate on details pertaining to the development and progress of their disorders. Finally, I asked them to share with me what had helped them to recover from their eating disorders, and where the turning point was.

This line of inquiry helped me to elicit details about participants' daily habits, and about how their eating disorder behaviour became embedded in those habits. The information pertaining to their recovery is important, as it highlights the specific events that precipitated recovery for each participant.

Throughout the interview, I started with open-ended questions such as: "Tell me a little bit about your maternal grandmother", proceeding to more explorative questions such as: "Would you like to elaborate on that?" Finally, as I made notes throughout our conversation, I asked the participants to confirm whether I had understood them

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correctly. At the end of each interview, I showed the participants the behavioural patterns relevant to their experiences that had emerged through our conversations, and asked them whether they agreed with my observations. In this way, we clarified misunderstandings and reached consensus about my perceptions of their experiences.

In concluding the interviews, I checked with every participant to make sure that I had not elicited information that left them traumatised or otherwise disturbed. I furthermore encouraged each participant to seek counselling if anything that had transpired from our conversation should later cause them uncertainty or discomfort. As a research psychology student, my scope of practice was limited in this study in that I was not in a position to offer any form of counselling or therapy during or after the interviews. I therefore offered to help them to locate a suitable person if they needed counselling. Approximately one month after I interviewed the fourth participant, I contacted each of the four participants via e-mail to check whether they had experienced any negative effects that might possibly have been related to the interviews. Each of the four participants responded, and none of the four had experienced any such negative effects. I again thanked each participant for taking part in the study.

3.2.4.4   Data analysis

Leech & Onwuegbuzie (2007) describe data analysis as a systematic search for meaning, and depict seven methods for qualitative data analysis. In brief, the seven methods are:

> A. Constant comparison analysis
>
> Constant comparison analysis, according to Leech & Onwuegbuzie (2007), is the best option for addressing an overarching research question, where the objective is to identify themes utilizing the entire data set. Constant comparison analysis was originally designed for use in grounded theory studies, where it was undertaken abductively, that is sampling continued until the themes that emerged iteratively from the data were saturated. However, more recently the method has been adapted so that it can be undertaken inductively, allowing themes to

emerge from a complete data set after data gathering has been completed. The method involves systematically coding chunks of textual data while constantly checking new chunks with existing codes. Similarly coded data chunks are then grouped into themes.

B. Classical content analysis

Classical content analysis comprises the same steps as constant comparison analysis, except that where themes are created inductively in constant comparison checking, they are created by counting the number of times a code appears in classical content analysis (Leech & Onwuegbuzie, 2007).

C. Keywords-in-context

Keywords-in-context is used to analyse text for comparisons of how participants use specific (key) words 'in context' by comparing the words that directly precede and succeed the key words (Leech & Onwuegbuzie, 2007).

D. Word counts

Word counts focus on participants' distinctive vocabulary, or 'linguistic fingerprints'. The assumption here, according to Leech & Onwuegbuzie (2007) is that a person will use a word that is important to him or herself more frequently than other words. That is, the more often a word is used, the higher the level of significance of that word for the participant.

E. Domain analysis

Domain analysis is used for describing relationships among concepts, for example 'X is a kind of Y' or 'X is a result of Y', where X and Y represent 'domains', or "[...] units of cultural knowledge" (Leech & Onwuegbuzie, 2007, p. 570).

F. Taxonomic analysis

Taxonomic analysis and componential analysis follow domain analysis as further analytical steps. Taxonomic analysis is used to identify the relationships among all the terms in a domain; and

G. Componential analysis

Componential analysis highlights differences between subcomponents of domains (Leech & Onwuegbuzie, 2007).

Other authors describe methods of data analysis that they have designed because none of the usual methods suited their specific research needs. An example is the method of interpretive phenomenological analysis, as described by Larkin *et al.*, (2006).

H. Interpretive phenomenological analysis

Interpretive phenomenological analysis is an approach to analysis that allows the researcher to identify patterns of meaning in a data set. Larkin *et al.*, (2006, p. 104) do not describe the analytic steps in this paper, but they mention a number of authors that have described these steps; each adapting the steps to suit their purpose. As the authors put it, "…it may be more appropriate to understand interpretive phenomenological analysis as a 'stance' or perspective from which to approach the task of qualitative data analysis, rather than a distinct 'method'." Interpretive phenomenological analysis, as described by Larkin *et al.*, (2006) provides a very good framework for the analysis of the present data. However, it results in a more idiopathic, 'meaning centred' description of data than I aimed to produce and I therefore eliminated it as an option for analysis of the present data.

3.2.4.5 Choosing a suitable method of data analysis

Of the methods described above, constant comparison analysis and classical content analysis seemed to be the best options for analysing the present study's data. I opted against using the original constant comparison method because of the explorative nature of the current study. Furthermore, due to the extremely limited access that I had to participants, I could not engage in the iterative method of

gathering and analysing data that is the hallmark of grounded theory research. For this reason, the original constant comparison method did not seem to be suitable for the present study. Therefore, I looked to content analysis as the most likely method applicable to the analysis of the current data.

The literature on content analysis seems to be disjointed, as researchers continually adapt the method according to their needs. According to Hsieh & Shannon (2005, p. 1277), content analysis is "...a family of analytic approaches ranging from impressionistic, intuitive, interpretive analyses to systematic, strict textual analyses." These authors describe three approaches to content analysis, namely conventional; directed; and summative.

A. Conventional content analysis

Conventional content analysis is used in explorative studies, where literature concerning the research topic is limited and employs inductive category development (Hsieh & Shannon, 2005).

B. Directed content analysis

Directed content analysis is used to extend existing theory about a phenomenon. In this approach, categories are systematically defined prior to analysis, using the existing theory as guiding framework (Hsieh & Shannon, 2005).

C. Summative content analysis

Summative content analysis, as described by Hsieh & Shannon (2005) seems similar to what Leech & Onwuegbuzie (2007) describes as the keywords-in-context method of analysis. According to Hsieh & Shannon (2005), words in text are identified and quantified to investigate their usage (manifest content analysis), which is then interpreted for their underlying meanings (latent content analysis).

Thematic analysis

Braun & Clarke (2006) describe a method they simply call 'thematic analysis', which they claim is a flexible method to apply to qualitative studies as it does

not rigidly espouse a specific theoretical framework. It is a method used for identifying patterns in data, similar in this respect to constant comparison analysis and interpretive phenomenological analysis.

Thematic content analysis

I eventually settled on a method described by Burnard (1991) as 'thematic content analysis' to analyse the data in this study. The method is akin to the method of constant comparison analysis as described by Leech & Onwuegbuzie (2007), and to Braun & Clarke's (2006) thematic analysis. However, I found Burnard's description of the method unambiguous and easier to follow than the other two, while it was readily applicable to the data obtained in this study. Furthermore, in contrast to the original constant comparison method, Burnard's (1991) thematic content analysis is not specifically intended to derive theory and was therefore better suited for the analysis of the data in my explorative study.

Thematic content analysis as described by Burnard (1991) is a method adapted from the grounded theory approach of Glaser & Strauss (1967), together with other papers on content analysis. Thematic content analysis is used with data from semi-structured, open-ended interviews that have been recorded and transcribed in full. It aims to produce "…a detailed and systematic recording of the themes and issues addressed in the interviews and to link the themes and interviews together under a reasonably exhaustive category system" (Burnard, 1991, p. 462).

The data that I obtained from the four participants was transcribed *verbatim* and then analysed by following the steps, or phases, delineated by Burnard (1991):

1. I made careful notes about the ideas that emerged from my discussion with each participant prior to commencing the data analysis.
2. I read and re-read each transcript by noting general themes that emerged from the text (data immersion).
3. I used the list of general themes together with the full transcripts to develop a list of headings under which to describe the content by accounting for as much of the interview data as possible (open coding).

4. I re-read the list of headings and grouped them together under higher-order headings with the aim of reducing the number of 'sub-themes'.

5. I re-worked the new list of headings to ensure that every heading is unique and cannot be subsumed under another heading.

6. I approached a peer reviewer to generate her own list of headings by following the steps above. We compared our lists and discussed differences and similarities until we reached mutual agreement on a final list. In so doing, I attempted to curb my own bias in the coding process.

7. I compared the transcripts with the final list and was satisfied that the list of headings covered the content.

8. I worked through each transcript and coded the content according to the list of themes and sub-themes (Burnard uses the terms 'categories' and 'sub-headings'). I coded the transcripts manually by using Microsoft Word's highlighting function to colour-code the content.

9. I copied the colour-coded chunks of content into a separate document under their respective themes and sub-themes. (Burnard describes this operation as two separate steps if hard copies of the transcripts are used.)

10. I linked the copied sections from the text together into coherent paragraphs under the respective themes and sub-themes. Throughout this process, I referred back to the original texts to ensure that I did not misinterpret the data.

11. I summarised the results to highlight the participants' behavioural patterns that related to emotional intelligence and coping style.

3.2.4.6   Describing the data

Ayres, Kavanaugh & Knafl (2003) refer to within-case and across-case descriptions as a way to describe data after it has been analysed. I followed their example, and I thus presented detailed descriptions of each case (within-case description), and then I highlighted the similarities across cases (across-case description) according to the themes as a summary of the findings. In so doing, I tried to honour the uniqueness of my participants' experiences while emphasizing cross-cutting aspects of importance to this study. I discussed the results with reference to the existing literature, and finally integrated the results in terms of the multidimensional integrative approach to psychopathology (Barlow & Durand, 2012) to illustrate how the factors that are

relevant to this study interacted with each other in the development of the participants' eating disorders.

3.2.5 Validity and reliability

Issues such as validity and reliability, which are traditionally positivist concepts, are of less importance to interpretive researchers than the pragmatic worth of their studies (Ponterotto, 2005). With regard to validity however, Sandelowski (2000) contends that although two researchers may view the data very differently, they are likely to agree on the facts of an experience, even if they focus on different aspects. Therefore, it may be valuable to obtain a peer review of the transcription and analysis of an interpretive study to ensure *descriptive* validity. That is, the two researchers should at least agree that the facts of the data are recounted accurately. Furthermore, the two researchers should be able to agree on the meaning that a participant attributes to an event, and thus the researcher can establish *interpretive* validity of the data (Sandelowski, 2000). The same can be said for the reliability of the data: unless the themes extracted from the data are very abstract or have a very high level of inference, two researchers should at least be able to agree that a theme 'exists', regardless of their individual interpretations of that theme. Hence inter-coder reliability is not entirely impossible to achieve (Sandelowski, 2000).

Leech & Onwuegbuzie (2007) hold that the rigor and trustworthiness of qualitative studies should be ascertained, and that this can be achieved by: triangulation of data analysis techniques (methodological triangulation); assessing inter-rater reliability (Kappa's coefficient, or at least a discussion between researchers to fit better paradigmatically); and member checking (descriptive validity, interpretive validity, theoretical validity).

As mentioned earlier, I opted against using methodological triangulation in this study. However, 'inter-rater reliability ', 'descriptive validity' and 'interpretive validity' were established via discussion between researchers, as explained in the preceding section, to ensure the trustworthiness of the analysis, and by sending the written results to all of the participants and asking for their feedback regarding the interpretation of the data. I specifically requested that they check whether I used their statements correctly within context, and invited them to correct me if they disagreed

with my interpretations. Three of the four participants suggested a small number of very minor corrections, and I corrected my interpretations accordingly. In this way, I aimed to establish the credibility of the descriptions and interpretations.

There is one more vitally important aspect to research design in the social sciences: the research must adhere to ethical standards as specified for the particular discipline. The ethical considerations that are relevant to this study are discussed next.

3.3 ETHICAL CONSIDERATIONS

There were a number of ethical considerations to ponder before commencing with this study:

- Informed consent: Written consent was obtained from each participant with regard to the risks involved; benefits and compensation; the rights of each participant; and confidentiality. Please refer to Appendix II for the complete consent form.
- Confidentiality: Identities of participants were kept strictly confidential, and all identifying documentation is kept in a secure location accessible only to the researcher.
- Harm to participants: The participants of this study were not harmed in any way; neither physically, nor psychologically.
- The study was approved by the Ethics Committee of the University of South Africa (Unisa).

3.4 CONCLUSION

In an attempt to shed light on the mechanism of development of eating disorders, this dissertation intends to add to the body of knowledge on eating disorders by contributing to understanding the developmental mechanisms of eating disorders. This study was neither intended to generate theory, nor to test existing theory. It was merely a tentative exploration of the interaction of emotional intelligence and coping style in the development of eating disorders. For these reasons a qualitative,

exploratory research design was deemed most appropriate for this study. The interpretive paradigm, underpinned by Heideggerian phenomenology, was used as a guiding meta-framework. Four women who had suffered from eating disorders participated in this study, and I gathered data by conducting semi-structured, face-to-face interviews with each participant. I analysed the data by applying thematic content analysis, and presented the findings in both within-case and across-case descriptions. Lastly, I tried to ensure trustworthiness and credibility by requesting one peer to review my analysis of the data, and I asked the four participants for their feedback. The findings of this study are presented in the next chapter.

4. FINDINGS

Eating disorders develop over a long period of time. Indeed, the disorder itself is merely the visible expression of the turmoil that underlies it. The women that participated in this study opened their books of life to me, and allowed me to take a glimpse of that turmoil. The themes that were drawn from an analysis of their stories are presented in this chapter, ending with a summary of the most salient findings under each of the themes and sub-themes for all four women. The names that are used in this chapter to represent each of the four women are pseudonyms.

4.1 FINDINGS FOR CONSTANCE

I chose the pseudonym 'Constance' for this participant because her integrity and the steadfastness of her convictions were extraordinary to me.

4.1.1 Description of relationships: Grandparents, aunts, and uncles

Constance described her paternal grandparents as being largely absent in her life. Her paternal grandmother passed away when she was a small child and her paternal grandfather was very distant to her on the occasions that she recalled seeing him. She knew, however, that her father did not have a good relationship with her paternal grandfather, who was an alcoholic, but she believed that her father did have a good relationship with her paternal grandmother. She said that both of her parents speak very highly of her paternal grandmother. Her paternal grandparents had been divorced since her father's childhood.

Her father is one of five siblings, two of whom are deceased. He has a twin brother, with whom he does not get along, and a sister with whom he has a better relationship than with his twin.

When asked about her maternal grandparents, Constance said that her entire family, including herself, had had a very good relationship with both of her maternal grandparents, and that the family still maintains a good relationship with her maternal grandmother in particular. Her maternal grandfather is deceased, but she

commented that even her father respected him more than he respected his own father. She did not elaborate on her mother's siblings.

4.1.2 Description of relationships: Parents, siblings, and spouses

Constance recalled that the relationship between her father and mother was "a bit shaky" during her early childhood years, before she started school. She said that she remembers there being some "onrus" (unrest) in the house when she was a small child, and that her father "[...] was drinking a bit then". Their relationship had improved drastically over the years and her parents now share a very strong marital bond.

Regarding her own relationship with her father, she said that she felt that he was distant during her childhood and young adolescence. He worked "a lot" and to her it felt that he was "absent". She mentioned that she thought that he struggled to relate with them as children, saying: "I just think his understanding of what a father was, was a bit different when we were small". She did not remember "[...] sharing stuff with him". She describes her current relationship with him as very good, however, and feels that she can now speak to him about anything. By contrast, she portrays her relationship with her mother as always being good, although "[...] there were times when [they] misunderstood each other".

Constance has three siblings; an older sister, a younger sister, and a younger brother. She had always felt that her brother and her had similar personalities, in that both enjoyed spending time by themselves, whereas her two sisters were more social and enjoyed doing things together as a family. She had always been close to her brother and younger sister, but described her relationship with her elder sister as "shaky" throughout her childhood until young adulthood. The relationship has improved since then. She recollected that her elder sister, who had always been "very popular and very thin", had called her "fatty" as a child and had had a habit of belittling Constance in front of her elder sister's friends.

Constance first got married at the age of 23 years. However, she realised that she had "[...] married the wrong person", and divorced him in the same year. She said that he had expected her to change her appearance, by dyeing her hair blond and

losing weight to suit his ideal of what a wife should be and that she realised that she could not be the wife that he wanted her to be.

At the time of this interview, she had remarried, and was expecting her first child. She describes her relationship with her second husband as very good, and feels that she can discuss anything with him.

4.1.3 Loss of peer support structures prior to the onset of the eating disorder

Constance had a big circle of friends during her primary school years and said that she was very happy during that time of her life. She had only one close friend, but she felt that her friend shared a closer friendship with another girl than with herself.

At first, she attended the same high school as her primary school friends. However, she had a disagreement with her friends because she felt that she could not condone their behaviour:

> "I spoke out against some stuff they did and then they were sort of mocking me a little bit for that [...] It was also to do with my faith, because they would all go to church with me when we were in primary school but when we got to high school then they would be backbiting and talking behind each other and talking ugly about people [...] and from that day they were like 'Oh, why are you preaching at us like that?' And then I realised I can't talk".

She subsequently found that she didn't quite fit in with any other group of friends, and recalled feeling very lonely. Additionally, she felt misunderstood at home, because her family did not understand her desire to be by herself to do art or write in her journal:

> "[...] for a large part I just felt misunderstood and sort of isolated [...] sometimes in my family I also didn't feel like anyone there really got me [...] I just felt like I was a bit different to the people in my family [...] my family is very social [...] and they get their energy from each other".

It was against this background that her eating disorder first appeared. She recalled that she was eating at a restaurant with her family, feeling lonely, despondent and also uncomfortable after eating food that she did not want, and she thought that she

would feel better if she purged. She did not realise that this was the beginning of an eating disorder.

She transferred to a different high school at the beginning of her grade 10 year to accompany her younger sister. She remarked that although she had no difficulty in meeting people at her new school, she found it hard to trust them and consequently "[...] [kept] people at a distance". She said of her new school:

> "It was a weird set up; it was very different from other high schools, but I think I felt quite alone. I think I was scared to build friendships so I was quite alone; I didn't want to become part of a group or whatever."

During her senior high school years she managed to build good friendships, and has retained one particular friendship to date. She made one further comment regarding her peers at the time:

> "The problem there became - and it was always a problem - is being accepted by guys; that was a problem. The sort of boyfriend factor thing. I don't know why it was such a problem for me but I always had this desire - to want to be in a relationship with a boy when I was at school."

4.1.4 Development of belief systems

Constance had had a very profound need for approval and acknowledgement from her father, although she only realised this later in her life. She related how, in a spiritual revelation during pastoral counselling, it emerged that she was born prematurely and that her father was too afraid to touch her while she was in the incubator, and even for some time after she was brought home. As a result, she became convinced that he did not love her. Her need for affirmation form her father became strengthened throughout childhood, exacerbated by his careless comments about her appearance. She explained:

> "[...] when I was small my dad had this funny way when he would say about me, like 'Ja, sy is my mollige kind' […] and then I would feel like 'He's not really proud of me'. Or he would be talking to people and say 'Sy het regtig

vet en lelik geword' […] I always linked the 'vet en lelik' […] and that was just bad for me. I don't know why I was so sensitive about that but it bothered me. And then I always thought if I put on weight then for him I'm going to be 'vet en lelik'".

As a result of her father's remarks, Constance feared gaining weight because she believed that he would be disappointed in her. When she transferred to the new high school in grade 10, she found that the standard of academic performance was much higher than she had been used to and she found that she did not perform well compared to her peers. This distressed her tremendously, as she felt that she had based some of her identity on the fact that she had always excelled academically up to then. Suddenly, she "[...] really felt like going from somewhere where [she] really was a 'somebody' to going somewhere where [she] really was a 'nobody'". Consequently, she had to work extra hard to bring her academic work up to standard, which left little time for her usual sport and extramural activities. She started to gain weight, which aggravated her eating disorder. In the following year, she travelled overseas on a foreign exchange programme and continued to gain weight. The extent of her distress was evident when she commented:

"I remember when I put on that weight when we were overseas [...] I remember having nightmares about my parents that wouldn't want to take me home from the airport because I was just ugly or fat".

Her fear of disappointing her father was made plain when she told me that she chose to purge rather than to diet, because she did not want her father to see that she was trying to lose weight. She wanted to find a solution without having to admit that there was a problem to begin with, because she worried that he would think "I am weak, or maybe I need help".

She believed that this need for affirmation from her father was perhaps the reason for her need to have a relationship with a boy. The problem, as she explained, was not one of being overlooked by boys, but rather one of needing to be in a relationship with someone she could trust. She required an intellectual-emotional connection,

rather than a physical one. She said: "[...] it wasn't physical at all. In fact if the guy read it wrong and it became physical I would just break up with him".

Her need to feel valued by her father was so powerful that her life literally changed when her father made a speech at her wedding day to her first husband:

> "[...] for the first time in my life it hit me. It hit me and I can't tell you - and I know it is stupid to hit you then at the age of 23 - that my dad really loved me. And like suddenly it all made sense; why I may have been seeking attention from guys, and then I realised that I don't need this guy".

She explained that from that day onwards, her relationship with her father improved radically. She divorced her husband a few months later, and even though she had not been purging for some time, she only felt truly cured from her eating disorder after the divorce: "[...] I was still struggling there with it because it was still in my head, and then from there, from that divorce it was better, and I didn't think about it again".

4.1.5 Emotional intelligence and coping with stress

Constance described herself as a very independent person. Even as a child, she would refuse to accept help from her mother for school projects. She did not find it easy to ask for help from anyone, and she never discussed her unhappiness with her friends: She said: "[...] I would be there for my friends, but I would never really tell them when I was struggling [...] I would never really tell them when something was seriously a problem for me". She would share some of her experiences with her mother, but she downplayed them, because she denied their impact even to herself. She also said: "[...] for a large part of my life I was just pretending to be fine and perfect and I don't know why I did that".

She chose to focus on her academic work, art, and dancing, rather than to ponder over her despondency. Moreover, she would downplay her stress to try to convince herself that she was coping with it:

"I think I always felt people expected me to cope better with it so I didn't want them to know I actually wasn't coping [...] maybe in my own way I was very hard on myself. Like, I would say to myself: 'Ag, it's not really that bad, just get over it'".

Her tendency to avoid confronting problems was so strong that she fell behind in one of her subjects in school, because she chose to avoid going to class rather than to tell the teacher that she couldn't follow the subject matter because the classes were presented in Afrikaans instead of English. She recalled: "[...] instead of trying to be assertive [...] I just switched off". Consequently, when she had to prepare to sit for final examinations in this subject, her eating disorder symptoms became worse than they had ever been before, or since. She described how she used her eating disorder as a coping mechanism:

"[...] in a weird way [it felt] like a safe place [...] at a time when there seemed like a lot of pressure to perform and to be perfect, and to be like really top of my game, it felt like there was something offering me a way; like a charming kind of thing that was offering me a way to try get on top of it [...] to try and help me to conquer this, as though it would be an answer to some of these problems".

4.1.6 Behavioural patterns and habits

During her primary and early high school career, Constance had a very stable routine of attending school followed by extra mural sport activities; eating lunch with her family; then attending to homework. She enjoyed dancing and artwork and would often spend time alone engrossed in these hobbies. Dinner time was again family time.

When she transferred to the new school in grade 10, Constance and her sister needed to use the school bus for transport. This became a problem for her, as it did not allow time for her customary sport activities after school. In addition, Constance and her sister would often buy meat pies after school while waiting for the bus. Thus, she ate more food and did less exercise which, together with the more demanding academic schedule, led to the weight gain that aggravated her eating disorder. At

this time, the amount of food that the family consumed at home also started to trouble her. Her family had always enjoyed cooking and eating food, and as mentioned above, tended to sit down to both lunch and dinner together. She recalled:

> "[...] eating times were quite a thing in our family. So we would sit down at a table with my mom. My dad would sometimes come home, and then we would have lunch together like the whole family at the table, and we would have dinner like that too [...] we would have two kind of biggish meals. Well, it was nice, but a lot of food [...] we just ate a lot and that bothered me. Like in my mind it felt like too much [...] and it wasn't easy to say 'No, I don't want this'".

As described earlier, her personal stress mounted gradually as she gained more weight, and the eating disorder behaviour became habitual over time: "I didn't think it would be something I would constantly do, but it became something that I just did more and more".

4.1.7 Recovery

As described earlier, her eating disorder peaked just before sitting for her final Matric exams. Unable to face the prospect of failure and loathing herself because of the ED, she reached the brink of committing suicide. She recounted:

> "I think maybe God saved me because it was the day before [the paper] that that minister phoned me and asked me if I wanted to work [at the church] [...] now I could avoid the [problem] by thinking about this job and thinking that [...] I don't have to go to university and face these bad [results] [...] I think it also helped me also to realise that failure isn't the end of the world".

At about the same time, she had a terrifying dream in which she was being chased by something that wanted to kill her. For her, this was the true turning point as she realised that her eating disorder was going to destroy her. It was then that she decided to fight her eating disorder.

She battled her eating disorder for another three years before her first wedding day, as described earlier, which was the point at which she started to conquer her eating disorder. Since then, she had learned to speak about things that distress her, and her second husband had become her confidant. She had developed a sense of self-acceptance, an understanding of her relationships, and awareness that without self-acceptance, she would always bend to others' expectations of her. She had also learned to accept others for who they are, so as not to allow careless comments to cause her grief.

The findings for the second participant are presented next.

4.2 FINDINGS FOR ROSE

I chose the pseudonym 'Rose' for this participant because when I think of her, I picture a rosebud that is just beginning to open, revealing its beauty.

4.2.1 Description of relationships: Grandparents, aunts, and uncles

Rose knew very little about her paternal grandparents, as they lived abroad and very seldom visited the family. She could only tell me that she thought her father did not have a good relationship with his father (deceased), but that he was close to his mother. He has an older brother, whom he does not keep in contact with.

She described her maternal grandfather as strict, but said that he was a role model to her own father. Her mother, however, had had a poor relationship with her father, and Rose said that her mother "[...] was quite afraid of him". Rose described her maternal grandmother as a "dominant figure" in the family who valued wealth and beauty, and who strived to keep up the appearance of being a well-to-do family. She believed that her mother has a fairly good relationship with her maternal grandmother, although she said that her maternal grandmother"[...] hasn't had a very good influence on her children", in that she taught them to value material wealth, achievement, and physical appearance more than anything else in life.

Rose's mother has two siblings younger than herself: a sister about whom she did not elaborate, and a brother who is financially broke and lives with Rose's maternal grandmother.

Rose said that she herself had had a good relationship with her maternal grandfather up until his death when she was ten years old. Although she loves her maternal grandmother, she has lost respect for her due to the unbalanced values that she imposes on the family.

4.2.2 Description of relationships: Parents, siblings, and spouses

Rose described her father as a "loner" who "[...] doesn't like people". According to her father, "[...] it is better to be alone and not marry". Regarding her relationship with him, she said that she is "at peace" with him, but that they are not close.

Her parents had been divorced since she was ten years old. At that time, her father was, as she described him, an "occasional heavy drinker".

She depicted her mother as intelligent and said that she "[...] was a good mother for small children". When asked to elaborate on this, she only said that her mother "[...] is not approachable to speak with on emotional things". However, she views the relationship between herself and her mother as a good one.

She has one sibling, a younger brother with whom she shares a very strong bond, saying that "[...] he's almost like [her] best friend".

She is as yet unmarried.

4.2.3 Loss of peer support structures prior to the onset of the eating disorder

Rose never had a large circle of friends, but rather "[...] one or two best friends" during her primary school years.

She started her high school career in the same all-girls school as her primary school friends, but transferred to a mainstream school during her grade 9 year, primarily due to financial reasons. At first, she maintained contact with her old friends, but gradually lost contact first with the one and eventually with the other when she was in about grade 11, after their friendship had become "[...] a bit rocky".

She stated that she made friends easily enough in her new school. However, her comment that "[...] I didn't express my unhappiness in the school; I pretended I was

very happy in the new school, which I wasn't" confirmed that she did not fit in well socially at the school. She further commented that her friends started to reject her during grade 11. She remarked: "[...] I was in a very catty type of group, and I didn't really have a group of my own, I just floated around". By that time, her social life was limited to attending choir camps and occasionally socialising with her one remaining friend from primary school. By grade 12 she regarded herself as an outsider, and she felt that it was the worst year of her life.

4.2.4 Development of belief systems

Rose had always endeavoured to attain her maternal grandmother's favour: "[...] we measure our achievements according to if she is impressed or not". She went on to say: "I think most of us have problems because of that. I really do think that", and "[...] that's all she talks about really, how well we've achieved, how thin we are […] we used to value being beautiful and thin".

She suddenly started to gain weight for the first time in her life when she was in grade 10 and not surprisingly, she was anguished. She compared herself unfavourably to her best friend and girls from her school and choir camps and said: "I knew that I'm not happy [...] because I know I'm not thin… not as thin as other girls [...] this is why I'm not happy".

She was very sensitive to comments about her appearance, and became ever more so until she reached breaking point in her grade 12 year: "[...] comments about [my] body was almost like a slap; like a sword in your heart. It was in matric really that the remarks were very severe". Consequently, she started dieting and "[...] experimented with putting [her] finger down [her] throat".

By losing weight, she became attractive to the boys in her peer group, which served to motivate her to lose even more weight: "The moment I lost five kilograms, boys started liking me, so I couldn't not diet". By her first year at university she was underweight, but this made her the happiest that she had been in years. So entrenched was the need to be thin that when she could no longer maintain her unnaturally low weight she was again devastated: "[...] the first kilo I put back was like, I thought I was going to die".

4.2.5 Emotional intelligence and coping with stress

Rose was deeply unhappy, lonely, and increasingly isolated in her new school environment, and became ever more so as she started to gain weight. However, she could not recall making any effort at identifying, understanding, or reasoning about her emotions. She said that she just did not spend the time on introspection, and in retrospect thought that it might have just been too painful to do so.

She did not express her unhappiness with her situation. Rather, she presented a façade to her family and peers: "I wanted to pretend that I was happy; that I was fine [...] so that my mother could say that I'm fine to my grandmother".

She enjoyed art and dancing, and she kept herself busy by focusing on her schoolwork. When I asked her whether she felt pressured to do well at school, she replied: "No. I also thrive on achievement so that's what made me feel good; if I did well".

Rose attributed her unhappiness entirely to her belief that she was not as thin as other girls. For her, being thin literally meant being happy, and the attention that she received when she lost weight reinforced this notion in her mind. During her first year at university, directly after school, she was most content because she had become so thin that she was underweight. Her joy was short-lived however, because after that she gained weight back every year, which caused her tremendous distress and consequently exacerbated her eating disorder.

4.2.6 Behavioural patterns and habits

During her school career Rose followed a typical daily routine of attending school, eating lunch (usually a pre-cooked supermarket meal) alone at home, doing homework, and participating in some extramural activities (usually related to art or dancing), and then partaking in dinner with her mother and brother. She made two comments about her routine during this time. The first was that she never took sandwiches to school because she feared that the bread would make her fat. The second was that she thought that she ate a lot of food at home, especially at dinner time.

Her daily routine changed slightly in her grade 10 year, when she started to exercise less and after school: "…just went home and ate". Consequently, she gained weight very quickly at first, and then more gradually up until just before her Matric dance.

Rose's desperation to lose weight drove her to dieting. Gradually, the eating disorder behaviour replaced the strict dieting as a method of easing the distress of gaining weight. Towards the end of her grade 12 year, she had started to purge. By the end of her first year at university, her eating disorder had become uncontrollable and by her second and third years of university, she was purging as often as five times a day in an attempt to lose weight.

4.2.7 Recovery

Rose underwent counselling at the university at which she studied for a period of six months, and clinical treatment for a short time during her third year. She found the clinical treatment to be unpleasant and unhelpful:

> "[...] they bring you into a room and then they [...] there's all these psychologists and they ask questions, but you feel like a specimen because they just want to finish their degrees".

During the latter part of her third year at university, three things happened that contributed to her reaching a breakthrough in her eating disorder. Firstly, she attended pastoral counselling for her eating disorder and while this did not directly affect her eating disorder, she reported that it helped her to develop "[...] a close relationship with God". Secondly, she became involved in a relationship with a young man whom she enjoyed spending time with. Thirdly, she became fearful of the numerous health problems associated with her eating disorder.

It was in her fourth year that she finally reached the turning point in her life and she attributes this to a profound religious experience, which began with her brother speaking to her about God and her meeting some Christian friends. She recalled:

"I don't know anyone else who changed as much as I did. I don't know what changed. I just realised it was futile; I just saw a bigger picture. And it's like, I really know this can be healed with therapy, but for me it was really God that did it [...] I didn't really decide, it just stopped. I didn't get urges, and I had the feeling I was in control of my eating".

She developed a sense of self-acceptance and began to question the assumptions underlying her eating disorder. She said: "I started to understand why I had an eating disorder and the thought process behind it. I started to understand that the thoughts I had, that they were lies".

She considers herself to be cured of her eating disorder. However, she still suffers from severe anxiety, for which she is receiving medical treatment. She mentioned that she had been suffering from a form of trichotillomania (pulling out her eye lashes) since the age of seven years.

The findings for the third participant are presented next.

4.3   FINDINGS FOR KELLY

Kelly chose her own pseudonym. I found her flamboyant, approachable nature appealing, and we spoke comfortably with each other for nearly three hours.

4.3.1   Description of relationships: Grandparents, aunts, and uncles

Kelly described her paternal grandfather as a "manic depressive individual" who had witnessed two shocking tragedies (the death of his mother in a fire and the death of his friend during a war). She also described her paternal grandmother as an unaffectionate "iron lady" who "[...] ruled with an iron fist"; for whom achievement was important, and who would compare her children to each other and play them up against each other. She described her childhood visits to her paternal grandparents as something she did not look forward to. These visits were very infrequent, and she said of her paternal grandmother that "[...] there was no love; there was no warmth". Both paternal grandparents are deceased. Her father has one brother, whom he has only started relating to after the death of their mother.

She described her maternal grandfather as a very spiritual, lively person of Irish descent. She mentioned that he engages in binge-purge behaviour, but she did not specify the frequency of this behaviour. She said that she had always looked up to her maternal grandfather as her "spiritual guide"; someone that she truly admired, until upon introspection later in life she realised that he had had a major impact on her life and in the development of her eating disorder. Her relationship with him has since deteriorated.

She further described her maternal grandmother (deceased) as her confidant, to whom she was closer than to her own mother. The participant did not elaborate on her mother's relationship with her maternal grandmother, except to say that it infuriated her mother that Kelly confided in her maternal grandmother. However, she described a convoluted relationship between her mother, her uncle (five years older than her mother) and her maternal grandfather, saying that they phone each other excessively during the day and that her maternal grandfather is a controlling figure in that relationship.

4.3.2 Description of relationships: Parents, siblings, and spouses

Kelly had a very close relationship with her father during childhood. She felt that she could relate to his rebellious nature at the time, being a rebel herself. She described him as a brilliant man and she aspired to be like him. However, she felt that she did not possess his intelligence, skills, or endurance. She went on to say that he is also a very controlling, authoritarian man who would condescend and patronise her mother as well as herself, especially at parties. As a result, she now feels very anxious in his presence and said that "[...] he'd almost be constantly watching you and judging you".

She lost respect for her father when he had an extramarital affair when she was 13 years old. At that time, her mother suffered a mental breakdown and the participant felt that she had to take on the responsibility of looking after her mother, becoming her "mom's parent", and that the roles had never been reversed. Consequently, she does not have a strong emotional bond with her mother. She further explained that her mother was born with cerebral palsy and that she uses her handicap as a means to garner commiseration, and yet she lacks empathy for others, "[...] because she

had to survive in her life". For this reason, the participant had never felt that she was able to communicate with her mother. Her mother and father remained married until 1996, despite her father having had several extramarital affairs by then.

She has one brother who is younger than her. She perceives him to be almost as brilliant as her father, and she did not really share a connection with him when they were growing up. Accordingly, she "[...] felt like an absolute misfit in [her] own family". Nonetheless, they have recently gone into a business partnership together, and she said that she is finally getting to know him after many years of not being in contact with him, since he had distanced himself from her for as long as ten years when her eating disorder was most intractable.

She had been married twice and had divorced twice. Of her first marriage, she remarked that she had felt trapped by her controlling husband almost from the start of the marriage and had looked for a way to end the marriage. However, she had two children and could not bring herself to break up the family. Her means of escape finally came ten years into the marriage, when her husband had brought financial ruin upon them for the second time. The second marriage ended abruptly when she discovered that her new husband, to whom she had only been married for a few months, was a paedophile.

Regarding her relationship with her children, Kelly stated that they continually tell her that they love the relationship that she has with them, because they communicate well and because they can, and do, discuss everything with her.

4.3.3 Loss of peer support structures prior to the onset of the eating disorder

Kelly had a large circle of friends in primary school, and they were all very popular among their peers. However, at the beginning of her high school career, just after her father's infidelity, her family moved to another part of her old home town. She attended that school only for a period of six months and did not have time to establish strong friendships. After six months, the family relocated to another part of the country.

She commented that she felt very much out of kilter at her new school, and that the only acquaintance that she managed to make was not someone that she would usually spend time with. However, this person was kind to her and took the time to show her around the new school. She divulged that she yearned for the acknowledgement of the "popular group". She eventually got their attention during her grade 9 year, when she "[...] started smoking and drinking, and going to parties, and stopped studying". She remained friends with them throughout her high school career.

She remarked that even though she felt at home with this popular group of friends, the friendship was to the detriment of her health and her self-esteem. She recalled:

> "[...] they were all surfers, they all smoked, they all drank. So the peer pressure of staying in this group [...] every Monday you had to come and report back [...] all we did was party and socialise and surf, and also focused on how you look, because now you're on the beach in a bikini".

4.3.4 Development of belief systems

Kelly craved recognition from her father. As a child, she fairly idolised him. Unfortunately, as mentioned earlier, she did not perceive herself as being as talented or as intelligent as he was "[...] he was my hero, but with so many scrolls on his blazer – I looked at this and I thought: 'How on earth do I even try and compete?'" and her efforts to impress him were not met with success: "I kept thinking maybe I'll get that token of recognition or appreciation when I get my next 'A' [...] but it just never came". She believes that he learned this inability to show acknowledgement for efforts and success from his mother, for whom no achievement was good enough. She recalled: "[...] his family were very much 'well if you got 96% for an exam, what on earth happened to the other four per cent?'".

Furthermore, he often made derogatory remarks about her while she was growing up, and this affected her deeply:

> "I was always scrutinised or judged or being made fun of at the next party through my dad. Unfortunately the subconscious doesn't have a sense of humour and sooner or later, when you are behind closed doors, my gosh it

does hurt. When you're the joke of the party every single time, it's not that funny".

Kelly also recalled that her father's tendency to be critical extended to meals. She said that he would, for example, expect her and her brother to eat and enjoy snacks and junk food, even when they were not hungry or did not want the food, and that this had always caused her great anxiety.

Kelly internalised her father's extramarital affair as being her fault. She remembered:

"[...] when I went to his mistress' house for dinner one night [...] what greeted me at the front door was not only the mistress, but her daughter, who was a year older than me and was the show jumping champion. And on the mantelpiece in the lounge was all her trophies and [I] thought: 'That's why dad has left: Dad has left [me] because [I] wasn't good enough'. I didn't have any awards; I wasn't champion at anything I'd tried to achieve in [...] I thought he'd gone in search of a daughter that he actually wanted".

Subsequent to her father's affair, she felt isolated and desperately lonely; and she started to binge. She further recalled: "I had already started believing that I was fat. So I was almost living up to what I had been told all my life". She gained weight very quickly, following which her mother had her join a well-known weight-loss programme. Her diet was very successful and she followed it strictly for about four months. She explained how it happened that the dieting became uncontrolled:

"I went away on holiday [...] and I read a fashion magazine. In this [magazine] was an article of a girl who had bulimia and I thought: 'Bingo! Here's my ticket!' What person wouldn't want to devour whatever their heart desires, purge, and still look wonderful [...] within three to four months I lost 18kg and of course I was getting recognition from all my friends and family [...] [and] receiving compliments that I've never received in my life before [...] [and] the more recognition I was getting, the more it encouraged me to continue".

4.3.5 Emotional intelligence and coping with stress

Kelly felt very intense emotions in the months prior to the onset of her eating disorder. She vividly recalled her heartache following her father's affair, and especially following her visit to his mistress's home:

> "[...] I remember that feeling of hollowness in my stomach, looking up at all these movie stars on my wall; how they were smiling and laughing, and thinking to myself 'Am I ever going to smile again?' All I felt was this void inside – that level of depression where I thought 'it's been a week now, two weeks; it's not going away'. I remember [...] thinking 'How do I cope with this feeling of heartbreak?' I remember praying about it [...] I couldn't cope with it. I certainly couldn't turn to my mom because she was in an even worse state than me".

Although she could recall feeling aggrieved and lonely, she did not recall spending much time mulling over her emotions. When I asked her whether she paused to consider why she was binge eating, she said:

> "No I didn't. The reason being was the more I was sitting and analysing why, what, where, how, the worse it was actually becoming. The more people were involved in how I was feeling and where I was; people close to me – family [...] I could not deal with those emotions".

Moreover, she did not express her anguish verbally to anyone: "I didn't allow any of my friends in high school to see whether I was struggling with anything. I put on this façade of Miss Polyanna: life is just dandy; always cheerfulness". At home she similarly disguised her unhappiness:

> "I even made a comment to my mom and she said: 'you were always so cheerful; everyone loved being with you; you were so bubbly and happy' and I said: 'no, I wasn't. I don't remember ever being truly happy, because I was always scrutinised or judged or being made fun of".

Unable to communicate her distress to anyone, Kelly found ways to escape her sadness. For instance, just after the trauma of her father's infidelity, she created a make-believe world for herself:

"I remember hiding in my cupboard, creating this Never-Never land; this place of secrecy that I could just disappear to [and] sticking all these lovely pictures at the back of my cupboard. I don't know, maybe I was trying to hide from myself. I didn't know how to cope with what I was feeling".

Thereafter, she steeled herself against emotional distress:

"[...] I adopted this warrior facade [...] I thought: 'no man is ever going to hurt me again'. I kept the whole world at arm's length – good and bad emotions, and my eating disorder merely accentuated that. I didn't allow myself to cry after that and for a good two decades after that I didn't cry".

By the time she completed school, she had started therapy for her eating disorder, which had become her emotional crutch. She still had not overcome her underlying sorrow. She was already in a relationship with the man that was to become her first husband, and he was aware of her eating disorder. She started to work, progressed well in her career, and decided to leave her (then) boyfriend, until she fell pregnant unknowingly; she only discovered that she was pregnant when she was already seven-and-a-half months along. She abandoned her career, married her boyfriend, and became a full-time mother. Trapped in a dysfunctional marriage, it would be approximately ten years from the time that she first started therapy to the time that she finally overcame her eating disorder. Of the time in between she said:

"After [the first therapy] I left therapy for a while [...] until then, I didn't want to recover, because bulimia was fulfilling that void, although it was impossible, but it was serving a purpose. It was helping me cope [...] I was bingeing throughout, getting through my days".

4.3.6 Behavioural patterns and habits

Kelly maintained a fairly stable daily routine throughout her school career. She would attend school, partake in extra mural sport activities, have lunch at home, and then do her homework.

The aspects of this routine that changed as she became older, were those pertaining to her eating habits and social focus: As described earlier, her binge-eating started as she struggled to cope with overwhelming emotional distress: "I was drowning it in food – whether it was feelings of rejection, or a failed exam, I would drown that". After relocating to their new town, she occupied herself with her academic work initially, as she believed that the new school had a higher standard of education and that she needed to work hard to succeed there. However, she soon changed her focus to gaining peer acceptance, choosing rather not to be ridiculed for being a 'goodie-two-shoes'. While adapting to her new school and her unsettled home environment, her eating disorder behaviour increased and from that time she remained focused on being accepted by her peers, which in her mind was only possible if she did not gain weight. Thus, her eating disorder became part of her daily routine.

4.3.7 Recovery

Even though she was not serious about being healed in the time between first starting therapy and the time that she was healed at last, Kelly did undergo various forms of therapy; everything from acupuncture to hypnotherapy, but all to no avail.

She reached a turning point about three years prior to her first divorce, when she met a therapist that used a combination of hypnotherapy and counselling which focused on addressing self-acceptance, as well as confronting issues with (primarily) her father. Ten months into the therapy, she had to have dental surgery done. She finally comprehended the seriousness of her eating disorder and its consequences when the dentist explained to her that he had nothing to anchor her new teeth onto because her teeth were too brittle. This made her think about the effects of the disorder on the rest of her body, and she became frightened. From that day on, she never purged again and controlled her bingeing.

Since then, Kelly has spent a great amount of time doing introspection and confronting her own and her family's belief systems, and coming to terms with her relationships with others. She now dedicates her time to Inspirational Speaking, focusing on eating disorders and the devastating effects that emotional bullying can have, and works actively to educate others about these disorders.

The findings for the fourth participant are presented next.

4.4 FINDINGS FOR LEE

Lee also chose her own pseudonym. The sharp contrast between Lee's diminutive appearance and her tough personality intrigued me, and I was impressed by her strength of character.

4.4.1 Description of relationships: Grandparents, aunts, and uncles

Lee never knew her grandparents on either side (all deceased), and could not describe either the individuals or their relationships with her parents, save to say that her paternal grandmother was "[...] not really a granny type person".

Her father had one sibling; a sister. Regarding their relationship, Lee could only say that they were quite an indigent family and that "[...] he was just forever giving her money".

She recalled that her mother was very close to her aunts (that is, Lee's grandmother's sisters), and that her mother spent weekends with them while in boarding school. The one aunt in particular was described as "[...] a lovely, lovely person".

Her mother had two brothers who were much older than her mother, and consequently Lee barely knew them. Therefore, Lee had no relationship with her grandparents or with her aunts and uncles.

4.4.2 Description of relationships: Parents, siblings, and spouses

Lee described her father as an authoritarian, for whom no achievement was ever good enough. He would easily give constructive criticism, but very little praise. She

also said he was "[...] not there a lot". However, she never doubted that he loved her, and she described him as a very good person, but with "old school" convictions.

Her parents had had a "rocky" marriage, but they remained married until her mother passed away in 1996. She said that her mother was dominated by her father. Consequently, the participant had a poor relationship with her father while growing up, as she was upset by his treatment of her mother. Their relationship improved dramatically later in her life. Sadly, her father passed away one month prior to this interview.

She described her mother as a "wonderful, loving, generous" mom, who "[...] lived her life for her kids". Lee suffered a disfiguring accident at the age of 15 years, which resulted in her mother becoming very overprotective. Lee became reclusive after the accident and spent most of her time with her mother, even upon leaving school and going to university. Not surprisingly, she was devastated when her mother passed away after a long sickbed.

Lee is the second youngest of eight siblings. She has four brothers and three sisters. She is very close to her two youngest brothers and her youngest sister, although the sisters "[...] fought like mad" when they were young. Her four elder siblings were almost like another generation to her and she has never really enjoyed a close relationship with any of them. She mentioned that her eldest brother is "[...] just like [her] father" and that he used to "boss" the rest of them around. She also said that her second eldest sister is "[...] the beautiful one and [...] everything just landed in her lap because she was beautiful".

Lee is as yet unmarried. However, she has had one boyfriend for 14 years, whom she said "filled the void" after her mother's passing. Unfortunately, this was not a healthy relationship and her eating disorder was exacerbated by it. Lee said that she was afraid of being alone, therefore she stayed committed to her relationship with her boyfriend in the hope of a marriage that was not forthcoming: "[...] there's always the promise: 'When you get better; when you get better'". However, even when she had drastically improved after in-patient therapy, he still did not commit to marrying her, and she gradually relapsed. He finally broke the relationship up after she

discovered that he was planning to emigrate without her. She described the break-up as a very good turn of events, saying that: "I didn't realise it, but those 14 years I didn't live, I existed as an anorexic".

4.4.3 Loss of peer support structures prior to the onset of the eating disorder

Lee experienced increasing loneliness and isolation following her accident. Although she attended one private school during her entire school career, she became distanced from her friends following her accident. This was due partly to the fact that she was physically unable to attend school during the latter half of her grade 10 year. However, she conceded that her "[...] friends were amazing. They kept notes; they used to visit. They were absolutely amazing. They did everything for me, they really did". The more important reason for her becoming distanced from her friends was that she had become socially reclusive and had started to spend more time with her mother, who had become over-protective, than with her friends. She noted that it was very difficult for her to go back to school to sit for examinations at the end of grade 10:

> "[...] it was hard because, you know, when you're not there there's always rumours, that 'she's mentally retarded' and 'she's this' and 'she's that', so when you went back everyone's staring at you to see how bad you are, and are you a loony and whatever. So it was hard. It was very hard to go back."

During the latter half of her grade 10 year, she also avoided all other social situations outside of the school setting. She commented: "I also didn't go out, because if you go to the shops everyone would stare at you".

4.4.4 Development of belief systems

From a young age, Lee had the impression of never being able to do enough to impress her father: "[...] he was the kind that nothing was ever good enough. You know, if you did something well he'd say: 'But why didn't you get better?'". This may have influenced her drive for perfection, and she retained a fierce competitiveness after her accident. She said that because she was unable to eat after her accident due to the injuries she had suffered, she lost a lot of weight and consequently received a lot of compliments about her appearance. Her extreme drive for thinness

was subsequently triggered by a magazine article about an anorexic woman who said "I will never be beautiful so I've decided I'm going to make my body the thinnest out of everybody." She decided to follow suit, saying: "I'm never going to be beautiful so now I can be thinner than everybody".

4.4.5 Emotional intelligence and coping with stress

During the time directly following her accident, Lee did not want to share her emotions with anyone. She said that the only emotions she could recall feeling at the time were extreme frustration and disappointment with what seemed to her to be the non-existent progress of her medical treatment:

> "[...] in those times it was just very, very frustrating. I used to go for treatment and come home, and nothing was done [...] and then the next day nothing was done. It was frustrating [...] 'We'll leave it for three months and see if it comes right' and it didn't. And 'We'll leave it another three months' [...] there was a lot of waiting and nothing".

Moreover, she felt that she had no one to share her feelings with. She could not confide in her friends, because she said: "I wasn't close to my friends any more then. You know, they'd all come and visit but I really wasn't close to anybody". Likewise, she could not seek help from her parents because her father was emotionally unapproachable, and when she tried to speak to her mother "[...] she would start crying". Furthermore, even though her medical practitioners repeatedly advised her parents that she should receive counselling, her father refused as he did not believe that she needed counselling, because: "[...] if you saw a psychologist in those days you were a nut".

After returning to school, she regained good friendships, but she never discussed anything regarding her emotional state with anyone. As time progressed and as she started to engage in eating disorder behaviour, she cognitively knew that "things weren't right," but she did not spend time on introspection. Instead, as she said, she "[...] just sort of got on with doing things" to keep herself busy.

As she got older, she would completely avoid her family and friends during the times of greatest stress, because she knew that she would be scorned for her weight loss. This behaviour served to exacerbate her isolation, because when she was in her worst physical and mental state, her two brothers whom she was closest to refused to speak to her, saying that they would not "watch her die". This was a very tough emotional blow to her, judging by her statement that: "They wouldn't answer my phone calls. Do you know what it's like?"

Lee made two additional comments regarding her eating disorder as it pertains to her emotional intelligence and coping style. First, she said that her eating disorder afforded her sympathy when she "slipped up". She said: "I think I used it also for a bit of the sympathy [...] if I fail people won't be so hard on me because I'm an anorexic". Second, her eating disorder was something that she thought she could control and excel at.

4.4.6 Behavioural patterns and habits

Prior to her accident at age 15 years, Lee was academically strong, and took part in most of the sport and cultural activities that her school offered. She stated that she loved school, and hated holidays. She was also very popular at school. Her daily routine consisted of going to school, taking part in activities after school, then going home and doing homework. She would typically eat breakfast with her family; lunch either at school or at home in the form of a sandwich (no particular preference); and dinner with her family at the dinner table.

For a period of six months just after the accident, Lee did not attend school and did not go out at all except for medical treatments two to three times per week. During that time she was very weak and slept much of the time. When she had the strength, she occupied herself with hobbies that she enjoyed, such as needlework. Her mealtime routine changed drastically, because she no longer joined the family for meals. Instead she would take her meals, which had to be liquidised, in her room. She reported finding this very hard to cope with, because she felt isolated from her family while listening to them gathered around the dinner table. It was during this time that she lost a lot of weight and received compliments about her appearance.

She returned to school at the beginning of grade 11, but during the course of her grade 11 and 12 years, she was absent from school for much of the time. She recalled that her mother would fetch her from school very early for her medical appointments and that she "bunked" a considerable part of the time. However, she continued to be academically strong and kept her grades up. She also continued to take part in school activities, although to a lesser extent than before her accident. Thus, her daily routine changed in the sense that she spent less time at school and involved with school activities, and more time at home and with her mother. She did, however, start to socialise again. She commented that "[...] you know, you get used to the people staring at you after a while". Mealtimes returned to normal as before the accident. However, during her grade 11 year she started to display eating disorder behaviour. It was during this time that she read the magazine article that sparked the idea of being thinner than everyone else. At first, she exercised to get fit after her long period of inactivity. Then she started to "play games" with herself. She related:

> "[...] I started getting a bit fit and whatever, and it just started gradually. [I thought]: 'Why exercise?', and 'if I eat a little bit less [...] Oh, I can control the scales' and then it started becoming a game, you know [...] it wasn't so much of the eating, it was more a game [...] and then it became like a real game with me to not eat; to see how much food I can hide away; how much I can get rid of".

She said that the eating disorder became much more of a distraction to her than socialising, because "games occupy much more of your mind". At the time, she did not consider herself to be an anorectic. She would read about anorexia in magazines, but did not identify with persons with eating disorders. She said: "[...] at the time [...] you just think you're cleverer than anybody else".

By the time that Lee was a student at university, no longer living at home, she had stopped eating during the day altogether. She would "live on coffee" during the day, and only eat in the evening. She said that this occupied much of her thinking, but that it had become easy because nobody questioned her behaviour: As a "poor student", no one took notice of her when she did not eat lunch at the university

cafeteria, for example. At home she was with her family at breakfast and dinner time, whereas at university she no longer had to hide her food in order to get rid of it. Moreover, she continued to exercise. Thus, her eating and exercise routines became habitualised as time progressed, until eventually she did not think about not eating.

Nothing changed remarkably in her routines and behavioural patterns as she got older. However, she experienced that her eating disorder symptoms, especially exercising, became aggravated during times of great stress (such as when her mother, and later her father, passed away and during times of stress at work) as well as when she was involved in romantic relationships. This was particularly evident during her long, yet unfulfilling relationship with her latest boyfriend. Her statement that "I refuse to see him, because the minute I sit at a table with him I start eating like an anorexic again" epitomises this tendency.

4.4.7 Recovery

Lee underwent in-patient treatment for her eating disorder on two occasions. The first time she went into treatment was because she believed that if she could overcome her eating disorder, her boyfriend would finally commit to marriage. She was also pressurised by her family to undergo treatment. She was very motivated to recover, and was very compliant to the treatment. She made a breakthrough when, as she described, "something clicked" for her and she realised that she was making a distinction between 'her' and 'them'. She said: "[...] I looked around and I thought [...] these anorexics at this table; I can't stand watching these people". Unfortunately, she relapsed after that experience because she was still locked into a dysfunctional relationship with her boyfriend.

Eight years later, she again voluntarily committed herself for in-patient treatment, but discharged herself after two months because she felt that the facility "[...] was filthy, disgusting [...] really atrocious".

Two years after that, when she was physically and emotionally burnt out due to stress at home and at work, her weight plummeted to the extent that it became life-threatening and she was hospitalised by her family. At first she endured the treatment passively because she was too weak to resist. Upon recovering some of

her strength, however, her 'fighting spirit' once again took control of her actions, but to her benefit this time: She related that she became so angry at a nurse during that time that she vowed to herself to recover, just so that she could prove the nurse wrong and not have to see her again. She said:

> "I spent a week in that hospital and the woman there [...] basically said 'You're an anorexic and you'll be an anorexic forever and ever and ever, and you all lie'. Then they monitored my eating and everything, and no matter what I did, or didn't do she said 'You're lying' [...] and I said [...] 'I'm going to prove to you that I'm not lying'".

Her physical condition improved dramatically and she gained approximately 12 kilograms. She has since been consulting a dietician, and has managed to maintain a healthy weight. She triumphantly said: "[...] since then to now my life has turned around like you can't believe".

The most salient themes that were drawn from the data analysis are summarised in the next section.

4.5   SUMMARY OF FINDINGS

4.5.1   Description of relationships: Grandparents, aunts, and uncles

4.5.1.1   History of troubled family relationships

The three participants who knew their paternal grandparents all related at least one dysfunctional relationship between their fathers and their paternal grandparents, and only one participant was of the opinion that the relationship between her mother and both maternal grandparents was healthy and functional. Furthermore, the participants' parents generally did not seem to have stable, mutually supportive relationships with their siblings (that is, the aunts and uncles of the participants).

4.5.2   Description of relationships: Parents, siblings, and spouses

4.5.2.1 'Rocky' relationships between parents

All four of the participants spoke of troubled relationships between their parents. Two of these marriages ended in divorce, and only one had improved over time.

4.5.2.2 Distant to difficult relationships with fathers

During the time from the participants' early adolescence to early adulthood, two of the participants' relationships with their fathers can, at best, be described as 'distant'. That is, the participants did not share close emotional bonds with their fathers. The other two participants described their relationships with their fathers as poor, characterised by anger and resentment.

4.5.2.3 Impaired relationships with mothers

All, but one participant, described mother-daughter relationships that were at least somewhat impaired on a continuum ranging from overprotective / too close; to close-but-emotionally-reticent; to emotionally dependent from the mother's side.

4.5.2.4 Mostly normal sibling relationships

Participants' relationships with their siblings were mostly normal and functional, ranging to strong. The exceptions here were Lee's relationship with her eldest brother (whom she described as 'bossy') and elder sister (whose beauty she envied); Constance's relationship with her eldest sister (which she described as a very strained relationship); and Kelly's relationship with her brother (whom she had idolised and felt inferior to in her adolescent / young adult life stages).

4.5.3 Loss of peer support structures prior to the onset of the eating disorder

For various reasons, each of the four participants broke ties with the close friends that they had made during primary school, shortly after starting their high school careers. They all recalled feelings of loneliness and isolation during that time, and they all struggled to build new peer support structures. Only two of the four participants managed to establish subsequent lasting friendships during their school careers, but for Kelly, this was to the detriment of her health and well-being.

4.5.4 Development of belief systems

4.5.4.1 Fat is bad; thin is good

The belief that being fat is bad and being thin is good had been entrenched into the lives of the four participants from a young age: Constance and Kelly each associated approval and acknowledgement from their fathers with being thin; and Rose found favour with her grandmother through being thin and beautiful. Additionally, three participants were overtly derided for being fat - even if they were just a little chubby - and they received compliments for weight loss, which served as a motivator to lose even more weight. Furthermore, three participants pertinently mentioned being distressed upon gaining weight. In Lee's case, her deeply ingrained drive for excellence drove her to exceeding thinness when she began to believe that she would never be beautiful. The importance that she attributed to beauty may have stemmed from her perception that being beautiful means that life is 'easy', because she perceived her beautiful older sister's life to be comparatively effortless.

4.5.4.2 Even your best is not good enough

The four participants in this study had all developed a sense of 'just not being good enough' prior to the onset of their eating disorders. Lee and Kelly each held the belief that they could never do enough to earn the approval of their fathers; Rose judged herself according to her grandmother's hard-earned approval, and according to her physical appearance compared to that of her peers; and Constance's sense of identity faltered when she perceived her academic performance to be poor in comparison with that of her peers, while at the same time gaining weight and fearing resultant rejection from her father.

4.5.5 Emotional intelligence and coping with stress

4.5.5.1 Limited cognitive engagement with emotions

Each of the four participants experienced loneliness, isolation, and sorrow for extended periods (more than one year) of their adolescence. Lee also experienced extreme frustration following her disfigurement. Thus, they all perceived very intense emotions. However, they struggled to correctly identify, understand, and reason about those emotions: Rose thought that her unhappiness was solely due to her not being as thin as her peers; Rose and Kelly each avoided thinking about their emotions altogether because it was simply too painful for them; Lee was denied the

opportunity to engage with her emotions because her father deemed it unnecessary; and Constance denied her emotions to herself.

4.5.5.2 *Limited / no verbal expression of emotions*

None of the participants were able to confide in their fathers about emotional issues prior to the onset of their eating disorders. Furthermore, three of the four participants felt that they were unable to depend on their mothers for emotional support. Lee and Kelly were utterly unable to discuss their emotions with their mothers. Rose and Constance could share their emotions with their mothers, but were reserved in their communication. In addition, none of the four participants were able to discuss their unhappiness with their peers.

4.5.5.3 *Façades, avoidance, and distraction as means of regulating emotions and coping with stress*

None of the four participants knew how to cope constructively with the intense emotions that they felt. Three participants overtly pretended to be cheerful, and that their lives were 'perfect'. Constance and Rose actively avoided confronting the situations that distressed them, and all of the participants had distracters with which to keep them occupied; be it academic work, art, dancing, hobbies, or socialising, as a means of coping with stress.

4.5.6 Behavioural patterns and habits

4.5.6.1 *From stable routines, to compensatory behaviour, to the formation of bad habits*

Each of the four participants had stable, predictable routines during their late primary to early secondary school careers, and they all felt comfortable at the time. Gradually, their individual circumstances (Lee's accident; Kelly's and Rose's disrupted family and social lives; and Constance's disrupted social life and academic pressure) began to interrupt those routines and the participants were forced to adapt their customary schedules. For three of the participants, this adaptation led to weight gain; for Lee, it led to weight loss. The three participants that gained weight were so distressed by this fact that they began to engage in compensatory behaviour: Rose and Kelly dieted at first and later started purging, while Constance immediately

began purging to relieve her distress, and later turned to dieting to lose weight. Lee's eating disorder behaviour compensated for her disfigurement. Over time, their respective eating disorder behaviours became habitualised to the extent that they no longer thought about what they were doing. Lee and Constance both stated that their eating disorder behaviour became aggravated during times of distress, and Kelly said that her eating disorder had become her emotional crutch.

4.5.7 Recovery

4.5.7.1 Limited success under clinical treatment

Three of the participants underwent clinical therapy for their eating disorders, but with limited results: Rose found the treatment unhelpful; Kelly underwent years of unsuccessful treatment before finding someone who did help her; and Lee was treated successfully for her eating disorder, but not for the factors underlying her eating disorder, resulting in relapse.

4.5.7.2 Significant life events precipitated recovery

All four of the participants related significant life events that precipitated recovery from their eating disorders: Rose and Constance attributed their recovery to religious experiences; three participants mentioned that fear of the effects of the disorder scared them enough to begin recovery; Constance said that recognising that her father loved her was the tipping point; and for Lee, the journey began with her wanting to prove that she could overcome the disorder, and continued with her breaking free from her dysfunctional relationship.

4.5.7.3 Self-acceptance and understanding of self and others contributed to the recovery process

Three of the participants learned self-acceptance in the process of recovering from their eating disorders. They also gained insight into their own beliefs. Furthermore, all four participants gained insight into how their relationships with others affect their behaviour, and made positive relationship changes in their lives.

4.6   CONCLUSION

Constance, Rose, Kelly and Lee are four ordinary women not dissimilar to most other women who share the same demographic background. However, the interactions between their unique backgrounds, the circumstances that they experienced at critical life stages, and their interpretations of those circumstances within their reference frameworks, set their young lives on trajectories that culminated in the development of eating disorders. My presentation of the findings highlighted the most salient features of their stories, which will be discussed in the next chapter.

5.   DISCUSSION AND INTEGRATION OF THE FINDINGS

The objectives of this study were to: 1. Identify patterns of behaviour revolving around emotional intelligence and coping style within the context of individuals' lives with the aim of illuminating factors that contributed to the development of eating disorders; and 2. Integrate those factors in terms of the multidimensional integrative approach to psychopathology (Barlow & Durand, 2012) to represent a limited view of the mechanism of development of an eating disorder in individual contexts. In this chapter, I will discuss the most relevant findings of this study with reference to the existing literature, with emphasis on the interactive and cumulative nature of the factors that contributed to the development of an eating disorder. Thereafter, I will illustrate the roles of this study's most salient contributory factors in the development of an eating disorder, in terms of Barlow & Durand's (2012) multidimensional integrative approach to psychopathology.

5.1   DISCUSSION OF THE FINDINGS

I will begin with the discussion of the interpersonal context within which the participants' eating disorders developed, starting with family history; then focussing on the participants' relationships with their parents and siblings; followed by extending the discussion to the participants' broader social contexts. Next, I will discuss the development of the participants' belief systems, followed by the discussion of emotional intelligence and of their coping ability as reflected in their behavioural patterns and habits. Finally I will discuss their recovery from their eating disorders.

5.1.1 Interpersonal context within which the participants' eating disorders developed

A growing body of literature is focussing on the interpersonal relationships of persons with eating disorders, especially pertaining to the efficacy and application of newer forms of therapy specifically designed for eating disorders. Research has shown that the interpersonal relationships of persons with eating disorders impact on the onset, course and outcome of eating disorders (Keel & Brown, 2010; Lázaro, Font, Moreno, Calvo, Vila, Andrés-Perpiñá, Canalda, Martínez & Castro-Fornieles,

2011; Loth, Neumark-Sztainer & Croll, 2009; Robinson, Dolhanty & Greenberg, 2013; Tasca, Ritchie & Balfour, 2011).

5.1.1.1 Family history as contextual background

The present study extended beyond the core families of the participants and included third-generational family histories of relationships to provide a background for the context within which each individual's eating disorder developed. Participants indicated that the relationships between their parents and grandparents were generally characterised by discord. Of particular interest is the pertinent negative role that two of the grandmother figures played. This finding corresponds with the findings of Canetti, Kanyas, Lerer, Latzer & Bachar (2008), who investigated the relationships between the parents and grandparents of persons with eating disorders in a clinical sample of women with anorexia. They found that the paternal grandfathers tended to be controlling, while both the paternal and maternal grandmothers were rated lower on the care dimension compared to non-clinical controls.

Furthermore, the parents of the participants in the present study generally did not share mutually supportive relationships with their siblings. Thus, most of the participants' parents hailed from backgrounds that did not foster close interpersonal relationships, and in turn the participants' parents tended to have dissonant marital relationships, two of which ended in divorce.

5.1.1.2 The context of relationships with parents and siblings

The participants in this study all had strained relationships with their fathers, with at least two of the four longing for acknowledgement and a sense of acceptance from their fathers. These findings are similar to that of Jáuregui Lobera, Bolaños Ríos & Garrido Casals (2011), who found that the fathers in their study tended to have high control-low care type parenting styles. Interestingly though, they indicated that while their participants were receiving treatment for their eating disorders, the fathers became more caring. They ascribed this observation to changes in the parenting roles of the fathers: whereas prior to treatment they were perceived as being absent and controlling, during treatment they became involved in their daughters' struggles and responded by becoming less controlling and more caring.

As for the mother-daughter relationships of the participants in the present study, all but one of the four participants described caring mother-daughter relationships, although three of those mothers were unable to support their daughters emotionally. This finding contrasts with previous research of Jáuregui Lobera *et al.*, (2011) and of Swanson, Power, Collin, Deas, Paterson, Grierson, Yellowlees, Park & Taylor (2010), which indicates that mothers of persons with eating disorders tend to score lower on the care dimension than mothers of controls. This difference in findings is likely due to the differences in respective research designs, as the studies of Jáuregui Lobera *et al.* (2011) and Swanson *et al.* (2010) were quantitative case-control studies. Jáuregui Lobera *et al.* (2011) further assert that the mothers of daughters with eating disorders in their study displayed social withdrawal as a strategy for coping with emotions. Although the coping strategies of the mothers in the current study were not directly investigated, it was clear that three of the four participants were unable to discuss emotional issues with their mothers.

With regard to siblings, the four participants in the current study had mostly normal (ranging to good) relationships with their siblings. There were three prominent exceptions: Lee seemed to be envious of her elder sister's beauty; Constance had a very strained relationship with her elder sister; and Kelly felt inferior to her brother. Previous research has not focused on the quality of sibling relationships prior to the onset of eating disorders, but one study (Barr Taylor, Bryson, Celio Doyle, Luce, Cunning, Abascal, Rockwell, Field, Striegel-Moore, Winzelberg & Wilfley, 2006) has shown that negative comments by family members, including siblings, are detrimental to self-esteem and to the perception of available social support. Three of the four participants experienced overt negative comments about their physical appearance made by their family members or friends. Bailey & Ricciardelli (2010) found that negative verbal commentary predicted eating disturbance in their sample, as well as that negative commentary was associated with upward social comparisons, which is a tendency to compare oneself unfavourably to persons more attractive than oneself. Hardit & Hannum (2012) found that in their sample, mother and father criticism did not predict body dissatisfaction. However, they note differences between their own findings and those of previous researchers and ascribe their own findings to differences in elements included in the associations.

They also note that their own study included a non-clinical sample of college women who have already moved out of their parental homes, therefore parental criticism may not have played as significant a role in their findings as in previous research or in the current study. It is possible that the participants in the current study may have undervalued their own self-worth and their available support based on their own perceptions of how they compare with their siblings or with their friends, especially in the cases where hurtful comments were made about the participants.

5.1.1.3   Broadening the social context: feelings of isolation and loss of peer support structures prior to eating disorder onset

Each of the four participants suffered the loss of the close friendships that they had made during primary school shortly after starting their high school careers, causing them to feel lonely and socially isolated. Additionally, all but one of the participants experienced feelings of isolation in their home environments due to their individual circumstances at the time, just prior to the onset of their eating disorders. This finding is similar to but less specific than that of Bodell *et al.* (2011), who found that loss of social support, especially in combination with a greater number of negative life events, exacerbated the bulimic symptoms of the participants in their study.

Wonderlich-Tierney & Vander Wal (2010) found that perceived social support moderated the association that they found between social anxiety (fear of negative evaluations) and the manifestation of eating disorder symptoms. Fitzsimmons & Bardone-Cone (2011), on the other hand, failed to find significant evidence of moderation effects of perceived support on associations between anxiety and pathological eating behaviour. They ascribe this contrast with the Wonderlich-Tierney & Vander Wal (2010) study to differences in the study samples, where the more recent study involved a clinical sample with an older mean age as opposed to the previous study that included a non-clinical sample of young college students aged 18 – 20 years. They note that the difference in findings may indicate that social support may be of greater importance to younger women undergoing transitional phases, such as in the Wonderlich-Tierney & Vander Wal (2010) sample of young college students. This may be of relevance in the present study, which investigated perceived peer and family support prior to the onset of the eating disorders, at which

time the participants were in their early adolescent life stages and were undergoing both age-related and social transitions in their lives.

5.1.2 The development of belief systems within the life contexts of participants

The participants in this study were each strongly influenced by their family members' attitudes toward beauty and thinness. In some cases family members' actual comments had direct impact on the development of the belief that 'only thin and beautiful is good', whereas in other cases it was the perception of family values, such as that being beautiful means that life is 'easy', that contributed to participants' beliefs. Their beliefs were reinforced by receiving compliments from peers and family, and in some cases more attention from their male peers, upon losing as little as five kilograms in weight. This finding concurs with the integrated cognitive-behavioural model as presented by Williamson *et al.* (2004), in which they describe a synthesis of different theories on the development of eating disorders. In their discussion, Williamson *et al.* (2004) show that persons at risk of developing eating disorders build up specific self-schemas related to body size and shape that function to activate cognitive biases, which in turn lead to engaging in compensatory behaviour in an attempt to control body size and shape.

The influence of the media on the belief systems of the participants was not of direct relevance to this study, and was therefore not investigated. It is however important to note that two of the participants started engaging in eating disorder behaviour after reading magazine articles about bulimia and anorexia respectively.

The finding that participants in this study had developed a sense of 'not being good enough' is important. Vartanian (2009, p. 99) found that self-concept clarity, or "the extent to which individuals have a well-defined, coherent and stable sense of self," predicts the extent to which women internalise societal standards of attractiveness, and he interprets these results as indicating that women may attempt to define themselves through the internalisation of external standards of attractiveness if they do not have a clear and stable sense of self. It is possible that the pivotal events in the lives of the women in the present study impacted negatively on their self-concept clarity as much as on their sense of self-worth, especially given the sensitive

developmental phase that they were going through at the time. In turn, this may have resulted in increased internalisation of their *contextual* standards of attractiveness. An interesting point to note here is that the two fathers who were most critical of their daughters' appearance were also the two fathers who made it very difficult for their daughters to refuse food, either at the lunch or dinner table, or as snacks and junk food. This may have contributed to those participants' self-concept confusion.

5.1.3 Emotional intelligence

The participants in the current study all recalled experiencing intense emotions during their early adolescent years, and prior to the onset of their eating disorders. However, they lacked the skill to manage their emotions effectively at that time. That is, they experienced difficulty in identifying and understanding their emotions and in particular in expressing and regulating their emotions.

Fox (2009) found that the participants in his study, a qualitative study conducted with a clinical sample (anorexia only) of women of various ages, but with a mean age of 32 years, were able to discuss and reflect on their emotions, and therefore did not appear to have the high levels of alexithymia that persons with anorexia are purported to have according to previous research such as that conducted by Bydlowski *et al.* (2005) and Cochrane *et al.* (1992). Similarly to Fox's findings, the women in the current study were *retrospectively* able to give detailed accounts of their emotions at the time just prior to the onset of their eating disorders, even though their younger selves were unable to engage with those emotions at that time. This is also in keeping with the findings of Parling, Mortazavi & Ghaderi (2010) who argued that when controlling for depression and anxiety when measuring alexithymia in a clinical sample, the clinical group no longer presented with a higher level of alexithymia than the control group. Research by Hambrook, Brown & Tchanturia (2012) and Oldershaw *et al.* (2010) provides support for this finding. This finding is interesting in that the women in the present study were all undergoing transitions that were likely to have caused them a degree of anxiety, if not depression, prior to the onset of their eating disorders which, following Parling *et al.* (2010) and Hambrook *et al.* (2012), may have impacted on their ability to correctly identify, understand, and express their emotions.

Similarly to other studies (Joos *et al.*, 2009; Polivy & Herman, 2002; Williamson *et al.*, 2004; Zaitsoff *et al.*, 2002), Fox (2009) further discovered that the participants in his study inhibited the expression of certain emotions, specifically anger and sadness, and that the inhibition of anger tended to trigger eating disorder symptoms. The women in his sample inhibited their anger to protect their interpersonal relationships, and their sadness to protect themselves from being perceived as weak or for fear that it would lead to rejection by significant others. This observation resonates strongly with findings for the four participants in the present study. Fox (2009) goes on to discuss how the inability of his participants to express their emotions relates to the SPAARS model of emotional development, whereby "basic emotions develop in a modularized manner [...] in relation to environmental influences" (Fox, 2009, p. 298). The SPAARS model postulates that if a child's contextual environment facilitates the belief that they are not allowed to express certain emotions, those emotions become ego dystonic and threatening to the self. Both Fox's study and the present study seems to support this theory, as the participants in the current study feared expressing their emotions, and eventually utilised their eating disorders as a means of suppressing or coping with their emotions. Considering the respective contextual backgrounds of the four participants in the present study, the postulate that environment may inhibit the expression of anger and sadness makes sense.

Furthermore, Fox (2009) mentioned that his participants often experienced overwhelming emotions within their respective contexts, whether it was at home or at school; that those emotions were poorly expressed and managed; that given the young age of participants *at the time of experiencing those emotions*, the weight of the emotions was developmentally inappropriate; and that the participants' parents' lack of meta-emotional skills were detrimental to the development of participants' ability to manage and express their own emotions. Once again, the findings of the present study are very similar to Fox's findings. In the current study, the developmental age of the participants just prior to the onset of their eating disorders is potentially very important: Other studies on the development of emotional intelligence indicate that aspects of emotional intelligence are influenced by parenting styles (Kooiman *et al.*, 2004), is as yet underdeveloped in adolescence (Kafetsios, 2004), and underscores the importance of family interactions by showing

that parents and children mutually influence each other's perceptions of their own and others' emotional intelligence (Sánchez-Núñez, Fernández-Berrocal & Latorre, 2013). It is possible that the participants in the current study were too immature to cope with the emotional load of their respective challenges, while at the same time their actual inability was compounded by their perception that their parents were unable to help them manage their emotions and their simultaneous perception of their own incapacity to cope with those emotions. This observation supports the findings of Salguero, Palomera & Fernández-Berrocal (2012), who indicated that adolescents who display a combination of high attention to emotions, low clarity of emotions, and low perception of their ability to repair negative emotions are prone to poor psychological adjustment as well as increased anxiety, depression and social stress.

In summary, the findings of the current study seem to indicate that the participants may have had lower than average emotional intelligence. However, it is possible that this deficit in EQ may have developed as the result of a cascading set of circumstances that were beyond the control of the participants: As young adolescents, they experienced challenges that were too emotionally laden to cope with given that the participants were:

- developmentally incapable of dealing with those emotions;
- hampered in their ability to identify, understand, and express their emotions by the anxiety and depression brought on by their circumstances;
- restricted in their expression of emotions due to contextual constraints;
- unable to approach their parents for help because they did not perceive their parents as having the necessary skill to assist them, or because they were fearful of being perceived as weak and consequently of being rejected; and
- doubtful of their own ability to effectively deal with their emotions.

The findings related to the participants' ability to cope with the stress that they experienced will be discussed next.

5.1.4 Coping with stress as reflected by behaviour patterns and habits

Early adolescence is a tumultuous time for most people, and adolescents typically describe this stage as stressful. However, some people's experiences of stress are context specific and are perceived to be beyond their control, or beyond their management ability and resources (Seiffge-Krenke, Aunola & Nurmi, 2009). The participants in the present study reported that they experienced elevated levels of anxiety which was brought on by their various experiences prior to the onset of their eating disorders. They said that they coped with their distress by distracting themselves with various hobbies, avoiding reflection on their problems, and denying or downplaying the existence of their stress. They also avoided social situations that could potentially cause them distress.

The findings of the present study are consistent with the results of previous studies that investigated coping strategies in adolescents: Seiffge-Krenke *et al.* (2009) found that in a normal adolescent sample girls tend to use more active coping strategies, including seeking more social support, than boys do. They suggest that during early adolescence, problems relating to school and peers are dealt with more effectively when addressed directly, especially by seeking support and assistance. They also report that the adolescents in their sample were likely to use active coping strategies when facing stress related to school and peers, but were unlikely to do so in response to stress related to their parents or to themselves. In addition, they found that adolescents' perceived level of stress influenced which coping strategy they would use; under conditions of high levels of perceived stress, their sample was more likely to use withdrawal as a method of coping. These findings are reflected in the behaviour of the four participants in the present study. Moreover, adolescents that used internal (cognitive) methods of coping during stressful situations in early adolescence, experienced similar situations as being very stressful later in their adolescence. Martyn-Nemeth, Penckofer, Gulanick, Velsor-Friedrich & Bryant (2009) similarly showed that adolescents who experience high levels of environmental stress are prone to depression and the use of avoidant coping strategies as well as the use of food to relieve stress (see also Fryer *et al.*, 1997). These results may be relevant to the present study as these participants could not seek support from their families or peers, therefore resorted to coping strategies involving withdrawal, distraction, and emotion-oriented coping when burdened with stress that they were

otherwise unable to deal with during early adolescence. Furthermore, failing to learn more effective coping strategies, they applied those same ineffective strategies during stressful events in their later adolescent years.

During late adolescence, the four participants in the present study faced many important life decisions which were likely to have increased their future-related stress, following Seiffge-Krenke *et al.* (2009). As previously suggested by Compas *et al.* (2001), having failed to learn more adaptive coping strategies, the participants in the current study increasingly relied on their established coping strategies. While it is impossible to infer from this study that their respective eating disorders became coping strategies in and of themselves, the participants did indicate that they used their eating disorder behaviour to reduce stress, or that the behaviour increased when their levels of perceived stress increased. This observation supports the results of studies reviewed by Polivy & Herman (2002). Importantly, the eating disorder behaviour occurred in reaction to their perceived stress in general, of which weight gain became a *component* as their adolescence progressed. These findings reflect the work of other researchers who have found that persons with eating disorders tend to use deficient or inadequate strategies of coping with stress (Berman, 2006; Corstorphine *et al.*, 2005; Jáuregui Lobera, Estébanez, Santiago Fernández, Alvarez Bautista & Garrido, 2009), and that persons with eating disorders who have increased levels of anxiety and who use emotion-oriented coping strategies tend to display increased levels of pathological eating (Fitzsimmons & Bardone-Cone, 2011).

Wonderlich-Tierney & Vander Wal (2010) further suggest that eating disorder symptoms are related to the fear of negative evaluation, and that this relationship is both mediated by emotion-oriented coping, and moderated by distraction as a form of an avoidant coping style. The four participants in the present study all experienced negative evaluation, whether it was self-evaluation as in Lee's case, or due to negative commentary by family or friends. Furthermore Grilo *et al.* (2012) found that stressful life events, particularly work and social stress, predicted eating disorder relapse in their study. Lee (in the present study) also reported relapsing after experiencing interpersonal and work-related stress. The findings of the present study support the evidence that coping with stress and eating disorder behaviour is

probably linked, but it is important to emphasize that the maladaptive coping styles of the participants in the current study developed *prior* to the onset of their eating disorders.

To summarise, the participants in the current study used maladaptive coping strategies to deal with stress in their individual contexts because they lacked the resources and ability to do otherwise. Weight gain, or the intense fear of gaining weight, eventually became an *additional source* of stress related to the fear of negative evaluation, for reasons previously described and which were unique to each participant. Their respective eating disorder behaviours increased in relation to their perceived stress, or were employed in an effort to reduce their perceived stress, thus becoming *part of* their respective maladaptive coping repertoires.

5.1.5 Recovery

The experiences of the four participants in the current study pertaining to the clinical treatment for their eating disorders are roughly in line with the results of studies on the efficacy of different modes of treatment as described by Hay (2013), in that the three participants that underwent clinical treatment all dropped out of more than one treatment programme and one of the three relapsed after remission. Additionally, Hay (2013) and Le Grange *et al.* (2012) report that persons with eating disorders who receive clinical treatments seem to benefit more from those treatments which include components that address interpersonal problems, encourage family participation in the treatment process, and develop skills for coping with negative emotions.

A further finding that emerged from the studies of Hay (2013) and Le Grange *et al.* (2012) is that the remission rate following treatment for eating disorders remains a matter of concern, with less than half of the patients reaching full remission status (Vanderlinden, 2010). It is for this reason that Vanderlinden pleads for flexibility in clinical treatment settings, using case examples to illustrate the necessity to sometimes delve a little deeper into the background and course of development of patients' disorders in order to achieve success in treatment, which may need to be adapted or 'matched' to better suit the patient. The present study certainly seems to support his views. It also supports the views of Vandereycken (2012), who argues for

the plausibility of spontaneous recovery from eating disorders without the help of clinical treatment. Although the participants in the current study all received some form of counselling, if not clinical treatment, at some stage in the course of their disorders, three points in Vandereycken's paper are nonetheless pertinent to the current study: 1). In a study by Woods (cited in Vandereycken, 2012, p. 91) it was found that most of the 18 participants reported that the pivotal element in their recovery was the "empathic, nurturing support from a parent, boyfriend, or friend." 2). Patching and Lawler (cited in Vandereycken, 2012, p. 92) found that their participants spontaneously recovered when "they re-engaged with life, developed skills necessary for conflict resolution, and rediscovered their sense of self." 3). Each person has a unique recovery capacity consisting of internal and external resources which vary at different life stages and that, together with problem severity, influences the intensity of treatment a person may require. Accordingly, a person such as Lee in the present study who had a severe and enduring case of anorexia, was able to find the powerful resources within herself to initiate and maintain her recovery, whereas another person with a less severe disorder, but with minimal internal and external resources may need extensive treatment over a long period of time, and yet may never recover. The four women in the present study overcame their eating disorders when they realised that they had the ability to do so and chose to change their ways accordingly.

I will now present the integrated interpretation of the findings.

5.2   INTEGRATION OF CONTRIBUTORY FACTORS: INTERPRETATION OF THE FINDINGS FOR THE FOUR PARTICIPANTS

According to the multidimensional integrative approach to psychopathology of Barlow and Durand (2012), psychological, biological, and social influences interact in the development of eating disorders to cause the restriction of eating that typically precedes the onset of eating disorders. Anxiety is reduced by engaging in the eating disorder behaviour, either by continued restriction of eating or by bingeing and purging. The findings from the current study support this approach, and provide a clearer and more detailed description of the interactions among aetiological factors in the development of eating disorders. I must reiterate however that the focus of this

study was very limited, and that the following discussion relates only to the factors investigated in this study. It is possible that other cases may be influenced by different aetiological factors, albeit via the same mechanism.

In the present study, the primary driving force behind the development of the eating disorder was the participants' fear of gaining weight, which was fuelled by their fear of negative evaluation. This was true for all four participants, regardless of whether they developed anorexia or bulimia and moreover, this fear *preceded* the onset of the eating disorder, as opposed to being a characteristic of the disorder. The fear of negative evaluation itself was caused by the interaction of biological factors (possible inherited vulnerabilities; proneness to anxiety and to experiencing stress as overwhelming; and the developmental vulnerability of the participants' age prior to the onset of eating disorder); social factors (family background; contextual focus on appearance; social isolation; and lack of guidance in coping with emotions and stress); and psychological factors (need for acknowledgement; decreased emotional intelligence; and ineffective coping skills). The four participants experienced intense negative emotions in early adolescence, which for reasons detailed previously they were unable to cope with and thus they developed ineffective coping strategies, which once again were informed by the interactions of the biological, social and psychological factor dimensions. Over time, some of the participants gained weight while one lost weight, and this is where the developmental mechanism starts to vary for the different participants:

1. Lee developed an extremely negative evaluation of her own appearance following her accident, which she compensated for by 'becoming thin'. In addition, she initially received compliments when she lost weight after her accident due to being unable to eat normally, which fed into her need for acknowledgement. Over time, she increasingly restricted her eating and increased her exercising. This behaviour served two purposes: it reduced her anxiety with regard to gaining weight (and risking loss of identity associated with the acknowledgement that she received for losing weight); and it served as a coping strategy. Having never learned a more effective coping style, and being unable to break free from her dysfunctional relationship with her boyfriend, she maintained her eating disorder behaviour for over two decades.

2. Constance gained weight in response to changes in her activities; thus in a sense her worst fear became a reality, in that she feared gaining weight because she was afraid that her parents would reject her if she gained weight. Her initial purging behaviour was more of a stress response than an attempt to lose weight, however. Over time she purged more frequently in response to stress; thus the purging became a coping strategy. The purging sparked the characteristic binge-purge cycle which is the hallmark of bulimia nervosa.

3. The trajectories of Rose and Kelly are similar, although they have very different personalities. In both cases, their weight gain was caused by increased food consumption which in itself was a coping strategy, informed by their individual circumstances. The weight gain was a nightmare come true for these two women because to them it meant abject negative evaluation, and they responded by dieting. They lost weight by dieting, thereby gaining acknowledgement and receiving compliments, and then for slightly different reasons, each began to experiment with purging. For Kelly, the eating disorder behaviour developed into a coping strategy, while Rose's eating disorder behaviour spiralled out of control in an increasing attempt to control her weight.

Figure 5.1 illustrates the mechanism of the development of an eating disorder, within the context of the lives of the four participants.

PSYCHOLOGICAL INFLUENCES

- Need for acknowledgement / sense of 'not being good enough'
- Emotional intelligence:
  - Difficulty identifying, understanding and reasoning about emotions
  - Inability to and / or reservation about express(ing) emotions
  - Ineffective emotional regulation
- Coping:
  - Ineffective coping with emotions and stress

BIOLOGICAL INFLUENCES

- Possible inherited vulnerability: family history of psychological dysfunction and / or anxiety
- Prone to be anxious
- Prone to experience stress as overwhelming
- Developmental vulnerability (age prior to onset of eating disorder)

SOCIAL INFLUENCES

- History of troubled family relationships
- Real or perceived familial pressure to be thin and beautiful
- Social isolation (decreased perception of available social support)
- Lack of guidance in coping with emotions and stress

FEAR OF GAINING WEIGHT, DRIVEN BY FEAR OF NEGATIVE EVALUATION

EXPERIENCE OF INTENSE NEGATIVE EMOTIONS DUE TO STRESSFUL LIFE EVENTS

COMPLIMENTS AND ATTENTION RESULTING FROM WEIGHT LOSS

WEIGHT GAIN: DIRECTLY, DUE TO INCREASED EATING IN RESPONSE TO STRESS; OR INDIRECTLY, DUE TO CHANGES IN ACTIVITIES

EATING DISORDER BEHAVIOUR

Figure 5.1: A diagrammatic representation of the development of the participants' eating disorders, based on the Multidimensional Integrative Approach to Psychopathology (Barlow & Durand, 2012)

5.3 CONCLUSION

The discussion of the findings from this study is a clear illustration of the multi-factorial and cumulative nature of aetiological factors in the development of eating disorders. By utilising the multidimensional integrative approach to psychopathology of Barlow and Durand (2012), it was possible to grapple with the intricacies of individual paths that led to the development of an eating disorder, and to illuminate the roles of emotional intelligence and coping style in this developmental mechanism. Chapter 6 concludes this dissertation by touching on its relevance and its limitations, ending off with suggestions for future research and a reflection on my experiences in writing this dissertation.

6. CONCLUSIONS, RECOMMENDATIONS, AND REFLECTIONS

In this study, I set out to explore how individuals who suffer from eating disorders behave under conditions of distress, and how this behaviour relates to the development of an eating disorder within the unique context of an individual life. I aimed to illustrate this relation in terms of a known approach to understanding psychopathology, namely the multidimensional integrative approach of Barlow and Durand (2012). I conducted this study from the perspective of the interpretive paradigm, as it was best suited both to the design of my study and to understanding the inimitable stories that the participants so graciously shared with me.

In this final chapter, I provide answers to the research questions; I discuss the significance and limitations of the study; I offer recommendations for research and practice; and I reflect on the meaning of this study to me as a researcher, and as a person.

6.1 ANSWERS TO THE RESEARCH QUESTIONS

There were two research questions that this study aimed to address. The first question was: What persistent behavioural patterns, revolving around emotional intelligence and coping style, do individuals who suffer from an eating disorder display?

In keeping with the research presented in the existing literature on eating disorders, the four participants in this study developed behavioural patterns characterised by the inability to take effective cognisance of their emotions; limited verbal expression of their emotions; and coping styles that compensated for their inability to regulate their emotions by ensuring avoidance of or distraction from negative emotions.

The second question was: How do the factors identified in those patterns interact to contribute to the development of eating disorders within the context of individual lives?

Within the lives of the four participants of this study, specific individual biological, psychological (including diminished emotional intelligence and maladaptive coping styles), and social contextual factors interacted throughout their pre-adolescent and adolescent years to produce a marked fear of gaining weight that was driven by fear of negative evaluation. Then, when individual circumstances brought about unexpected fluctuations in their weight, and remarks with it, each participant responded in a manner aimed at either reducing the negative evaluations that they experienced, or at eliciting more of the positive evaluations that they received. None of the participants intended to, or even knew that they were in danger of sliding into an eating disorder. However each participant, for reasons unique to her own circumstances, became trapped in the eating disorder behaviour because that behaviour served a specific purpose, which was related to coping with stress, within their lives.

The questions that I set out to investigate in this study were successfully answered. In the next section, I will discuss the significance of this study.

6.2 SIGNIFICANCE OF THE STUDY

This study offers theoretical and pragmatic contributions. Theoretically, the study contributed not only to the understanding of eating disorders, but also to the description thereof. In terms of understanding, this study showed that the developmental mechanism of the participants' eating disorders are individually unique, informed by the relationships among an individual's background, context, and circumstances, and by how they impact on the ability to cope with emotional and other forms of distress. Most importantly, the study showed that the participants' disorders developed long before the first symptoms were visible, because the interrelationships between the fear of gaining weight, emotional dysregulation, and ineffective coping strategies that underlie their disorders were laid down during early adolescence, or earlier. The visible weight loss (or other characteristic aspects of the disorder) is merely a symptom of the chaos that lies within the individual participant.

Pertaining to the description of eating disorders, the findings of this study suggest that it may be necessary to engage in in-depth conversations with persons suffering

from eating disorders in order to describe how their disorder developed. In this regard, it is useful to apply a framework such as the multidimensional integrative approach to psychopathology of Barlow and Durand (2012) as a guide in directing questions and making linkages between contributing factors. In doing so, the researcher or clinician is able to identify gaps in their own understanding as well as in that of the participant or patient. In this way, I was able to discern how the behavioural patterns that the participants in this study formed related to their emotional intelligence and coping styles, and how this in turn influenced the development of their eating disorders. Finally, this framework may allow the researcher or clinician to comprehensibly illustrate the complex nuances of a dynamic developmental mechanism for eating disorders.

The pragmatic contributions of this study relate to the relevance of the findings for the prevention and treatment of eating disorders. It is important to emphasise that the disorders that plagued the lives of these four participants developed in response to *their perceptions* about whether they were acceptable to and wanted / loved by others, and that those perceptions were shaped by their unique contexts, both currently and historically. Furthermore, the *components* of eating disorders were functional within the lives of the individual participants: they developed in response to dysfunctions in the management of emotions and stress; dysfunctions which were influenced by family and other social interactions in conjunction with biological and psychological factors. This finding could explain why there are so many people who battle with eating disorder *symptoms*, even though full-spectrum disorders are relatively rare. If those dysfunctions, together with the underlying perceptions of worth, are not addressed in the treatment of the disorder, the disorder, or symptom, may be intractable. Similarly, interventions that focus on addressing the *underlying factors that contribute to* the development of body image dissatisfaction may be successful in preventing the development of eating disorders.

The limitations of this study are described in the next section.

6.3   LIMITATIONS OF THE STUDY

There are a number of limitations to this study. First, the availability of time and financial resources limited the scope of this study to two factors in the developmental mechanism of eating disorders. This study can therefore not be described as anything but exploratory. Second, it is impossible to generalise the findings of a study based on a homogeneous sample of four participants, therefore the study is limited in its application to the broader population. Third, the retrospective nature of the data and the reliance on single-participant interviews lends itself to perception and memory biases. However, gathering this data retrospectively allowed for a much more complete view of the development, progress, and eventual decline of the disorder. Fourth, and perhaps most importantly, my own biases may have played a substantial role in the interpretation of these findings, although I tried to prevent this to the best of my ability by obtaining peer consensus of the findings and by asking for feedback from the participants themselves.

Despite the limitations of this study, I am able to offer some recommendations for research and practice based on the outcomes of this study. These recommendations are presented in the next section.

6.4   RECOMMENDATIONS FOR RESEARCH AND PRACTICE

Limited in its generalisability as it may be, this study has highlighted some pertinent questions for future research. How do other factors implicated in the development of eating disorders interact within individual contexts to contribute to the developmental mechanism of these disorders? Could the fear of negative evaluation and the resultant fear of gaining weight, which developed within the individual contexts and circumstances, begin to explain the specificity of developing an eating disorder, as opposed to any other form of psychopathology? Lastly, the secrecy that is inherent in eating disorders has always been attributed to guilt and shame. Is it not plausible that it rather embodies the problem of being unable to articulate one's thoughts to begin with; of not knowing who to turn to or what to say when one needs help?

This study has also exposed pragmatic issues that could be addressed in the prevention and treatment of eating disorders. Regarding prevention, the long-debated issue of parental responsibility in the development of eating disorders

resurfaced in this study. While it has generally been accepted that blaming the mother or father for the eating disorder serves no purpose other than to aggravate the situation, it is undeniable that parents have a responsibility in preventing the development of eating disorders. This responsibility is situated in the need to support the age-appropriate emotional development and coping skills of their offspring, and equally important, to be aware of the impact of their words and their actions on their children's perceptions. Therefore, prevention programmes that include parental education about the development of emotional intelligence, coping skills, and the verbal expression and articulation of emotional content may yet prove to be effective.

Regarding treatment, clinicians should be more sensitive to certain aspects of eating disorders and to their relevance for treatment: 1. The developmental mechanisms underlying eating disorders may have become established over a long period of time, even before the onset of the disorder, most notably during sensitive developmental phases like early adolescence; and 2. The key tipping point into disorder could differ from individual to individual, underscored by unique events of significance to that individual only. It may therefore be important to first ascertain the key individual drivers of the disorder, rather than to treat every case as having the same underlying developmental path and therefore as requiring the same manualised treatment as every other case. While the importance of the restoration of healthy eating and BMI in eating disorder patients cannot be overstated, clinicians should also be mindful that the resolution of the underlying individual drivers of the disorder may be very important in the resolution of individual cases of eating disorders. Moreover, it is possible that certain pivotal life changes may need to take place in an individual's context to facilitate those resolutions, as illustrated by the examples in this study. Those changes may be beyond clinical influence, or may not happen during the time of treatment, as the patient may simply not be developmentally or mentally ready to attain the critical realisations that will lead to a breakthrough. This however, does not absolve the clinician from the responsibility of putting the patient on the right path to recovery, by taking the time to tease out those elements that are most important for maintaining the *individual's* disorder, and assisting the patient with finding ways to understand their impact on the development and course of the disorder. Stripped to its core, an eating disorder is an attempt at expressing the need for recognition as an individual person with value, worthy of love

and affection; a need to be *seen*. If there is one thing that this study emphasises, it is that the mechanism of development of an eating disorder is unique to the individual, and therefore each case should be investigated and treated individually; an affirmation of the person's value by the treating clinician.

6.5   FINAL REFLECTIONS

As stated in the beginning of this dissertation, my own experience with an eating disorder motivated me to conduct this study. In turn, this study has deeply affected me both professionally and personally. Professionally, as a researcher in the social sciences, one sometimes forgets that a study is conducted on people, not subjects. The interpretive paradigm that I chose for this study helped to drive that point home to me, and I am deeply grateful to the participants in this study for being so forthcoming and accommodating.

Personally, this study has illuminated my own trajectory into eating disorder behaviour. The journey, however, was not an easy one because it necessitated revisiting events and situations that I'd thought I'd put behind me. In this sense, I empathise with my participants and I appreciate their contribution all the more. Writing this dissertation literally made me ill: my eczema resurfaced and I experienced high levels of anxiety and irritability. I also drastically increased my consumption of sugary snacks, although not to the extent that it could be defined as bingeing. I also suffered several 'mental blocks', resulting in procrastination. Yet, I am at peace now that it is done.

This study has ultimately had a therapeutic effect on me because through it, I answered the question that led me down this path to begin with. That is to say, through reflection on the findings of this study, I was able to identify my own trajectory into disorder. This study has also shown me the areas of my life that need work and I have taken strides to address my own residual issues. So then, to complete the circle back to the opening of this dissertation: I finally lay my weapons down; my war is won.

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8. APPENDICES

8.1 APPENDIX I: THE INTERVIEW GUIDE

Introduction

Introduce myself to the participant and explain my aim with the dissertation and the purpose of the interview. Obtain written informed consent.

Question 1

Obtain genogram of family, including relationships with significant others. Elicit information related to conflict and times of transition, such as changing schools (if family relocated); going from primary school to secondary school; deciding what to study (if anything) after school; any significant events that specifically effected participant.

Question 2

Obtain 'genogram' of friendships from early adolescence to onset of eating disorder. Elicit information related to conflict and times of transition, such as relocations.

Question 3

Using genograms, focus on times of conflict and uncertainty and ask pertinent questions about what emotions were experienced; ability to perceive, identify, understand and think about emotions; how participant coped with emotions; what (if any) assistance was sought.

Question 4

Elicit details about the development and progression of, and recovery from, the eating disorder.

8.2 APPENDIX II: WRITTEN INFORMED CONSENT

I hereby give consent that I may be interviewed, knowing that the information that I provide will be used by the interviewer in her dissertation. I understand that I will be asked questions regarding my family, my friends, myself and certain patterns of behaviour.

I understand that I will be interviewed for the duration of between two and three hours, depending on how long it takes to provide sufficient information.

I understand and consent to the fact that the interview will be recorded on a digital recording device; that the recording will be kept safe and secure; that the information will be used only for the purpose of this dissertation; and that only the interviewer will have access to the original recording.

Risk

I understand that there is no risk, of either a physical or psychological nature, involved in participating in this study.

Benefits and compensation

I understand that there is no direct benefit for me in participating in this study, and that I will receive no compensation for my time. However, I understand that this study may contribute to the understanding of the development of eating disorders, which may assist others in being effectively treated and assisted after having been diagnosed with an eating disorder.

Rights of participant

I understand that I will be treated with respect and with empathy. I declare that I participate in this study voluntarily. I understand that I may terminate the interview at any time.

Confidentiality

I understand that all personal information that I provide, as well as my identity, will be kept strictly confidential. The findings of the study may be published in professional

journals, presented at conferences, or presented in workshops. I understand that my personal details and identity will not be revealed at all.

By signing this consent form, I declare that I have read it and that I fully comprehend my rights as well as what is expected of me. I declare that my part in this study has been explained to me, and that none of my rights are being violated.

Name:_____

Date of birth:_____

Contact number (optional):_____

Date:_____

8.3   APPENDIX III: INDEMNITY FORM

I, ……………………………………..…………, hereby agree to be interviewed by Yolanda Mitchell, as a participant in her research.

I confirm that my participation in the research is entirely voluntary and I accept all risks involved therein. Accordingly, Yolanda Mitchell shall not be liable for any loss, damage, injury or illness of whatsoever nature and howsoever caused, suffered by me (to my person or property).

Signature of participant:...

Signature of witness:....................................... Print Name:......................................

Signed at: ………………………. on this ……………. of …………… 2012.