

Exploring salient shifts and transdiagnostic factors in eating disordered women

Francesca Favero

Department of Psychology

The University of Cape Town

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ABSTRACT

Carbohydrate addiction is said to be the sustained dependence on hyperpalatable foods rich in carbohydrates and sugar. This addiction manifests in increased consumption of carbohydrates through binging: a behaviour typically associated with eating disorders. There is a lack of consensus amongst relevant experts as to whether carbohydrates are physiologically or psychologically addictive. With an increased focus on carbohydrate addiction, an outpatient treatment programme, HELP, has been established in Cape Town, South Africa, to specifically address this issue. This research aimed to explore, pre- and post-intervention, the possible presence of, and subsequent shifts in, the maintaining mechanisms identified in the transdiagnostic model for eating disorders. However, the potential for the emergence of other perpetuating factors was not discounted and the nature of the analysis allowed for this possibility. Eight women between the ages of twenty-two and fifty, who had completed the outpatient treatment programme in the last six months, were interviewed. They were asked to speak retrospectively about their personal difficulties, eating and food, and their experience of the treatment. Thematic analysis was employed to identify themes arising from the data. Five themes congruent with the transdiagnostic model's factors emerged: over-evaluation of weight and shape, core low self-esteem, interpersonal difficulties, clinical perfectionism and mood intolerance. A variety of sub-themes, elaborating upon the various ways in which the disordered eating was maintained, also emerged from the data. Shifts in these maintaining mechanisms were identified. Although, not necessarily indicative of recovery, the results suggest that the outpatient HELP programme had a positive overall influence on the participants; and that the transdiagnostic model may be useful in understanding and guiding the treatment of clients who engage in this type of treatment programme.

Key words: eating disorders; binge eating disorder; carbohydrate addiction; transdiagnostic model; maintaining mechanisms; thematic analysis; outpatient treatment.

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Introduction

Obesity is an increasingly prevalent condition in South Africa with 56% of women and over 29% of men being either overweight or obese (Puoane, Steyn, Bradshaw, Laubscher, Fourie & Lambert, 2002; van der Merwe & Pepper, 2006). Obesity, and the non-communicable diseases with which it is often co-morbid, create an extra burden in terms of the increasing cost of healthcare provision. South Africa is said to experience a quadruple burden of disease due to pre-transitional diseases such as communicable diseases and nutritional deficiencies, non-communicable diseases and HIV. Targeting risk factors of morbidity such as obesity, diabetes, hypertension and high cholesterol is key in trying to improve the general health status of South Africans (Bradshaw et al., 2003). Obesity has also been linked to binge eating disorder (BED). As such as, thirty percent of obese people presenting for weight loss treatment also presented with BED (Dingemans, Bruna, & van Furth, 2002; Vamado et al, 1997).

Carbohydrate resistance and carbohydrate addiction

Carbohydrate resistance refers to the unsuccessful metabolising of carbohydrates (Noakes, 2013); often also referred to as insulin resistance. People who are insulin resistant are in a pre-diabetic state and highly likely to develop Type 2 diabetes. The increased consumption of carbohydrates fuels carbohydrate resistance and by extension: diabetes, obesity and other associated health problems like heart disease. The prevalence of diabetes in South Africa is between 8% and 10% (Brown, 2013). It is expected that these numbers will rise in the future (Molleutze & Levitt, 2006). Compared to other African developing nations, South Africa's prevalence is particularly high, with Ghana's 3, 2% and Kenya's 2, 8% (International Diabetes Foundation, 2010). Early dietary intervention is vital as it has the ability to positively alter the metabolic abnormality of hyperglycaemia in pre-diabetic people. Subsequent weight loss will result in decreased metabolic abnormality and thus a regression in pre-diabetes (Molleutze & Levitt, 2006). To mitigate the adverse side effects of being carbohydrate resistant and having pre-diabetes, a low carbohydrate diet is needed.

Noakes (2012) postulates that a carbohydrate addiction contributes to the health related problems of diabetes and obesity. This is especially relevant in South Africa where at least 60% of people range from being overweight to morbidly obese. Sugar addiction is equivalent to a carbohydrate addiction, as the over-consumption of carbohydrates and sugar both induce an over-release in insulin for people who have carbohydrate resistance (Noakes,

2012). While sugar addiction is not an official diagnosis, research increasingly yields data suggesting that hyperpalatable foods can be addictive. There are many parallels between the consumption of hyperpalatable foods and substance dependency. Sugar has been labelled as an addictive substance because it mirrors other forms of addictions: craving, cross-sensitization, withdrawal symptoms and bingeing being common presenting features (Avena, Rada & Heobel, 2008). The priming of endorphins and dopamine associated with the consumption of alcohol is also triggered by sugar and carbohydrates (Fortuna, 2012). However, there is some controversy as to whether sugar is physiologically addictive as a substance, or if the abuse of carbohydrates is a process addiction fuelled by acquired cognitive mechanisms (Hammersley & Reid, 1997), there appears to be a consensus that carbohydrate addiction does exist.

The overconsumption of sugar can lead to adverse health states, such as hypertension and cardiac complications, that are also associated with prolonged use of alcohol (Lustig, Schmidt & Brindis, 2012). Individuals with sugar addiction often have added mental health problems of anxiety and depression (Teitelbaum & Fiedler, 2010). For individuals who are genetically predisposed to addiction, increased use of a substance can lead to tolerance, meaning a greater quantity of the substance would need to be consumed for the same effect to be achieved (Smith, 2012). In the case of a carbohydrate addiction this can lead to binge eating and subsequent weight gain and obesity due to acquired insulin resistance (Teitelbaum & Fiedler, 2010).

The link between addiction and eating disorders. Eating disorders, not otherwise specified (EDNOS) is a residual category of diagnosis for eating disorders. Diagnosis is made upon confirmation of a clinically severe eating disorder, paired with the elimination of anorexia nervosa and bulimia nervosa as possible suitable diagnoses. This exclusionary step of diagnosis reflects a lack of positive diagnostic criteria that need to be met (Fairburn & Bohn, 2006). In clinical settings EDNOS is the most common eating disorder diagnosed. In samples of adults receiving treatment at an outpatient level around half of them suffer from an EDNOS (Fairburn & Bohn, 2006; Murphy, Straebler, Cooper & Fairburn, 2010).

Binge eating disorder (BED) was traditionally diagnosed as an EDNOS but since the publication of the DSM V in May 2013, BED is now a stand-alone diagnosis. BED was approved for inclusion in the DSM V in order to decrease the number of vague EDNOS diagnoses, and to provide many with a more detailed and precise diagnosis in order to allow

for more efficacious treatment plans (American Psychiatric Association, 2013). BED entails recurrent episodes of binge eating with an absence of excessive weight-control or compensatory measures. In this context, binge eating refers to the consumption of more food than would be objectively consumed in a given period of time, with a lack of control experienced over said consumption (Murphy et al., 2010). With marked increase in carbohydrate consumption and a failure to reduce consumption despite potential adverse health and wellbeing outcomes; it is evident that there may be a significant overlap between carbohydrate addiction and BED or EDNOS.

Drawing on the transdiagnostic model, eating disorders are best understood through their shared, overarching clinical features; not through divisive characteristics associated with sub-types (Fairburn & Bohn, 2005; Fairburn, Cooper & Shafran, 2003). In general, eating disorders can be said to be sustained to a greater or lesser extent through the interaction of five maintaining mechanisms: an overevaluation of eating, shape and weight and the control thereof, core low self-esteem, interpersonal difficulties, clinical perfectionism and the inability to tolerate certain moods (Fairburn et al, 2003). As such, solid interventions should aim to address these specific factors in treatment.

Failure to successfully explore and deal with the thoughts and emotions that precede the identified disordered behaviour may result in symptom substitution. Symptom substitution entails the replacement of one set of symptoms with another. When this emerges, it is often referred to as a 'cross addiction'. This may occur when treatment does not fully equip clients with sufficient skills to navigate the thoughts and emotions that underlie the dysfunctional behaviour (Hofmann, 1983). In this context, a person may report an absence of symptoms relating to carbohydrate addiction or BED. However, if that individual has failed to address their low self-esteem or interpersonal difficulties, they may begin to exhibit symptoms pertaining to other compulsive behaviours such as excessive gambling or sex addiction. The sex addiction, for example, then becomes a proxy for the original carbohydrate addiction and the underlying maintaining mechanisms still remain strong.

Harmony Eating and Lifestyle Programme (HELP). HELP is an outpatient treatment programme situated in Cape Town, South Africa. It aims to treat carbohydrate addiction, and is primarily aimed at overweight and obese individuals who feel they lack control over food (Jackman, 2013). HELP is designed to help individuals, feeling that their addiction to carbohydrates has a negative psychological or physical impact on their life, to

cease with carbohydrate abuse. HELP involves psycho-educational lectures aimed at nutrition, self-esteem and trauma, a meal plan, 12-step work and various other therapeutic interventions (HELPdiet, 2012).

The diet advocated by HELP is low in carbohydrates and high in fat. Carbohydrates are limited to 50g per day and should come from fruit or carbohydrate rich vegetables. Processed carbohydrates and sugar are strictly off the menu. This follows the belief that people who are addicted to carbohydrates can never be entirely free of their carbohydrate addiction, and so they must work on their recovery continuously through abstaining from carbohydrate consumption (Noakes, 2013).

Uncertainty regarding the nature of carbohydrate addiction. HELP conceives the problematic relationship between individuals and hyperpalatable food not only as a carbohydrate addiction, but as a substance addiction (Noakes, 2012). Conflict in the field as to whether this is purely a substance addiction or a process addiction that looks uncannily similar to an eating disorder muddies the proverbial water. Carbohydrate addiction is not currently a formal diagnosis. On examining the issues associated with such an addiction it appears the problem being described is a melting pot of addiction and an eating disorder due to the unhealthy and distressing relationship that exists with food.

Dependence is characterised by a combination of three or more distressing and impairing symptoms that arise from the consumption of a given substance. An increased tolerance for the substance may be experienced. Other symptoms include withdrawal, a failure to reduce or control one's use despite attempts to do so and a continued use of the substance despite recurrent psychological or physical problems that are caused or worsened by such consumption (American Psychiatric Association, 2000). It appears that people presenting with a carbohydrate addiction may meet the above diagnostic criteria; thus suggesting it should be classified as a substance addiction. However, one could argue that a process addiction resembling an eating disorder would also meet these criteria when substituting 'substance' for 'behaviour'. There is little certainty whether the primary feature of a carbohydrate addiction lies in the physiological component of consuming the hyper-palatable foods or the behaviour associated with the over-consumption of the hyper-palatable foods (Liu, von Deneen, Kobeissy, Gold, 2010.) Therefore with little research on the topic it is difficult at this stage to clearly assert whether it is the one or the other. For the purpose of this research, the presenting problem was conceptualised as an eating disorder due to the fact

that carbohydrate addiction is not a particularly well-defined concept. In addition, it is contended that the symptomology presented resembled that of an eating disorder, and not necessarily of a chemical addiction. With BED only recently being a DSM sanctioned diagnosis, it is possible that conceptualisation of 'carbohydrate addiction' as an eating disorder (BED) was overlooked.

Treatment options. There is a severe lack of literature on the nature and impact of carbohydrate addiction treatment. Thus literature on the treatment of eating disorders and chemical dependency, which parallels the kind of treatment that HELP entails, was consulted. HELP uses treatment modalities such as group therapy sessions, psycho-education, and provides a carbohydrate and calorie controlled diet plan.

Interactional group therapy is a common tenant of substance abuse treatment. There are many therapeutic factors of group therapy that are said to instigate change and facilitate recovery. These include factors such as interpersonal learning and altruism through receiving and giving feedback, feelings of hope and not being alone (Kivlighan & Holmes, 2004). Group therapy is especially useful in the treatment of addiction and eating disorders as maladaptive patterns of interpersonal attachment that maintain the addiction are sufficiently worked through by bolstering self-care and affect regulation (Fernández-Aranda, Bel, Jiménez, Viñuales, Turón, & Vallejo, 1998; Flores, 2002). For example, significant changes were found in eating behaviour in obese women who engaged in binge eating after a total of 24 group therapy sessions (Seamoore, Buckroyd & Stott, 2006). Group therapy was semi-structured; entailed psycho-education about nutrition, cognitive behaviour therapy, and issues like body image and relationships. There was a significant ($p= 0.008$) difference between baseline and follow up scores on the Binge Eating Scale (BES) indicating a reduction in binge eating behaviour and cognitions (Seamoore et al., 2006).

A group-based outpatient programme for the treatment of eating disorders also found significant differences in posttest scores of eating disordered symptoms and attitudes compared to pretest scores (Schaffner & Buchanan, 2008). There was also a significant reduction in incidences of binge eating post-treatment. The programme entailed skills groups and process groups. Skills groups are psycho-educational in nature, aiming to disseminate knowledge and skills to successfully equip clients with healthy coping skills as an alternative to engaging in disordered eating. In process groups patients discuss emotions and personal

issues that they felt contributed to their eating disorder being upheld (Schaffner & Buchanan, 2008).

Very Low Calorie Diets (VLCDs) of between 800-1200 calories a day have been used in conjunction with various therapeutic methods to decrease binge eating. VLCDs have short-term successes in reducing instances of binge eating, but long-term weight loss was not consistent according to a review of the treatment of BED (Wonderlich, de Zwaan, Mitchell, Peterson & Crow, 2003). There is improvement in the number of binge-eating episodes initially, at the end of the month-long diet. However, at twelve and fifteen month follow-ups, binge-eating episodes increased to approximately the same incidence as before treatment (Telch & Agras, 1993).

Rationale for research. Carbohydrate addiction can be personally distressing and has implications for public health. The lack of specific literature raises questions regarding what successful and robust treatment for carbohydrate addiction would look like. Theoretical disagreements surrounding the nature of carbohydrate addiction potentially fuels this uncertainty. If assumed to be a physiological process, dietary measures alone should suffice. If identified as a process addiction or a form of an eating disorder the implications for treatment are different. In addition, the outcome measures for determining what recovery would look like will also differ depending on how the problem is conceptualised. With little targeted treatment available; interventions need to be helpful. This may entail borrowing a hybrid of ideas used in the treatment of obesity, eating disorders and addiction. HELP's treatment plan combines group therapy, a diet-plan, 12-step work and other vital therapeutic interventions.

Aims and objectives

Aim

The overall aim of this research was to explore and gain insight into the subjective experiences of individuals who participated in HELP's treatment programme for 'carbohydrate addiction' in relation to facets of the transdiagnostic model. Further insight into the manifestation of individuals' eating distress, and a more detailed comprehension into how factors, that appear to contribute to and to perpetuate the undesirable eating behaviour, are experienced by participants could provide results with the utility of guiding treatment and laying the ground-work for further research to be conducted on this topic.

Research Question. How do eating disordered women describe their HELP treatment experiences?

Interpretivism

This study adopts a qualitative interpretivist, epistemological approach. Interpretivism entails understanding the subjective meaning that individuals attribute to actions or events (Bryman, 2012). A basic assumption underlying this approach is that an understanding of human life cannot be derived from an external reality; but must be understood from within individuals' experiences. As a result interpretivism has an emphasis on individuals' subjective experiences within their specific contexts (Nieuwenhuis, 2007). This is a favourable framework for this research as it is congruent with the study's aim to explore individuals' subjective experiences of treatment. Consequently, a positivist or social constructionist framework would be ill-suited for this research.

The transdiagnostic model. While the overarching epistemological approach is an interpretivist one, the aforementioned transdiagnostic model plays a central role in this research. This model becomes a secondary theoretical approach as it informs the way in which this study conceives eating disorders and how they are maintained. All of the research on the transdiagnostic model has been quantitative in nature (Fairburn et al., 2003; Fairburn, Shafran & Cooper, 1999; Shafran, Cooper, & Fairburn, 2003; Waller, 2008). No qualitative research has explored the deeper experiences underlying the model's categories.

Methodology

Design

An exploratory, qualitative approach will be used in this study. An interpretivist perspective was employed. This perspective has an ontological assumption that individuals possess an interior reality which informs one's subjective experiences in one's life (Terre Blanche & Durrheim, 1999). Understanding individuals' experiences aids in generating a better understanding of carbohydrate addiction, eating disorders and the potential role of HELP. Deep, rich qualitative data is preferable in this instance as it will help generate an authentic and holistic picture of the potential influence of the intervention. Semi-structured interviews were conducted with. Each interview lasted between thirty five and forty five minutes.

Participants. A sample of eight individuals were selected by means of purposive sampling; a non-probability sampling method. This sampling method was employed because the population required was difficult to locate, and the sample selection needed to be based on similarity of shared experiences (Babbie & Mouton, 2001; Maree & Pietersen, 2007; Smith, Flowers & Larkin, 2009). In this case, that the participant had completed treatment. Individuals who had completed treatment were first contacted telephonically by a staff member of HELP. The aim of this research was explained to them. They were asked whether they would be interested in being interviewed and whether permission was granted to release contact details to the researcher for further correspondence. A contact list of individuals willing to participate was provided, and they were subsequently contacted to schedule interviews. HELP is a new programme with a relatively small number of people who have completed treatment. This made any form of probability sampling unfeasible. The sample size was also restricted as there was not a large number of individuals willing to participate in the study.

Sampling was based on the following inclusion criteria: participants must be at least eighteen years old and completed treatment of carbohydrate addiction with HELP. There was no exclusionary criterion of gender; however none of the few males in the programme volunteered to participate. All ages were welcome to participate in the study, resulting in a diverse sample with participants' ages ranging from twenty-two to fifty years. All participants were white, except for one who was 'coloured'.

Data collection

Data was collected by means of semi-structured interviews. Semi-structured interviews are employed mostly in qualitative research as they can provide detailed descriptions of an individual's subjective life and the meanings they attach to their experiences (Kvale, 1938). Semi-structured interviews are often selected as a means of rich, personalized data collection where there is a need to probe and be able to ask follow up questions; and when a high response rate is a priority (Gray, 2004).

Semi-structured interviews allow for flexibility. The interviewer is able to change the order of questions on the interview schedule and can ask follow-up questions when necessary – depending on how the interview is unfolding. In this way the interviewee is also able to influence the direction of the interview in accordance to what they feel is important to talk about (Moredyk, 2009; Wilson & Maclean, 2011). This is especially useful in the context of

this research in which fairly sensitive topics were covered. Semi-structured interviews have the benefits of both structured and unstructured interviews: allowing for flexibility, whilst still being able to steer the interview in a productive fashion (Babbie & Mouton, 2001). This has utility for this research as the transcripts will not be filled with lots of extraneous data.

Semi-structured interviews were conducted with each participant (see Appendix A for interview schedule), and recorded digitally. The interview allowed for a deeper understanding of carbohydrate addiction and the potential influence that HELP had on each individual. It also provided them with the opportunity to reflect upon their process in treatment.

Data analysis

Data was analysed by means of a thematic analysis. Thematic analysis is a mode of data analysis that is used to identify patterns and themes within a data set (Braun & Clarke, 2006). Themes and sub-themes are repetitive ideas or topics that are found within the data (Bryman, 2012). An advantage of thematic analysis is that it is flexible both theoretically and in its application (Braun & Clarke, 2006; Bryman, 2012). It allows for a range of epistemological approaches and is well suited to the interpretivist framework being used. In addition, its flexibility allows for the choice and distinction of making use of an inductive or theoretical thematic analysis. The former is inductive in nature, while the latter is a top-down approach and makes use of theory consulted before data collection (Braun & Clarke, 2006). A combination of these two types of thematic analysis has been used in this research as the use of the transdiagnostic model's maintaining mechanisms of eating disorders are central to the data collected and the analysis thereof. However, it was equally as important to approach data from an inductive perspective and allow for themes to emerge naturally from the data.

The process of analysing data by means of thematic analysis follows various phases (Braun & Clarke, 2006; Bryman, 2012; Wilson & Maclean, 2011). The first step in analysing the data was transcribing the interviews and becoming familiar with the content. After transcription was complete the transcripts were read multiple times to identify emerging themes. Next, these themes and subsequent sub-themes were named and defined. At this stage the themes were not final as the second researcher, my supervisor, was consulted regarding the emergent themes and sub-themes. Various unclear themes or sub-themes identified by the second researcher were discussed and redefined. Once themes had been agreed upon, the themes were reviewed. This was done through the construction of a thematic map: a diagrammatic depiction of the relationships between themes. This helped to ensure that the

themes were congruent with the extracts of the data that had been coded. The final phase of thematic analysis lies in the production of the final report. Appropriate extracts from the data were chosen in order to bolster the final analysis and argument constructed.

Ethical considerations

Conforming to ethical guidelines is vital in the process of conducting research. Such conformity aids in preserving participants' welfare; and following prescribed ethics facilitates a focus on upholding one's responsibilities as a researcher (Wassenaar, 2006; Wilson & Maclean, 2011).

This research had no risks of physical harm. The possibility of incurring psychological harm was mitigated through a number of means: participants were ensured that information conveyed would remain confidential and that names and identifying features would not be present in the reporting of findings. The sensitive nature of the topics which were discussed and the stigma attached to mental health issues made it vital to ensure confidentiality. Participants were fully briefed on the possible psychological discomfort of talking about sensitive issues. Participation was strictly voluntary, allowing for participants to maintain their autonomy. Informed consent was obtained to ensure that participants were fully aware of both possible risks and benefits, and their rights as a participant to withdraw from the study at any time (see Appendixes B and C). All participants were given a referral sheet with the contact details of various support services should they become distressed after the interview (see Appendix D)

Results and Discussion

Five main themes emerged from the data. These emerged themes can be understood and defined in relation to the transdiagnostic model's five maintaining mechanisms. This model provides a theoretical framework for understanding the functioning and maintenance of eating disorders. The table below summarises the emerged themes and sub-themes.

THEMES	1) <i>Over-evaluation of weight and shape</i>	2) <i>Core low self-esteem</i>	3) <i>Interpersonal difficulties</i>	4) <i>Clinical Perfectionism</i>	5) <i>Mood Intolerance</i>

SUB-THEMES	a) All-or-nothing thinking	a) Lack of self-love	a) Co-dependency	a) Unrealistic standards	a) Uncomfortable emotions
	b) Acceptance	b) Inadequacy	b) Selflessness	b) Prioritising perfectionism	b) Mood management
		c) Low self-efficacy	c) Needs	c) Rigidity	c) Coping
		d) Balanced self-appraisal	d) Social support	d) Flexibility	
				e) Self-acceptance	

Figure 1

Theme 1: Over-evaluation of weight and shape

The *over-evaluation of weight and shape* refers to the excessive and unwarranted influence of body weight or shape on self-evaluation (American Psychiatric Association, 2000). While this is not reflected in the diagnostic criteria of Binge Eating Disorder (BED) in DSM V, it is suggested that this is a present feature in BED (Grilo et al., 2008; Masheb & Grilo, 2000). Fairburn et al (2003) concur in their adoption of a trans-diagnostic view of eating disorders, citing the over-evaluation of weight and shape as the core psychopathology of all eating disorders.

“I always tell myself when I’m thin or when I lose the weight, my life will be organised. If I lose the weight everything will be so much better, my job will be going fantastic, my boyfriend and I will be fine, my mom and I will sort our nonsense out – and it never happens.” –Ella

“I was getting distressed with my weight; I was going on diets, I was running or gyming or doing whatever I thought I could...and then I started hating myself, and then I started isolating, not wanting to go out; certainly never buying any clothes again because G-d forbid I should buy a size 14. –Caroline

The undue influence given to weight and shape is exacerbated and maintained through an obsession with these factors. The assumption of ideal weight being the criterion for positive emotions results in the weight and shape of the individual being the site of control. This control happens through obsession. Anxiety is at the centre of this obsession. Waller (2008) argues for a trans-transdiagnostic model of eating disorders with all individuals with eating disorders possessing the attributes identified in the transdiagnostic model, but falling under the category of anxiety disorders.

Participants saw weight as being an all-important aspect in their lives. It emerged that there was an equal distress over being and feeling fat, and an expressed desire to be skinny. Weight loss was heralded as a pre-requisite for various domains of life to be functional; compounded by a belief that one could not experience happiness if weight was above a certain threshold. This can be understood in the context of thin-ideal internalisation, concerning the degree to which one accepts and adopts the Western, sociocultural model of attractiveness being equivalent to being thin (Dittmar, Halliwell, & Stirling, 2009). If internalised an individual typically engages in behaviours to abide by the societal ideal as a proxy for attaining happiness and social acceptance (Boone, Soenens, & Braet, 2011; Thompson & Stice, 2001). Both Ella and Caroline describe this process, Ella remarks that weight loss will ‘magically’ improve her work environment and interpersonal relationships, while Caroline describes her self-worth and interpersonal involvement being contingent on her weight.

Sub-theme A: All-or-nothing thinking

Participants spoke about ‘messing up’ their food intake and then needing to have a ‘fresh start’ of acting correctly. This conveys a need to rigidly control their self-perceptions so that they remain perfect. The time between the rule violation and starting over is constructed as a moratorium of all eating rules. Both Daisy and Ella speak about the sense of ruining their food intake, followed by subsequent suspension of previously rigid ‘rules’

“There was that I’m going to start again on Monday and until Monday I am going to have pizza” –Daisy.

“[If I had] something bad and then [sic] be upset with myself because I’ve eaten a bag or I’ve really messed up the diet, why don’t I just carry on?” –Ella.

Nolen-Hoeksema (2005) describes this process aptly, suggesting that abstinence-violation effect explains this phenomenon. If the abstinence from food as prescribed in your diet has been violated then extreme guilt will ensue. The lack of control experienced has a demoralising effect on the individual. Subsequent *all-or-nothing thinking* results in bingeing. The lack of a perceived middle ground creates a false dichotomy between bingeing and restricting. The graphic below summarises the links between the *over-evaluation of weight and shape*, and other maintaining mechanism identified.

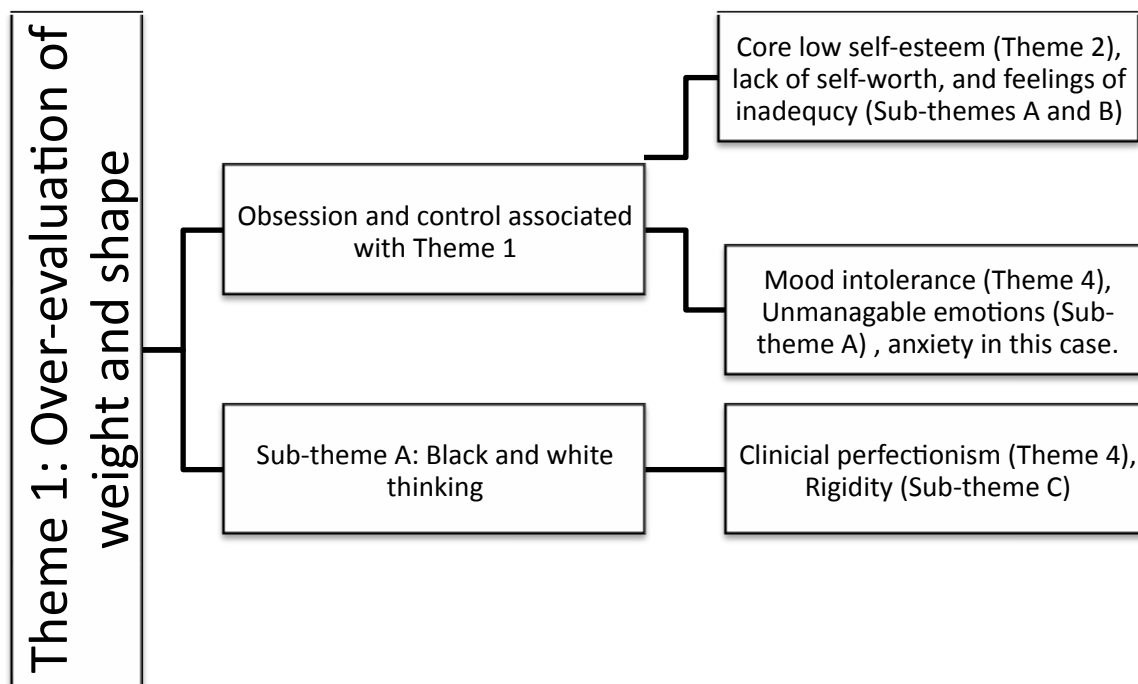


Figure 2

The obsession and distress participants feel about being overweight or obese has been regarded as a manifestation of the eating disorder's core psychopathology. What is not considered is that this expression of distress, with factors such as *core low self-esteem*, is not actually pathological, but perhaps a very human response to being situated in a society that is unwelcoming of larger women. There is the double bind whereby women are encouraged to love themselves despite their weight or shape, whilst concurrently women who are overweight or obese are shamed into weight loss (Saguy, 2011). This poses a dynamic situation when dealing with the health risks associated with obesity.

Sub-theme B: Acceptance

“Before if I didn't look like a certain way then I couldn't be feeling fine. So it's this whole shift around feel fine first and then you will look fine, rather than try and look fine but you haven't fixed the feelings part.” – Athena

Participants demonstrated an understanding that weight and shape were not prerequisites for the experience of general satisfaction and positive emotions. This theme was much more apparent in participants' perceptions related to the period after completion of the HELP intervention. Athena speaks clearly about the change in thoughts and feelings

experienced three months post treatment completion. Self-reports of lack of *over-evaluation of shape and weight* only three months after treatment should not however be mistaken for a full recovery. While recovery from an eating disorder has traditionally been identified by a reduction of symptoms, this is becoming a less subscribed to view (Noordenbos, 2013). A decrease in symptomology does not necessarily coincide with the resolution of underlying factors, such as personal trauma. Eating disorders are typically complex and chronic, with high rates of relapse. Recovery is often equally as complex and takes much time and patience to maintain (Sonnenklar, 2011).

Theme 2: Core Low Self-Esteem. *Core low self-esteem* is characterised by a persistent and pervasive negative view of the self. This negative appraisal of the self is unwavering and a stable part of the individual's identity (Fairburn et al., 2003). Self-esteem is conceptualised in various ways. Some theorists postulate that it comprises of self-efficacy and self-worth (Franks & Marolla, 1978). Tafarodi and Swann (1995) have a similar understanding of self-esteem, but use the term 'self-liking' instead of self-worth, and emphasise that this not only based on subjective acceptance but social acceptance too. From the data three sub-themes of *core low self-esteem* emerged.

Sub-theme A: Lack of self-love

"I didn't like myself, I hated myself, everything ... I was always upset with myself about something. I was always disgusted or disappointed in myself." –Ella

Ella's feelings of hatred and worthlessness towards herself are not limited to being related to a single area, such as having negative appraisals about one's weight and shape, but are unconditional and stable schemas (Fairburn, et al., 2003).

Sub-theme B: Inadequacy.

I never thought I was good enough, you know. But, I mean, I was. I was – you know, looking back on it I had all the credentials because that's what he fell in love with...you're just fighting this whole battle trying to prove that I'm good enough for him and his family" –Bianca

Bianca reflects on her relationship with her ex-partner; she doubts her adequacy as a partner and sees herself only as worthy because of her 'credentials'. In addition to not feeling good enough for herself, she feels the pressure to show her ex-partner and his family that she

is worthy. While it may appear that the first two sub-themes are both encompassed in Franks and Marolla's (1978) category of self-worth, it is contended that this is not the case here due to the way in which the sub-themes emerged. A *lack of self-love* differs from *inadequacy*. A *lack of self-love* speaks to a seemingly inherent and persistent dislike of one's self, while *inadequacy* revolves around not feeling 'good enough' in terms of one's own self and actions, with an emphasis on worries of social acceptance. *Lack of self-love* does not present with this feature and is conceptualised as an intrapersonal factor, *inadequacy* has the added interpersonal dimension. The interaction between *inadequacy* and other themes is conveyed graphically, below.

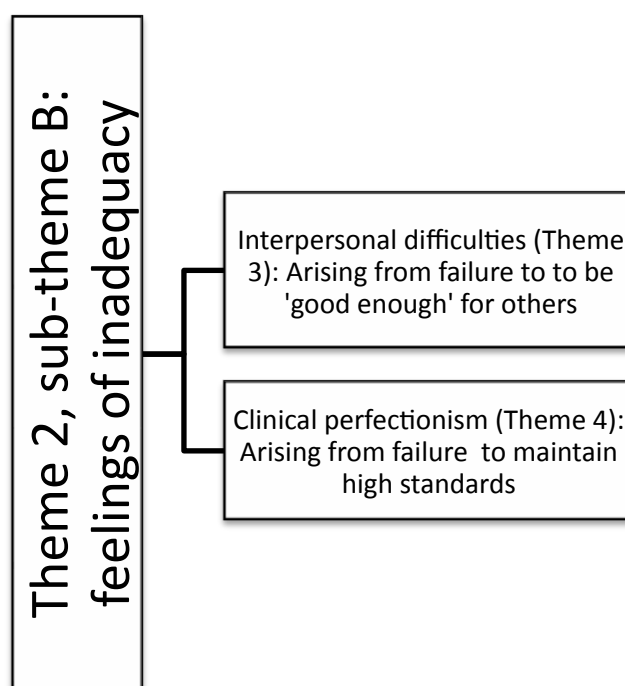


Figure 3:

Sub-theme C: Low Self efficacy

Low self-efficacy, as defined by Bandura (1977) is the lack of belief in one's ability to be successful in in certain situations.

“I was starting to feel quite a despair and wondered if I would ever be able to do it; to keep the weight off... before then (treatment) I did attempt to do the low carb diet and I was a complete disaster at it. I'd stick to it for a week and then I wouldn't.” –Fiona

Low self-esteem and *low self-efficacy* are two constructs that commonly have a reciprocal relationship. This is illustrated above in the excerpt where Fiona doubts her ability to maintain weight-loss and subsequently is not efficacious in her endeavour to adhere to the diet. In this regard, self-efficacy is often linked to future behaviour. The theory of planned behaviour (TPB) demonstrates how a low perception of behavioural control can undermine the intentions of behaving in a certain way (Ajzen, 1991). Behavioural intentions based on subjective norms and attitudes towards behaviour, predict behaviour. However, this process can be short-circuited if there is low perceived control over behaviour. (Pickett et al., 2012). Participants reported the perceived inability to control bingeing behaviour and adhere to healthy eating regimes. This is congruent with the TPB model. Self-efficacy and a low perception of behavioural control thus can actively undermine change in eating disordered behaviour and will therefore maintain the eating disorder.

Sub-theme D: Balanced self-appraisal

“There have been patches where I have felt better about myself and there have been patches where I haven’t felt as good. But I generally feel that there is an overall improvement in how I feel as opposed to a sense of unhappiness” –Gina

What is described by Gina is a more balanced and nuanced appraisal of herself. This theme was particularly identifiable when participants spoke about their experiences of self after having completed the HELP programme. *Low self-efficacy* and low self-esteem have been identified as prognostic features of eating disorders, indicating poorer outcomes of treatment (Bardone-Cohen et al., 2010). This is connected to *core low self-esteem* being a challenge to any change. It often manifests in feelings of hopelessness with regard to the ability to change (Fairburn et al., 2003). This combined with *core low self-esteem* being a stable and constant part of one’s identity; it would be unusual for participants to report a drastic changes in a short period of time.

Theme 3: Interpersonal Difficulties

Interpersonal difficulties vary in their presentations. Current interpersonal difficulties are known to precede binge episodes, while long standing interpersonal difficulties often have the effect of decreased self-esteem. In turn this may result in individuals trying to attain goals such as controlling weight, shape and eating (Fairburn et al., 2003).

Sub-theme A: Co-dependency

Co-dependency broadly refers to an incapability to sustain functional relationships (Co-Dependents Anonymous, 1988). Co-dependent people will typically allow another's behaviour impact and influence their life disproportionately, and will thus desperately attempt to control others' behaviour (Beattie, 1987). Some of the main components of *co-dependency* include enmeshment, compliance and control.

“The level of unhealthy relationships I was in, and abusive relationships I was in progressed. There was very much an enmeshment. I would lose my sense of self and find it very difficult to see the boundaries between you and I; what’s your stuff and what’s my stuff. My whole life would basically be consumed by this person; it would be all about this person. So I would fix my loss of self-love, loss of acceptance, low self-esteem, and insecurities through another person.” –Hannah

Hannah talks about having an enmeshed relationship with weak boundaries, being absorbed in the relationship to the extent that she loses sight of her own self-concept. Enmeshment occurs when emotional boundaries are not successfully established. It refers to a pattern of behaviour where psychological fusion between individuals is so strong that it hampers an individual's development and sense of self (Barber & Beuhler, 1996). Low self-esteem resulting from a weak sense of self serves to entrench a co-dependent way of relating and cements the need to engage in eating disordered behaviour.

Hannah's co-dependent relationship is primarily characterised by complicit behaviour and by using the other person as a yard stick for how she should feel or act at any given time (Morgan, 1991). Control also emerged as a co-dependent, *interpersonal difficulties*. Often control is a primary feature, as one person attempts to control another's behaviours. This often stems from a need to be needed in relationships, paired with the belief that other people are not able to look after themselves (Co-dependents Anonymous, 2010).

“With my boyfriend it’s the control problems. Because the control issue goes from your food to the relationships, your work to everything...I tend to act like his mother. And we end up having this huge fight about everything, because I want to be in control of everything.” –Ella

Control is a cognitive construct that is commonly observed in individuals with eating disorders. It is connected to a failure to self-regulate anxiety; thus experiencing a feeling of

control over an anxiety-inducing threat results in increased self-efficacy, and dissipated anxiety (Sassaroli, Gallucci & Ruggiero, 2008). Ella explains that her difficulty in relinquishing control has adverse effects on her relationship with her partner. Attempts to control another person's behaviour illustrate that the control surrounding food, weight and shape extends to interpersonal relationships too. This demonstrates how the core psychopathology of eating disorders interacts and is maintained through other facets (Fairburn et al., 2003). In this context the need for control can be understood as reactionary to a perceived lack of intrapersonal control, and thus as the driving force and motivation for engaging in behaviour to regulate unmanageable cognitions and emotions (Fairburn et al., 1999).

When failing to control another person successfully (inter-active control), an individual may turn to another domain upon which to exert control. This can manifest in more stringent control regarding one's own food intake and weight (intra-active control), or even through *clinical perfectionism*. Alternatively, the low levels of control associated with bingeing behaviour may result in the compensation through intense control within relationships (Jarman, Smith, & Walsh, 1997). Any of these variations function in a way that sustains the eating disorder.

Sub-theme B: Selflessness

Being selfless entails side-lining one's own needs in order to ensure that the needs of others are met (Bachner-Melman, Zohar, Ebstein, & Bachar, 2007). This can take the form ignoring one's needs altogether (seen through a restriction or overconsumption of food); going out of one's way to ensure the happiness of others to the detriment of one's own: people pleasing. *Selflessness* can have different functions in the context of the eating disorder. *Selflessness* through restrictive self-expression may manifest in order to secure interpersonal relationships. Alternatively, it has been suggested that eating disordered individuals serve the needs of others before their own due to an inability to conceive that their own needs are worthy; and the belief that others are not able to attend to their own needs (Bachar, Gur, Canetti, Berry, & Stein, 2010) thereby making them hopefully indispensable. Herein lies a link between the maintaining mechanisms of *interpersonal difficulties* and *core low self-esteem*. Within eating disordered women a significant negative correlation has been found between *selflessness* and self-esteem (Bachner-Melman et al., 2007).

“[On being a people pleaser] I think it’s because of that responsibility I took on a little girl to keep my parents happy. I was a good girl, I didn’t do any rebellious things, and I kept my curfews. I just didn’t do anything because I felt responsible for keeping my family together.” –Daisy

Many participants attribute their *selflessness* to feeling over-responsible as a child. Daisy talks about how she was always a ‘good girl’ in hopes of being able to exert control over the functioning of her family. This illustrates the view that selflessness acts in a way to secure interpersonal relationships. Controlling one’s self in order to control others represents a fusion of intra and inter-active controlling behaviours. The need to follow rules explicitly and maintain an image of being a ‘good girl’, or the ‘perfect girl’ as Martin (2007) calls it, has its connection to the maintaining mechanism of *clinical perfectionism*

Selflessness and striving for personal perfection function concurrently. Martin (2007) asserts that perfect girls “carry the old world of guilt –centre of families, keeper of relationships, care-taker of friends –with the new world of control/ambition –rich, independent and powerful” (p. 18). At the centre lies the need for and then subsequent rigid control over myriad domains to be maintained. The flowchart below illustrates the dynamic roles of *selflessness* and control.

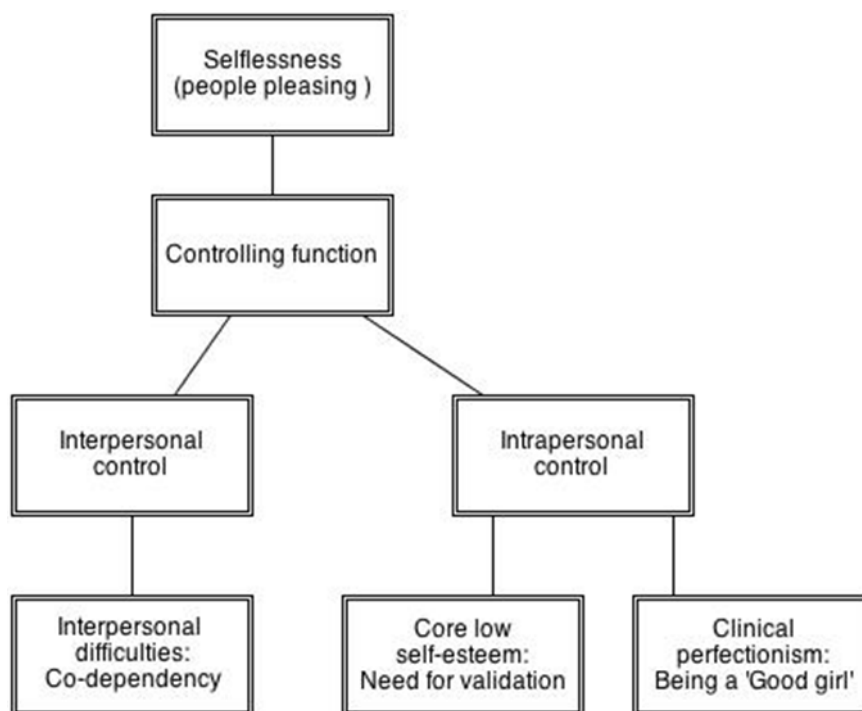


Figure 4

Sub-theme C: Needs

Needs is defined as the recognition of one's own needs. In this context the needs focused upon are Maslow's (1943) lower order need of love/belonging, and the higher order need of esteem.

“I don't moan about it; I just take it all on ...but then I am resentful. And now, after the (trauma) weekend (for HELP), I realise that I can take care of myself first. So if my mother needs to go to the doctor, I can go to gym and come back, and take her to the doctor. Whereas before, if I had something to do, I'd cancel that and then sort her out. And I was cross. Whereas now I'm putting me first.” -Daisy

Daisy describes being able now balance her needs and the needs of others with the absence of guilt. There appears to be a greater understanding of her own needs as worthy and that attending to the needs of others does not have to be at the expense of herself. This theme emerged in the context of participants talking about their experiences after having completed the HELP programme. Gaining autonomy is an important factor in the recovery of an eating disorder. This includes being able to voice and express one's own thoughts and feelings rebuilding interpersonal relationships in an adaptive, healthy way (Vanderlinden, Buis, Pieters, & Probst, 2007).

Sub-theme D: Social support

Social support comprises of various dimensions: emotional, appraisal, instrumental and informational (Langford, Bowsher, Maloney, & Lillis, 1997). It can have a direct impact on mental health, but can also buffer the potential stressors facing an individual (Stansfeld, Fuhrer, & Shipley, 1998). Low perceived social support and a low quality of interpersonal relationships are highly predictive of binge eating (Grisset & Norvell, 1992; Stice, Presnell, & Spangler, 2002). As such, increased actual or perceived social support can help sustain recovery from an eating disorder. However, there are negative aspects of social support as it can be unhelpful if the quality of support is perceived to be inadequate (Stansfeld et al., 1998).

“As a group have decided to continue, we meet every Tuesday night. And we're starting to follow the 12 step programme as it relates to eating... we've stuck together and it sustains you after the programme...I mean just this morning one of the girls was having a hard time, so she SMSs and then a few girls phone her, so there is a huge support.” -Caroline

This does not seem to be the case here as the social support is deemed sufficient and helpful, and is varied in its dimensions. None of the participants described having meaningful social support when they described their experiences prior to completion of treatment, only after treatment had been completed. For those who struggle to maintain healthy interpersonal relationships it can be difficult to garner meaningful social support from those around them. Above, Caroline notes that continued support after out-patient treatment is beneficial as it instils a sense of community. Increased social capabilities, including making social contacts and being less isolated are important aspects of recovery and are correlated with a decrease in eating disorder symptomology (Noordenbos, 2011).

Theme 4: Clinical Perfection. Fairburn, et al (2003, p.515) define *clinical perfection* as the “over-evaluation of the striving for, and achievement of, personally demanding standards, despite adverse consequences.” Conceived as an over-evaluating system, *clinical perfection* is similar to the *over-evaluation of weight and shape* (Fairburn et al., 2003). In some instances clinical perfectionism only manifests in terms of one’s appearance (*over-evaluation of weight and shape*). It is not crucial that there is *clinical perfectionism* in multiple spheres of life (Shafran et al, 2003), but this often does occur. Sub-themes that emerged speak to *clinical perfectionism* in domains other than weight and shape. Mostly what emerged was a tendency of *clinical perfectionism* to manifest within the work-environment.

Sub-theme A: Unrealistic standards

‘I should know better and I should be able to do it...you’ve got to live up to a higher standard than everybody else.’—Ella

Participants report having personal ‘rules’ for achievement that they would not impose on others. This indicates that the perfectionistic ideals are not global, but are an intra-personal factor. The pressure Ella feels to be better than others is not socially prescribed but is internally motivated. This is referred to a self-imposed perfectionism and is known predictor of eating disorders (Castro-Fornieles et al., 2007). Martin (2007) argues that women’s desire to be perfect is the unintended result of feminism. After second wave feminism, many more women had joined the work-force. However despite notions of shared parenting responsibilities women still largely remained in charge of parenting and domestic matters. With this extra burden women went into overdrive, into ‘superwoman-mode’. With historical discourses of women not being able to achieve as men could, doing everything was not enough. Everything had to be done perfectly in a way that appeared effortless. This ‘effortless

perfectionism' became the new standard of being a woman, and this message has been passed down from the preceding generations (Martin, 2007).

Sub-theme B: Prioritising perfectionism

Congruent with Fairburn, et al's (2003) definition of clinical perfectionism, there are adverse consequences that result from clinical perfectionism. What emerged was that participants constructed being perfect as so important that they would be willing to sacrifice their own desires to uphold the 'perfect' image.

“I would stay in work that was not really meaningful for me because I had to uphold that successful professional image” –Athena

Athena, a management consultant would rather be unfulfilled in her employment than risk being seen as unsuccessful. The possibility of the threat of being judged by one's self or others is enough to ignore one's own needs and desires. Striving for perfection, present in individuals with high levels of selflessness, is then linked to the inability to put one's own needs first.

Sub-theme C: Rigidity

Rigidity is a crucial part of clinical perfectionism. Rigidity occurs through refusing to let go of maladaptive ways of behaving and refusing to adopt better styles of performance (Egan, Piek, Dyck & Rees, 2007).

“I was very tough on myself around things like, things had to be done in a certain way at a certain time. Like career, for example. I had to be successful professionally, I had to be in demand from a client perspective.” –Athena

As a concept rigidity is not only linked to eating disorders, but to the perfectionism associated with obsessive compulsive personality disorder (OCPD). The need to ensure the rigidity of behaviour is linked to control. Rigidity often manifests in the strict adherence to self-imposed goals and standards. This can be in terms of rigid control of food and weight, or in other areas (Shafran & Mansell, 2001), such as occupationally as Athena describes above. She states that her goals must be achieved in a very rigid, specific way. The *rigidity* creates a feeling of increased control over the achievement of high standards. Conversely, if goals are not met, feelings of inadequacy may arise due to the importance placed on succeeding. Control is a common link between sub-themes A, B and C. This is represented visually, below.

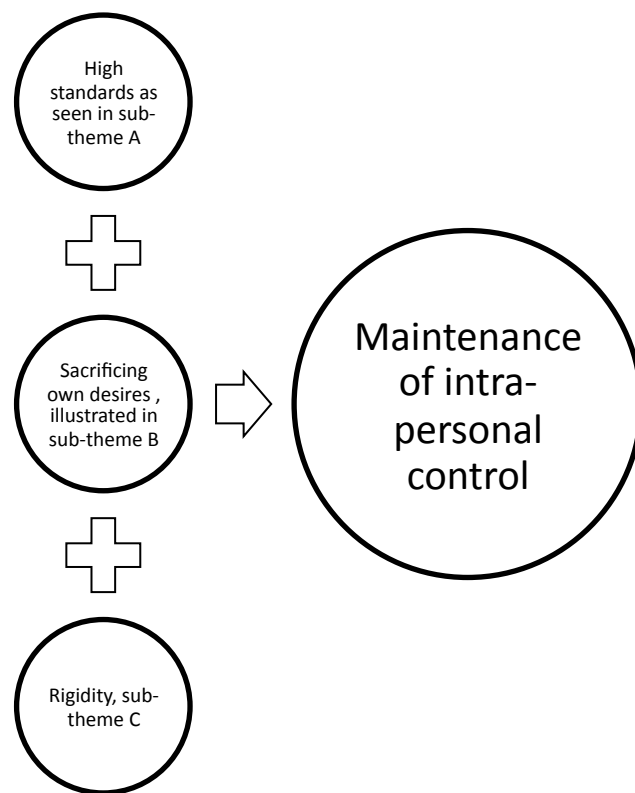


Figure 5

Sub-theme D: Flexibility

“I’ve been less rigid about ‘Well, it’s got to work this way’ and ‘I’ve got to be the perfect parent, because everything had to be perfect in the past’ ; now I’m like things don’t have to be perfect, things can be just the way they are.” –Athena

Participants expressed a decrease in rigid thoughts and behaviour and describe themselves as being ‘softer’ and ‘less hard’ after completion of the outpatient treatment. Shifting from rigidity to flexibility appeared exclusively after treatment completion. Typically

in recovery from eating disorder perfectionism does decrease over time. However, it still remains elevated compared to healthy controls (Bardone-Cone, Sturm, Lawson, Robinson, & Smith, 2010).

Sub-theme E: Self-acceptance

“I realised I don’t have to compete with myself; and also just acknowledged myself because I do a lot of things right. I always feel like I should do more with my sons at school. But now, when the teacher says ‘You can’t do more.’ I believe it. Whereas before, I’d still go on and think it’s me.” –Daisy

Participants described a shift in their perceptions of themselves as imperfect human beings. There was a decrease in the over-evaluation of the self, based on maintaining self-imposed standards. It is interesting to note that the ways in which sub-themes D and E emerged was within an interpersonal and family-oriented domain. While perfectionistic tendencies were almost exclusively related to the relationship with food or within the work environment, shifts were not identified in these domains. Perhaps the most salient shifts had been related to the family, or perhaps this points to a lack of change in occupation-based perfectionism as this appears to be a very entrenched pattern of operating.

Theme 5: Mood intolerance.

Sub-theme A: Uncomfortable emotions

Many emotions emerged as unbearably uncomfortable, resulting in intolerable levels of distress. These included anger, sadness, frustration, exhaustion, loneliness and anxiety. Both anger and anxiety will be examined more closely.

I don’t express it at all [anger]. I have only ever had one shouting match with one person in my life. It was lovely, it was liberating and I just screamed at the person at the top of my voice. I’d never done that.” –Fiona

Suppressed anger is linked with perfectionism. It is suggested that this relationship could be moderated by gender, with women being more affected by this (Arugueté, Edman & Yates, 2012). It is thus not a surprise that eating disordered women tend to score higher on anger-inhibition scores than non-eating disordered women (Zaitsoff, Geller, & Srikameswaran, 2002). Fiona talks about only ever expressing anger outwardly on one occasion. It is argued that through socialisation girls are taught that anger should not be

expressed; the expression of anger is seen as something that can threaten interpersonal relationships (Cox, Stabb, & Hulgus, 2000). This threat makes anger a mood that is challenging for some women to tolerate. The concern over ensuring the continuance of interpersonal relationships through the inhibition of one's own feelings and needs here is similar to that observed in the function selflessness plays in maintaining eater disorder psychopathology.

Participants also highlighted anxiety as a prevalent mood that was difficult to tolerate. Gina describes eating food as a way to control and decrease the feelings of anxiety.

“Stress, anger, anxiety are probably the big triggers. So situations where you’ve been placed in some form of stress and you have not, in that situation been able to negotiate an outcome that is of benefit to you because just some situations are like that, and then finding comfort or being anesthetised by eating and just shutting those things down.” –Gina

It is not altogether surprising that anxiety emerged as unmanageable emotion as anxiety at the heart of the obsession of weight and shape plays a role in maintaining eating disorders. The idea of eating disorders being classified as an anxiety disorder (Waller, 2008) may suggest that while mood intolerance facilitates that maintenance of eating disorders, the core psychopathology of an eating disorder relates to the regulation of anxiety.

Sub-theme B: Mood management

With the above moods being difficult to tolerate, four coping mechanisms used to mitigate these feelings emerged: Binging, smoking, overworking and isolating. As the most cited method of dealing with challenging moods, binging will be expanded upon. In addition, cross-addiction between maladaptive coping mechanisms will be discussed.

Binging: The experience of negative mood-states is seen as the primary precipitating factor in binge eating. The binge-eating episode is often negatively reinforced as it reduces the intensity of the unmanageable emotions (Whiteside et al., 2007).

“I wear my heart on my sleeve so if I’m upset, you know if I’m upset. And then food was my comfort, it was the one thing...I might not have been able to control the situation but the food was one thing I could control...You would eat and consume whatever it was, pies, chocolates, sweets, and then you’d be upset with yourself because you’d done it, and then you would do it more because that’s your comfort.” –Ella

Moderating unmanageable emotions essentially leads to the emergence of more unmanageable emotions; thus creating a self-perpetuating cycle of coping. Below is a graphic that demonstrates the roles of mood intolerance and control in relation to destructive behaviour.

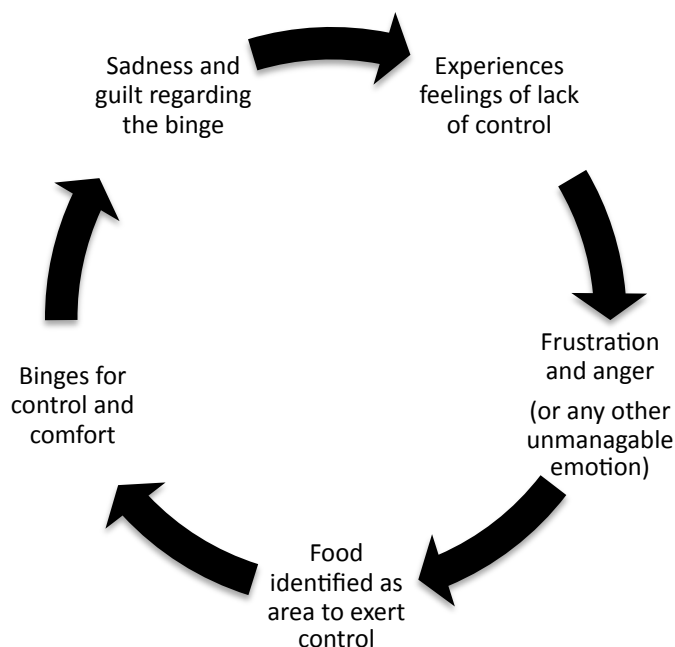


Figure 6

Cross-addiction: Symptom substitution through cross-addiction typically emerges when healthy coping mechanisms have not been integrated or when underlying personal trauma has not been sufficiently resolved. Individuals with BED tend to have fewer strategies and skills to regulate emotion in a healthy way. As a result some may engage in more maladaptive behaviour in order to cope with unmanageable feelings (Whiteside et al., 2007). Other unhealthy coping mechanisms may arise to either supplement or replace the eating disordered behaviour.

“I will cross-addict from food to work to exercise; all those cross coping mechanisms... I exercise and I’m an exercise maniac. And that’s a cross addiction of mine, I run so that I can eat more. So they are interlinked.” –Gina

Gina explains the dynamic relationship between her unhealthy methods of mood tolerance: over-eating, over-working and over-exercising. The overworking has its roots in clinical perfectionism which often serves to decrease the anxiety regarding the over-evaluation of weight and shape. Conversely, over-eating and over-exercise feed off and

maintain each other, but both function in the same way as the over-working does to quell the anxiety.

Sub-theme C: Coping

“I realise now that I used to eat on it [unmanageable feelings], and now I just sit with [it]. I may go off on my own and just spend 20 minutes meditating or something. Or if we’re at a function or something, I just sit with it and let it be there.” –Caroline

After treatment completion participants report having more skills for tolerating distress than they did before. Before, there was an inability to endure uncomfortable emotions and reactionary behaviour resulting in short-term dissipation of emotions was employed. This improved coping has resulted in a decrease in eating disordered behaviour.

Reflexive analysis

“Reflexivity galvanises discourse precisely because it expresses the silence within us.” (Nazarak, 2011, p. 81).

With the sample comprising of women much older than myself, it is possible that due to the age difference there was some reticence to divulge personal information compounded by an inverse of power based on having a much younger person conduct the interviews. While I did not feel that older members of the sample were explicitly cagey, I did notice that the younger participants were considerably more comfortable in talking about their personal experiences. This difference could have been linked to me being a twenty-two year old student, but may also be accounted for by generational differences and linked beliefs around self-revelation. After suspecting this I did at times begin to feel unsure of my own ability to conduct successful interviews. It is possible that this tangible insecurity lead to further reticence from participants.

The majority of the sample was comprised of women who are in high-powered and prestigious occupational positions. Being an interviewer constitutively gives one more power than the interviewee who is asked to be vulnerable and talk about personal matters. It is possible that being questioned by a young interviewer, with only one academic degree, may have been unsettling for some participants. Most of the interviews were conducted in seminar rooms in the psychology department at the University of Cape Town to ensure a neutral meeting spot that had definite privacy and minimal noise. However, two of the eight

participants insisted on being interviewed in their own homes as they expressed feeling more comfortable in doing so. This may have been an attempt to level the power relations of the interviewer/interviewee relationship by having the interview take place on 'home ground'.

Adopting the transdiagnostic model as a specific lens of focus may also have caused bias in the reporting and understanding of the results. With a firm theoretical framework it is often difficult to detach completely from the theory. Perhaps if the study was purely inductive in nature, the data could have been interpreted differently.

Limitations and suggestions for future research

Part of the data was contingent on retrospective self-reports due to a one time interview. It would have been preferable to interview participants twice, once before entering and once after completing treatment. This design was originally intended, but was subject to change due to time constraints and a decrease in clients during the specific block intake that would have been used for sampling. Baseline interviews may have allowed for greater insight into potential shifts in the maintaining mechanisms. In addition, all, but one participant had only completed treatment three months prior to being interviewed. This has possible implications for the stability of shifts that emerged. Three months is not a very long period of time, so any apparent shifts must be interpreted tentatively. The sample comprised mainly of white women; this could have influenced results due to culture. Future research is encouraged to obtain a sample that is more ethnically representative of South Africa.

There are extraneous variables that could have possibly influenced the results, such as additional individual therapy. It is also possible that shifts in experience, perception or mood may be due to a placebo effect. The small sample size of eight women is not sufficient for generalisation. While this is a possible limitation it was never intended that these results be generalizable: this was an exploratory qualitative study. Due to the paucity of research into treatment for 'carbohydrate addiction', it is recommended that larger scale, as well as longitudinal quantitative studies be conducted to investigate treatment effectiveness and qualitative outcomes in future.

Conclusion

Sub-themes, relevant to each of the maintaining mechanism, were expanded upon for a more detailed analysis of their manifestation and functionality; this is not explicit within the literature. The maintaining mechanisms were found to be interlinked in numerous ways. Some

apparent shifts were experienced by participants after completion of treatment. However, these shifts do not imply recovery from an eating disorder. Based on the results it can be argued that the HELP outpatient programme may have had some positive influence on individuals' distress and dysfunction. The transdiagnostic model could therefore be useful in providing a framework for treatment; as this study provides further information about the explicit content of the categories within that framework, and how individuals may experience these identified perpetuating factors throughout treatment.

There is not much information regarding effective treatment for the proposed category of 'carbohydrate addiction'. Information acquired from participants' interviews yields insight into the nature of 'carbohydrate addiction' and how it may be better understood within an eating disorder framework. This could assist those managing the HELP programme to recognise needed adjustments to the programme, and thus enable them to create a better tailored and more effective treatment programme for future clients. Replication of this programme by professional colleagues could lead to enhanced treatment for those struggling with obesity linked to BED or EDNOS and its comorbid diseases.

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Appendix A

Information form

Invitation and purpose

My name is Francesca Favero and I am an Honours student from the department of psychology at the University of Cape Town. You are invited to participate in a research study which aims to explore the potential influence of HELP.

Study procedure

If you choose to participate in this study you will be interviewed on one occasion. The interview will be approximately 45 minutes. The aim of the interviews is to help me to

understand what brought you to the programme and how, if at all, the programme may have influenced you.

Possible benefits and risks

A benefit of participation is that you will be able to share your experiences. Through this you may find the process personally cathartic and/or rewarding insofar as that you will have a platform to reflect upon any personal changes you may have experienced during the programme. In addition, you may provide helpful information in assessing HELP. This feedback that the organisers would receive will be vital for possible changes to the programme and will provide them with a deeper understanding of the programme's potential impact.

There are no overt risks in participation. You may potentially find talking about certain topics to be distressing. However, you are not obliged to answer any questions with which you may feel uncomfortable. If you experience any distress following the interview please consult the referral sheet for a list of various support services you can consult.

Alternatives

You may choose not to participate in this study. This will not have any effect on any possible future treatment you receive from HELP.

Voluntary participation

Participation in this study is strictly voluntary. You have the right to refuse to answer any questions you do not wish to answer. You may discontinue your participation at any time. This will not have any bearing on your relationship with the organisers of HELP or the treatment you receive during the programme.

Confidentiality

Any information you choose to share will be strictly confidential. The recordings will be deleted from the recording device as soon as they are digitally uploaded to my personal, secure computer. All files will be password protected to ensure your privacy and confidentiality. The

interviews will be recorded with a digital voice recorder and then subsequently transcribed. The only people who will have access to the recordings will be me, my supervisor and possibly a third party transcriptionist who will sign a confidentiality waiver. Your name and any identifying features will not be mentioned in the research report.

Contact details

If you have any questions, queries or concerns, do not hesitate to contact myself, Francesca Favero on 0832844723, or my supervisor, Dr. Despina Learmonth at the Department of Psychology, University of Cape Town (UCT), on 021 6503425. If you would like to speak to the Chair of the Ethic committee about this study you may contact Rosalind Adams on 021 6503417.

Appendix B

Consent form

**Informed consent form
University of Cape Town
Consent to participate in a research study:
How HELP helps: An exploration into the impact of carbohydrate addiction treatment.**

Please initial box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the

information, ask questions, and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.
3. I understand that my confidentiality will be upheld at all times. No personal information, which could be used to identify me, will be used in the writing up or reporting of this research.
4. I agree to take part in the above study.

Participant's name _____ Participant's signature _____

Date _____

Researcher's name _____ Researcher's signature _____

Date _____

Appendix C

Referral list

If you experience any psychological distress after the interview has ended please seek help. In the first instance, contact your counsellor from HELP at Harmony House - **021 790 7779** or **082 703 6629**

Should you be unable to make contact or would like to make use of another appropriate support service, please consult the list below:

12 step fellowship support groups (no charge for service)Narcotics Anonymous (NA):

Follow the link to find a nearby meeting or phone their 24 hour crisis line

http://www.na.org.za/meetings_cape_town.htm or **083 900 6962**

Eating Disorders Anonymous (EDA):

Follow the link to find a nearby meeting or phone Thembi for more information

<http://www.eatingdisordersanonymous.org/meetings.html> or **082 909 3203**

Crisis call centres (no charge for service)

Life line: **0861 322322**

SA Depression and Anxiety Group:

Suicide crisis line: **0800 567 567** or Help line: **(011) 262 6396**

*Appendix D***Interview schedule**

- How did you arrive at the decision to sign up for HELP?
- How do you view yourself?
- How do you imagine other people view you?
- How would you describe your relationship with other people?
- How would you describe your relationship with food?
- How do you generally cope with your emotions?
- What is your desired outcome for treatment; what would recovery look like to you?

