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VAN DER MERWE, L

COMING OUT OF THE PANTRY:

CO-CONSTRUCTING WOMEN'S STORIES

PHD (PSYCHOLOGY) UP 2004

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Coming out of the pantry:

co-constructing women's stories

By

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the requirements for the degree

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Supervisor:

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"The woman's folly is loud; she is undisciplined and without knowledge. She sits at the door of her house, on a seat on the highest point of the city, calling out to those who pass by, who go straight on their way. 'Let all who are simple come in here!' she says to those who lack judgement. **'Stolen water is sweet; food eaten in secret is delicious!'** But little do they know that the dead are there, that her guests are in the depth of the grave."

(Proverbs 9:13 - 18)

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DEDICATION

to

A chorus of excessive food stories

*René Toohey (artist living in Oslo Beach, SA – Tel: 082 365 7948) painted this picture especially for this thesis. The painting is entitled: "Fat Ladies".

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LETTER OF ACKNOWLEDGEMENTS

Dear supporters

I would like to express my appreciation and thanks to you as personal, academic and institutional supporters for assisting me in making this thesis possible:

- Financial support provided by the Centre for Science Development is hereby acknowledged. Opinions expressed or conclusions drawn in this thesis are those of the author and must not necessarily be ascribed to the Centre for Science Development.
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- My Lord for Your healing and wisdom.

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With many thanks

Lieuwkje

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LETTER OF AN ABSTRACT

Dear reader

The study sought to discover various meanings with regards to women's relationships with food in excess. Within a post-modern, social constructionist and narrative therapeutic framework; a narrative inquiry was adopted in order to attain this goal as this is an attempt at the direct description of experience within context and without any consideration for its origins or causes. Within a qualitative framework, the unstructured interview viewed as therapeutic conversations; reflexive diary of researcher-participant and series of drawings were adopted as the methods of choice in order to gather the stories of the participants and research-participant with respect to interpretations of the meaning of described phenomena. The sample comprised five participants and researcher-participant who were all Afrikaans speaking, Christian, female, married with one or two children, ranging in age from 30 to 40. In addition, all subjects at the outset of the study had a bodyweight as defined as obese (≥ 45kg) according to the medical model. They are also within a career setting. On analysis of the data with content analysis as method, several main discoveries were identified including: discourses were described within psychological, environmental and developmental framework, whereas the alternative stories were described primarily within a psychological framework. Furthermore, the psychological aspects of obesity in existing literature comprise mainly self-esteem issues, psychological disturbance, intrapsycic- and interpersonal factors. This study's alternative stories highlighted psychological functioning within the narrative therapeutic context, whereas the implication is that the narrative therapeutic input in this study created more avenues to study psychological functioning of the obese at grass roots level. Therefore, the psychological functioning moved from discourses to alternative stories as discoveries from destructive internalised voices of control to constructive externalised voices of control owned by participants and researcher-participant. Discoveries by using expressive arts further revealed that self-portraits gave a fuller description of an individual's identity at a certain point in time during and after therapy. Co-constructed drawings at the end of the therapeutic process served as reflection upon the process by all parties involved and brought closure to the research process with each individual. Furthermore, these various expressive drawings could be used as examples of narrative documents in future research and as a validation tool for participant's decisions in living preferred narratives as discoveries in this thesis and in their future life. Upon reflection, this thesis reveals an immensely practical application of the post-modern, social constructionist and specifically the narrative therapeutic approach to psychology. This study mainly contributed in two areas: the psychological dimension of alternative stories and the contribution of drawings in the

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qualitative paradigm. In conclusion, the discoveries of this study highlight the necessity for future studies, focussing on psychological functioning, being helpful in deriving fuller and richer descriptions and refining theoretical grounding in ever-growing new fields of research.

Greetings
Co-author and researcher

Key words as postscript:
Post-modern thinking, social constructionism and narrative ways of thinking
Narrative therapy and narrative inquiry
Discourse and alternative story
Psychological, environmental and developmental dimensions of human functioning
Qualitative research methods and reflexivity
Obesity and eating disorders

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OPSOMMENDE BRIEF

Liewe leser

Hierdie studie het ten doel om verskeie betekenisse, in verband met vrouens se verhoudings met kos in oormaat, te ontdek. ‘n Narratiewe ondersoek is binne ‘n post-moderne, sosiaal-konstruksionistiese en narratiewe terapeutiese raamwerk onderneem. Hierdie studie is ‘n beskrywing van belewenisse sonder om die oorsprong of oorsake daarvan in aanmerking te neem. Binne ‘n kwalitatiewe navorsingsraamwerk, is deurtastende ongestruktureerde onderhoude in die vorm van terapeutiese gesprekke, ‘n reflektiewe dagboek van die navorser-deelnemer en ‘n reeks tekeninge gebruik om interpretasies van die betekenis van genoemde verskynsel van deelnemers te bekom. Die steekproef het bestaan uit vyf deelnemers en die navorser-deelnemer. Dié deelnemers is Afrikaans-sprekend, Christen, vroulik, getroud met een of twee kinders en het gewissel tussen die ouderdom van 30 tot 40. Aan die begin van die studie het al die deelnemers ‘n liggaamsgewig gehad van (≥ 45 kg) oorgewig volgens die mediese model, daarbenewens was almal ook beroepsgerig. Tydens die analise van die data, deur middel van inhouds-analise, is verskeie ontdekkings geïdentifiseer, wat die volgende insluit: diskoerse wat beskryf is binne sielkundige, omgewings- en ontwikkelingsdimensies. Alternatiewe stories as ontdekkings is hoofsaaklik beskryf in terme van sielkundige funksionering van oorgewig vroue. Van verdere belang is dat die sielkundige aspekte van obesiteit in bestaande literatuur basies uit selfbeeld, psigologiese versteurings, intra-psigiese en interpersoonlike faktore bestaan. Hierdie studie se alternatiewe stories het die sielkundige funksionering binne die narratiewe terapeutiese konteks uitgelig. Die implikasie hiervan is dat die narratiewe terapeutiese inset in hierdie studie meer geleenthede skep om die sielkundige funksionering van oorgewig persone op ‘n primêre vlak van interpretasie te ondersoek. Die spesifieke fokus is op die deelnemers se sielkundige funksionering waar diskoerse na alternatiewe stories en ‘n destruktiewe, geïnternaliseerde stemme van beheer na konstruktiewe, ge-eksternaliseerde stemme van beheer verskuif. Ontdekkings in die gebruik van tekeninge het verder onthul dat self-portrette ‘n duideliker beskrywing van ‘n individu se identiteit gedurende en na terapeutiese ingrepe weergee. Ko-gekonstrueerde tekeninge aan die einde van die terapeutiese proses dien as ‘n reflektiewe nadenking oor die proses deur alle partye en was van hulp met die terminering van die terapeutiese proses met elke individu. Verder kan die verskeie tekeninge gebruik word as voorbeelde van narratiewe dokumente in toekomstige navorsing en ook as ‘n bevestiging vir die deelnemers se verkose narratiewe ontdekkings gedurende hierdie studie en in hul toekoms. In reflektiewe nadenking, onthul hierdie studie dat die post-moderne, sosiaal-konstruksionistiese en spesifiek die narratiewe terapeutiese benadering tot sielkunde uiters prakties

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toepaslik is. Hierdie studie lewer hoofsaaklik in twee areas bydraes, naamlik: die sielkundige dimensie van alternatiewe stories en die bydrae van tekeninge in die kwalitatiewe paradigma. Ter afsluiting, die ontdekkings van hierdie studie beklemtoon die noodsaaklikheid van verdere navorsing wat fokus spesifiek op sielkundige funksionering van oorgewig vroue. Dit sal dan juis lei tot 'n deegliker en meer omvattende beskrywing van teoretiese begrondingstellings wat weer nuwe navorsingsterreine ontsluit.

Groete
Mede-outeur en navorser

Sleutelwoorde as naskrif:
Post-moderne paradigma, sosiale konstruksionisme en narratiewe denkwyses
Narratiewe terapie en narratiewe ondersoek
Diskoers en alternatiewe storie
Sielkundige-, omgewings- en ontwikkelingsdimensies van menslike funksionering
Kwalitatiewe navorsingsmetodes en refleksiwiteit
Obesiteit en eetversteurings

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I - Letter of invitation

A celebration feast of women

Dear reader

Letters can be so personal and at the same time very formal in nature. I have chosen to write my thesis in letter form so that you as the reader can see glimpses of the personal nature of this study as well as the neat academic package it is supposed to be according to the requirements of a Doctoral thesis. Listening, talking to and seeing you in person would have been so much better for me, because I like meeting people face to face, having conversations and responding to one another on a personal level.

I have been in private practice for four years now as a therapist using narrative ways in conversation with people, more widely known in the psychological field as patients or clients. Since my approach to therapy in this study precluded an observation and objective account, I have made full use of my participation in the relationship process.

I would like to acknowledge my researcher role as the central position of the construction of knowledge in this study. All findings are constructions, personal views of reality, open to change and reconstruction. Anderson and Goolishian (1988) define the construction of meaning and understanding in the construction of human systems as a constantly changing, creative and dynamic process.

My understanding of the meaning of the word reconstruction is that people have unique ways of understanding and experiencing different words, the meaning of which could be reconstructed in a conversation between people. My clients, readers of this study, I as the researcher, I as the therapist, I as the reflector and health professionals could possibly read English, but imply and apply different meanings to certain words or ideas. Reconstructed meanings, I propose, are at an inter-subjective level. Reconstruction does not imply that the original linguistic account was deficient but, rather, that all communicative actions are an infinite source of possible new expressions and meanings (Anderson & Goolishian, 1988). I also propose that the purpose of providing a reflexive account allows you as the reader to reanalyse the material and to develop alternative interpretations and explanations (Banister, 1994).

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This study is based on conversations between specific women and me as therapist, an overview of literature, my own story, and my researcher and reflexive voice. A context of reflexivity is provided through a process in which I as the researcher am simultaneously a performer in and audience to my own performance, and have a consciousness of my production (see Tomm, 1987). This context creates new choices for persons regarding the authoring of themselves, others and their relationships (White & Epston, 1990). Therefore I am a co-author of all the letters in this thesis. MacIntyre (1981) states that "…we are never more (and sometimes less) than the co-authors of our own narratives" (p.213).

Consequently, the starting point for me doing this thesis in the first place is my own story about my relationship with food in excess. Taking on a reflexive stance is thus of the utmost importance to convey the researchable aim of this study which is to create a verbal space for women to allow their voices to be heard as regards their experiences with their relationship with food in excess as individuals, groups or communities. The research question explores various meanings that women could construct with regards to their relationships with food in excess.

In this study you are hereby cordially invited to a celebration feast of women. Here follows women's words when they talk about their relationship with food in excess:

"I love food!"

"Food is my friend!"

"I am passionate about food!"

"Food has so many possibilities…"

"Food helps us to nurture ourselves and others."

"I need food as much as I need air to breathe."

What then could be an effective way to describe obesity in a different light than that of previous research material? For the purpose of this study narrative ways of thinking opens up space for the deconstruction of well-known concepts in the field of psychology, namely obesity and self-esteem. In the literature search the concept of excessive eating practices is interpreted as a search for obesity, implying that excessive eating practices could possibly be a deconstruction of the concept or label of obesity. Likewise, the literature study surrounding women's thinking and feelings about themselves in excessive eating practices is explored by using familiar concepts like self-esteem, obesity and psychology. In other words, I assume these concepts to be social constructions whose social and psychological meanings are contextually bound.

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The word deconstruction, in my understanding, is a breaking down of psychological meanings in the context of literature, media and for the benefit of this study, women's personal meanings. This allows for the underlying meanings of the concepts to be questioned. The assumption is that people often live their perceived answers, by conforming to the rules of labels placed upon them by society and themselves. For example, women respond in a certain way to the label of obese women or fat person without asking the underlying question(s). In this study the underlying question could be, how do women, experience their relationship with food in excess? Another question could be, what experiences will women tell when asked about whom and what society or the media portray as the perfect and healthy woman? Another possible question – how do women perpetuate the label? There are a vast number of possible questions to be asked.

In Narrative letter-II, my adoption of narrative ways of thinking in therapy places me within a post-modern and social constructionist framework which offers useful ideas about how power, knowledge and truth are negotiated in families, the media and other social contexts surrounding women's relationship with food in excess. Consequently, in Narrative letter-II the narrative conceptualisation of the abovementioned concepts in this study are regarded as conversations with women where reality is continually created and re-created in the here and now. Lieblich, Tuval-Mashiach and Zilber (1998) state that in the context of life-story research in psychology, the broad issue of the linkage between story and reality can be translated to (among other things) the relationship of self-narrative and personal identity, which resides in the hidden domain of inner reality.

The Letter of different concepts–III comprises a literature review in which a theoretical overview of the field of obesity and self-esteem issues surrounding the label of obesity is examined. In this study, an alternate account of the construction of the label of obesity, as seen in women, throughout literature, will be given. While not denying the importance of a body of literature on the subject of obesity, the alternate view is that through narrative exploration, within a relational setting, other important discourses and alternative stories of women and their relationship with food in excess, will surface. From this premise, the study focuses on how women's discursive practices concerned with their relationship with food in excess impact on their feelings and thoughts about themselves. Consequently, these narratives are of psychological importance as we look at how women experience the eating of food in excess and the meanings they link to their experiences.

At the conclusion of the Letter of different concepts-III the choices women have in a fatty food dominated society are investigated. Living a healthy life style, finding happiness or taking

responsibility for own choices; as different alternatives, are discussed. Lastly, the alternate story surrounding the social construction of the label of obesity from literature as a review on the possible success stories will be discussed.

Searching for a way in which to integrate all the conversations proved to be a challenge. In Letter of the research process-IV the research design and process as a narrative inquiry, together with the personal experience of doing the research, are reflected on and critically evaluated throughout. This letter describes the manner in which the women and sample characteristics were selected. This is followed by a description of the data collection process. Lastly, the process of analysing the data is described. There are many different forms of qualitative research, but for the purpose of this study the focus will be on analysing the data and presenting the results in the form of discoveries, mainly with the use of content analysis. The literature study, transcribed texts of six narrative conversations with each individual, as well as the researcher's reflexive diary and the reflection notes on the reflections of the data, will amount to a large volume of text. According to Neuman (2000), content analysis is useful for problems involving a large volume of text.

In Letter of discoveries-V the results in the form of discoveries, as well as the discussion thereof, are presented by using the method of content analysis. Discourses and alternative stories are formulated from text and after analysis, presented in the form of various discoveries as constructed meanings. Further results in the form of discoveries through drawings are presented in Letter of more discoveries-VI of which some are the researcher's account and some the researcher-therapist and the participants' co-constructed accounts of the possible discourses and alternative stories.

In Letter of reflections-VII it is clearly stated that this thesis does not claim to be fully representative of women's relationships with food in excess, rather the outcome is presented by drawing a comparison between literature, narrative conversations and the researcher's story. By using narrative conversations as psychotherapeutic intervention, close attention to the participants' discourses can be given and alternate life stories may be created, that may otherwise not have been considered part of the experience. In this study the participants and my story will be buried within the pages of the final product. Finally, the outcome of this study remains to be read and evaluated so as to its value to the field of psychology.

Waiting with you for the stories to unfold
Co-author and researcher

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II - Narrative letter

Different ways of thinking…

Dear reader

Time and my lived experience evolved and enriched my narrative perspective in context of the process of my Doctoral study to date (January 2004). At the time of describing the theoretical and practical contexts as regards a literary overview, I have completed the experiential process and transcription of the data collected as well as an oral examination involving the reading of a broad literature base. Consequently, the description of both contexts with regards to a literary overview is my view on narrative ways of thinking at this point in time. I don't assume that my assumptions about written text on narrative ways of thinking are cast in stone. As this thesis enfolds, I would like to reflect throughout making space for different possibilities of meanings through the medium of written language.

Concerning the matter of taking a reflexive stance throughout the letters in this study, MacLeod (2002) states that while there is a clear rationale for investigator reflexivity, there are dangers associated with it as well. In the first instance, a focus on the construction of the account by the researcher rather than what is being accounted for can be problematic. Secondly, there is a danger of the exercise slipping into a personal confession either of the reflexive positioning (the discursive positioning assigned to him/herself by an individual – Davies & Harré, 1990) of the researchers or of their emotional investments. In this study the researcher also becomes a researcher-therapist. Regarding this issue, Mills and Sprenkle (1995) state that therapists' greater awareness of personal issues, however, is not simply a training issue. This awareness is an increasing expectation in the field for all therapists who are bringing themselves into client systems and influencing these systems in the tradition of the therapists' own interpersonal histories.

MacLeod (2002) further questions the maintenance of the crucial aspect of researcher reflexivity while avoiding the dangers. MacLeod addresses two important aspects, namely:

- a researcher's reflections of self in the research process need to be explicitly linked to political practice,
- researcher reflexivity should address the interactional, relational and power dynamics of the research at hand, rather than focusing on a confession of emotional or discursive positioning of the individual researcher.

In this study the theoretical and practical are two main contexts for describing narrative ways of thinking.

Theoretical context with regards to a literary overview

In today's world context Mills and Sprenkle (1995) state that family values, for increasing numbers of people, are less rooted in sacred principles of church and community than in a very private mix of personal, situational beliefs. Anderson (1990) proclaims that the transition from the modern era to the post-modern era is marked by a flagging societal belief in one absolute, fixed reality for all people and an increasing acknowledgement that our culture embodies an infinite variety of equally valid ways to view the world.

This study's theoretical context with regards to a literary overview is set in the post-modern era, social constructionist perspective and narrative ways of thinking. A post-modern and social constructionist world is described by Parry and Doan (1994) as a place without any single claim to a truth universally respected, and a growing realisation that no single story sums up the meaning of life. It is also a place in which so much is happening to so many so fast that no story or theory is sufficient to correspond fully to its subject matter.

The post-modern era is described by O'Hara and Anderson (1991) as:

> A society enters the post-modern age when it loses its faith in absolute truth – even an attempt to discover absolute truth. The great systems of thought like religions, ideologies and philosophies, come to be regarded as social constructions of reality. These systems may be useful, even respected as profoundly true, but true in a new, provisional, post-modern way. Few people expect that one truth ought to work for everybody (p.22).

Freedman and Combs (1996) structure the post-modern and social-constructionist worldview according to four ideas about realities as follows:

- realities are socially constructed;
- realities are constituted through language;
- realities are organised and maintained through narrative; and
- there are no essential truths.

Writings on post-modernism frequently focus on ideas regarding text and narrative, paying attention to the importance of dialogic multiple perspectives, self-disclosure, lateral versus hierarchical

configurations, as well as to process rather than goals (Lax, 1992). Further emphasis is placed on the self being conceived not as a reified entity, but as a narrative; text is not something to be interpreted, but is an evolving process; the individual is considered within a context of social meaning rather than as an intra-psychic entity; and scientific knowledge or what would be considered undeniable facts about the world, yields to narrative knowledge with emphasis placed more upon communal beliefs about how the world works (see Gergen & Davis, 1985; Lyotard, 1988; Sampson, 1989; Sarup, 1989).

The main focus in this study's therapeutic context is on creating a space, where women can tell their stories about food. Neimeyer (1993) defines reality by the stories people live and the stories people tell. Amundson (2001) argues what a story is or is not measured against the ability of a story to perform specified tasks in the real world. Empirically then an idea – be it scientific or ideological – is never left to rest. Narrative ways of thinking offer useful ideas about how power, knowledge and truth are negotiated in families, the media and other social contexts surrounding women's relationship with food in excess. For example: The media or social context (power source) depicts a successful woman as someone with a perfect and thin body-image, therefore the truth about overweight women must be that they are out of control concerning their relationships with food in excess.

Consequently, a description of some ideas surrounding the social constructs of power, knowledge and truth is given within a social scientific paradigm.

An argument on power relations begins with Bateson's ideas about power that centres on two themes, already familiar within the family therapy literature (Flaskas & Humphreys, 1993).

- The *first theme* is that the concept of power is an epistemological error, that one individual cannot hold unilateral power over another because people are always subject to the constraints of being part of a relationship (Bateson, 1972). Later challenges were made to the Batesonian equation – the equation beginning with a commitment to understanding relationships in terms of circularity and complimentarity, leading to the impossibility of unilateral power, and this in turn leading to a negation of power in the theory and practice of family therapy. Bateson's writings on power brought critiques from different psychological perspectives to the fore in the 1980's (Flaskas & Humphreys, 1993). See critiques on Bateson's discussion on power (Goldner, 1985; MacKinnon & Miller, 1986; Dell, 1986; Imber-Black, 1986; Luepnitz, 1988; Hoffman, 1988, Goolishian & Winderman, 1988).

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- The *second and connected idea* is that a punctuation of the world, using the notion of power, is potentially unethical and toxic in its effects (Bateson, 1972).

However, Foucault argues that we predominantly experience the positive or constitutive effects of power that we are subject to power through normalising truths that shape our lives and relationships. These truths, in turn, are constructed or produced in the operation of power (Foucault, 1980). The will to truth is a notion that Foucault derived from Nietzsche in *The Genealogy of Morals* (Nietzsche, 1956/1887). It involves traditional philosophical questions such as; what is the world? What is man? What is knowledge? How can we know something? (Foucault, 1988). Foucault suggests that today this has changed to the historical reflection on ourselves and asks; what are we today? (Foucault, 1988). This opens the possibility of exploring how our lives are produced through cultural knowledges and practices (White, 1997).

In reaction to Bateson, Foucault radically departed from any idea of power as monolithic and unilateral. In this sense, he developed an idea of power that is intensely interactional, thus power cannot be seen as something in itself, but rather shows itself through the evidence that can be found in everyday interactions. Foucault drew an inseparable link between knowledge and power; the discourses of a society determine what knowledge is held to be true, right, or proper in that society, so those who control the discourse control knowledge. For Foucault, power is knowledge and knowledge is power (Freedman & Combs, 1996).

In summary, Foucault's most important ideas are the ideas of the productive potential of power, the notion of power as relational, the need to study power in the context of the specific social relationships in which it occurs, and the possibility of resistance (Flaskas & Humphreys, 1993). Phillips (2001) states, regarding the concept of resistance, that a great deal of learning comes from recognising the polarities in resistance. It is necessary for self-regulation, and without it people cannot maintain their boundaries. So when you choose a particular course of action, not only will you need to accept a loss, you will also need to work with the resistance.

In concluding the reasoning regarding power and knowledge, Flaskas and Humphreys (1993) explored intersections between Foucault's work on power, and the way in which systemic family therapy has engaged with the task of theorising about power. Intersecting Foucault's ideas with the problem of theorising about power in family therapy revealed both a firm point of connection as well as major points of contrasts. The point of connection is Foucault's commitment to a radically relational analysis, which resonates strongly with systemic family therapy's commitment to

recursive analysis, and to Bateson's first theme of an opposition to any unilateral conception of power. The parallel difference, though, is that Foucault came to centre on a relational analysis of power, whereas family therapy initially censored power altogether from its theory horizons, and has subsequently been restricted in its discussions to theorising about power around the oppositional poles of Bateson's original two themes.

Another contrast is family therapy and Bateson's concept of power-as-restrictive-only versus Foucault's focus on the productive forms of power. While Foucault's work always potentially enables an analysis of oppressive power relationships, there are major limitations in his work as a political philosophy and theory. However, Foucault rejects a politics of knowledge that searches for a prescriptive theory base, while systemic family therapy has embraced the more traditional approach to knowledge (Flaskas & Humphreys, 1993). Narrative inquiry is used as research design in this study.

Regarding a theoretical framework for this study James (1907) notes:

> No theory is absolutely a transcript of reality, but any one of them may from some point of view be useful. Their great use is to summarise old facts and lead to new ones. They are only manmade language, conceptual shorthand, as some would call them, in which we invent our reports of nature; and language, as is well known, tolerates much choice of expression and dialects (p.25).

James tells us clearly that theories and facts regarding people always emerge in *language* and in *context*. According to Amundson (2001) in *language* there are many ways to express things, and in *context* there are dynamics which relativise our theories and facts. Both concepts are described as follows;

- Anderson and Goolishian (1988) state that by *language*, they do not refer to a specific focus on signs, structure, or style. Rather, they refer to linguistically mediated and contextually relevant meaning that is interactively generated through the medium of words and other communicative action. It is in language that people are able to maintain meaningful human contact with each other and through which they share reality. To be in language is a dynamic, social operation. It is not a simple linguistic activity. To be in language is, however, a distinctively human process because it is through language that people are capable of forming the shifting communities of meaning to which they belong and that are for them the inter-subjective realities in which they exist (Anderson & Goolishian, 1988).

- The *context* is described as that language that is part of a culture; it is based on public criteria or rules (agreements in practice), and these rules cannot be learnt explicitly, as they are the products of deep cultural agreement that form the background against which sentences make sense. In other words, we become socialised into a language and cultural system and we cannot just assign any meaning to language, as we see fit (Besley, 2002). In this study the label of obesity could be placed within a cultural context, because as Besley stated specifically, the participants and the researcher-participant of this study became socialised into a language and cultural system.

In this study the focus is to adhere to a narrative way of thinking, within a post-modern context, in talking about women's relationships with food in excess, thus narrative ways of thinking being the post-modern *context* and therapeutic conversations, letters, drawings and a reflexive diary being the medium of *language*.

Epston and Madigan (1995) state that adherents to narrative orthodoxy have brought gendered considerations to the treatment of formal eating disorders. In this study the focus is on the telling of food stories of the female gender, which makes the mentioning of the influence of feminism in the post-modern era inevitable. Goldner (1991) writes that the feminist "preoccupation with and critique of power, secrecy, hierarchy, control, and expertise produced a commitment towards creating alternative, participatory, democratic forms of therapy" (pp.120-121). Goldner (1991) also cites the influence of feminism on respect for process as a therapeutic end in itself, and argues that feminists have been major contributors to the popular post-modern idea of *conversation* over *intervention*.

In other ways, the feminist critique has been wielded with political fervour and insistence that is seemingly incompatible with the post-modern denunciation of absolute truth (Mills & Sprenkle, 1995). Addressing this issue, Goldner (1991) asserts that the post-modern tradition is potentially paralysing for both feminist and traditional strategic therapists because it questions the absolute truth of each theory. Recognising this restriction, Mills and Sprenkle (1995) argue that the feminist critique has taken the post-modern theory of social constructionism to new levels, critically examining their nation's social construction of gender roles and asking therapists to use their voice in the therapeutic conversation to challenge the roles they feel are unhealthy for families.

Important to note that the participants of this study are obese women only and the research aims to create a space for their voices to be heard and adheres to the feminist idea of conversation over

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intervention. The possible danger could be that women tell their food stories and then what? A further research question arises, what will be the aim of merely telling the meaning of their stories and reflecting upon it? What would the end be, if the narrative means to a therapeutic end are not clearly defined?

Theory on narrative therapy in practice as context in regards to a literary overview follows.

Narrative therapy in practice as context with regards to a literary overview

Narrative therapy evolved in the family therapy arena in the late 1980s in Australia and New Zealand (Besley, 2002). Since then it has been extended to other counselling settings and a burgeoning literature has arisen around it. Narrative therapy offers new ways of thinking about people and about therapy and counselling (Besley, 2002). The question arises, what are these new ways of thinking?

The Dulwich Centre, Adelaide, founded by Michael White, describes narrative therapy as being premised:

> …on the idea that the lives and the relationships of persons are shaped by: the knowledges and stories that communities of persons negotiate and engage in to give meaning to their experiences: and certain practices of self and of relationship that make up ways of life associated with these knowledges and stories. A narrative therapy assists persons to resolve problems by: enabling them to separate their lives and relationships from those knowledges and stories that they judge to be impoverishing, assisting them to challenge the ways of life that they find subjugating; and, encouraging persons to re-author their own lives according to alternative and preferred stories of identity, and according to preferred ways of life. Narrative therapy has particular links with Family Therapy and those therapies which have a common ethos of respect for the client, and an acknowledgement of the importance of the context, interaction, and the social construction of meaning (http://www.massey.ac.nz/~Alock/virtual/narrativ.htm).

White and Epston (1989, 1990) make it clear that narrative therapy is considerably informed by Foucauldian notions. They argue that notions of power have been “much overlooked in the therapy culture generally, and in benign view that we frequently take of our own practices” (White & Epston, 1990, p.18). Besley (2002) underlines the necessity for therapists to always assume that they are participating in domains of power and knowledge and are often involved in questions of

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social control. Considering this view, therapists must work to demystify and unmask the hidden power relations implicated in their techniques and practices.

Doan (1998) argues that social constructionists shun expert domain of knowledge in favour of the lived experience of individuals. It seeks to privilege the voice of the individual and the liberating of their passions, intentions and preferences. In the context of clinical practice and narrative way of thinking about power and knowledge narrative therapists are sometimes misunderstood in the sense that they are seen as only giving voice to the client and defeating the expert domain of knowledge. I agree with White in saying, it is about equalising the power and knowledge, the individual as well as the expert knowledge must have a space to be heard. Power and knowledge could be productive and are not just destructive. In this study knowledge within the context of women's experiences of obesity is relevant. For example: The therapist's research done on obesity and therapeutic skills, participants' and researcher-participant's stories, media, societal views as well as the story of the role of genetics in theory and practise on obesity.

Knowledge within the cultural context of women's experiences of obesity could by narrative means be deconstructed, with a therapeutic end in mind. White (1993) says that the purpose of the deconstruction process is that people "might become aware of the extent to which certain modes of life and thought shape our existence, and that we might then be in a position to choose to live by other modes of life and thought" (p.35).

> Deconstruction has to do with procedures that subvert taken-for-granted realities and practices: those so-called truths that are split off from the conditions and the context of their production; those disembodied ways of speaking that hide their biases and prejudices; and those familiar practices of self and of relationship that are subjugating of persons' lives (White, 1993, p.34).

The purpose of the deconstruction process in this study is to become aware of genetic predisposition in some obese women according to literature and the medical treatments of obesity and this could be helpful in making informed decisions with regards to such treatments. Thus, not to discount the effect of the role genetics and medicine play in women's relationship with food in excess or obesity as described in Letter of different concepts-III. As Doan (1998) argues, the self can be viewed as a socially constructed entity, but genetically likely stories influence this process throughout.

Genetics as a relevant knowledge within the context of women's experiences of obesity are noted in Doan's (1998) question "is the notion of genetically likely stories invalid"? (p.383) and replies:

> Dismissing any account of genetic or biological underpinnings of human behaviour in the name of social constructionism actually renders it more likely that such genetic essentials will control us. Evolutionary psychology tells us that most genetic influences are just that: predispositions rather than predeterminations. But our ability to rise above such genetic invitations depends in large part on being aware that they exist. Knowledge brings empowerment – the chance to override genetic impulses. It helps us realise that we're going to have to do it, that genetics is not going to help. This process is analogous to being aware of cultural discourses so that one can make decisions in relation to them (p.383).

Wright (1994) states that people have the tendency to self-deceive, that is, to pretend that our stories are more privileged than others. We are therefore more prone to construct some stories about the self than others. In this study the role of genetics in the origin of obesity could be denied, which could have an effect on the holistic story – thus only knowing in part, while the aim of this study is to incorporate different parts of the meanings of the stories (including the role of genetics) of the women regarding their relationships with food in excess.

Furthermore, the familiar notion of diagnosis embraces the idea that there is an objective problem, and that the therapist can arrive at an objective description of that problem (Anderson & Goolishian, 1988). A shift from social structure to the linguistic domain, as a way of describing and understanding problems, moves us from the notion of empirical objectivity and representational language. It is not easy, however, to give up the notion that there really is data waiting to be discovered. For the patient or client, the expert's diagnostic label of their self tends to become seen as part of their essential nature and of their identity. Gergen (1990, 1991) suggests that the language, power and use of diagnostic deficits can be totalising and thus totally affect the past, present and future of a person's life so that the self becomes saturated by the pathology. Although the intent is to help the client, the treatment or intervention can end up inadvertently totalising (totally describing), pathologising and disempowering the client, as well as producing social hierarchies that erode notions of interdependence and community. The expert knowledge and the scientific outlook of traditional Western psychology which is based on the biomedical model of mental illness objectifies, individualises and normalises the subject through diagnosis that has the effect of locating the problem within the person (Besley, 2002).

The narrative approach challenges the way Western psychology generally emphasises the individual subject. It especially challenges the mental health areas where experts often appear to know more about people's lives than the people do themselves, and where the professional focus upon personal deficits emphasises one's failures or weaknesses rather than one's accomplishments and strengths (Besley, 2002). As stated above, narrative therapy uses Foucault's analytics of power which involves the notion that power can be positive and productive and not just repressive and negative (Foucault, 1977). In its challenge to the truths of humanism, of the traditional psy-sciences, of deficit models, of objectively neutral expert stances, narrative therapy as a counter-therapy could perhaps be considered to be post-psychological (McLeod, 2000).

Rather than viewing the word as revelatory – a carrier of mind, spirit, observation or truth – the emphasis is on language as a form of social action. Words are used by people in the living of communal life – to bring others closer, to keep them at a distance, to send them in this way as opposed to that, and so on. Words are more like significant glances and warm laughter than mirrors of the truth (Gergen, 1995). White and Epston (1990) argue that when engaging in language, we are not engaging in neutral activity. There exists a stock of culturally available discourses that are considered appropriate and relevant to the expression or representation of particular aspects of the experience, including those that we refer to as self-understandings, are mediated through language. And it can be expected that those truth discourses of unitary and global knowledge contribute significantly to this mediation of understanding and in the constitution of personhood and of relationship (White & Epston, 1990). In a sense a culturally available discourse could be described as a dominant narrative.

According to Polkinghorne (1988) a discourse is a unit of utterance – it is something written or spoken that is larger than a sentence. A discourse is an integration of sentences that produces a global meaning that is more than that which is contained in the sentences viewed independently. There are various kinds of discourses, and each kind links the sentences that compose it according to distinct patterns. Macleod (2002) chooses the word, 'conceptualisations' in a post-modern context rather than the word, 'definition' that supposedly gives the impression of definitive closure. The conceptualisation of discourse is linked to theoretical issues, and thus is in a constant state of re-appraisal and re-working. According to MacLeod (2002) various authors attempt to grapple with the nature of discourse. Various features emerge from their attempted conceptualisations, namely:

- an underlying regularity;
- the constructive effects of discourse; and
- implications in terms of meanings and practices

(see some; Burman, 1994; Henrique, Hollway, Urwin, Venn & Walkerdine, 1984; Davies & Harré, 1990; Fairclough, 1992).

MacLeod (2002) summarises the concept of discourse as having constructive, but also restrictive power in the cognitive, emotive and behavioural process of an individual, families and communities. It has a dual character, simultaneously constructing and restricting what can be known, said or experienced at any particular socio-historical moment. Discourse allows for shifts and flexibility, as a tension is constantly created between the constructive and restrictive, productive and undermining aspects of a discourse.

White, following Foucault, writes that we tend to internalise the dominant narratives (discourses) of our culture, easily believing that they speak the truth of our identities (Freedman & Combs, 1996). White (1997) notes that people come to therapy either when dominant narratives are keeping them from living out their preferred narratives or when

> …the person is actively participating in the performance of stories that she finds unhelpful, unsatisfying and dead-ended, and that these stories do not sufficiently encapsulate the person's lived experience or are very significantly contradicted by important aspects of the person's lived experience (p.14).

Gergen (1985) says:

> Social constructionism views discourse about the world not as a reflection or map of the world, but as an artefact of communal interchange (p.266).

Hoffman (1990) reports that the social construction theory sees the development of knowledge as a social phenomenon and holds that perception can only evolve within a cradle of communication. Social construction theory posits an evolving set of meanings that emerge unendingly from the interactions between people. These meanings are part of a general flow of constantly changing narratives. Social constructionism is anchored in a philosophy of community processing (Hoffman, 1990).

Hoffman (1990) explains that social construction theory is really a lens about lenses. Hoffman's (1990) term the lens of a second-order view comes from mathematics and merely means taking a position that is a step removed from the operation itself so that you can perceive the operation *reflexively*. These views are really views about views. They often make you more aware of how your own relationship to the operation influences it, or allow you to see that a particular

interpretation is only one among many possible versions. A second-order view would mean that therapists include themselves as part of what must change; they do not stand outside. The social constructionist perspective shifts from the therapist as primary mover to therapist as participant (Mills & Sprenkle, 1995). Pragmatically in a narrative context, the process of determining the purpose of therapy should, in a narrative sense, be as co-created and collaborative an endeavour as possible.

This study's orientation with therapy practice as context with regards to a literary overview follows.

Orientation in Therapy

Where several theoretical approaches differ is in their beliefs about the most helpful way to steer (or not to steer) the conversation (Mills & Sprenkle, 1995). Anderson and Goolishian (1988) propose that we live with each other in a world of conversational narrative, and we understand ourselves and each other through changing stories and self-descriptions. To be in dialogue is to attempt to understand others and to involve oneself in the co-evolution of understanding and meaning. According to Anderson (1990) therapy is aimed at; "the form-giving, meaning-making part, the narrator who at every waking moment of our lives spins out its account of who we are and what we are doing and why we are doing it" (p.137).

Anderson and Goolishian (1988) pose fundamental questions with regards to therapy, based on five premises:

- *What is therapy?* Human systems are language-generating and simultaneously, meaning-generating systems. The therapeutic system is a linguistic system.
- *What are the goals of therapy?* Meaning and understanding are socially and intersubjectively constructed. A therapeutic system is a system for which the communication has a relevance specific to itself.
- *How is the target of treatment identified?* The therapy system is a system that is distinguished by the problem rather than a social structure that distinguishes the problem. The therapeutic system is a problem-organising, problem-dis-solving system.
- *What is change?* Therapy is a linguistic event that takes place in what we call a therapeutic conversation. Change is the evolution of new meaning through dialogue.
- *What is the role of the therapist?* The role of the therapist is that of a master conversational artist – an architect of dialogue – whose expertise is in creating a space for and facilitating a dialogical conversation. The therapist is a participant-observer and a participant-manager of

> the therapeutic conversation. A position of not knowing does not imply that the therapist has no expertise, but it does imply that the therapist must leave all preconceived notions about clients and an ultimate standard of their health out of the therapy room (Atkinson & Heath, 1990). In contrast to the post-modern view that the new-style therapist must come from a position of not-knowing, Hoffman (1990) suggests that it is better to be aware of these ideas than not. Kelly (1955) argues that the therapist must expertly maintain an open and intensely curious stance regarding all of the possible meanings inherent in the problem system. The task is not to edit problematic stories or identify faulty narratives, but to elaborate the complaint. If the therapist is able to create a context, through intensely respectful inquiry and listening, change will follow as a matter of dialogical course (Mills & Sprenkle, 1995).

Anderson and Goolishian (1988) claim that understanding in the therapeutic conversation, is always a process which is never fully achieved. We only understand descriptions and explanations. We do not understand events because, in this view, there is never a single event to describe, and no particular understanding exhausts all the potential infinities of meaning. Epston (1994) reflects upon the meaning of reconstructing a conversation as that "two of us conversing even minutes before may not agree on what was actually said because we each hear selectively" (p.31). Through the therapeutic process, we co-create and co-develop the systemic realities around which we have meaning for each other, and through which we continually reorganise our mutual living and our self-descriptions (Anderson & Goolishian, 1988).

A narrative therapist uses language that is deliberately non-sexist, ethnically neutral, and avoids medical model terms that many mental health professionals use which unthinkingly objectify and 'pathologize' people; like referrals, case notes, clinical work (Besley, 2002). Gergen (1995) argues that if language is a central means by which we are related; then it is from relations that we draw the sense of things, thus it is this consciousness of relatedness that also creates an enormously exciting dialogue within the therapeutic realm. Both the language and how it is used are important. Language can blur, alter or distort experience as we tell our stories; it can condition how we think, feel and act and can be used purposefully as a therapeutic tool (White, 1995).

Narrative therapy consists of a disciplined questioning process. White and Epston (1990) describe *relative influence questioning*: In this way the problem is externalised and objectified as an influence outside the life of the family members and is subject to their influence and control. Externalising the problem helps the person to gain a reflexive perspective on their life and to

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challenge the truths that define, objectify or subjugate them as they explore new options (Besley, 2002). Mills and Sprenkle (1995) describe *unique outcome questions*: The family story pits the entire family against the externalised problem, rather than the problem attaching itself to the character and worth of the clients themselves. Written narratives of client's lives are also powerful therapeutic tools used in this approach.

O'Hanlon (1994) remarks that through use of their most well-known technique, externalisation, narrative therapists are able to acknowledge the power of labels while both avoiding the trap of reinforcing people's attachment to them and letting them escape responsibility for their behaviour. Externalisation offers a way of viewing clients as having parts of them that are uncontaminated by the symptom. This automatically creates a view of the person as non-determined and as accountable for the choices he or she makes *in relation* to the problem. Roth and Epston (1996) believe that the process of engaging in externalising conversations is a form of resistance to the culture of pathology that often pervades professional conversations. Such 'pathologizing' conversations invite those struggling with problems to blame themselves, to feel guilty or ashamed for having problems, and to experience themselves as helpless to act against problems without acting against themselves.

Epston (1994) notes that assisting clients to see that their problems are separate from who they are as people, creates a possibility that they can intervene and make changes, rewrite their stories so that the problem has less influence over them. *Thus people are not the problem themselves, but are beset by a problem that is external to their personhood.* White (1993) believes that as persons become engaged in these externalising conversations, their private stories cease to speak to them of their identity and of the truth of their relationships. Thus, people experience a separation of their stories and become "free to explore alternative and preferred knowledge of whom they might be" (p.39). O'Hanlon (1994) states that if narrative therapists don't believe unequivocally, that people are not their problems and that their difficulties are social and personal constructions, then they won't be seeing transformations where clients live out their preferred realities. Relating externalising as a narrative technique to this study could be helpful in exploring new options in the participants experiences and the effects it has on how they think, feel and act rather than their and society's set ways of thinking about being obese or fat.

According to O'Hanlon (1994) separating clients from the labels they bring is no easy task and the appeal of the narrative approach may stem, in large part, from its unique approach to doing just that. Following the therapeutic sequence is a bit like building an arch, brick by brick. If you try to do the

last step without having patiently spent time doing the first ones, your arch isn't going to hold up. Here follows O'Hanlon's (1994) description of the fundamental structure of the narrative approach:

- The collaboration with the person or the family begins with coming up with a mentally acceptable name for the problem. Naming something gives it a different place. As soon as you name it you frame it (Phillips, 2001).
- Personifying the problem and attributing oppressive intentions and tactics to it.
- Investigating how the problem has been disrupting, dominating or discouraging the person and the family.
- Discovering moments when clients haven't been dominated or discouraged by the problem or their lives have not been disrupted by the problem.
- Finding historical evidence to bolster a new view of the person as competent enough to have stood up to defeated or escaped from the dominance or oppression of the problem. The narrative therapist wants to root a new sense of self (in solving problems) in a past and future.
- Evoking speculation from the person and the family about what kind of future is to be expected from the strong, competent person that has emerged from the interview so far.
- Finding or creating an audience for perceiving the new identity and new story. Narrative therapists use letters, asking for advice for other people suffering from the same or similar problems, and arranging for meetings with family members and friends, to accomplish this social validation.

The aim of externalising conversations is to reach unique outcomes. In narrative ways of thinking the battle over specified ways/means of achieving particular outcomes is useful to the extent that it helps us to feel more confident. Specified means however must bow to particular context, namely *this patient, with this problem, in this time and place* (Amundson, 2001). Furthermore, outcome or unique outcome is perhaps the most salient aspect of an empirically informed therapy – the ability to answer the question "How will we know when we are done?" Borrowing from the solution-focused and behavioural therapies, it is outcome that drives therapy. Therapy then calls to service that which is useful. Reflection and experimentation mean considering outcome and the ends to which therapy might be put (Amundson, 2001). In narrative therapy unique outcomes differ from the solution-focused ideas, however, because the emphasis is on helping families realise times when they were able to decline the invitation to cooperate with the problem (White, 1993; White & Epston, 1990).

The narrative therapist looks for experiences that are not currently being storied, which do not fit into the dominant (problem) narrative (Zimmerman & Dickerson, 1994). When unique outcomes which are experiences from the past are selected, they contribute to a past history for a new story, but historical examples of unique outcomes are unlikely to be recalled unless the therapist intentionally draws them out (Hewson, 1991). Hewson (1991) highlights the reconstruction of the past history of the new story as a powerful literate means. White (1993) argues for the development of a new story that has a rich past history. Hewson (1991) explains that the new story is not a turn-off from the old road, but the continuation of a different, old road – one on which the person had been travelling without previously recognising that they were doing so, thus the new story is really a new-old or alternative story. Furthermore, Hewson (1991) remarks that the dilemma is not whether the person should change direction at some hypothetical cross roads, but whether they want to maintain the old story as their dominant story or side step that story (path) and give another well-trodden path (the new-old story) dominance in the future.

The pragmatic question for this study arises, what does my practise of narrative therapy entail? The client is the expert and stays the expert in narrative conversations. I am thus a conversational expert and an expert on my own story about my relationship with food in excess, as well as a well informed expert on literature concerning eating disorders. In the same way, the women in this study are the experts on their stories surrounding their relationships with food in excess and as the researcher-therapist I will listen to them from a not-knowing position and with an inquisitive attitude.

I have grown up in a society where I was taught to see myself as being the problem, for example: I am a dominating person, rather than I stand in relationship to a monster of fear that I will be rejected, therefore I must control the situation. I am thus part of the problem or I am the problem. With narrative ways of thinking in practise, I became aware of the power that I have as an individual when I externalise the problem and say that I am not the problem, but that the problem is the problem. This allows me to see clearly that I stand in relationship to a monster of fear of rejection and I can take direct action against this fear. I am then in control of how much I will allow this fear-monster to affect my behaviour, thoughts and feelings.

In search of my own theoretical position in therapeutic practices, I have read many texts with regards to the different schools of thought in psychology and came to the following understanding of the literature. The psychological view of a person started off with seeing so-called abnormal behaviour as a result of a person being possessed by demons, to the person being labelled as having

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a pathological problem, thus having the problem inside the person, to the problem existing in relationships with other people. The paradigm shift for me is to see individuals and their problems as an equation where the person stands in a relationship with his or her problem.

This paradigm shift has been difficult for me, because it was safer for me to label and diagnose a person with certain pathology. From the literature and my Masters Psychology training I have learnt that by placing a person's problem in a certain category, it is thought to be possible to explain all human behaviour. If all human behaviour could be labelled or explained, then human behaviour could be predicted and necessary treatment plans implemented. For example: with obese women the suggested treatment, according to the literature and weight management programmes is often that the person must lose some weight to gain a positive self-esteem and body-image. This troubles me, because my opinion is that women have more stories than just an obese story and that if we challenge or question dominant discourses, new-old stories or alternative stories may emerge. Consequently, challenging the assumption that women must loose weight to gain a positive self-esteem and body-image.

During my Masters degree in counselling psychology I did not consider the possibility of questioning scientific observations or labelling people or categorical systems. I know that this has to do with the discourse I maintained which dictated that I must follow the leader assumptions under all circumstances, even if it means jumping into the fire. My knowledge of human behaviour fitted into neat little boxes. This gave me structure, but at the same time made me fearful to trust my instinct and knowledge that a person is an expert on his or her own life. Foucault (1980) speaks about power and knowledge as if they are the same concept. I think that my knowledge that a person is an expert on his or her own life was previously dominated by my perception that power structures in the psychology-training milieu reflected the equation that knowledge equals power.

One further discourse that was deeply ingrained into my belief system was that I could only help a client as far as I have learnt or grown in a certain area and if I don't deal with my problems and sort myself out, I cannot help anyone. By questioning this discourse through a narrative way of thinking I have come to an enriched understanding that I am the expert of my life, and the client is the expert of his or her life. I make the choice then that my therapeutic helping could be of value when I respect, listen and challenge the client about his or her life story with the aim of reflecting in a compassionate way.

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In the past four years I enjoyed using different narrative ways in conversations with clients. I have experienced and seen clients realise their own potential/skill in standing against problems. I am thus excited about this study and what I am going to learn together with the participant women about their meanings with regard to their experiences of their relationships with food in excess.

From my personal notions in practice to a description of the narrative tools used during the therapeutic conversations with these specific participants.

Narrative tools used during the therapeutic conversations

Important to note that in this study the following specific narrative tools are used:

- *Externalisation of the problem* is used to focus the individual woman's attention away from seeing herself as the problem, instead opening up more possibilities for her to realise the choices she has within her relationship with food in excess and her choosing to, or not to take responsibility to live out her preferred story(s).
- The aim is to reach a fuller description of the story through the art of *deconstructed questioning* of the dominant narratives or discourses and re-constructing the discoveries of significant new-old stories. Telling your story involves understanding what has happened for you, the context in which it happened, and its impact on your current way of being. Telling and understanding what your story means to you, helps you to decide what story you want to tell in the future and what you will have to do in order to make the story happen (Phillips, 2001).
- A general *narrative letter* as narrative tool is used. Like Epston (1994) letters allow my thinking about my clients and about therapy to be as transparent as possible. Letters ought to be moving experiences, doorways through which everyone can enter the family's story and be touched by the bravery, the pain and even the humour of the narrative.
- The researcher-therapist as well as each individual woman makes use of the *reflexive stance* at the conclusion of each conversation with the aim to obtain learning experiences from the therapeutic process and relevant life stories told during the conversation. I like to call these warming down exercises. I propose that alternative or new-old stories are also highlighted through a reflexive stance collaborated between the researcher-therapist and each individual woman.
- *Art therapy* as a tool in narrative therapy is used. According to Carlson (1997) narrative and art therapies share certain theoretical beliefs that are consistent with one another. Among these are the ideas of recapturing hidden aspects of self-expression or lived experience, the

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principle of co-construction in understanding the therapeutic relationship, and the belief in the creative abilities of persons.

- *Externalising women's internalised beliefs formed at the developmental age of a child*: This narrative tool, was used during narrative conversations with several participants, especially in the context of traumatic experiences in their childhood. According to DeFoore (1988) we all entered the world wide open, totally vulnerable. People have found that there is no such thing as forgetting, that unneeded or painful memories are only blocked from conscious memory so we can move forward and continue to function. This means that subconsciously each of us remembers that experience of being totally open and vulnerable. We knew the greatest love and the greatest pain in that stage of our existence. This is why it is safe to say that within each of us is a soft vulnerable self (*the inner child*), however deeply it may be buried in the subconscious mind (DeFoore, 1988). In a narrative context the construct 'inner child' are externalised and could be viewed as women's internalised beliefs formed at the developmental age of a child.

Some specific taking-it-back practices used in this study

White's (1997) taking-it-back practices as a narrative tool is a means for therapists to decentre their power as being supposedly the only expert in relationship to clients in a given therapeutic context. Important to note that in this study the following specific taking-it-back practices are used based on White's (1997) readings on taking-it-back practices:

- *Re-membering conversations*, which bring to the centre of this work the knowledge and skills that have been generated in the significant memberships of persons' lives through their histories, and that identifies options for new memberships that are potentially generative of other knowledge and skills of living. *Re-membering practice* as taking-it-back practice is used during the therapeutic conversations in the form of the co-creation of a fictitious celebration party where significant members in relation to the individual woman's experience are invited. This is for the validation or compassionate witnessing by significant others of each woman's meaningful experiences told during the therapeutic conversations.
- *The telling and re-telling of stories* of persons' lives that contributes to the multiple contextualisation of the actions and events of life, that links the stories of person's lives to shared purposes, values and themes, and that is generative of 'thick' description. This thesis is based on *the telling and re-telling of stories* of specific participants, researcher-participant, as well as stories within literature regarding women's relationships with food in excess.

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- *Therapists embrace an ethical responsibility* to identify the ways in which these therapeutic conversations are shaping their work and lives, in which they acknowledge the contributions of the persons who consult with them. My ethical responsibility in this sense is to acknowledge the participants contributions to this thesis not in only shaping my personal food story and their own food stories, but also contributing to creating a space for other women in my private practice as well as other women who the participants encounter in the future. Recognising the fact that I claim to be the co-author of this thesis in conjunction with the participants and literary voices on this particular topic.
- *Transparency* that engages therapists in situating their expressions by rendering visible, to persons seeking consultation, the different contexts of these expressions, including those of culture, race, gender and class, and this will encourage therapists to embody their speech acts by acknowledging the purposes and the lived experience that shape these acts. In this study the therapist-researcher and researcher roles are transparent in the sense that culture, race, gender and class issues are addressed in different letters throughout this thesis.

Reflected conclusions upon the literary overview

Theory and practice are not a problem to be resolved in any final sense, but rather a problem to be solved case by case; and historical moment by moment (Amundson, 2001). Doan's (1998) concluding thoughts in *The king is dead; long live the king: narrative therapy and practicing what we preach* questions narrative therapists' and in this study, my own, will to recognise theoretical assumptions as assumptions, and be aware enough not to be fooled into believing that they are true.

On the basis of Doan's (1998) proclamation that if postmodernism has a rally cry, it is most likely **"beware of the tyranny of singular accounts"** – especially those claiming to have the truth, the whole truth, and nothing but the truth. In contrast, Doan (1998) depicts a growing concern that narrative is falling prey to the tendency of reifying its metaphors, making gurus of its leaders, and acting as if its underlying assumptions are somehow more privileged than those of the other therapies. Further, Doan states that one would expect a great reluctance on the part of its practitioners to embrace **"the one, true way of doing narrative therapy."**

O'Hanlon (1994) critiques narrative therapy by highlighting scepticism with regards to claims of narrative therapists being nondirective. There is a clear and consistent therapist agenda. Therapists often introduce a metaphor or some new language to the client. Narrative therapists would generally bristle at the suggestion that they use hypnosis, but they do. The biggest concern about

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narrative therapy; like most other popular movements, is that many therapists will use it merely as a clever device. O'Hanlon (1994) also argues that inevitably many therapists will ignore the heart of narrative therapy, its fierce belief in people's possibilities for change and the profound effects of conversation, language and stories on both therapist and client.

Parry and Doan (1994) have suggested that narrative is particularly suited to the challenge of life in a post-modern world that may have arisen due to the post-modern context in which all of us increasingly find ourselves. According to Doherty (1991) narrative therapists see there jobs not as providing insight, promoting differentiation, clarifying boundaries or prescribing tasks, but as dissolving problems through the liberating process of dialogue.

In reflected conclusion Amundson (2001) says:

> Narrative types would do well to attend forensic conferences, biomedical discussion and work with ethics and discipline. They would benefit from drawing circles to pull these perspectives in, rather than try to climb fearfully higher away from them. Find a home for these narratives and you will be richer. Add to this process a bit of irony and self-depreciation, think small and local, leave the big questions outside the consulting room for those who think themselves grand, visit the outlanders in cognitive science, medicine and naturalistic philosophy, even steal from them the useful, and then how can our patients lose (p.187)?

Leaving this letter with so many more ideas to explore and narrative stories to tell, the story of my thesis can continue making meaning and reflecting upon the specific dominant narratives, such as obesity and self-esteem issues regarding obesity in Letter of different concepts-III.

Narrative greetings
Co-author and researcher

III - Letter of different concepts

Who or what is the gingerbread man?

Dear reader

"Run - run as fast as you can, you can't catch me, I am the gingerbread man!"

An old nursery rhyme

In this letter obesity is equated to the gingerbread man that is presumably running from someone that can not seem to catch him. An analogy is drawn between the gingerbread man and obesity. Contradictions and assumptions regarding psychological research surrounding obesity and the situation the gingerbread man is in at the moment are investigated in this letter. In search of the conceptualisation of what the research question is asking from literature, the starting point of the race from which women's relationship with food in excess is captured, begins with certain concepts like obesity, fat women and self-esteem issues surrounding the label of obesity. There have been a large number of research studies on the subject of obesity. In a similar way the gingerbread man has been chased for as long as the nursery rhyme exists.

Rothblum (1999) encourages researchers to ask the following questions: How can psychology take the lead in effecting a paradigm shift about research on weight loss? How many published studies will it take before scientists take a stand that it has convincingly been demonstrated that most people don't loose much weight and then regain some of this weight when treatment ends? These questions confirm my preliminary question; is weight-loss the only construct in obesity success stories or could there be other constructs? In a similar way, how many times are children taught that the gingerbread man is running all the time without considering any other possibilities? Wiggens, Potter and Wildsmith (2001) state that psychological research into eating practices has focused mainly on attitudes and behaviour towards food, and disorders of eating. Using experimental and questionnaire-based designs, these studies place an emphasis on individual consumption and cognitive appraisal, *overlooking the interactive context in which food is eaten*.

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Obesity is not included in the current (fourth) edition of the Diagnostic and Statistical manual of Mental Disorders (American Psychiatric Association, 1994). According to Rothblum (1999) clinical psychologists have a major role in perpetuating errors and inconsistencies related to body weight. As practitioners, they see clients who come to therapy for weight-loss (and eating disorders). As clinical researchers, they study dieting and factors that contribute to weight-loss. As educators in clinical psychology training programs (and related courses in undergraduate psychology programs), they include the topic of obesity, and textbooks reflect this coverage. And the general media interview clinical psychologists when breakthroughs happen in this field, such as the news about identifying the obesity gene in laboratory animals (Rothblum, 1999). When we say obesity, what is it we are describing? For some it could be an explanation of their eating behaviour, for others it could be a label of some sorts.

How is obesity defined according to several experts on the subject?

DiGirolamo, Harp and Stevens (2000) note that obesity has been known to exist for many thousands of years. Obesity is the most common nutritional disorder of recent years in Western societies (Concise Medical Dictionary, 1998). Seidell (1997) states that the estimation of world prevalence of obesity reveals that as many as one billion people are overweight. As a matter of fact obesity seems to be a worldwide problem, especially in South Africa (Schoeman, 1993). DiGirolamo et al. (2000) comment that it seems almost paradoxical that, in the time in history when efforts are made to reduce famine and its consequences worldwide, major health risks are uncovered in the Western world and in some third world countries, that are linked to unlimited food availability, excessive food ingestion, and enhanced fat accumulation in the body. Friedman (1999) states that a wealth of evidence points to the fact that in Westernised countries people suffer from obesity, whereby individually people get fatter as they get older, and collectively the population grows fatter year after year.

Ilson, Crystal and Wells (1987) state that the Latin word for obese is "obësus" which means grown fat by eating, from the past participle of "obedere" that means to eat away. The Concise Medical Dictionary (1998) describes obesity as the condition in which excess fat has accumulated in the body, mostly in the subcutaneous tissues. Obesity is usually considered to be present when a person is 20% above the recommended weight for his/her height and build. The accumulation of fat is usually caused by the consumption of more food than is required for producing enough energy for daily activities. However, recent evidence indicates that a genetic element is involved. Hunger and

satiety appear to be controlled by peptide messengers, encoded by specific genes and acting on the brain (Concise Medical Dictionary, 1998).

According to Schoeman (1993) the diagnosis of obesity is trivial, and is often labelled morbid obesity. Hyper obesity – often called morbid obesity – is defined as being ≥100 pounds or (45kg) above ideal body weight (Chandarana, Holiday, Conlon & Deslippe, 1988; Weiss, 1984). There are also two types of obesities, hypercellular obesity refers to grossly obese people due to an abnormal amount of fat cells, while hypertrophic obesity involves enlargement of adipose tissue cells with lipid during adult years and pregnancy (Bray, 1989; Hirsch, Fried, Edens & Liebel, 1989; Björntorp, 1984).

Obesity is seen as a medical problem, as an illness and can be the cause of other diseases. Extreme or morbid obesity is a serious health risk associated with increased mortality and morbidity for several diseases, including coronary artery disease, hypertension, Type-II diabetes, hyperlipidaemia and joint problems (Manson, Colditz, Stampfer, Willet, Rosner, Monson, Speizer & Hennekens, 1990; Must, Jacques, Dallal, Bajema & Dietz, 1992; Gortmaker, Must, Perrin, Sobol & Dietz, 1993). Obesity is linked with an increased incidence of certain types of cancer and musculoskeletal disorders (Van Itallie, 1985; Visscher & Seidell, 2001). Obesity, insulin resistance and diabetes are reaching epidemic proportions (Seidell, 1997).

According to Bosman, Van der Merwe and Hiemstra (1984) illness is defined or labelled as a disorder, affection, disease or ill health. Bosman et al (1984) describe disorder as a person being mentally disturbed or deranged. Anderson and Goolishian (1988) say however, they find that labelling is always a dangerous process, because it connotes problems as fixed or invariant. On the contrary, they believe that systems are fluid, always in change, never stable, and finite. That is, the membership of a system should not be thought of as fixed; as the problem definition changes, so can the membership. For example in this study labels like obesity, fat women and self-esteem issues surrounding the label of obesity are not fixed and could change or evolve during the process of writing this thesis.

Furthermore, being labelled with a mental disorder could have stigmatisation attached to it. Literature conveys that stigma produces prejudice and discrimination (Drury & Louis, 2002). Most people who have a condition that is stigmatised take pains to avoid situations in which they are stigmatised (Hughes & Degher, 1993; Myers & Rosen, 1999). Studies suggest that an obese woman may delay or avoid health care if she feels her health care provider holds a bias against or

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berates her because of her weight (Olsen, Schumaker & Yawn, 1994; Packer, 1990). Rodin, Silberstein and Striegelmoore (1984) argue that in our society obesity is met with punishment – psychological, social and economic – and the sanctions appear to be more severe for females than for males. Surely one root of women's fear of overweight lies in the harsh negative views of society toward obesity – particularly toward obesity in women. According to Molinari and Riva (1995), obese persons may experience emotional distress on encountering the negative feelings of society and can internalise these, modifying their self-images. The question arises, is it possible that stigmatisation of obesity as an unhealthy medical condition, limits health professionals to run after the gingerbread man? Hereby meaning that more holistic ways of helping women with their relationship with food in excess could possibly be explored when health professionals and, in particular psychologists, start investigating the concept of obesity in a narrative therapeutic way within a post-modern context.

Here follows a further description from existing literature on the subject of the origins and nature and relevant aspects regarding obesity.

What are the origins, nature and relevant aspects regarding obesity?

How could we describe the gingerbread man? Similarly, what does a literary overview portray as the etiology of obesity? DiGirolamo et al. (2000) argues that although many strides have been made in understanding the regulation of food intake and utilisation, and in the treatment of obesity, considerably less is known about the etiology and pathogenesis of most cases of obesity. Many classification criteria have been proposed, but there continues to be no consensus reached regarding the best etiological classification for obesity (DiGirolamo et al., 2000).

Friedman (1999) notes that obesity is clearly determined by a great number of factors, other than food intake alone, whereby complex interaction among genetic, physiological and behavioural variables affects both the development and maintenance of the obese condition. In addition, the particular way in which these factors determine the effects of food differs from individual to individual. This statement of Friedman stimulates the question: What is the reason for the gingerbread man to run? In a similar way, what is the reason for a body of literature to describe certain women as being obese or fat? An ongoing debate about the causes and factors surrounding obesity varies from psychodynamic concepts, the regulating of anxiety and dependency on external cues, as well as psychological based arguments and arguments that view socio-cultural factors as part of the development of obesity (Gous, 1995).

The focus of the present study will be on physiological, psychological and socio-cultural factors in the development of obesity.

What are the physiological factors regarding obesity?

Genetic predisposition

Chagnon, Pérusse and Bouchard (2000) state, that the field of the genetic and molecular basis of human obesity is currently receiving a lot of attention from both the research community and the general public. Much of the recent progress has occurred in the identification of new genes and molecules that are involved in the regulation of the energy balance, which may play a role in the obesity phenotype expression. These studies were initiated after it was observed that there is a significant heritability level for human obesity (Chagnon et al., 2000).

The most significant advances in the last few years have been the cloning of the genes that are responsible for obesity and co-morbidities in the single-gene rodent models of obesity. A new biochemical pathway, with a large spectrum of action, has been uncovered from the characterisation of leptin (Chagnon et al., 2000). The Leptin protein is highly similar among species, with 83-84% similarity between rodents and humans (Zhang, Proenca, Maffel, Barone, Leopold, Friedman, 1994; Ogawa, Masuzaki, Isse et al., 1995). Serum Leptin is secreted by the adipose tissue and is highly correlated with fat mass, but also with other adiposity variables such as body mass index (BMI) and percent body fat (%fat) (Rosenbaum, Nicolson, Hirsch et al., 1996; Hickey, Israel, Gardiner et al., 1996). Leptin has also been shown to be synthesised in placenta from pregnant women. There is a gender effect: all the body fat values of women are two to three times higher than those of men (see Considine & Caro, 1997), probably because of the influence of sex steroids such as estrogens, progesterone and androgens (Rosenbaum et al., 1996).

Chagnon et al. (2000) summarises that the identification, in humans, of mutations in two of the genes, Leptin (LEP) and Leptin-Receptor (LEPR) gene, and in the melanocortin receptor 4 gene, represents the first direct evidence of the involvement of genes in human obesity. The results of the two genome-wide scan efforts that have been published so far are disappointing in that they have yielded relatively few new candidate chromosomal regions or candidate genes for the genetic basis of adiposity and obesity in humans. Other scans on different human populations and the cloning of the genes responsible for the quantitative trait loci observed in multigenic animal models of obesity will uncover additional and more promising candidate genes that will contribute to the ongoing

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efforts to identify the genetic and molecular basis of the common forms of human obesity (Chagnon et al., 2000).

Stunkard (1993) describes how genetic factors do influence human obesity. Risch (1990) states that the risk of becoming obese when a first degree relative is overweight or obese can be quantified with a statistical value called the lambda coefficient (λ_s) which is defined as the ratio of the risk of being obese when a biological relative is obese compared to the risk in the population at large, regarding the relevance of obesity. Stunkard (1993) highlights a series of family studies that has firmly established the familial nature of human obesity. However, family members share environments as well as genes, and family studies by themselves cannot distinguish between the contributions of these two kinds of influences. An alternative view is that the increases in obesity seen in many Western countries over the past few decades are not reflective of genetic changes but of gene expression, facilitated by the environment (Wardle, 1996). According to Wardle (1996) comparison of twins reared together with twins reared apart also shows how little a shared upbringing contributes to similarity in body size. Most evidence point to environmental effects contributing about one third of the variation in body size in 20th century Western environments.

The most widely held view is that genes confer a susceptibility or predisposition to obesity and genetically predisposed individuals may be especially susceptible to aspects of lifestyle such as low activity and high fat diets, and gain weight more readily (Wardle, 1996). According to Friedman (1999) myths regarding treatment implications of the genetic predisposition must be dispelled, of which one is the idea that obesity is inevitable. Predisposed individuals probably cannot get away with the lifestyle of those without such a predisposition and may find weight-loss harder, but it is not impossible. Similarly, the offspring of the gingerbread man could have a ginger trait or gene, but they don't necessarily have to run or be caught by someone else to be called gingerbread men or women.

Developmental factors

For women, the central event for the development of obesity is pregnancy (Bray, 1989). A woman who becomes pregnant will be several kilograms heavier, two years after the pregnancy than a woman who was not pregnant. The optimal weight gain for pregnant women during pregnancy is 10-12kg. As the body weight increases, the optimal weight gain to minimise fetal loss declines; for women who are more than 50kg above desirable weight, a weight gain of 6 to 8 kg is optimal for fetal survival.

Furthermore, Bray (1989) notes that obesity can begin at any age. During the first year of life, the size of fat cells increases nearly twofold, but there is no measurable increase in the fat cells (Bray, 1989; Gray, 1989). When obesity appears in the age group (4 to 11 years), there can be a progressive deviation of body weight from the upper limits of normal for height and age; this may be called progressive obesity. This obesity is usually life long and is associated with an increase in the number of fat cells. Hypercellular obesity appears along with the onset of menstruation, which usually occurs at an earlier age in obese girls (Schoeman, 1993). Bray (1989) has found that obesity mostly develops after the end of puberty. Estimates from several sources have suggested that less than one third of obese adults were obese in childhood. Thus children who were lean throughout development can become obese in late adolescence or adulthood if they remain in positive energy balance for sufficient periods (Epstein, 1993).

Blackburn and Kanders (1994) conclude that when obesity does develop in individuals below 35 or 40 years of age, it seems to be fraught with greater health risks than when it begins in life. Epstein (1993) concludes that obesity is a developmental disorder. The relative risk of obesity increases with the age of the child, suggesting that the older an obese child, the more likely he/she will become an obese adult. Wadden and Foster (1992) argue that one obvious consequence is that at the same age, obese adults who where also obese as children will have been obese longer, which may have implications for disease and treatment. With regards to the stigmatising effects of labelling, the description of obesity as a developmental disorder could imply that if an individual has the disorder as a child and does not shake it by puberty, an individual will be obese for life even if he/she undergoes treatment. In a narrative therapeutic setting the aim would be to highlight times in an individual woman's life where she did not think of herself as fat or obese, while growing into an adult or times where she could stand up against labels in any preferred way. In this way the women are given a choice to practise the preferred stories against the label of obesity as a developmental disorder. Similarly, the gingerbread man could start realising different attributes he has and start questioning the label of being a man rather than a woman disguised as a man or the label of being made out of gingerbread.

Physical inactivity

Historically, physical inactivity has been seen as playing a major role in the development of obesity, thus obesity developed due to decreased activity, rather than overeating (Johnson, Burke & Mayer, 1956; Rose & Mayer, 1968). Other investigators fuelled the controversy by also suggesting that obese persons did not eat more than non-obese persons, again suggesting that people become obese

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as a result of inactivity (Corbin & Fletcher, 1968; Wilkinson, Parken, Pearlson, Strong & Sykes, 1977). Epstein (1993) argues that there is a methodological flaw in concluding that obese children burn fewer calories than non-obese children on the basis of lower activity levels and that these lower activity levels contribute to the development of obesity. Activity measures do not measure caloric expenditure and it must be taken into account that expenditure depends upon both activity and body weight.

The potential role of inactivity in the development of obesity has been revitalised by Dietz and Gortmaker (1985). They showed that television watching, a major source of inactivity in children's lives, was positively associated with obesity. The more television a child watched, the more obese he/she was. Epstein (1993) notes the underlying assumption of the television watching analysis, that excess television watching or engagement in other sedentary activities precludes time spent being more active, such that excess sedentary behaviour becomes a marker for inactivity and a risk factor for obesity. Another example of a sedentary activity is children playing computer games and working on the computer for many hours on end. According to Epstein, Smith, Vara and Rodefer (1991) the observation that obese children are more likely to choose sedentary activities than non-obese children has been replicated in laboratory settings using behavioural economic analyses of choice. Nevertheless, several studies have shown that sedentary individuals are heavier than those who are physically active (Bouchard, Depres et al., 1993; Gortmaker & Dietz, 1990). Very physically active individuals are rarely obese (Williams, 1997). In a narrative therapeutic setting, highlighting sedentary versus physical activities in the participants lives, could give a fuller description of choices they have to partake more in physical activities as to increase their preferred healthy lifestyle. In a similar way the gingerbread man could start running with a specific destination in mind.

Eating style

The stereotype image of the obese person as a glutton who constantly eats with abandon has been repeatedly reinforced by the media (Friedman, 1999). DiGirolamo et al. (2000) describes the underlying cause of obesity in the majority of patients as being one of excess energy intake, inadequate energy expenditure, or a combination of both. Mahan and Arlin (1992) argue that overweight is only partly caused by overeating. Zdrodowski's (1996) notes how the eating behaviour of women classed as overweight is always accounted for in terms of their size. If they ate a lot they were greedy and so it was no surprise that they where fat. Conversely, though, if they ate only a little, it was because they where on a diet – due to their size. Research of this topic is

plagued by poor methodology to measure food intake, because of the tendency of obese individuals to under-report their food intake (Schoeller, 1995) and that only small deviations in energy balance sustained over time are necessary to produce large difference in body weight in the long term (Seidell & Flegal, 1997).

In literature there are controversial debates with regard to the effect of dietary fat on caloric intake and body weight (Popkin, 1998; Willet, 1998). There is evidence to indicate that subjects tend to consume more calories when the diet is higher in fat and this can result in heavier body weights. Nevertheless, many of the long term studies that show associations between fat intake and body weight are confounded by differences in economic development and physical activity level (DiGirolamo et al., 2000). In relation to the life world of an obese person, possible binge-eating episodes, on a daily and weekly basis as well as constantly being on diets could be an integral part of the eating style or pattern. It is difficult to define what constitutes an eating binge, but two proposed criteria provide a reasonable first approximation. They are eating more food in a discrete period of time than most people would eat, combined with a reported lack of control during the binge. Whatever refinements in the diagnosis may occur in the future, the definition of binge eating disorder has had the valuable result of characterising a group of distinctively different obese persons (Wadden & Stunkard, 1993).

Nauta, Hospers and Jansen (2001) note that several researchers have found that dieting itself has negative effects as well. Frequent dieting might be associated with increased cardiovascular and all-cause mortality (Blair, Shaten, Brownell, Collins & Lissner, 1993; Lissner, Odell, D'Agostino, Stokes, Kreger, Belanger, & Brownell, 1991), that results in pathological changes in cognition and affect (Brownell & Rodin, 1994; Foreyt, Brunner, Goodrick, Cutter, Brownell, & Jeor, 1995; Friedman & Brownell, 1995; Polivy & Herman, 1992). The literature is inconclusive as to the causal role that dieting plays in the development of binge eating in obese people (Howard & Porzelius, 1999). However, in a study of Telch and Agras (1993), it was found that caloric restriction leads to binge-eating episodes in obese people.

In the eating style context, the gingerbread man analogy could simply be deconstructed in changing the running verb with eating as verb and the catch verb with swallow as verb, thus "eat, eat as fast as you can you cannot swallow me I am the gingerbread man". Similarly, the above research highlights important trends, but fails to explore women's relationships with food in excess; especially the when, what, how and how much food intake and the function of the eating process for an individual woman. In White's (2002) South African study, a group of matric girls made lists of

reasons why people might decide to eat as follows: for comfort, for fun, for company, for a healthy diet, for energy, because they were lonely, feeling bored, to try things they saw advertised, to punish critics, because they are angry, to please other people, to celebrate, to show appreciation, to show love, to spite someone who has critised them, to show someone they cannot control them. White (2002) continues by saying that results in obesity and is by itself not generally considered to be an emotional illness, but when everything is considered the sufferer almost always finds a lot of feelings mixed up in his or her reasons for eating too much. The question remains as to the psychological factors regarding obesity?

What are the psychological factors regarding obesity?

Rodin, Silberstein and Striegel-Moore (1988) suggest that while daily conversations and popular press clearly indicate the importance of weight in women's lives, psychological research has largely neglected the issue. For many years obesity was ascribed to psychopathological determinants, such as low frustration tolerance and lack of will-power (Stunkard & Wadden, 1993; Wadden & Stunkard, 1985). However, further research has changed our understanding of obesity, and psychopathology is now seen more as a consequence, rather than a cause, of obesity (Rand & Macgregor, 1990).

Consequently, the concept of psychological distress requires clarification. Obesity has consequences for physical morbidity via different physical complications and diseases, and so do psychological morbidity, therefore it is not a unitary concept. Common place assumptions of psychological distress and of the contribution of psychological factors to the state of obesity are not supported by consistent research evidence (Friedman & Brownell, 1995). In this study the following psychological factors are discussed, namely: psychological disturbance, intrapsycic- and interpersonal factors.

Psychological disturbance specific to the obese

Although weight dissatisfaction is common among adolescent girls so as to approach a normative discontent (Rodin et al., 1984), it is more severe in obese girls. With the problem of body-image disparagement, many obese feel that their bodies are ugly and despicable and that others view them with hostility and contempt (Stunkard & Mendelson, 1961). Body-image disturbance is the mental picture that an individual has of his/her physical appearance (Gardner, Morell, Urrutia & Espinoza, 1989). Freedman (1988) states that body-image consists of the following aspects: visual, cognitive,

emotional, kinaesthetic, historical and more especially a social aspect; therefore an obese person sees herself as she thinks others see her. There is a general consensus in literature that obese persons have a disturbance in their accuracy regarding their body size. They often block their own reactions towards their own body-image, inner needs and feelings (Gous, 1995). The perception of women regarding their body-image and especially their weight is a highly emotional issue. Stunkard and Mendelson (1961) further say that it makes no difference whether the obese is also talented, wealthy or intelligent; their weight is their only concern, and they see the whole world in terms of their weight.

The obese have disturbances in self-evaluation also; therefore feelings of guilt and shame over their inability to control their weight are likely to diminish their self-esteem in some areas of functioning (Wadden & Foster, 1992). From adolescent to womanhood it seems that the obese experience a sense of personal ineffectiveness that is intricately tied in with their own distorted evaluations of self and personal standards, including, but not limited to, distorted evaluations of physical body. Related to this, one would expect that sense of personal effectiveness if less related to generalise expectations. These expectations concern one's control over reinforcements and are conceptually associated with self-concept and ego-strength, especially as defined by subjective perceptions of what one is vis-à-vis what one believes to be the ideal standards (Woods & Heretick, 1983-1984).

Within a feminist theoretical framework the feminine body is constructed as an object to be looked at (McKinley & Hyde, 1996) and because of this construction; women learn to view their bodies as if they are outside observers. They internalise cultural body standards so that the standards appear to originate from the self and believe that achieving these standards is possible, even in the face of considerable evidence to the contrary. This experience of the body as an object and the beliefs that support this experience is called objectified body consciousness (McKinley & Hyde, 1996). The gingerbread man analogy could be that the female gender of the gingerbread man is observing herself as being unacceptable, without considering others positive feedback and therefore she continues to run.

Intrapsycic factors

Here follows some intrapsycic factors from literature as a possible cause or consequence of obesity:

- *Depression*: Low self-esteem, social avoidance and body-image dissatisfaction may need to be included alongside clinical states of depression and anxiety, as significant symptoms of psychological distress (Hill & Williams 1998). According to Smith and Petty (1995) a

variety of behaviours have been associated with mood regulation, one example being overeating (Frost, Goolkasian, Ely & Blanchard, 1982).

- *Anger and frustration*: As stated above the emotion of anger and feelings of frustration with regards to an obese women's dependence upon people or situations are replaced with feelings of hunger (Gross, 1983).
- *Anxiety*: Wise (1981) explains that the eating situation is filled with tension and anxiety. The act of overeating helps to relieve the person of his/her tension and anxiety.
- *Self-nurturing*: Obese people often feel that some types of food or all types of food have the power over them and can force them to overeat, even though rationally they do not want to. Wise (1981) further suggests that when a child experiences a lack of nurturing from the mother figure, the child could start overeating to nurture him or herself.
- *Locus of control*: Obese women are more prone to have an external locus of control, possibly because they feel that they have less personal control over their social environment and over their impulses and desires (Rodin, Schank & Striegel-Moore, 1989). Rotter (1975) distinguishes between an internal or external locus of control. In the first case, individuals believe that they are personally responsible for and in control of the choices they make in different circumstances. In the second case, individuals believe that external forces or circumstances are to blame or as the saying goes "it is out of my control, so I can't help it, whatever will happen, will happen". However, with relation to weight reduction, controversial findings have been reported. Some support the superior ability of internals to lose weight, while others found no difference between internals and externals, at least in the short term (Nir & Neuman, 1995). Friedman (1999) reasons that the obese state may be followed by an external locus of control orientation rather than precede it.
- *Gender role identity*: Roden et al. (1988) propose that maternal modelling of a highly appearance-invested mother or one who worries about, or disparages her own looks, may abet a daughter's development of disturbances in body-image and eating.

Interpersonal factors.

Here follows some interpersonal factors from literature as a possible cause or consequence of obesity:

- *Family dynamics*: Gous (1995) states that there is a minimal amount of literature available focussing on the family dynamics of obese persons. A possible reason for this according to Louw (1989) is that obesity is not necessarily related to specific pathology in a family. Although it is theorised that a focus on female appearance starts in childhood through

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parental commentary and continues to impact a woman's body and psychological functioning in her adult life (Swartz, Phares, Tantleff-Dunn & Thompson, 1999).

- *Intimate relationships*: Gous (1995) states that obese persons may possibly lessen their activities, because of their fear of handling certain stressful situations. To become obese, could be a possible defence against their fear of sexual functioning or a fear to partake in intimate relationships with significant others.
- *Traumatic incidents*: It could be a cause of obesity (Gross, 1983). For example, an adult survivor of sexual abuse in childhood, where the woman has an unconscious need to be strong and large to protect herself, obesity is a means to an end in itself. Another example is the loss of a loved one at an early age, where obesity becomes a way of dealing with the grief the woman experiences at certain points in her life.

Furthermore, in search of different contexts in which obesity is placed, one of the salient concepts used in literature studies with regards to obesity are women's self-esteem issues.

How are self-esteem issues regarding obesity defined according to several experts on the subject?

The question arises as to the origin of the word self-esteem. Let us start with self as the base word in self-esteem. Many psychologists refer to William James (1890) when talking about self-components. The important issue is James's answer to the question, "What self is known?", and here we see that the self is easy to recognise; it consists of material components, others' evaluations, and inner psychological mechanisms. More than 100 years later Bruner and Kalmar (1998) describe self as being somewhat unstable over extended time – a fact that should not be overlooked. Autobiographies are typically full of turning points featuring presumably profound changes in selfhood. Our fixed identity in the eyes of the law is not matched psychologically by the subjective twists and turns in our self-conceptions, perhaps the more so under conditions of rapid cultural change (Lifton, 1993).

Within a post-modern context self grows in an environment of its own making. The events and circumstances that shape it are themselves constructed, products of self-generated meaning making shaped to fit our growing conceptions of selves (Bruner & Kalmar, 1998). The events we encounter are coded and filtered at the very entry port by our perception of the world (Bruner, 1973, 1992; Neisser, 1988; Niedenthal & Kitayama, 1994). So while the experienced world may produce self, self also produces the experienced world, all of which suggests that the self is not only constructed,

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but also that its mode of construction is massively hermeneutic. Perhaps it is this interpretive feature of self-construction that imposes certain conceptual structures upon self (Bruner & Kalmar, 1998). In this study the defining process of women's selves is co-constructed between the therapist and an individual woman. The subjective nature of conversations allows for unique constructions of selves, which in itself is possibly larger than the description given regarding an obese person or obesity. Within a post-modern context the assumption of human nature is that an individual has more stories than just an obese story and that the obese story could be part of the fuller description of the individual's self. Furthermore the combination of the words self plus esteem will be described according to experts on this subject.

Brown and Dutton (1995) address the fact that numerous theorists have attempted to define self-esteem. These attempts have ranged from an emphasis on primitive libidinal impulses (Kernberg, 1975) to feelings of existential security in a meaningful universe (Solomon, Greenberg & Pyszczynski, 1991). Brown and Dutton (1995) take a less exotic approach and define self-esteem in terms of feelings of affection for oneself, no different in kind than the feelings of affection one has for others. Brown (1996) questions the assumption made in research with regards to improvement of self-esteem (Mruk, 1995), that people's feelings about themselves depend on what they think about themselves, and that self-esteem can be improved by thinking you have many positive qualities. Brown (1996) argues that many people with low self-esteem believe they have many positive qualities, but they still do not feel good about themselves. In this study the therapeutic intervention – narrative conversations, include women's verbal accounts of their feelings and thoughts about themselves and others, as well as thoughts and feelings of affection. Rather than separating these two levels of self-affection, thoughts and feelings could have an effect or influence on each other at any given point in time and situation, thus being interwoven with one another. Furthermore, negative feelings do not necessarily cause negative thoughts and visa versus. The same could be said for positive thoughts and feelings. Supporting research regarding the interplay between affective and cognitive processes has been done (see, Erber & Tesser, 1992; Parrott & Sabini, 1990; Petty, Schumann, Richman & Strathman, 1993; Smith & Shaffer, 1991).

Further Smelser (1989) identifies the almost universally accepted components of the concept of self-esteem as follows:

- There is first a cognitive element; self-esteem means characterising some parts of the self in descriptive terms; power, confidence, agency. It means asking what kind of person one is.
- Second, there is an affective element, a valence of degree of positiveness or negativeness attached to those faces identified; we call this high or low self-esteem.

- Third, and related to the second, there is an evaluative element, an attribution of some level of worthiness according to some ideally held standard.

Within normal populations, high self-esteem is characterised by general fondness for oneself; low self-esteem is characterised by mildly positive or ambivalent feelings toward oneself rather than excessively negative feelings toward oneself (Baumeister, Tice & Hutton, 1989). According to Abell and Richards (1996), researchers have begun to look at the specific issue of thinness versus fatness, and at how satisfaction with the shape of one's body can affect self-esteem. This has been a particularly salient aspect of body-image for psychologists to investigate, since our society has often been described as one that is obsessed with the issues of weight and body shape (Faust, 1982; Mintz & Betz, 1988). In general, researchers have found that women who express greater dissatisfaction with their weight and body shape tend to have lower self-esteem scores than women who have a healthier body-image. This difference tends to be true for pre-pubescent girls (Fabian & Thompson, 1989; Mendelson & White, 1982, 1985), for adolescent females (Fabian & Thompson, 1989; Martin, Housley, McCoy, & Greenhouse, 1988), and for adult females (Mintz & Betz, 1988; Thomas, 1989). A woman's feelings about her weight may be a particularly crucial aspect of her body-image (Abell & Richards, 1996).

Body-image may be understood as a multidimensional self-attitude toward one's body, particularly its appearance (Muth & Cash, 1997). Body-image is associated with how people think, feel and behave with regard to their own physical attributes (Rosenblum & Lewis, 1999). Across the life span, body-image can be seen as a vital aspect of self-worth and mental health (Potash, 2002). Potash (2002) notes that body-image undergoes change during adolescence. The combination of adolescents' changing physical appearance, their increasing cognitive abilities, and their capacity for introspection may render them particularly vulnerable to excessive and negative preoccupation with their own and others' perceptions of their bodies (Rosenblum et al., 1999). Body-image lies at the heart of adolescence as it is an important part of identity development, particularly at the stage of adolescence when accommodation to pubertal change is a key developmental task (Ferron, 1997).

Molinari and Riva (1995) further state that obese women feel themselves socially undesirable and consider obesity as a largely negative condition. An obese person was described as heavy, slow, unhappy, unlikeable, crude, nervous, tense, introverted, stupid, pessimistic, fearful, weak, indolent, insecure, static, passive and inconsistent. Obese people are typically characterised as physically unattractive, flawed in character and personally responsible for their overweight condition (Lewis,

Cash, Jacobi & Bubb-Lewis, 1997). Furthermore they are commonly described as lazy, ugly, stupid, lacking will power, incompetent and indulgent (Richardson, 1971; Larkin & Pines, 1979). The consequences of such stereotypes have been shown in many studies. For example, some results showed that obese people are less likely to be hired for jobs or positively evaluated compared to non-obese candidates (Rothblum, Miller & Carbutt, 1988; Jasper & Klassen, 1990), obese people where less likely to receive a service, help or advice than their non-obese counterparts (Steinberg & Birk, 1983; Pauly, 1988).

Existing self-esteem literature supports the proposition that people low in self-esteem are generally more dependent on and more susceptible to external cues that carry self relevant implications (Campbell & Lavallee, 1993). Of particular relevance is the research that has examined self-esteem differences in reactions to self-relevant feedback or information (Jones, 1973; Shrauger, 1975; Swann, Pelham & Krull, 1989). Campbell and Lavallee (1993) propose that low self-esteem people tend to be more threatened by negative feedback and more gratified by positive feedback and that such individuals are more reactive to their social environment. Drury and Louis (2002) balance the literature proposing that obese people have low self-esteem by stating that the obese are not a homogenous group. Although body-image dissatisfaction is correlated with Body Mass Index (BMI) (Hill & Williams, 1998; Sarwer, Wadden & Foster, 1998), low self-esteem is not always the inevitable result. Obese women who reject the cultural standard of thinness equalling beauty report higher levels of self-esteem and self-confidence (Fuller & Groce, 1991; Packer, 1990). However, both groups of obese women – those with low self-esteem and those with high self-esteem – have been found to delay or avoid health care (Packer, 1990).

Within a narrative therapeutic framework, women having a high or low self-esteem have choices in any given social environment and their choices have certain consequences. According to Phillips (2001) the powerhouse in any story is the will of the characters to get or do what matters to them. So they need to know what matters; it needs to matter enough that they are prepared to work for it, and they need to understand what it would take to get what they want. In this study the aim is to allow a space where women become aware of their choices regarding a low or a high self-esteem which could have an effect on their self-awareness as individuals, thus knowing oneself and exploring one's own feelings and thinking about oneself.

Conceptualising the concept of self-awareness follows. Self-awareness is internally focused attention and may increase the accessibility of one's general self-schema or self-concept, which in turn can influence collecting and processing self-relevant information (Carver & Scheier, 1981;

Carver, Lawrence & Scheier, 1996). According to Natsoulas (1998) a person's self-awareness must take place in any instance of consciousness that is based on evidence from the past. Natsoulas (1998) describes several kinds of self-awareness as follows and states that one cannot be conscious in their absence:

- Self-witnessing is the relevant outcome to which factors like one's intellectual, moral, or religious powers, abilities, traits, dispositions or tendencies as well as spiritual, social and material facts about oneself, may have contributed, such as a habitual way of thinking about the world or treating other people.
- Appropriation to oneself is to be not only aware firsthand of the particular piece of one's behaviour or segment of one's stream of consciousness that would serve as evidence, but also to be aware of that piece or segment as being one's own.
- 'Retrowareness' of oneself involves concurrent awareness, now, of a past happening or state of affairs.
- Inner awareness is the act of remembering something in particular. One must be concurrently aware now of oneself as now apprehending that which one had earlier apprehended.
- With consciousness extended backward, a present 'retrowareness' of one's past experiences occurs. Past experience meaning, for example, one perceiving, emoting over, particular that was taking place, had taken place, or was going to take place.
- One must have thoughts regarding one or more characteristics that may belong to the intellectual, moral, or religious dimensions of one's personality, and one must make judgments regarding how the remembered evidence bears on whether those characteristics do so belong.

Following the analogy of the gingerbread man; are the ginger bread man and the obese women being self-aware and if so what are they aware of themselves? The assumption in this study is that women's obese story is possibly the story that overshadows women's thoughts and feelings about themselves. Bruch (1962, 1969) states that obese patients fail to discover or tend to block their awareness of impulses, feelings and needs that originate within themselves. The failure to respond to external and inner cues is the central core of their psychopathology. The inability of obese patients to respond to their body-image, inner needs, impulses and feelings stems from their tendency to block them. The obese patients substitute feelings of anger or frustration or dependency needs for feelings of hunger. They tend to distort their own body-image by changing the visual stimuli from their own bodies (Gross, 1983). Alternatively, Phillips (2001) notes with regards to self-awareness that if you are more aware of where you're reasoning comes from, you

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become more aware of how important it is to your thinking in the future. It allows you to see what impacts on you and what you may have missed. In the narrative therapeutic context of this study, women in relationships with food in excess could become self-aware or more self-aware in the process of the therapeutic conversation and this is part of their realisation of preferred narratives they could choose to live by. Therefore self-awareness is an important ingredient in finding new-old stories in a person's past which could be relevant in one's future becoming the preferred narrative for one to live by.

From above mentioned literature, the conclusion could be drawn that obese patients are depicted, at a self-awareness level, as being pathological in nature, thus being branded with a label that they cannot be self-aware like normal people. Brown (1993) is of the opinion that the definitions of obesity and overweight have been the subject of substantial medical debate, in part because they must be based upon inferred definitions of normality or ideal body proportions. Further Brown (1993) states, that cultural beliefs define what is normal and therefore constrain the choices of behaviours available to an individual. In this study, within a narrative therapeutic framework, women in the obese category could become self-aware or more self-aware during questioning of the discourses in their obese story. The aim of facilitating self-awareness is for the purpose of collecting and processing self-relevant information for a fuller description of an individual woman's life world of obesity and beyond.

After exploring self-esteem issues surrounding obesity as a starting point for a fuller description of the context in which obesity is researched in this study, there follows a description of the socio-cultural context in which the gingerbread man or obese person is running.

The socio-cultural context regarding obesity

Is the socio-cultural context with regards to obesity and the gingerbread man a marathon, a chase or a quest or something else and for what reason? Here follows some socio-cultural factors:

Cultural factors

Cultural stories determine the dimensions that organise people's experience (Zimmerman & Dickerson, 1994). Cultural stories are not neutral (Bruner, 1990). They lead to constructions of a normative view, generally reflecting the dominant culture's specifications, from which people know themselves and against which people compare themselves (Zimmerman & Dickerson, 1994).

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Culture refers to the learned patterns of behaviour and belief characteristics of a social group. A cultural system of thought and behaviour may be shared by an isolated tribe or in a complex society, an ethnic group or social class. Culture includes directly observable material aspects, like diet or productive economy, as well as important ideological components, such as aesthetic standards of ideal body type; the relationship of the material aspects of culture to the etiology of obesity may be directly demonstrated while the relationship of ideological components and obesity remains more speculative (Brown, 1993).

While cultural influences may be less important than genes in a statistical sense, they are more important in terms of the treatment and prevention of obesity. This reason is simply that cultural predispositions to obesity are changeable. A culture is an integrated system, so that a change in one part causes changes on the other levels (Brown, 1993). In fact, culture is the primary reason for the evolutionary success of humans because of its distinct advantages of greater speed and flexibility over genetic evolution (Brown, 1986). Braten (1984) defines a socio-cultural system as a "meaning-processing system of interacting participants who maintain and transform the identity of themselves and of their network through a more or less shared understanding of both themselves and the world" (p. 193). He further states that this shared understanding is neither subjective nor objective, but that it is intersubjective, generating the subject complimentarity.

According to Sarlio-Lahteenkorva, Stunkard and Rissanen (1995), of all conditions for which a person may be stigmatised in our culture, the stigma of overweight may be the most debilitating. Research in obesity demonstrates that there is a widespread, culturally acceptable stereotype and negative attitude of obese people (Jasper & Klassen, 1990; Lewis et al., 1997). These stereotypes may stimulate prejudices and poorer treatment of obese people (Jasper & Klassen, 1990), thereby potentially limiting their social and economic success. Since obesity is immediately visible to others, it can affect most social interactions. The stigma of overweight has two aspects: stigmatisation of appearance of the body and the stigmatisation of the character of the person for the moral failure of not controlling one's weight. Fatness is symbolically linked to psychological dimensions such as self-worth and sexuality in many societies in the world; but the nature of the symbolic association is not constant (Brown, 1993). Friedman (1999) states that cultural artefacts are clearly constructed with the thin person in mind, narrow supermarket aisles and seats in buses, planes and theatres are all designed to accommodate the thin person. Restaurant booths, telephone booths and conventional furniture all tend to pose difficulties for the obese members of society, potentially denying them from full participation in the culture. English (1993) highlights the fact that obese people are culturally isolated in subtle and not so subtle ways.

South Africa is a mixture of cultures pertaining to traditional and developed societies within a multi-cultural context. In the context of this study the participants are women, from a traditional and developed white, Afrikaans speaking society. According to Dollan (1991) white women are under cultural pressure to value thinness and thus to diet for the sake of appearance (Melnyk & Weinstein, 1994). Senekal, Steyn, Mashego and Nel (2001) conclude that their research results indicate that the weight pattern of black South African students follows the pattern found in black American females, while whites in this country follow the pattern of white westernised groups. In America, in traditional societies in which women attain status primarily through motherhood, the symbolic association increases the cultural acceptability of obesity. A fat woman, symbolically, is well taken care of, and she in turn takes good care of her children. The cultural ideal of thinness in developed societies, in contrast, is found in societies in which motherhood is not the primary means of status attainment for women (Brown, 1993). In this study the participants are a mixture of both abovementioned symbolic associations, thus being career women and caregivers at the same time. In a narrative therapeutic framework, women's feelings and thoughts could be explored regarding their possible mixed symbolic associations of what makes a culturally perceived good enough or healthy woman.

Societal expectations

Despite societal expectations of slimness, the prevalence of obesity is increasing (Kuczmarski, Flegal, Campbell & Johnson, 1994; Lyznicki, Young, Riggs & Davis, 2001). Freedman (1988) refers to the social norms that are neurotic in nature and they set impossible standards for female beauty, resulting in body-image disturbance and the destruction of women's self-worth. During the 20th century, the ideals of beauty for women, and to a lesser extent for men, have increasingly emphasised slimness. The increasing discrepancy between actual versus desired body weights has led to normative discontent with weight among women and has promoted efforts to lose weight (Friedman, 1999).

Blackburn and Kanders (1994) state that in industrialised societies, social epidemiologists find that *fatness varies in relationship to many different roles*, including gender (women are fatter), life course position (fatness increases until people become elderly, then declines), ethnicity (African American women in the United States are fatter), socio-economic status (lower socio-economic status women are fatter), marriage (married men are fatter), parenthood (the more children a woman has the fatter she is) and residence (people living in rural areas are fatter). Concluding that specific mention of the female gender regarding obesity is more prevalent in literature than that of the male

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gender. The question arises as to the power relations men, the media, and health businesses portray with regards to societal expectations of women forced to be thin in order to be regarded as beautiful.

Rothblum (1999) argues that the power relations at play are nested in the billions of dollars that are at stake and many companies would lose revenue or go bankrupt if women became satisfied with their bodies to the point of not joining health clubs, not undergoing plastic surgery, or wearing comfortable clothing that was unrelated to the annual changing fashion dictates. Furthermore, Rothblum (1999) predicts a rapid and vicious backlash on the part of the corporate sector and related institutions, such as the media and medical establishment. Rothblum proposes that the health professionals with specific mention of psychologists should predict this backlash. Questioning this situation would mean berating the intimate relationship between research and politics.

Could we be certain beyond a shadow of a doubt that the gingerbread man or obesity is who society, literature and media say he or it is? Could walking instead of running after the gingerbread man lead us to a slower search or lead us astray in trying to understand him or it? Thus, is it possible to approach the description of the concept of obesity differently than what the medical model has defined it to be? Could the deconstruction of the label of obesity lead health professionals and women to a fuller understanding of their experiences with food in excess? Consequently, could the treatment of obesity as literature depicts it lead health professionals on a different path of healing methods for women?

Treatment in reflection

Here follows a description of the concept of physical and psychological health regarding obesity:

The concept of physical health regarding obesity requires clarification

Rothblum (1999) states that obesity is usually presented as a condition that correlates with, or leads to, physical health problems, and this fact is sighted in many of the weight loss treatment studies as the reason for attempting to lower body weight. It is important to point out that the association between obesity and physical health problems is based on studies of obese and non-obese people, not on obese and formerly obese people.

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In other words, the fact that thin people are healthier than fat people does not mean that formerly fat people (successful dieters) necessarily will also be healthier than fat people who have not dieted or who can not lose weight. For example, obesity and physical health risks may be due both to genetics, or to a third variable, so that changing one of these factors (weight) may not change the other (health) (Rothblum, 1999). Treatment, with the goal of a long-term successful outcome would be more complete once the psychological impact of obesity is understood and focused on (Friedman, 1999).

The concept of psychological health regarding obesity requires clarification

While the links between obesity and physical health problems are well established, the same is not true of those between obesity and psychological health (Hill & Williams, 1998). This apparent preservation of psychological health is all the more surprising given the stigma attached to obesity (DeJong & Kleck, 1986) and the measurable social and financial penalties of obesity (Gortmaker et al., 1993; Sargent & Blanchflower, 1994). The concepts of disease prevention, wellness, and health promotion are basic and common-sensical in theory, however in practice they are anything but basic or simple to enact. Barriers to health care utilisation exist and health care providers, including nurses, need to be aware of these barriers, particularly those associated with weight as overweight and obesity contribute to much morbidity (Drury & Louis, 2002). Psychologists also need to be aware of these barriers and they need to be part of a multi-disciplinary team effort in helping people who are struggling with overweight.

On an individual level self-esteem appears to be related to positive mental health or psychological well-being (Mruk, 1995). As Bednar, Wells and Peterson (1989) say, for instance, “It has been repeatedly demonstrated that self-esteem and psychological health are related to favourable psychological consequences in a variety of psychological situations” (p. 190). Colvin, Block and Funder (1995) note that traditional conceptions of mental health have held that well-adjusted people perceive relatively accurately the impact and ramifications of their social behaviour and possess generally valid information about the self. Therefore, it is not surprising that when individuals are asked to recall self-defining characteristics, mentally healthy people recall positive traits with greater ease and frequency than do people lacking in mental health (Kuiper & Derry, 1982; Kuiper & MacDonald, 1982). In a narrative therapeutic setting, being self-aware of one’s self-esteem could open up an understanding of the possible choices and consequences of those choices women have with regards to their relationship with food in excess or not in excess.

A holistic approach to the care being provided to the client should include a focus on health and well-being, not weight. This approach needs to encompass not only health outcomes, but also needs to take into account each individual's perspective on success, health status, weight history and goals related to appearance and body size, and that nurses must refuse to participate in cultural stereotypes related to fatness and challenge the sexist bias inherent in the cultural ideal for women's bodies (Allan, 1994). Culture is the key to prevention; the existing beliefs and practices of populations at greater risk for obesity must be understood if appropriate and effective health intervention is to be designed (Brown, 1993). Drury & Louis (2002) suggest that emphasis needs to be placed on evaluating and optimising life style patterns such as stress reduction, exercise and healthful eating habits.

An alternative exploration in a narrative therapeutic setting could be the deconstruction questioning process itself in search of treatment, intervention or conversations regarding obesity. According to the analogy, does the gingerbread man understand his quest? Could he be after happiness, health, quality of life or something else? What other possibilities are there? In a similar way, having narrative conversations and discovering new meanings, could open up alternative ways of treatment, rather than using a general set of symptoms and treatments clarified and categorised as in literature. For example, weight reduction can be approached as a partnership between the client and providers (multi-disciplinary team), rather than a directive such as weight-loss aimed at the client (Drury & Louis, 2002). Here narrative therapists/ psychologists could play a major role in helping the other health providers as members of a multi-disciplinary team and the clients in challenging cultural stereotypes related to fatness, finding discourses and new-old stories or alternative stories for individual and team success in treatment.

Concluding reflections

Upon reflection, a new phrase of this letter's nursery rhyme comes to mind: *"Eat, eat as slow as you can, then you will taste me, I am the gingerbread woman"*. In explanation of this reflection, the *eating metaphor* in the label of obesity could be more appropriate than the running. Where as the *slow paced metaphor* allows for a slower pace where the narrative researcher-therapist in collaboration with the participant-women could explore their verbal meaningful accounts with regard to their relationships with food in excess. The *taste metaphor* could refer to an evaluative experience of how good or bad the gingerbread woman tastes or how destructive the label of obesity could be versus the deconstruction of the label of obesity in being constructive through the use of narrative conversations. The *gingerbread woman* metaphor could refer to the feministic viewpoint

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of women being more obese than men and as stated that the specific mention of the female gender is more prevalent in literature than that of the male gender and the power relations this entails.

In conclusion, regarding the etiology of obesity the question remains; what makes this, already well-trodden subject important to research again? Stunkard's (1993) perspective is that at the present time, however, we know enough to help patients to a better understanding of their obesity. The information about the influence of genetic factors, for example, can help to relieve the shame and guilt that so many obese people feel about their weight, while the importance of environmental factors provides them with the hope that they may be able to control their weight. Once again this is the perspective of a professional or expert on obesity.

How does the gingerbread woman or obese person construct meaning to the description of the etiology of obesity? This study proposes in Letter of the research method–IV that women talking about their relationship with food in excess will give some understanding of what meanings they attach to their experiences and knowledge about obesity. A shift is made from the experts seen as the health professional's knowledge *to also incorporating the experiences and knowledge of so called obese women at grass roots level.*

With careful exploration
Co-author and researcher

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IV - Letter of the research process

The way the yet untold narratives unfold

Dear reader

Lieblich, Tuval-Mashiach and Zilber (1998) state that people are storytellers by nature. Stories provide coherence and continuity to one's experience and have a central role in our communication with others.

Once upon a time the second participant told a food story…

"Dear friend

I walk into a dress shop. A beautiful dress catches my attention and I see myself wearing this dress. I am very hopeful as I come closer and start searching through the dress sizes. It stops at number 18! Instantly I am upset. Who gives the people making dresses the right to decide which dresses will suit me or not?

Still upset I decide to go and drink a cup of coffee at Wimpy. It is wonderful to treat myself - to do something for myself. The other side of me wonders "what will the people say of the chips and bread that I am eating"?

I then start to wonder, like so often before, who and what I am. Am I the type of person I want to be or am I the type of person that society wants me to be? My mind says to me that I am OK. My heart says I am not OK. To whom shall I listen, my mind or my heart?

I do enjoy my life. I really love and enjoy food - healthy and unhealthy food. Every time I eat, I enjoy the experience. To treat other people with great food is wonderful. The other side to it is not so nice. To say 'no' and make excuses not to go for a swim in front of others is not so nice. To wear dark long pants when everybody else is wearing shorts in the midst of the heat is not so nice. To wear loose hanging clothes and oversized shirts over an oversized skirt is not so nice. To be self-conscious when standing in a diet shop to really believe and know that diets don't work, but still to believe that a wonder diet pill exists, is not so nice. You hope that the wonder diet pill causes food to taste so badly that you just can't eat it.

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I am wondering about spectacles that can make food unattractive or spectacles that make you look so thin when others look at you. Immediately I feel very guilty…God made me whom I am. He gave us food to eat and He takes care of us. How can I be so ungrateful? This brings me to another point. Did God make me the way I am or did I make myself the way that I am? Do others see me through the media's eyes or do they see me like God wants them to see me? It is not a sin to be very tall or small or short. Why is it a sin to be fat? Do people hear what they see or do they see what they hear?

Please see me like God sees me and not according to the prescription of social expectations. Don't look at me, but see me for who I am and listen to what I have to say.

Greetings
The second participant"

Upon reflection, there could be different types and levels of stories within one story. In this example the story is focussed on this participant's relationship with food in different contexts, namely:

- physical (large dress sizes),
- psychological- (feelings of guilt and anger),
- self-esteem issues- (to be self-conscious),
- and socio-cultural (what do others say?) context.

In a narrative therapeutic setting this participant's story is an example of what Phillips (2001) reflects:

> Life as we know it is for most of us not just our story. We interact with people every day, friends, colleagues, strangers. Every interaction brings with it new possibilities or re-runs of old ones. It is often easier for us to be carried along by other people's stories and expectations than to keep to our own stories. Why? (p.14)

Setting the table

In this letter an overview of the research process of this study will be given. Secondly a motivation for using qualitative research methods in the post-modern, social constructionist and narrative therapeutic framework will also be provided. Thirdly, the way in which the participants were

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selected and sample characteristics will be described. A detailed description of the data collection process will follow. Lastly, the process of analysing the data will be described.

Aim of the research

In short, the aim of the research is to discover various meanings with regards to women's relationships with food in excess. The stories were gathered from female participants, researcher participant and literature. The discoveries within the stories in the form of discourses and alternative stories can be used in future to create a verbal space for women to allow their voices to be heard with regard to their experiences with their relationship with food in excess as individuals, groups or communities.

Research method

Qualitative research methods will be used in the present study to elicit the understanding of the meaning of women's experiences in their relationship with food in excess. One of the reasons for using qualitative methods is in the nature of the large volume of text acquired which necessitates some form of qualitative analysis. Other reasons for choosing qualitative research methods are in the nature of the research question. The focus is mainly on the meanings women give to their food stories, whereas qualitative research methods include their reflection of real life; they provide us with 'thick' description (Miles & Huberman, 1994) and rich, descriptive, colourful detail (Neuman, 2000; Silverman, 1993) and they will help us understand the participant's personal perspective (Bryman, 1988). Parker (1994) defines qualitative research as the interpretive study of a specified issue or problem in which the researcher is central to the sense that is made. In this current study the researcher participates in the research process by moving between different roles, namely a researcher-co-author, researcher-therapist and researcher-participant role. The researcher's selected domain of interest here will be a particular aspect of action and experience, but it could just as well be a reflexive study of part of the discipline of psychology itself.

According to Punch (1998), qualitative research elucidates the meaning that people attach to social life in natural settings. Its richness and complexity means that there are different ways of looking at analysing social life, and therefore multiple perspectives and practises in the analysis of qualitative data. In accordance with the variety and diversity in qualitative approaches Punch (1998) emphasises the point that there is no single right way to do qualitative data analysis – no single methodological framework. Much depends on the purposes of the research, and it is important that

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the method of analysis is integrated from the start with other parts of the research, rather than being an afterthought. At this point, the aim as researcher in the process of analysing the data is being **able to say, not only in one letter, but from beginning to end, how the conclusions in the form of discoveries, were reached.** One of the ways in doing this would be in taking a reflexive stance as researcher throughout the writing process within the thesis and by using a reflexive diary, with the aim of separating the researcher as participant from the researcher as the co-author of this thesis.

Dey (1993) is of the opinion that qualitative analysis is a way of transforming data into something that does not exist. Although various authors have identified a large volume of literature with regard to obesity and surrounding subjects in general, the aim of this specific qualitative study is to obtain a fresh view of the data. A fresh view of the data could simply be attained by placing it within the post-modern, social constructionist and narrative therapeutic framework. In this study, content analysis is used in understanding human behaviour, in the transforming, interpreting and making sense of data. The assumption is that the research process of this particular study could be a fresh view elicited by the research question and way of answering the question in this specific paradigm. The danger could be in not seeing the danger of the limitations of this study's underlying assumptions.

Narrative inquiry is this study's qualitative research design. According to Plummer (1995) narrative inquiry is:

> The analysis of how stories mark our identities; identities mark our differences; differences define 'the other'; and 'the other' helps structure the moral life of culture, group, and individual. Narrative analysis is the analysis of formal properties of stories and of social roles of stories (p. 19).

Lieblich et al. (1998) construct the mission of psychology to be an exploration and understanding of the inner world of individuals. One of the clearest channels for learning about the inner world is through verbal accounts and stories presented by individual narrators about their lives and their experienced reality. Plummer (1995) notes that a narrative is a story with a beginning, middle and end that reveals someone's experiences. The story is one's identity, a story created, told, revised, and retold throughout life. We discover ourselves, and reveal ourselves to others through the stories we tell (Lieblich et al., 1998).

Lieblich et al. (1998) describe some basic features of conducting narrative studies applicable to this study as follows:

- It results in unique and rich data that can not be obtained from experiments, questionnaires or observations.
- No two interviews are alike, and the uniqueness of narratives is manifested in extremely rich data.
- Every new text retains the air of an enigma, a vivid mystery that generates a mixture of excitement, challenge and apprehension.
- There are usually no a priori hypotheses, where as the specific directions of the study emerge from reading the collected material, and hypotheses then may be generated from it.
- It is interpretive, and an interpretation is always personal, partial and dynamic.
- It requires dialogical listening to three voices at least; the voice of the narrator as represented by the tape or the text; the theoretical framework which provides the concepts and tools for interpretation and a reflexive monitoring of the act of reading and interpretation, that is, self-awareness of the decision process of drawing conclusions from the material.
- In the process of this study, the listener or reader of a life story enters an interactive process with the narrative and becomes sensitive to its narrator's voice and meanings.
- This narrative research does not require replication of results as a criteria for its evaluation, thus readers need to rely more on the personal wisdom skills and integrity of the researcher.
- Interpretive decisions require justification.
- This narrative research is highly time consuming for the researcher.

This study contributes to a first level of interpretation and could serve as a basis for future studies by generating hypotheses and theories while reading and analyzing the narratives, and in a circular motion as proposed by Glaser and Strauss's (1967) concept of 'grounded theory', can enrich further reading, which refines theoretical statements and so on, in an ever growing circle of understanding.

Here follows a description of the qualitative methods used within a post-modern, social constructionist and narrative therapeutic framework.

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Qualitative methods within the post-modern, social constructionist and narrative therapeutic framework

The research question of this study is linked to the post-modern, social constructionist and narrative therapeutic framework, with the main focus on the narrative perspective. The assumption is that qualitative methods are compatible with the narrative therapeutic perspective for various reasons, some of which are discussed below. In the frame of the narrative perspective the usage of an analysing method that is sensitive to context and capable of showing the complexities of discourses and alternative stories as power related entities in the stories of women with regards to their relationships with food in excess, are needed. Authors such as Miles and Huberman (1994) and Neuman (2000) state that this is exactly what qualitative analysing methods do, whereas *explanations tend to be rich in detail, sensitive in context,* and capable of showing the *complex processes or sequence of social life*. With regards to the complex processes or sequence of social life the narrative perspective could be coloured by the way narrative language is formulated and constructed within terms like, discourses and alternative stories as power related entities.

Silverman (1993) critiques contextual sensitivity in terms of qualitative studies that demand that we interpret their observations in terms of assumed social contexts. The danger in this study could be that contextual sensitivity could be highly suggestive in the generating of the research question and the research process thereafter. Silverman (1993) suggests that we reformulate questions about the impact of context on behaviour into questions about how participants actively produce contexts for what they are doing together. Using contextual sensitivity in the formulation of the research question, literature study, research process and interpreting of discoveries could place the researcher in the position where the focus is on own assumptions about what context is relevant in this situation.

In psychology and related fields, narratives are used for diagnosing psychological and medical problems (Capps & Ochs, 1995; Herman, 1992; Wigren, 1994). In the literature overview of this study obesity is depicted as mostly a medical problem and is solved accordingly, whereas weight-loss is important. In reaction to this Rothblum (1999) asks, “Why hundreds of research studies, using the same methodology, are accepted for publication year after year that show little weight-loss” (p. 367)? Consequently, a co-constructive, reflexive and qualitative narrative with regards to women’s relationship(s) with food in excess could endorse a paradigm shift in the attitudes of health related fields. In many studies in sociology, the narrative is used to represent the character or lifestyle of specific subgroups in society, in this study defined by their female gender, and their

relationship with food in excess, in literature labelled as obesity. From a social, cultural or ethnic point of view some social groups are frequently discriminated-against minorities whose narratives express their unheard voices (Lieblich et al's, 1998). In applied work, clinical psychology uses the narrative in the context of therapy. Restoration, or development of the life story through psychotherapy is considered the core of the healing process (Epston, White & Murray, 1992; Omer & Alon, 1997; Rotenberg, 1987; and others). In this study therapeutic conversations are mainly used as a way of collecting data.

It is important to highlight Lieblich et al's (1998) description on the reading process of the story as text:

> …that we sometimes read the story as text, and interpret it as a static product, as if it reflects the 'inner', existing identity, which is in fact constantly in flux. Moreover, each procured story is affected by the context within which it is narrated: the aim of the interview (for example, getting a job or participating in a study), the nature of the 'audience', and the relationship formed between teller and listener(s) (for example, are they similar in cultural background or of the same or different gender?), the mood of the narrator and so forth. Hence the particular life story is one (or more) instance of the polyphonic versions of the possible constructions or presentations of people's selves and lives, which they use according to specific momentary influences (p.8).

In qualitative analysis, there is a strong emphasis on describing the world as different observers perceive it. The perceptions of subjects are often in an advantaged position in qualitative research, because of the access; they can enlighten the researcher to the meanings of actions for particular observers (Dey, 1993). The constructivist approach, as advocated by Gergen (1991) and Van-Langenhove and Harre (1993), for example, claims that individuals construct their self-image within an interaction, according to a specific interpersonal context. Furthermore, by studying and interpreting self-narratives, the researcher can access not only the individual identity and its systems of meaning but also the teller's culture and social world.

As stated, it is through language that we are capable of forming the shifting communities of meaning to which we belong and that are for us the inter-subjective realities in which we exist (Anderson & Goolishian, 1988). In this study the qualitative ways in which the not-yet-said can unfold in the yet untold food stories are the following:

- unstructured interviews viewed as therapeutic conversations;
- reflexive diary of researcher-participant;

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- series of drawings; participants' self-expression through drawing a self-portrait; participants' and researcher-therapist's co-constructed drawings of reflections upon four conversations.

The above mentioned qualitative ways, with specific emphasis on the therapeutic conversations and reflexive diary of the researcher-participant, employ language as a tool to give detailed descriptions of situations and events. The series of drawings used are projective means of communicating data and are highly inter-subjective in nature.

Unstructured interviews viewed as narrative therapeutic conversations

Within a post-modern framework, feminist research makes great use of the semi-structured and unstructured interview (Punch, 1998). Reinharz (1992) points out that there is no single uniform perspective in feminism on such topics as researcher-interviewee relationships and self-disclosure. Rather there is openness to different possible meanings of these things in different research situations. Feminist-based interview research has modified social science concepts, and created important new ways of seeing the world:

> By listening to women speak; understanding women's membership in particular social systems, and establishing the distribution of phenomena accessible only through sensitive interviewing, feminist researchers have uncovered previously neglected or misunderstood worlds of experience (p.44).

Consequently, being a female researcher, possible bias could exist towards women telling their story purely on grounds of gender. Within the post-modern framework, feminist-based unstructured interviews in the form of narrative therapeutic conversations are used as a qualitative tool in this study, as in clinical practice. In this study the themes in the narrative therapeutic conversations can be addressed in the form of discourses and alternative stories in a way that acknowledges the idiosyncratic nature of each individual client's experience.

Epston (1994) suggests that a narrative therapeutic conversation is by its very nature, ephemeral.

> After a particularly meaningful session, a client walks out aglow with some provocative new thought, but a few blocks away, the exact words that had struck home as so profound may already be hard to recall. Two of us reconstructing a conversation we had even minutes before may not agree on what was actually said because we each hear selectively (p.31).

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Furthermore, joining our clients in conversation allows for a space in which we can relate as individuals who are equally responsible for the creation and co-creation of reality. Stepping out of the positivist realm, we join our clients in the creation of a story in which we, as therapists become characters (Caeser & Roberts, 1991; Freedman & Combs, 1996). The reflexive nature of this approach to therapy implies a partnership that can critically comment on itself (Fruggerri, 1992; Hoffman, 1992; Lax, 1992). Time and space for reflection in therapy promotes experience of experience, and it is through the experience of reflecting that we make meaning of it (Freedman & Combs, 1996).

When meaning and understanding are regarded as socially constructed, it becomes possible for the therapist to join the problem-organising/problem-solving system as a participant-observer and participant-facilitator (Anderson & Goolishian, 1992). In joining this system the therapist does not propose to be an expert, knowing all the answers. The position of not-knowing is not a glib, evasive statement, but rather a stance in therapy that acknowledges that understanding is socially constructed by people in conversation. Meaning is therefore not static and nobody can ever claim to know the truth. When a therapist is tentative and curious as apposed to all-knowing, a new circle of meaning is created that allows for the dialogical creation of a new narrative (Anderson & Goolishian, 1992; Freedman & Combs, 1996). Furthermore, not-knowing refers to a set of assumptions made within the narrative therapeutic conversations between therapist and client. According to Strauss (2001) a therapist always has his/her own prejudice, but needs to listen in a way that allows for the emergence of new meanings. Consequently, when a therapist questions in a manner that does not imply answers, the not-yet-said can unfold into the yet-untold narratives.

Reflexive diary of researcher-participant

Reflexivity is perhaps *the* most distinctive feature of qualitative research (Tindall, 1994). Reflexivity, then, is about acknowledging the central position of the researcher in the construction of knowledge that “the knower is part of the matrix of what is known” (DuBois, 1983, p.111), that all findings are constructions, personal views of reality, open to change and reconstruction. We need to make explicit how our understandings were formed.

According to Schon (1983) reflection-in-action is:

> When someone reflects-in-action…he is not dependant on the categories of established theory and technique but constructs a new theory of the unique case…He does not keep

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> means and ends separate but defines them interactively as he frames a problematic situation. Because his experimenting is a kind of action, implementation is built into inquiry (p.68).

Tindall (1994) suggests that this is best done by keeping a detailed journal or reflexive diary which explores who you are, why you chose the particular topic, your initial purpose(s) and intention(s), procedural notes, what you did when and in what context (field notes and diagrams), decisions made with rationales, how you felt, confusions, anxieties, interpretations, what led to clarification; in fact anything that you believe has affected the research. The journal may then be used to structure a reflexive account or be included alongside the research report and transcripts. Phillips (2001) states, that keeping journals is a popular way of logging what occur to you during the research process. That may well be all that it is - a log; no more, no less. If we have been honest with our feelings and thoughts, and look at our writing over a period of time, we may see a pattern of thoughts which allows us to interpret or think further. Two questions arise; is the writing honest and is there desire to make something of the writing, rather than it merely being an end in itself? In this study the reflexive diary will be used in two ways, namely, as a text from which I could formulate my own discourses and alternative stories as researcher-participant and included in this thesis' discoveries. It is important to note that the reflexive diary, set in a certain time period during the research process, is not included as an Appendix of this thesis, because of its personal nature and for ethical reasons.

Series of drawings

Having an actual picture to show significant others is a powerful tool for change (Ball, Piercy & Bischof, 1993; Zimmerman & Shepherd, 1993). Carlson (1997) proposes that when art therapy techniques are applied to the basic principles of narrative therapy, it enhances the potential for therapists and families to open the door to externalising conversations that lead to new life. Mills (1985) explains that art can have a powerful effect on clients by helping them evoke hidden aspects of themselves and it allows the clients to explain themselves in their own personal way.

The series of drawings used as projective means in communicating data in this study are described as follows:

- *Self-expression through drawing a self-portrait*: Within this study's aim of exploring women's ideas and meanings they make of their experiences of themselves in relationship with their food in excess, the drawing of a self-portrait is applicable. Wadison (1973), in discussing the techniques used in art therapy, offers two interesting ideas on its benefits.

One is the idea that the art performed in therapy offers the client the ability to make a self-portrait. This is significant because clients are more likely to be honest about their view of themselves in drawing. The second idea is that of permanence. Wadison explains that what the client draws is impervious to distortions of memory; therefore the work that they do in therapy serves as a visual reminder to them.

- P*articipants' and researcher-therapist's* c*o-constructed drawings of reflections upon four conversations*: In this study co-constructed drawings are used between a specific client and myself as researcher-therapist as a tool for summing up and concluding the therapeutic conversations and to highlight alternative stories discovered in a visual way. This activity was based on ideas of co-constructed drawings about engendering hope (Weingarten, 2000). Another way people can change their relationship with the problem is by discovering times in their lives when they were able to resist the problem (White, 1993, 1995). These alternative stories serve as a gateway to new meaning for people. In this study the co-constructed drawings can serve as a reflection in itself and in so doing amplify the alternative stories.

Verification

The trustworthiness of this study can be based on the following steps of verification:

- *Informed consent* (Tindall, 1994): Good research is only possible if there is mutual respect and confidence between researcher and participants (Tindall, 1994). One separate conversation with each individual at the outset of the narrative therapeutic conversations was held to fully inform the prospective participants in advance of participant and researcher's expectations, aim of research and procedures. This placed the prospective participants in a position to give informed consent or to decline participation. Example of an informed consent form is in Appendix A.
- *Verify the results through triangulation* (Creswell, 1997; Jordan, Van Rooyen & Strumper, 2002; Neuman, 2000; Silverman, 1993): Triangulation allows illumination from multiple standpoints, reflecting a commitment to thoroughness, flexibility and differences of experience (Tindall, 1994). In this study three levels of triangulation were used: firstly, investigator triangulation (two other researchers, from the social sciences gave input into the data analysing phase, one researcher from start to finish and the other researcher gave an overview reflection of the work); secondly, data triangulation - three sources (unstructured interviews viewed as therapeutic conversations, reflexive diary of researcher-participant; and a series of drawings), were used to gather data.

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- *Providing a rich, thick description of the participants* (Cresswell, 1997; Miles & Huberman, 1994): The researcher described the participants and researcher-participant in detail. This rich description of the participants will allow the information to be transferred to other settings because of shared characteristics.
- *Keeping a register of data* (Miles & Huberman, 1994): Notes of relevant events and the state of affairs were made and regularly studied while analysing the data. The researcher made handwritten notes in a specific book denoted for this purpose throughout the research process.
- *Providing a detailed description of the process* (Miles & Huberman, 1994; Neuman, 2000): A detailed description of how the thesis as a whole was conducted was provided. This involved a precise description of the selected subjects, the concepts used, theoretical ideas and research methods and process. Neuman (2000) refers to this as the natural history of the project / thesis. Outsiders reading this study can see and follow the researchers' actions exactly.
- *Auditing for future researchers* (Miles & Huberman, 1994): The research was sufficiently detailed for a secondary researcher to arrive at similar discoveries by using the original data. Different discoveries using the original data could add to rich and thick descriptions of the data, adding multi-perspectives.
- *The mechanisation of registration* (Neuman, 2000): Another measure to verify the data was to use tape recordings in order to ensure correct reporting results in the form of transcriptions of the therapeutic conversations the researcher had with each individual participant.
- *Narrative documents* (White & Epston, 1990): There are two levels of verifying this step: Firstly, within the thesis - one participant's expression through telling her story in letter form, art therapy, and narrative letter from researcher to participants as a taking-it-back practice; secondly, the thesis itself is written in letter form true to narrative documented form.

Selection of participants

Sampling strategy

The sampling strategies was to find participants who were not in the process of loosing weight and were not planning to loose weight according to a weight management programme. Through the process of questioning, the sample strategy was based on how effective the research question could

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be answered. The sampling strategy was formulated on grounds of doing research at grass roots level with ordinary people that crossed my path or I theirs through ordinary everyday living. This in itself was a daunting task for the sensitive and ethical way I wanted to proceed in selecting the participants. I realised that I could not just go up to a so called obese person and say that I wanted them to participate in this study, because I could clearly see that they were fat. Bickman and Rog (1998) consider narrative methods as real-world measures that are appropriate when real-life problems are investigated. The main strategy I had was to build trusting relationships with women with a bodyweight as defined as obese (≥ 45kg) from a medical perspective and ages ranging between 30-40 years, in different social circles I was participating in.

I came into contact with the first participant in her own business as a shop owner, where we built a trusting relationship over several months before she became interested in taking part in this study. The second participant was referred to me by a mutual friend and colleague. The third participant was a previous client of mine, who wanted to discover herself in relationship with her body and food (at the outset of her participation in this study, she had already participated in seven individual therapeutic conversations in a professional relationship with me). As I conversed with one of my dear friends and colleagues about my research study, she became interested to partake as the fourth participant of this study. I came to know the fifth participant from church activities we had done together and she also became interested in taking part in this study. Each participant I encountered came to know about my research topic by everyday conversation and wanted to know more about my research. In the process of casually talking about my research topic, I expressed the need for participants and each one of them wanted to participate and took the initiative by suggesting that I include them in my study.

As one of the verification steps of the data of this study the sampling strategy was to base the selection process of the prospective participants on ethical procedures, where informed consent, protection of participants, confidentiality, anonymity and accountability were of the utmost importance. This was accomplished by setting apart one session at the beginning of the planned therapeutic sessions. During this session participants were specifically informed of the process of therapy, confidentiality and anonymity. Researchers' and participant's expectations of their participation in this study were highlighted. The participants were also ensured of their free will in participating or not in this study and that if by any chance they wanted to stop their participation during the course of other sessions they were free to do so. All the participants willingly participated in the therapeutic process from start to finish.

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The aim of this study is not to generalise the findings to the larger population, but rather to gain a deeper understanding of these particular participants' experiences in relationship with food in excess. In a narrative sense the aim is to provide a rich, thick description of the participants through narrative inquiry and content analysis.

Description of the sample

In this study, based on narrative inquiry, the located sample is a homogeneous sample. There are six participants including the client participants and the researcher-participant:

- *The client participants*: Afrikaans speaking, Christian, female, married with one or two children, ages ranging between 30-40 years, with a bodyweight as defined as obese (≥ 45kg). Four participants have been overweight since childhood, gradually becoming obese in early adulthood and one participant has been overweight since the birth of her first child and became obese with the birth of her second child. The participants are in a career setting, where two of the participants have their own businesses.
- *The researcher-participant*: Afrikaans speaking, Christian, female, married with one child, aged 32 with a bodyweight defined as obese (≥ 45kg) at the outset of this study, has been overweight since late adolescence and has experienced obesity in the last two years, also in a career setting, within private practice.

Data collection

Lieblich et al. (1998) state that data can be collected as a story (a life story provided in an interview or a literary work) or in a different manner (field notes of an anthropologist who writes up his or her observations as a narrative or in personal letters). It can be the object of the research or a means for the study of another question. It may be used for comparison among groups, to learn about a social phenomenon or historical period, or to explore a personality.

The data collection took place at different levels, as follows:

- *unstructured interviews viewed as narrative therapeutic conversations*: six individual narrative therapeutic conversations with each person, whereas the first conversation was based on informed consent and expectations (not tape recorded), four conversations were based on telling the story and the last conversation was based on participants' and researcher-participant's co-constructed drawings of reflections upon four conversations. Each conversation (approximately 25 conversations and transcribed into 450 pages), lasted

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approximately 60 minutes and was recorded on a tape recorder and then transcribed for later analysis at different times during the period 16 April 2002 until 31 May 2003. All the therapeutic conversations where held at my private practice at my home, with no outside disturbances and in a therapy setting. At each appointment an individual participant made a next appointment and if there were unforeseen circumstances the participant made a later appointment telephonically or via e-mail. All the participants completed six narrative therapeutic conversations with the researcher-therapist during the time period allocated above at different time intervals between appointments.

- *reflexive diary of researcher-participant*: This was written in letter form at different intervals during the time period of 16 April 2002 until 22 April 2003 including; reflection of all the above mentioned therapeutic conversations, reflection of the discussions had with regards to my D-proposal with all the role players involved and reflection of random discussions with significant others.
- *series of drawings*: participants' self-expression through drawing a self-portrait were drawn as homework and handed in at different times during, or at the termination of the therapeutic conversations, participants' and researcher-therapist's co-constructed drawings of reflections upon four conversations drawn at the last conversation viewed as a follow-up conversation.

The research question

? As stated, the research question of this study explores the various meanings that women could construct with regards to their relationships with food in excess.

The construction of the main question directing the flow of the discussion is important, as it should not pre-empt any responses (De Vos & Van Zyl, 1998). At the outset of this study within the time period of writing my Doctoral proposal, I formulated the aim to be; to allow women's stories to be told. The stories would focus on exploring the women's experiences in various situations and challenging discourses surrounding their relationships with food in excess. The aim was explained, that I, as researcher-therapist would in conjunction with the participants, co-construct an alternative story or stories. My assumption was that through a narrative way of conversing with women they would be liberated to come out of the pantry. Consequently, I already had it in mind to formulate discourses and alternative stories from the text and this could be noted as researcher biases and assumptions.

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The data analysis process

According to Newman (2000), data analysis in qualitative research means a search for patterns in data. Kelly (1990) includes multiple levels of analysis, with the researcher as an integral part of the research process. As research design of this study the essential idea in narrative inquiry is to use narrative methods within a therapeutic context for a smaller group to provide more in-depth understanding of constructs with regard to obesity (Lieblich et al., 1998).

To achieve the objectives of the current study, the following research procedures, as supported by Lieblich et al. (1998), were followed. Lieblich et al's (1998) model for the classification and organisation of types of narrative analysis with the aim of deriving at discoveries is used. Within this model different possibilities for reading, interpreting, and analysing life stories within two main independent dimensions emerge:

- holistic versus categorical approaches
- content versus form approaches

Lieblich et al. (1998) visualise these two dimensions as intersecting, resulting in a matrix of four cells, which consist of four modes of reading a narrative, as follows:

HOLISTIC-CONTENT	HOLISTIC-FORM
CATEGORICAL-CONTENT	CATEGORICAL-FORM

In this study the focus is on the *categorical-content analysis*. The narrative materials of the excessive food stories are processed analytically, namely, by breaking the text into relatively small units of content and submitting them to descriptive treatment. *Categorical-content analysis*, according to Lieblich et al. (1998), enables access to people's identity and personality. One of the clearest channels for learning about the 'inner' world is through verbal accounts and stories presented by individual narrators about their lives and their experienced reality. This is normally called *content analysis*, which is, in fact, the classical method for doing research with narrative materials in psychology, sociology and education (Manning & Cullum-Swan, 1994; Reisman, 1993). In this study narrative inquiry aims to derive narrative materials from a clinical setting through therapeutic conversations, art therapy and letters, guide participants and researcher-participant to see a dominant story (discourse) and an alternative story, helping them to re-author their stories and to clarify what choices they may have and wish to make (Winslade & Monk, 1999).

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According to Neuman (2000) *content analysis* is useful for problems involving a large volume of text. A researcher can measure large amounts of text with sampling and multiple coders. *Content analysis* can reveal messages in a text that are difficult to see with casual observation. The creator of the text, or those who read it, may not be aware of all the themes, biases, or characteristics. In the current study, the literature study, transcribed text of five narrative conversations with each individual, the researcher's reflexive diary and the reflection notes on the reflections of the data, will amount to a large volume of text. *Content analysis* could allow the researcher to take a reflexive stance in analysing the data.

An example: By using narrative conversations as psychotherapeutic intervention, close attention to the participants' discourses can be given and alternative life stories may be created, that may otherwise not have been considered part of the experience. As researcher in a reflexive stance with reference to the reflexive diary, possible avenues are created to address my deeply entrenched self-perception or discourse, like food comforts me in times of stress. With a literature study of discourses and alternative stories about women's relationships with food, the plot surrounding food stories is thickened. *Content analysis* will enhance the main contribution of this study, which is to present the community with enriched food stories in the format of a narrative inquiry.

Neuman (2000) refers to adequacy in qualitative research, which means that the emphasis is not on the number of participants used, but the quality of data collected. Consequently, the relatively small number of participants in this study is not considered problematic; as saturation in the conversations was reached and no more information was needed (Creswell, 1997; Jordan et al., 2002; Neuman, 2000). Common features promoted by several authors (Creswell, 1997; Lieblich et al., 1998; Manning & Cullum-Swan, 1994; Neuman, 2000; Punch, 1998; Reisman, 1993) were used as guide for the content analysis of the data. The data was analysed in the following three steps:

Step 1: Open coding

Open coding constitutes a first level of conceptual analysis with the data. The idea is to open up the theoretical possibilities in the data (Punch, 1998). Although Neuman (2000) states that the researcher aims with open coding to focus on the data and assign code labels for themes, in this study, with open coding the aim is to discover discourses and alternative stories from broad responses.

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For the purposes of clarification of concepts with the aim to 'operationalize' the relevant concepts through the following steps in the process of content analysis, a possible definition of discourse and alternative story follows:

- *Discourse* has variously been described by MacLeod (2002) and other authors in II-Narrative letter. In summary, a discourse has constructive, but also restrictive power in the cognitive, emotive and behaviour process of an individual, families and communities. It has a dual character, simultaneously constructing and restricting what can be known, said or experienced at any particular socio-historical moment. Discourse allows for shifts and flexibility, as a tension is constantly created between the constructive and restrictive, productive and undermining aspects of a discourse.
- *Alternative story* has been described by Hewson (1991) in II-Narrative letter as the new-old story. With the shifts and flexibility that the concept of discourse allows for during the narrative therapeutic conversations and the deconstruction of discourses, opens up space for the new-old story or alternative story to be explored by the researcher-therapist and participant. The new story is not a turn-off from the old road, but the continuation of a different, old road – one on which the person had been travelling without previously recognising that they were doing so, thus the new story is really a new-old story, hopefully with constructive power in the individual participants' life.

Keeping the aim of the therapeutic conversations in mind, with its underlying assumptions from a narrative perspective, the open coding was conducted, in stating discourses and alternative stories as broadly as possible.

Step 2: Axial coding

Axial coding is where the main categories which have emerged from open coding of the data are interconnected with each other (Punch, 1998). Strauss and Corbin (1998) state that the purpose of axial coding is to group the data that was fractured during open coding. Thus axial coding is about interconnecting the substantive categories which open coding has developed by looking for categories or concepts that cluster together.

Within the context of the narrative therapeutic conversations the focus was on the deconstructing questioning with regards to discourses and power relationships in people's lives that have a certain effect on their way of thinking, feeling and acting and consequently, the movement to alternative stories. Axial codes, like all other codes, should emerge from the data, and should not be forced

upon the data; whereas the natural data in this study is presented as discourses and alternative stories. Comparisons can be made between reappearing themes or concepts. New themes or concepts and questions can arise from axial coding. The connection between a theme and data is strengthened by multiple occurrences (Neuman, 2000). After re-reading data from the axial coding in the form of discourses and alternative stories, different themes from which discourses and alternative stories are described from text, emerged.

Step 3: Selective coding

Selective coding is the third stage in content analysis. Punch (1998) states that in selective coding the objective is to integrate and pull together the developing analysis with a central focus around which it is integrated. In this step of selective coding, the focus is on finding a higher-order concept, a central conceptual category at the second level of abstraction. All the participants are taken into consideration at this stage, not as a separate entity, but as a whole. According to Neuman (2000), selective coding involves examining the previous categories to make comparisons and contrasts after data collection is complete. In this final step the aim is to reach a richer description of the data by means of integrated discoveries, followed by a discussion thereof.

Concluding reflections

At the outset of this study a participant said that she wanted to participate because she believed that she could learn a lot about herself and that she specifically wanted to help me by telling her story, because she said: ”You don’t have a thin body either, you are overweight yourself. I think you will understand more about my experience of being fat, because you are also fat”. Reflecting upon this statement the assumption could be that only fat people understand fat people with further reference to a feeling of belonging in a certain group against another group of people possibly in opposition and possible anger towards the apposing group. Awareness of this assumption and possible bias could contribute to distancing the researcher from also being a participant in this study.

Important to note that the reflexive stance used throughout this thesis could be helpful in reaching a point where the grand narratives such as obesity, in using content analysis, could be deconstructed, especially in the final letter, as being in the final analysis not merely other truths, but just another point of view. Finally, recognition is given that we as narrative thinkers share certain assumptions. Narrative therapy in the words of Doan (1998):

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> Narrative therapy has been associated with the assumptions of post-modernism and social constructionism; both of which support the notion that there are no truths, just points of view (p.379).

Hopefully this thesis depicts the different forms these assumptions could take in actively reading this thesis with whatever paradigm the reader chooses.

Co-author and researcher

Post script: Approximately 450 pages of transcriptions of the 25 conversations tape recorded are not included in this thesis.

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V - Letter of discoveries

Discovering food stories within conversation

Dear reader

It is a valuable discovery finding something that was there all along, but not realising it could become a new or fresh view of something old. In this study old discoveries could be new discoveries and unique within the context of each participant's and researcher-participant's food story separate from or connected to previous literary studies. Possibly you as the reader could have a similar or different discovering process.

The aim of this letter is to present the discoveries of the data analysis. Using content analysis the content of the four therapeutic conversations of each participant and the researcher-participant's reflections within the reflexive diary are given as discourses and alternative story discoveries. This includes a presentation of the coding, followed by an interpretative discussion of each integrated discovery found in the selective coding. The discoveries presented are the researcher's and two other researchers' accounts of the important discourses and alternative stories as co-constructed during the therapeutic process by the researcher-therapist and the participants and during the reflective construction of the researcher in the role of researcher-participant.

Discoveries

The data analysis is presented below. The first step (OPEN CODING) was designed to develop broad categories and organise the data into discourses and alternative stories. The second step was to interconnect the categories (AXIAL CODING) by grouping the broad discourses and alternative stories identified in the open coding in locating various themes. Thirdly, the various discourses and alternative stories identified in the axial coding were integrated and refined (SELECTIVE CODING) by making use of the different categorical levels; and making comparisons and contrasts.

Discoveries of open coding

With the use of open coding one example of discourse discovery from participants and the researcher-participant text is given in Table 1.

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Table 1: Examples of discourse discoveries from open coding related to the participants and researcher-participant

Response	Open coding	Discourse
First participant: What is bad about my husband's work load is that he goes away from home three or four times a year. When he is home, there is all this pressure from his friends and everything, and then I talked to him yesterday and he said that he won't come home late. I don't want him to come late from work and to go and drink with his friends and then he gets angry with me. But then they travel with one vehicle and they do go and drink and the time he wants to go home the others convince him to stay and drink with him…This happens regularly. This is what angers me so much, absolutely, this is not very nice.	• Husband's work load • Goes away from home • Pressure from his friends • I talked to him • Said he won't come home late • I don't want him to be late and to drink with his friends • He gets angry with me • They do go and drink • This happens regularly • This is what angers me so much	D1 – Anger about my husband's work load and peer pressure from his colleagues affects my relationship with my husband on a regular basis.
Second participant: When I confronted my husband, we talked about it and he said yes it does bother him that I picked up so much weight…he said it is for the children's sake. It really made me think about it when he said this. Because he, you know, it won't bother him now, my children are still small and my husband says that he comes from a family where his mother and his grandmother were large women and then I asked him, but did this bother you? Then he said to me yes, sometimes it did bother him. And then I thought to myself and this angered me again, because why must it bother a child, because a child of two years old has the perception that this is his mother and he is proud of this…	• I confronted my husband • We talked • It does bother him that I picked up so much weight • It really made me think • My children are still very small • My husband comes from a family… with large women • I asked him, did this bother you? • Sometimes it did bother him • This angered me again • A child of two years old • This is his mother and he is proud of this…	D1 – Anger towards husband's expectations for me to lose weight just like his mother before he will accept me, unlike my child's unconditional acceptance for who I am no matter how much I weigh.
Third participant: It is like I said, it was never an issue for me, I was thin 10 years ago, you know, and I really did not think that I will ever become overweight, but anyway, when I became pregnant with my first child, I picked up 40 kg. And you know in a way, how can I put it, my husband was happy that I was pregnant and everything, but he did not really accept the fact. I don't think he was ready to be a father at that stage and this really bothered me, even angered me.	• Like I said • It was never an issue for me • I was thin • Did not think I will ever become overweight • Pregnant with my first child • I picked up 40kg • My husband was happy I was pregnant • He did not really accept the fact • Don't think he was ready to be a father • This really bothered me • Even angered me	D1 – Anger and blame towards my husband for not accepting me with regards to my overweight in the context of my first pregnancy and that he was not ready to be a father when I became a mother affected me to pick up 40kg.

Response	Open coding	Discourse
Fourth participant: I really suffer, because of my overweight body and you know I really do feel it more and more in my neck. I tell you today, in this time where I have not yet admitted this to my husband, because I am ashamed of this and it is embarrassing, but I suspect that my breast are becoming to large for my stomach muscles. While my husband and I can talk about anything, I am too embarrassed and ashamed to talk to him about how much I suffer with my overweight. I think it has something to do with me wanting to be dignified at all times.	• I really suffer • My overweight body • Do feel it more and more in my neck • I tell you today • I have not yet admitted this to my husband • I am ashamed of this • It is embarrassing • I suspect my breasts are becoming too large for my stomach muscles • Embarrassed and ashamed to talk to him • Me wanting to be dignified at all times	D1 – Shame and embarrassment affect me in not communicating with my husband about my experience of my overweight body in relation to him, because "I wanted to be dignified at all times".
Fifth participant: My husband tells me often that I do too much for other people and I think he is jealous, you know that I maybe just think of someone else and do something special for them on a specific day and he maybe needed me to be there for him all the time and I was not sensitive to his needs. Do you understand what I am saying to you? And then on a day like this he will confront me with this, so that I go out of my way to help him, but he does not thank me, but take it for granted.	• My husband tells me often • I do too much for other people • I think he is jealous • I maybe just think of someone else • Do something special for them • He maybe needed me to be there for him • I was not sensitive to his needs • You understand what I am saying • He will confront me • I go out of my way to help him • Does not thank me • But take it for granted	D1 – When I feel taken for granted by my husband, I tend to do too much for other people, while neglecting my husbands' needs and him expecting of me to be there exclusively for him.
Researcher-participant: Something I discovered a year ago about myself and food is that I could not hate food, because whenever times are tough or easy I tend to nurture myself with food.	• I discovered • About myself and food • Whenever times are touch or easy • Nurture myself with food	D1 – I could not hate food, because whenever times are tough or easy I tend to nurture myself with food.

Important to note that alternative stories were developed during the narrative therapeutic process and are given here as one example from participants and the researcher-participant text in Table 2.

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Table 2: Examples of alternative story(s) discoveries from open coding related to the participants and researcher-participant

Response	Open coding	Alternative story
First participant: Something that I sometimes do if I know that I am going to be alone, I will go and sit down and do some material painting or some needle work or do something that take my thoughts away from the tornado…the effect this have on me is that everything becomes more clear and I don't want to overeat. I feel I am doing something productive. I feel I can cope more.	• I sometimes do • I am going to be alone • Go and sit down • Do some material painting or needle work • Take my thoughts away from the tornado • Everything becomes more clear • Don't want to overeat • Doing something productive • Can cope more	A1 – When I am creative in painting and needlework it helps me to deal with the tornado experience and it makes me feel that if I am productive I can cope.
Second participant: I believe that hope is an inner attitude of openness towards God's people and love…you experience what you expect and you expect what you are open to.	• I believe • Hope is an inner attitude • Openness towards God's people and love • You experience • You expect • What you are open to	A1 – Believing in the definition of hope is helpful and gives me hope and openness to others and myself.
Third participant: Last time I saw you and talked to you, I have learnt how to love myself, to accept myself, to accept and forgive people that I love, to talk to my friends and husband about my problems; thereby giving expression to my emotions.	• I saw you • Talked to you • Have learnt • How to love myself • Accept myself • Accept and forgive people I love • Talk to my friends and husband • My problems • Giving expression to my emotions	A1 – In the context of a previous therapeutic relationship with the researcher-therapist I have learnt how to love myself, to accept myself, to accept and forgive people that I love, to talk to significant others about my problems; thereby giving expression to my emotions.
Fourth participant: After this study I want to move on to a healthy lifestyle. I think the crux of combating overweight is in making a lifestyle adjustment with the aim to have a healthier lifestyle.	• Move on • A healthy lifestyle • Crux of combating overweight • Lifestyle adjustment • Healthier lifestyle	A1 – To have a healthy lifestyle is the crux of combating overweight.
Fifth participant: I have two examples where I have said no to others when they want to take me for granted and misuse me; by saying "I can do this much and not any more".	• Two examples • I have said no to others • To take me for granted • Misuse me • I can do this much and not anymore	A1 – Saying no and setting boundaries to others is helpful when they want to take me for granted and misuse me.

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Response	Open coding	Alternative story
Researcher-participant: To see the first and following participant's interest in discussing their relationship with food in excess showed me that "I am not alone in my struggle to make meaning of my experience with food."	• Participant's interest • In discussing • Their relationship with food in excess • Not alone • In my struggle • To make meaning • My experience with food	A1 – Interpersonal sharing relieves my lonely struggle to find what food means to me.

Due to a large volume of text see Appendix B for discourses and alternative stories as discoveries from open coding.

Discoveries of axial coding

Within the narrative therapeutic conversations the focus was on the deconstructive questioning with regards to and rich descriptions of **discourses** and power relationships in people's lives that have a certain effect on their way of thinking, feeling and acting and consequently, the movement to **alternative stories**. The general aim of axial coding is to interconnect the broad categories identified in the open coding. The various categories are integrated and refined. In the process of examining and re-reading the data presented as discourses and alternative stories in the open coding, various themes became evident. Due to a large volume of text the discourses (18 themes) and alternative stories (10 themes) are listed as follows.

Discourses according to themes from axial coding:

Theme 1: In relationship to anger and frustration
Theme 2: In relationship to fear, loneliness and rejection
Theme 3: In relationship to love / hate and comfort
Theme 4: In relationship to sadness and hurt
Theme 5: In relationship to guilt
Theme 6: In relationship to inferiority
Theme 7: In relationship to mistrust
Theme 8: Internalised beliefs
Theme 9: Body perceptions
Theme 10: Voices of control
Theme 11: Overeating in action
Theme 12: Communication in action

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Theme 13: Blaming in action

Theme 14: In relationship to stressful situations

Theme 15: In relationship to traumatic experiences

Theme 16: Familial themes and voices

Theme 17: Socio-cultural power and voices

Theme 18: Living with an overweight identity

Alternative stories according to themes from axial coding

Theme 1: In relationship to self-worth, self-love and love from others

Theme 2: Learning experience and externalised decision

Theme 3: Constructive communication in action

Theme 4: Participating in creative arts and handiwork

Theme 5: Taking initiative in business

Theme 6: Personal abilities in action

Theme 7: Story before marriage when I was fit and thin

Theme 8: Participating in alternative ways of taking care of myself

Theme 9: Prospective healthy lifestyle

Theme 10: Prospect of taking care of physical appearance

See Appendix C for the complete version of discourses and alternative stories as discoveries according to various themes from axial coding.

Integrated discoveries of selective coding and discussion

In the process of placing the individual participant's and researcher-participant's discourses and alternative stories as themes, the necessity for further refining on an integrated level, became evident. From selective coding, the previous themes are examined and combined; highlighting comparisons and contrasts between the participants and the researcher-participant.

Integrated discourses

Here follows an integrated view of the collective discourses according to themes from axial coding.

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Theme 1: In relationship to anger and frustration

Integrated Discovery
From the axial coding women's feelings of frustration underlined the emotion of anger. In relationship with food in excess the participants and researcher-participant portrayed anger in relationship toward their spouse, others and themselves as follows: • *Anger directed towards their spouse included*: husband's expectations for her to lose weight after being pregnant, that according to spouse, children are ashamed of their mothers when they are fat, that a mothers responsibilities toward her children did not allow her to exercise and take control of eating habits, that the husband's needs were more important than her own, that women felt taken for granted, that the husband spent too much time away from her and that husbands' friends thought of her as too controlling. • *Anger directed towards others included*: society's (with the focus on thin people) exploitation of, unfair treatment, insensitive teasing and remarks to fat people in general, society's perception that fat people were stupid or not fit to do a certain job, society's perception that thin people are more successful than fat people, society's expectations that a fat person must lose weight with wonder treatments or an all or nothing thinking with regards to diets, mother's voices that said that certain types of clothing made you look fatter or thinner, others taking responsibility out of her hands, people thinking that her genetic make-up was the cause of her fatness, society's non-acknowledgement that binging was an acceptable way of coping, and the label of a fuller figure implying that she was fat, family making misuse of her financially, others not reciprocating love as good as she gave love and others not allowing discussion of taboo subjects within families. • *Anger directed towards herself included*: after the process of overeating, for not choosing to eat healthy, for not expressing her emotions in other ways, for placing other's needs above her own, allowing herself to waist her energy on guilt feelings.

Discussion

According to DeFoore (1988) anger is one of the feelings that come when our safety is threatened. Anger is a protective response. Without anger as an ally we are only afraid (DeFoore, 1988). It is interesting to note from this discovery that the direction of anger is mostly toward others consisting of family and society. A possible explanation is that it has something to do with the notion that society's negative views towards obese people justify the participants' anger towards society. Therefore it is justifiable to blame society for not understanding or hearing or seeing how difficult the experience of a fat person is. Anger could then become a destructive influence where the obese

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person does not take responsibility for these feelings, rather blaming society, others and themselves. As stated in literature the obese patients substitute feelings of anger or frustration or dependency needs into feelings of hunger (Gross, 1983). It is possible that overeating is a way for participants to keep on being angry towards others and themselves, thus perpetuating a vicious circle of not losing control over their anger. It seems like the overeating process could have a pacifying effect on their feelings of anger.

In the narrative therapeutic context anger could be externalised, where the person is in a relationship with anger as if anger has a life of its own. The obese person is free to choose to buy into anger's destructive power or use anger to a constructive advantage, for example an obese woman could choose to use her anger as a productive power in her business, expressive arts or spending more time in communicating how anger is affecting her and the person she is in a relationship with. Anger as construct in relational context to obese women is rarely discussed in literature. Future research on this topic in relation to women's relationship with food in excess could be done.

Theme 2: In relationship to fear, loneliness and rejection

Integrated Discovery
As depicted from axial coding in relationships with food in excess the participants' and researcher-participant's fear was described within different contexts as follows: • Fear in terms of loneliness and rejection in relationship with significant others and sometimes during the overeating process. • Fear of failure in work and studies and not eating healthy and following an exercise program. • Fear of not being good enough. • Fear of accumulating more weight. • Fear from unwanted attention from men. • Fear that her daughter will also become overweight. • Fear of early death caused by health risks. • Not being fearful enough of medical situation to lose weight. • Fear of being caught when eating alone. • Fear of being left alone when other overweight people lose a lot of weight.

Discussion

As stated in literature, surely one root of women's fear of overweight lies in the harsh negative views of society toward obesity – particularly toward obesity in women. Fear is the natural first-

level reaction to threat (DeFoore, 1988), in the context of the feeling of being rejected and lonely. From this discovery there are physical and psychological levels of experiencing fear within relationships and different roles. DeFoore (1988) continues by saying that because we are hurt, we learn to fear. We fear being hurt again. Fear is natural. Deny your fear and you don't have it, it has you. Your actions are then governed by your fear, and you will find yourself feeling like a victim in any fearful situation. By denying or suppressing our fear, we give away all of our power. By claiming and embracing fear as our own, we claim the power to act and to protect our *vulnerable inner child* (DeFoore, 1988).

In a narrative context the construct 'inner child' are externalised and could be viewed as women's internalised beliefs formed at the developmental age of a child. Understanding and learning from their experiences and internalised beliefs formed at the developmental age of a child, the participants could choose to live out a preferred story of resolving fearful situations, regardless of the past stories of the destructive power of fear. Fear as construct in relational context to obese women is rarely discussed in literature. Future research on this topic in relation to women's relationship with food in excess could be done.

Theme 3: In relationship to love / hate and comfort

Integrated Discovery
From the axial coding women's love / hate relationships and feelings of comfort are described in terms of people and food as follows: • *Love / hate and people*: sacrificial love from her will draw others to reciprocate love and acceptance, her need to be loved by others in the context of the essence of who she is, children give unconditional love and support, she hates thin people thinking that they know how it feels to be fat, nobody can love like she can love, the belief that she is not worthy to be loved, people in general cannot love her, pleasing others and taking care of them so that she will be acknowledged as a good enough person or daughter, she consoles herself with food when her mother does not console or take care of her, she makes food like her mother to console herself with the loss of her mother, she hates it when others are dishonest with her about how she looks, she hates others unrealistic expectations; and since childhood significant others comforted her with food. • *Love / hate / comfort and food*: Food is a loving and comforting place, overeating makes her feel better for a short while, food and the tornado (overeating process) has been there for her, unwanted attention from men drives her to find comfort in food, food is a reward, overeating has a calming effect on her, eating comfort food after punishing herself by

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putting herself down, she has a passionate, loving, friendly and special relationship with food, she has a love-hate relationship with food, self-pity and food as a place of comfort go hand in hand; and food as her comforter tells the lie of "just one more piece of bread, don't worry it won't make you fat…".

Discussion

On the one hand this discovery highlights participants' desire for being loved perfectly in relationship with significant others, which in effect is never satisfied, only by food. Then also food's function has been to comfort and take care of them in the absence of significant other's care and nurturing relationships. As stated in literature in White's (2002) South African study, a group of grade 12 girls made lists of reasons why people might decide to overeat; to comfort themselves, to show appreciation and love are among the reasons. When our need for love isn't perfectly met, each of us is hurt as a natural part of growing up. This may have been unintentional, as is the case with much abandonment and neglect. Our parents may have had serious problems of their own; however, they may have deliberately hurt us (DeFoore, 1988). From literature Wise (1981) suggested that when a child experiences a lack of nurturing from the mother figure, the child could start overeating to nurture him or herself.

In the narrative context the need women have to be loved and comforted by significant others are replaced by their experience of overeating food as a comfort. Food is described more as a friend rather than an enemy. This could be a powerful reason for maintaining their overeating pattern even after being on several diets and trying to lose weight. Love / hate and comfort as constructs in relational context to obese women are rarely discussed in literature. Future research on this topic in relation to women's relationship with food in excess could be done.

Theme 4: In relationship to sadness and hurt

Integrated Discovery
From the axial coding the experience of sadness and hurt is a justifiable reason for overeating, after negative comments; gossip and judgement from others have taken place. Sadness and hurt are expressed within seclusion and away from others, because "crying in front of others makes you vulnerable, therefore I do not show my emotions". Participants and researcher-participant expressed from data that they do not feel heard or listened to by others, especially in context of their hurt and pain. Also from data in terms of sadness and hurt and the handling of such emotions are not taught by mothers, therefore sadness and hurt cannot be shown to others.

Discussion

DeFoore (1988) reasons that when we are afraid of losing control, it's not anger we are afraid of, but the anger that has been building up over a long period of time. It results from being hurt and sad and keeping all the feelings inside. Hurting is part of loving and therefore, it is also a part of living. We are hurt because of how incredibly vulnerable we are. This is a natural part of being a human being and living on this planet. There is nothing wrong with hurting. The important thing is what we do about it (DeFoore, 1988). From this discovery it is clear that the participant's and researcher-participant's discourses of hurt perpetuated the overeating process.

In a narrative context the stories of women's relationship to sadness and hurt are possibly in alliance with their relationships to the above mentioned discourse relationships. It is possible that these discourse relationships, like anger, frustration, fear, loneliness, rejection and hate could be perceived as being more visible than sadness and hurt. Therefore sadness and hurt places the participants at a vulnerable position and disable them to face their every day life they live in, whereas anger and frustration could be helpful for them to cope with every day stresses. Hurt and sadness as constructs in relational context to obese women is rarely discussed in literature. Future research on this topic in relation to women's relationship with food in excess could be done.

Theme 5: In relationship to guilt

Integrated Discovery
The participants and researcher-participant experienced *guilt* within relationship with someone with regards to several issues as follows: • *Husband*: for fighting with him, he might be ashamed of her overweight body. • *Others*: being ashamed of her weight in the presence of others in general, when others challenge and force her to take responsibility for her eating habits and a healthy lifestyle, when she thinks bad things about others and are angry with them, when her overweight has a negative influence on her daughter's eating habits, when she considers herself, her children and her husband's needs less important than others. • *Themselves*: being overweight, every time she overeats (before and after), that she was not a good enough daughter while her mother was still alive, not being allowed to be thin because this will make her sexy and attractive to men.

Discussion

Guilt is usually accompanied by a sense of self-blame, remorse and a desire to make amends for real or imagined wrongdoing (Erikson, 1963). As stated in literature, the obese have disturbances in

self-evaluation also; therefore feelings of guilt and shame over their inability to control their weight are likely to diminish their self-esteem in some areas of functioning (Wadden & Foster, 1992). Further in literature, Stunkard's (1993) perspective was that at the present time, however, we know enough to help patients to a better understanding of their obesity. The information about the influence of genetic factors, for example, can help to relieve the shame and guilt that so many obese people feel about their weight, while the importance of environmental factors provides them with the hope that they may be able to control their weight.

In a narrative context women's relationship to guilt has sexual overtones, whereas the overeating process and the physical result of experiencing being fat become a protection for women to not participate in physical and sexual activities but rather choosing to live with the guilt. Guilt as construct in relational context to obese women is rarely discussed in literature. Future research on this topic in relation to women's relationship with food in excess could be done.

Theme 6: In relationship to inferiority

Integrated Discovery
The participants and researcher-participant experienced *inferiority* within relationship with someone with regards to several issues as follows: • *Husband*: not good enough in his eyes, her feelings and thoughts are not important to him, he must make her feel better about herself, his needs are more important than hers, she is not sexually pleasing enough for her husband, he takes her for granted. • *Others*: others negative feelings toward her makes her feel bad about herself, she is everybody's caregiver and can't say "no" to others to the detriment of herself, others opinions and needs are more important than her own, not good enough in others' eyes, she carries others' burdens and is the least in relationships, others are superior to her because she is overweight. • *Themselves*: she feels like she is nothing special and is being treated like a doormat, she feels taken for granted, overeating makes her feel worse about herself, she overeats when she puts herself down or sacrifices her time for others, low self-worth is sometimes a hindrance to her self-confidence, believes she is not good enough for she is a failure, like others she also does not believe in her own abilities, she believed she was nothing and now she believes that she is nearly pretty.

Discussion

Erikson (1963) defines inferiority as feelings of worthlessness and inadequacy, coming from the self and the social environment and negative emotional orientation toward success and achievement in one or more of the following components, such as; social skills, cooperativeness and interpersonal sensitivity. Furthermore, the social environment also generates feelings of inferiority through the process of social comparison. This can encourage feelings of inferiority through the negative value that it places on any kind of failure. A sense of learned helplessness may result from subjective perceptions of inability, and constitutes a belief that one's efforts have little to do with success or failure and that the outcome of most situations is largely outside one's control (Erikson, 1963).

In the narrative context 'inferiority' as a construct is in the name itself a disabling power in the participant's life, for example feelings of not being good enough or being the doormat. It is possible that comparison could be the power entity underlying the construct 'inferiority'. Comparison between the fat participant and society's views or thin peoples' views could possibly play a role, for example; the fat person comparing herself with a thin person as being superior or successful. Inferiority as construct in relational context to obese women is rarely discussed in literature. Future research on this topic in relation to women's relationship with food in excess could be done.

Theme 7: In relationship to mistrust

Integrated Discovery
The participants and researcher-participant experienced *mistrust* in relationship with someone with regards to several issues as follows: • *Husband*: having an affair, his love for her in the context of painful experiences. • *Men in general*: when women don't give their man sex they will find it with someone else. • *Others*: to help her to lose weight. • *Themselves*: her intuition about certain issues, to lose big amounts of weight and to get to goal weight, she will always stay at the point of a see-saw with her weight.

Discussion

In this discovery the discourse is mainly described according the construct of mistrust. According to Erikson (1963) mistrust is an emotional wariness, a lack of confidence in the good intentions of others, and doubt about one's own lovableness. In a narrative context the construct mistrust is mostly focussed on the husband or men which could be an indication of mistrust toward sexual

intentions and toward skewed bodily experiences of themselves. Weight being a changeable factor on a continuous basis could be the visual expression of the participants' mistrust. Mistrust as construct in relational context to obese women is rarely discussed in literature. Future research on this topic in relation to women's relationship with food in excess could be done.

Important to note that themes 1 to 7 are interconnected in terms of the feelings and emotions that are described; which could be an indication of the participants' emotional meanings attached to their relationship with food in excess. These themes are also hermeneutic in nature in that they constantly influence the appearance of each other in relationship to the participants. From data the main theme, which could be described as a change agent, of the participants' emotional experience are their relationship to anger.

As stated in literature, rather than separating women's thoughts and feelings of affection toward themselves; these two levels of self-affection could have an influence on each other at any given point in time and situation, thus being interwoven with one another. Furthermore, as stated, negative feelings don't necessarily cause negative thoughts and visa versa. The same could be said for positive thoughts and feelings. Supporting research regarding the interplay between affective and cognitive processes has been done (see, Erber & Tesser, 1992; Parrott & Sabini, 1990; Petty, Schumann, Richman & Strathman, 1993; Smith & Shaffer, 1991). In theme 8 there is a movement from women's emotional experiences to cognitive experiences depicted as the construct 'internalised beliefs' as follows.

Theme 8: Internalised beliefs

Integrated Discovery
Depicted from axial coding most of the discourse discoveries in the whole picture of data analysis are described at a cognitive level, where internalised beliefs about themselves have been formulated at some point in time. The participants' and researcher-participant's internalised beliefs are described in relationship with husbands and men in general, others, weight, reasons for losing weight and personal beliefs as follows. • *Relationship with husband*: The need to have a perfect relationship with her husband, husband must be a knight in shining armour, in marriage, intimacy is depicted by open communication rather than sex, sex should be seen as holy by men, weight gain during pregnancy gives her husband the right not to have sexual intercourse, she has the right to know where her husband is at all times, she must always do what her husband wants her to do, her husband only thinks she looks pretty when she is thin, her husband does not believe

that she is capable of losing weight, she believes that her husband will take another woman.

- *Relationship with men in general*: All men are alike with regards with their sexual desires, all men treat women like sexual objects, men should be held in high regard all the time, men are supposed to eat more than women, she will be better than boys or men at being holy.
- *Relationship with others*: Others opinion of her is important, people have negative perceptions of me in general, she rebels against the thinking that she "must show others that she has control over her eating habits at all times", her mother's family taught her how not to show emotions, children cannot complete tasks as adequately as adults, all thin people are judgemental toward fat people, others judge her according to her clothing and not for who she is, she wants others to be fat with her, others must accept her for who she is and not for how she looks, she is showing society that she is disrespecting her body by overeating, the older a fat woman the more socially acceptable she is, it is more important to help others to the detriment of herself, being the victim in relationship to others makes her holier than them and it is ok to pity herself.
- *Relationship with weight*: Overweight will cause something bad to happen to her unborn child during pregnancy, it is too difficult for her to lose weight, she needs to put a switch on in her mind to be able to start to lose weight, pregnancy and having children give her the right to overeat, happiness is equated to being overweight, she must draw the line somewhere so that she could lose weight, losing weight can always start tomorrow, she questions the necessity to lose weight if others like her just the way she is, weighing herself on a scale isn't good for her for this triggers her to achieve the perfect body weight, diets and quick fixes are a death sentence, restrictions with regards to dieting cause her to have an unrealistic, unhealthy and unnatural relationship with food,
- *Reasons for losing weight*: for her husband to find her more attractive, to prove her family members wrong that she can lose the weight, to look good in her clothes, to make other women jealous, to make men desire her, she lives in fear that her husband will leave her for another woman, to win a competition between girlfriends, and so that her son will not be ashamed of her at school.
- *Personal belief*: Her inner being, maturity, wisdom, passivity and dreamer like qualities are more important than her physical appearance, she is the type of person who loves to eat good food, she can't live without good food, she wants to feel better about herself more than feeling guilty, she regards herself as having a high self-image regardless of her negative body-image, she defines beautiful people primarily as being beautiful within their personality, she is happy for not having a closet-problem like other eating disorders,

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overeating is not such a big psychological problem and need not be talked about, she must work herself to death to please everyone, her dignity in wearing bigger dress sizes and honesty about being overweight are more important than to implement a healthy life style, it is better to be a plain and uncomplicated person rather than a highly sophisticated, sexually attractive person, the price to pay in terms of delicious food is too high in order to have a healthy life style, she is dependant on food just like an alcoholic is dependant on alcohol, it is her fate to be like her mother, she doesn't accept positive feedback all the time, their belief that sex is bad and he does not love her or do things for her in the right way.

Discussion

According to Smuts (1992) an individual develops a certain attitude or perspective throughout their life span. Within the context of individuals' nature and quality of their relationships and interactions with others, they have unique perceptions of the world. Individuals' unique perceptions could also be constructed as unique discourses that have come into existence during their life span. As stated, the construct of self-awareness is described as internally focused attention that may increase the accessibility of one's general self-schema or self-concept, which in turn can influence collecting and processing self-relevant information (Carver & Scheier, 1981; Carver, Lawrence & Scheier, 1996). The process of self-evaluation culminates in a process of self-awareness. As described by Natsoulas (1998), a person's self-awareness must take place in any instance of consciousness that is based on evidence from the past.

In a narrative context internalised beliefs are decisions that participants make to belief in a certain way at a certain timeframe and context in the past that has become internalised beliefs in the present. These beliefs are internalised truths in the sense that the participants do not question their validity in their every day lives. Internalised beliefs could be described on a cognitive level, which refers to how people think, learn and remember (Jordaan & Jordaan, 1987). Cognitive ability is related to sensory observation persons make, their communication with other people and their ability to process information (Louw, 1996). Internalised beliefs are formed on a cognitive level and this discourse discovery varies from internalised beliefs formed from past experiences as follows:

- Sexuality and communication issues with regards to husbands and men.
- In relationship towards others, the participants and researcher-participant had internalised beliefs that they where not good enough.
- Internalised beliefs about weight issues in a relational context also appeared.

- Personal beliefs of the so-called very valid reasons to keep their weight at an overweight level, thus becoming and playing an overweight role.

By means of a deconstructive questioning process, within the narrative therapeutic context, the validity of internalised beliefs of obese women in the present are explored. The experience of this deconstructive process tends to open up avenues of new thought processes about their internalised beliefs that serve as a change agent from absolute truths to relevant constructs. Personal agency is given to the obese women to explore more options of how to deal with above mentioned internalised beliefs. The construct of internalised beliefs in relational context to obese women is rarely discussed in literature. Future research on this topic in relation to women's relationship with food in excess could be done.

Theme 9: Body perceptions

Integrated Discovery
Participants and researcher-participant have the following perceptions of their bodies: • She is fat and ugly and fat is unacceptable, must be hidden by oversized clothes, and is negative about restrictive physical activities. • She tells herself that she is unacceptable and unloved by others and herself for being fat and ugly. • Her body-image is a by-product, but is not who she really is and others judging her accordingly. • She is conscious of the fact that she is very visible to others. • She is disgusted and ashamed of her fat body. • She does not like looking at her fat body. • She does not have confidence in her physical appearance and links this to a low self-worth. • Her body-image is low or high depending on how she feels on a certain day. • Self-image is more important than her body-image.

Discussion

In this discourse discovery body-image are constructed as body perceptions and could be synonymous with talking about women's relationship with food in excess or as depicted in the literature the label of obesity. Emphasis is placed on self-image being more important than body-image, possibly implying that there is an unequal premise placed on different levels of psychological functioning in that emotional and cognitive levels are more important than an individual's physical being. Therefore there could be stages during the overeating periods that

obese women ignore their overweight as if it is not important. From literature a woman's feelings about her weight may be a particularly crucial aspect of her body-image (Abell & Richards, 1996). From literature obese women often block their own reactions towards their own body-image, inner needs and feelings (Gous, 1995). Importantly, across the life span, body-image can be seen as a vital aspect of self-worth and mental health (Potash, 2002).

As stated, body-image may be understood as a multidimensional self-attitude toward one's body, particularly its appearance (Muth & Cash, 1997). As described in literature, the feminist theorists reason that the feminine body is constructed as an object to be looked at (McKinley & Hyde, 1996) and because of this construction; women learn to view their bodies as if they are outside observers. Although obese women are very visible in body size, they do not experience the real size of their bodies; but only experience themselves as fat or non-existent.

In a narrative context, the social aspect of body perceptions dictates that obese women see themselves with regard to their own perception of others perceptions of them, possibly highlighting the disturbance of their body perceptions. The way women perceive their bodies could also be changeable at certain stages of their actual weight, constantly influencing the way they feel and think about themselves. In a sense diets and weight loss becomes the enemy in the way they perceive their bodies as good enough or not.

Theme 10: Voices of control

Integrated Discovery
From axial coding it is clear that most of the participants' and researcher-participant's voices of control is internalised voices from an external source, where their husband, children, family, society, circumstances, financial stress, the overeating process and time are blamed or described as having the control over their eating habits or basic emotional, cognitive and behavioural functioning on a day to day basis. The construct of voices of control are described in terms of their relationships with food in excess with words like, "I feel overwhelmed and restless", "this makes me feel powerless", "out of control", "not taking responsibility for my eating habits" or "I cannot lose weight by myself". Furthermore, the construct of voices of control are described in terms of participants' dependency on others' perceptions of them or thoughts, feelings or actions toward them as follows: • Her happy or sad feelings depend on her husbands happy or sad feelings. • When she experiences doubt or mistrust in her relationship with her husband she continues to do something even to her own detriment.

- She is oversensitive to other's perception of her overweight.
- She is always waiting for something to happen to trigger her into starting to lose weight and this makes her doubt if she must or must not start to lose weight.

Discussion

In this discourse discovery the construct locus of control found in literature are constructed as voices of control. A voice of control means that there are various relevant internalised voices from significant others in the participants' lives from past experiences that have control of how they think, feel or act in the present. A voice of control is internalised voices from an external source. Voices of control could also be described as a dependency upon others. The literature reported that obese women are more prone to have an external locus of control, possibly because they felt that they had less personal control over their social environment and over there impulses and desires (Rodin, Schank & Striegel-Moore, 1989). As stated by Friedman (1999) an external locus of control orientation may follow from, rather than precede, the obese state. However, as stated, with relation to weight reduction, controversial findings have been reported. Some support the superior ability of internals to lose weight, while others found no difference between internals and externals, at least in the short term (Nir & Neuman, 1995). In the narrative context the construct of internals and externals could be described as follows.

- Internals are persons who have the ability to externalise their voices of control and take personal agency or responsibility for their overweight; and
- Externals are persons who hold on to their internalised voices of control as absolute truths in their lives.

Within the narrative therapeutic framework the narrative tool of externalisation is especially valuable to help the abovementioned externals to explore the power relations they have with the voices of significant others in the past and how they could have personal agency in choosing to ignore the voice, discard it or embrace it as their own.

Theme 11: Overeating in action

Integrated Discovery
Overeating is the main action taken by the participants and researcher-participant in their relationships with food in excess. From axial coding it became clear that the overeating process had certain triggers to start and within the midst (middle) of, description within various contexts. In general the overeating process **starts** in reaction to conflict in significant relationships, work and

financial stress, as well as types of food in terms of its taste.

- *Conflict in significant relationships (others and self)*: her husband does not spend time with her and her child, avoiding conflict with husband, when she and her husband experience difficulties in their sexual relationship, husband does not respect and treat her like a queen, when she suspects her husband lusts after other women, when her husband does not do what she expects of him, she is afraid that her husband will be late from work, too demanding expectations from others and herself with regards to a healthy life style and restrictions of diets, after family gatherings where she feels rejected and not good enough, overeating once during a period of dieting triggers her into a cycle of overeating, her belief that there is still a lot of time to work on a healthy lifestyle, she unconsciously prepares herself to overeat, passivity triggers her overeating, conflicting feelings and emotions of anxiety, frustration, fear of being alone, helplessness, discouragement, depression, guilt, anger towards her mother and others, conflicting thoughts through negative self-talk; and during times of menstruation she tends to overeat more.
- *Work and financial stress*: not communicating with her husband about financial difficulties, overeating as an escape from her day to day stressors.
- *Types of food in terms of its taste*: she likes delicious food, does not like diet food.

Description given in terms of being in the **midst (middle)** of the overeating process includes: it is a passive action while spending time with her child and in front of the TV, her brain works overtime, eating happens automatically, it is an overactive thinking process, worrying is present, it is a friend or an enemy, it is like a wind that twirls, like a tornado experience, it has a paralysing effect on her where she can space out and not take responsibility for what she is feeling.

From axial coding overeating is sometimes linked to past experiences like molestation and loss of significant others.

Discussion

Interesting to note that overeating is depicted in this discovery as a process with a beginning and middle with the possibility that it does not end unless it is stopped. Depicted from this discourse discovery there are different reasons for the participant and researcher-participant to overeat. From literature, in relation to the life world of an obese person possible binge-eating episodes, on a daily and weekly basis and constantly being on diets could be an integral part of the eating style or pattern. It is difficult to define what constitutes an eating binge, but two proposed criteria provide a reasonable first approximation. They are eating in a discrete period of time more food than most

people would eat, combined with a reported lack of control during the binge (Wadden & Stunkard, 1993). However, from literature, historically physical inactivity has been seen as playing a major role in the development of obesity, thus obesity developed due to decreased activity, rather than overeating (Johnson, Burke & Mayer, 1956; Rose & Mayer, 1968). Furthermore, Smith and Petty (1995) stated that a variety of behaviours have been associated with mood regulation, one example being overeating.

Also stated, the literature is inconclusive as to the causal role that dieting plays in the development of binge eating in obese people (Howard & Porzelius, 1999). However, in Telch and Agras' (1993) study, it was found that caloric restriction leads to binge-eating episodes in obese people. Furthermore overeating is sometimes linked to past experiences like molestation and loss of significant others (see the relationship to traumatic experiences as integrated discovery later in this letter).

In a narrative context overeating in action could primarily be connected to their emotional level of psychological functioning, whereas they experience conflicting feelings and emotions of anxiety, frustration, fear of being alone, helplessness, discouragement, depression, guilt, anger towards others; and conflicting thoughts through negative self-talk. This discovery is the possible crux depicting the necessity for researching the psychological functioning of obese women and their relationship to food in excess.

Theme 12: Communication in action

Integrated Discovery
Depicted from data the participants and researcher-participant described problematic communication skills, whereas in relationship with others and themselves they are left alone, misunderstood and unheard on an emotional level. Problematic communication skills are described as follows: • She and her husband struggle to communicate about work, sex, their marriage, her feelings and how she thinks about things. • She demands to be heard by others in a specific way and they just don't know how to listen to her. • She demands that people must talk to one another and sort their problems out. • She is always the listener in relationship with others, keeping peace in conflict situations. • She avoids confrontation.

- She used different coping skills like ignoring someone, confrontation, the silent treatment and talking nicely and none of them seemed helpful in relationship with significant others.
- She feels she does not have the skills to communicate to others how she feels.
- She rather withdraws herself from relationships than interacting with others.
- Constant negative feedback from others makes her believe that she is unacceptable.
- Talking about her overweight body makes others uncomfortable because it's supposed to be a taboo subject.
- Women's bodies also have a voice which is not heard.

Discussion

Although depicted from this discourse discovery, some participants describe the need to be heard and experience feelings of being misunderstood; they do not partake in communicating their needs, thoughts and feelings to significant others possibly because they are not confrontational in a relational context. Another possible reason could be their high expectations they set for significant others to think, act and feel just like them within specific contexts. The possible perception could be that others need to understand and take the initiative in constructive communication. According to Dimbley and Burton (1985) communication may be filtered or blocked by attitudes, beliefs and values. Attitudes are particular views of people, situations and events. They are based on beliefs. These are the most common causes of difficulties with interpersonal communication. These filters shape what we say before we say it and affect what we interpret what others say to us (Dimbley & Burton, 1985). In a narrative context the lack of communication skills in relationship with significant others and themselves tend to be destructive in how participants think, feel and act, whereas constructive communication skills could be learned or re-learned.

Theme 13: Blaming in action

Integrated Discovery
Blaming others and self for being overweight is a clear discourse discovery from axial coding. The participants and researcher-participants blaming action is described as follows: • *Blame husband for*: not spending enough time with her and their child, for spending time with friends and she is alone at home, her being overweight, not having sex with her even though she did not have sex with him or didn't want to have sex with him for long periods of time, her fear with regards to her possible failure in the workplace, disillusionment in marriage, not taking her needs into consideration, not helping her to have a healthy lifestyle since her marriage and pregnancies.

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- *Blame others for*: the media and society for making her believe that she is unacceptable for being a fat person, family of origin for demanding that she take care of them since childhood, for making her feel guilty when she does not help significant others, her being overweight and her excessive eating habits, the male gender for their unwanted attention and declaring that they are the superior gender.
- *Blame herself for*: overeating and after overeating, not having a healthy lifestyle since her marriage and pregnancies, not making people listen to what her needs are or to show them who she is, listening to self-pity and being the victim.

Discussion

Within a narrative context, as regards internalised voices of control, whereas individuals believe that external voices of significant others or circumstances are to blame. In this discovery the media, society, husbands and others are blamed. Possibly within families, blaming of others and self are a discourse that people abide to so that they don't take the responsibility or don't recognise that they have the personal agency to take the responsibility for what is happening to them at a certain given moment in time. Blaming-story(s) could possibly be destructive to these participants' experiences of becoming healthy or happy within themselves.

Theme 14: In relationship to stressful situations

Integrated Discovery
Stress was described by the participants and researcher-participant as a common reason for an overeating episode; therefore they have the justifiable right to escape present negative thoughts, feelings or behaviour. Stressful situations vary from work, financial, family and other relationship related situations. Overeating in times of stress gives them a short lived energy spurt to continue functioning within a given situation. Stressful times give them a good reason to pick up weight.

Discussion

From this discourse discovery stressful situations vary from work, financial, family and other relationship related situations. In a narrative context overeating in action has the possible function of helping participants to continue functioning in stressful situations as a possible justification for gaining weight. From literature, obese persons may experience emotional distress on encountering the negative feelings of society and can internalise these, modifying their self-images (Molinari & Riva, 1995).

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Theme 15: In relationship to traumatic experiences

Integrated Discovery
From axial coding unresolved traumatic experiences are linked to the reason or a reason why participants tend to overeat within different contexts. Related to these women's relationships with food in excess are; childhood molestation and loss of a significant other.

Discussion

Traumatic incidents could be a cause of obesity (Gross, 1983). For example an adult survivor of sexual abuse in childhood, where the woman has an unconscious need to be strong and large to protect herself and obesity is a means to an end. Another example is the loss of a loved one at an early age, where obesity becomes a way of dealing with the grief the woman experiences at certain points in her life. Phillips (2001) stated that the powerhouse in any story is the will of the characters to get or do what matters to them. So *they need to know what matters* (possible traumatic event); it needs to matter enough that they are prepared to work for it, and they need to understand what it would take to get what they want.

Theme 16: Familial themes and voices

Integrated Discovery
Within the family context the axial coding revealed various internalised beliefs of different family members, participants and researcher-participant as follows: • Children must come first and be protected no matter what. • Children must always be accepting of their mothers' body weight. • Her husband is just like her father. • She serves her husband, because her mother served her father and this is what women do. • Mother's voice: "a man is the boss and a woman is a slave". • Family time is very important. • Her mother-in-law's voice: "men can look on the menu, but they must eat at home" and "we must lose some weight otherwise our husbands will find other women". • Genetically it is more difficult for her family members to lose weight. • Health risks in her family of origin; high blood pressure, cholesterol and heart attacks. • She feels unacceptable as a person in the context of her mother discussing others' overweight. • Family routine of eating in front of the TV. • She is the peacemaker in her family where she places everybody else's needs above her

own.

- According to her mother and/or other members of the family overeating behaviour is a comfort in times of stress and work pressure.
- In the context of family gatherings family discussions lead to unpleasant emotional experiences which leads to overeating.
- Crying about a loss of a loved one is not helping her and her family to come to terms with this loss.
- Sexuality has been a taboo subject since childhood within her family context.
- Father's voice: "always look at the bright side in life" culminated into her wanting "not to just accept positive feedback all the time".
- She must rescue her family, because they cannot live without her.
- *Gender role identity*: mothering her husband, the sign of a happy family is the presence of a consistent, steadfast, dignified and well dressed mother figure, her responsibilities as a mother cause her to lose control over her healthy lifestyle, her mother needed to push aside many of her dreams in the early years of her marriage and therefore she is pushing many of her dreams aside for the moment, she decided to nurture herself with food just like her mother nurtured herself with food and this is OK, she often dieted with her mother since childhood where they restricted their food intake, she has learnt her love for food from her mother, after the loss of her mother she has been fulfilling her mother's role in her family of origin by preparing the same food like her mother becoming the mother and grandmother in her own family and with her children, she believes that mothers can overeat while they are pregnant, because they are mothers and this is what mothers do, in many ways she has become like her mother in character and in relationships with others.

Discussion

There is a minimal amount of literature available focussing on the family dynamics of obese persons (Gous, 1995), even though the family is the basic building block of society. As stated, a possible reason for this, according to Louw (1989), is that obesity is not necessarily related to specific pathology in a family. Although, it is theorised that a focus on female appearance starts in childhood through parental commentary and continues to impact a woman's body and psychological functioning in her adult life (Swartz, Phares, Tantleff-Dunn & Thompson, 1999). This discovery opens up many issues surrounding the family dynamics playing a role in these participants' relationships with food in excess. While no two families are alike; each operates according to its own rules and traditions, directed by the needs and personalities of its members,

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they are also a reflection of the society in which they participate. Internalised beliefs with regards to feelings, thoughts and behaviour in their relationship with food in excess are possibly modelled during childhood and strengthened through the practicing of these in a relational context. Future research could be done in discovering the meanings women give to their food-experiences within their family of origin and its relevancy in their present family as adults.

Theme 17: Socio-cultural power and voices

Integrated Discovery
Within the socio-cultural context the axial coding revealed various voices from society and Afrikaans culture that affected participants and researcher-participant to formulate internalised beliefs as follows: • If a girl becomes pregnant before marriage she has to marry the father of the baby. • "Men are kings, women are slaves". • Women believe that they are servants of men. • Afrikaner, Christian men are the head of the household, women are the wife, mother and caregiver of children. • Society judging her according to her looks, therefore she is unacceptable. • Fat people cannot do their work properly. • Afrikaners are fat, because they love eating meat. • Society equates thinness with success in the workplace. • In the 1970 and 80's sexuality was considered a taboo subject. • In 1970 children were allowed to be seen and not heard and family members did not talk about painful experiences or express their emotions, but now in 1990 families communicate more and children's voices are allowed to be heard. • Considering others and serving others are important Christian virtues. • Experiencing group pressure from other overweight women to be fat with them, "so that we won't be alone". • When women become pregnant they should eat for two. • We always eat with our eyes so if the food table looks pretty and full of unhealthy food, we tend to overeat. • "If you are fat, you are not supposed to wear revealing clothing". • Media portrays a thin is beautiful message. • Fat people are failures. • All female teenagers through all centuries can tell stories about diets and their unhealthy

effects on her as an individual.

- Society believes that fat people are to be blamed because they are fat.

Discussion

As stated, despite societal expectations of slimness, the prevalence of obesity is increasing (Kuczmarski, Flegal, Campbell & Johnson, 1994; Lyznicki, Young, Riggs & Davis, 2001). From this discovery it is clear that socio-cultural factors have a major effect on these participants regarding their relationships with food in excess. As stated the participants and researcher-participant sample consisted of the following characteristics; Afrikaans speaking, Christian, female, married with one or two children, ages ranging between 30-40 years, with a bodyweight defined as obese (≥ 45kg); and in a career setting, where two of the participants have their own businesses and researcher-participant is in private practice. Each of these characteristics could also be vantage points from which these participants experience and describe socio-cultural factors within discourses. From this discovery, the socio-cultural events set in the historical context of these participants life span development is set in the 1970 and 80's where sexuality was considered a taboo subject, as well as in the 1970's where children were allowed to be seen and not heard and family members did not talk about painful experiences or express their emotions. In 1990 families communicate more and children's voices are allowed to be heard. Consequently, historical context implies that a person does not live or experience in a vacuum, but rather that each person develops within a particular set of circumstances determined by the historical time in which he or she is born and the culture in which he or she grows up.

As stated in literature, cultural stories determine the dimensions that organise people's experiences (Zimmerman & Dickerson, 1994). From literature, while cultural influences may be less important than genes in a statistical sense, they are more important in terms of the treatment and prevention of obesity. This is simply for the reason that cultural predispositions to obesity are changeable. A culture is an integrated system, so that a change in one part causes changes on the other levels (Brown, 1993).

Theme 18: Living with an overweight identity

Integrated Discovery
The participants and researcher-participant experienced *an overweight identity* in relationship with someone with regards to several issues as follows: • *Overweight identity*: being overweight since childhood where she matured faster than her

peers giving a fat body-image, her thyroid gland, genetics, high cholesterol and health risks have a influence on her being overweight, she is well informed regarding diets and weight-loss methods but decides not to adhere to them because they have failed her in the past, she wants acceptance for who she is and not just for how she looks, she links her self-confidence to "who she is" and her self-worth to "how she looks", during pregnancy she accumulated a lot of weight, her perception that she is fatter than she is at a given moment in time, she does not want to be reminded that she is fat all the time, she gives up easily during the weight-loss period due to her impatience to reach goal weight, after gaining 40 kg or more she starts to worry about her weight and the struggle with diets start again, believing she is a happy person and feeling that she does not look so bad in comparison to other fat people stops her from losing weight, since childhood she was less intent on caring for her physical appearance than other children, since childhood physical activity has been unfamiliar to her and therefore unwanted, her overweight stood in her way of boys liking her during childhood, restricted food intake always makes her want to overeat afterwards, missing her mother during her two pregnancies made her gain a lot of weight.

Discussion

Erikson (1963) defines identity as comprising a content component, what one thinks about, one's values, beliefs, and traits and an evaluation component, the significance one places on each component of the identity. In terms of this discovery, these participants have developed an overweight identity. Erikson (1963) further explains that the content component of identity emerges as the inner or private self and the public self.

As stated in literature, body-image lies at the heart of adolescence as it is an important part of identity development, particularly at the stage of adolescence when accommodation to pubertal change is a key developmental task (Ferron, 1997). From literature in the matter of gender role identity, Rodin et al. (1988) proposed that maternal modelling of a highly appearance-invested mother or one who worries about, or disparages her own looks, may abet a daughter's development of disturbances in body-image and eating. The issue of feelings of confusion of obese women in relational context is rarely discussed in literature. Future research on this topic in relation to women's relationship with food in excess could be done. Although the adolescent identity of overweight women has been widely researched, more research could be done specifically with reference to the overweight-identity and gender role identity of adult obese women.

Alternative stories

Here follows an integrated view of the collective alternative stories according to themes from axial coding.

Theme 1: In relationship to self-worth, self-love and love from others

Integrated Discovery
From the axial coding the participants and researcher-participant described self-love, self-acceptance, self-worth and love from others as follows: • When she turns self-hate into self-love, being proud of herself and becoming her own mother and comforter she feels nurtured and alternative ways of comforting herself are explored. • Self-forgiveness and self-acceptance help her to stop blaming others and herself for being fat and overeating. • It is her responsibility to listen and accept herself. • Self-acceptance enables her to feel better about herself, to take care of her physical appearance, to comfort her body by physically holding her body in times of stress, to deal with negative comments in a more constructive manner, to experience other's acceptance of her on a more regular basis, to accept others just as they are and to take responsibility for a healthy lifestyle. • Her relationship with God has given her a better understanding of His fruit of the Spirit such as; patience, love, self-control, self-confidence and self-respect. • Self-acceptance is her friend against unwanted male attention and she strives to be seen as equal to the male gender. • Self-worth enables her to prove to others that she can live a healthy lifestyle, to change her perception of other people's negative perception of her being fat and ugly and to believe that she is good enough and worthy just because she is who she is and it does not matter what others say. • She feels worthy through her handiwork and others compliments. • She has the right to allow her voice to be heard, because she is worth being listened to with regards to her experiences of her relationship with food in excess. • Her experience of being loved by others living or dead, comforts, means a lot and brings healing to her. • Spending more time with her husband and children makes her feel more loved and accepted.

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- Her experience of God's grace, mercy and love has made her more thankful for who she is just like she is in the moment.

Discussion

Self-love and self-acceptance are depicted as alternative discoveries. The construct of self-love and self-acceptance in literature on obese women has not been described as a preferred story, therefore research possibilities are endless. Self-love and self-acceptance could possibly be helpful in making new meanings surrounding the body-image distortion these participants struggle with. Accepting and loving yourself on a physical, psychological and spiritual level, with special emphasis on acceptance and love of your overweight body, could be a starting point in searching for new meaning regarding the reason to lose weight, or to seek happiness and health, as well as the experience of obesity. Possibly, with this alternative story the discourse to love or nurture themselves with food shifted to them taking responsibility of nurturing themselves in alternative and more healthy ways on an emotional level of human functioning.

From literature, there are social norms that are neurotic in nature and they set impossible standards for female beauty, resulting in body-image disturbance and destroying women's self-worth (Freedman, 1988). Self-worth could be conceptualised as an individual feeling good about themselves regardless of negative thoughts or perceptions. In every day language self-worth could be described as a person being worthy in relation to the good work he or she is doing. Depicted from this discovery self-worth is described in terms of participants work making them worthy and the right participants have to be listened to and to be heard, just because worth is a given attribute without the necessity to earn it. Further research on this matter is needed and could be challenging.

Furthermore, the loving support from significant others is depicted as an alternative discovery. Significant others consist of friends, family and God. Depicted from data, experiencing love and support from significant others have a healing effect on the participants. New research could be done on the role which support from significant others could play in creating a healthy and more constructive environment for obese persons to take responsibility for living healthier lifestyles.

Theme 2: Learning experience and externalised decision

Integrated Discovery
From axial coding most of the alternative stories in the whole picture of data analysis are described at a cognitive level of psychological functioning, where learning or re-learning experiences and decisions or re-making decisions about themselves have been formulated in the past and

reformulated at some point during and after the therapeutic conversations. The participants' and researcher-participant's learning experiences and decisions are described as follows:

Learning experience	*Externalised decisions*
• Good judgement helps her to understand and plan alternative strategies to combat her overeating process or tornado experience. • Talking about painful experiences can be difficult, but remembering friends from the past in these difficult times enables her to remember that she was not alone. • If she looks after herself on different levels everything will fall into place and this is her responsibility. • She hopes for hope and happiness for her family after the therapeutic conversations and she knows the importance of having hope within relationships. • Proving others wrong, happiness and health are some reasons for her to lose weight. • It is not important anymore to try and please others the whole time and her opinion is important. • It is important to not be stuck in the past but to focus on the future by living daily in the here and now. • Perseverance helps her to sort out difficult problems and intellectual and emotional stumbling blocks. • Expressing her emotions and her changed perception that she is beautiful even though she is fat makes her more	• She is going to think twice before acting impulsively and be calm with regards to others and the overeating process or tornado. • She chooses to believe differently than negatively about herself. • Becoming more mature, taking courage and responsibility for her actions. • She is going to set goals for herself and work on her goals. • She chooses not to allow the media and society's opinions with regard to overweight influence her negatively anymore. • Happiness does not depend on others, only on herself, and this will be her motto in life. • She wants to be a winner. • She is going to make use of spiritual support from God and emotional support from friends and family to lose weight. • People must take or leave her just as she is even if they accept it or not, she is who she is. • She will lose weight on her own time and without punishing herself. • A few years ago she made a calculated decision that she will never ever pay someone again to help her to become thin, because the answer to a healthy

human and approachable to others. • Self-awareness about several issues in relationship with significant others with regards to her relationship with food in excess enables her to understand herself and others. • There are more stories to describe herself with than only a fat story. • "Wanting to" rather than "must" lose weight could be a healthier and more workable alternative to overeating. • Others' unhealthy relationships with food give her a wake-up call for her own health and well-being status. • She does not need to lose weight because by dressing herself professionally she likes how she looks, but limited options in larger dress sizes brings the reality to her that she needs to lose some weight. • Her definition of success in losing weight is:" A good day for her is when she did not overeat to satisfy her emotions, used more fat free products to combat high cholesterol or have a moderate fat intake". • For the first time in many years she feels that she has discovered herself as an individual separate from her mother. • She is not alone in her struggle to make meaning of her experience with food. • Her "sexuality" is a special gift. • The freedom of choice is an act of her will to carry out her decision about something.	lifestyle is within her. • To change her overweight condition to a more healthy weight she decides to make a lifestyle change. • She is going to a dietician and is committed to lose weight for health reasons only. • She is motivated to lose weight after hearing others' success stories. • Set rules don't work for her, so the only rule would be "low fat and healthy". • She is not going to pity herself anymore but focus on the good things and characteristics that she has. • She has decided to incorporate memories of her mother in her life thus helping her not to focus on overeating anymore. • Spend more time with her family and nurturing herself. • To have authority to say no to someone without losing her softness as a woman. • To set boundaries with regards to what she is prepared to do for others or not. • To incorporate her experience of her physical body into her thoughts and emotions. • To use externalisation of her problems and to go for walks in times of stress more often. • To take full responsibility for her past hurts and to break free from her own "blaming game". • To "eat herself to the death, because others do not listen to her" is not an

• Her body has a voice just like her mind, emotions and soul. • Her family has outgrown her rescuing act and this makes her feel a sense of loss, but at the same time a sense of release and relief. • Consuming food is important for us as people/human beings to stay alive, thus to survive.	option anymore.

Discussion

Above mentioned description of the internalised beliefs discoveries as discourses, could be applied to the learning experience and externalised decision of the alternative story discoveries, whereas the difference is in the possible constructive learning experiences through narrative therapeutic conversations regarding participant's internalised beliefs which were previously set in their ways, restrictive and unchangeable. Learning experiences possibly enable participants to become self-aware about several issues in relationship with significant others with regards to their relationship with food in excess and this enables them to make responsible decisions concerning their health and happiness. The decision-making process becomes more evident in the light of the participants' learning experiences as alternative stories, whereas the possibility of choices becomes more evident. New research could be done on these aspects of the learning experience and decision making process on a cognitive level of psychological functioning, regarding women in relationship with food in excess deciding to create a healthy lifestyle.

Theme 3: Constructive communication in action

Integrated Discovery
Depicted from data the participants and researcher-participant described constructive communication, in the context of therapeutic conversations, relationship with others and themselves as follows: • *In context of therapeutic conversations*: feels more in control of eating habits and other areas of her life, her passion to create has been rekindled, is reconciled with her inner-child, experienced healing, found herself again, her voice and opinions are heard, to face herself and others, made her grow as a person, learnt self-love, self-acceptance, forgiveness of self and others and how to talk to others more often, talking about her relationship with

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food in excess and her body opened up space for other overweight people to disclose their experiences, her feeling that she belongs somewhere, to openly talk about women's sexuality with others, enriching herself as a person.

- *Others*: protects herself from negative feedback from others by not telling others about her creative handiwork she has done, is used to being praised for her creative abilities, saying no to others when they want to take her for granted and misuse her, positive feedback from others about her weight-loss and that she looks good makes her feel good about herself, communicates more with her husband in general, how to discipline the children, her sexual needs, feelings and about her health needs, takes courage to talk to her family of origin about past taboo subjects, expressing her opinions and emotions to others, communing with God in a mistrust relationship about her relationship with food in excess is helpful, setting boundaries by communicating her needs to others, spending time with her family around the dinner table so that they can communicate better, continued constructive communication with regard to her relationship with food in excess is nessasary for her and others to reach a healthy lifestyle.
- *Themselves*: Positive self-talk, allowing her body to speak to her more often and then listening, being aware of the healing factor of staying in her room to deal with her feelings and emotions through self-talk.

Discussion

According to Dimbley and Burton (1985) one basic purpose that we all have in communicating is to give, get and exchange information. The act of communication is a kind of behaviour. Therefore we communicate with others in order to modify their behaviour. People learn to communicate in different ways according to their upbringing. So the idea that communication is a kind of behaviour helps people to look at why they communicate as they do. For example, if a person isn't good at apologising to people, this is because he or she hasn't learnt much about how to do this (Dimbley & Burton, 1985).

Furthermore, it could be said that everything we learn, every piece of information that we acquire changes our behaviour to some extent in the end. Every piece of communication which we experience may affect our attitudes and beliefs in some small way (Dimbley & Burton, 1985). Within this study communication could be very powerful and constructive in assisting women in their relationship with food in excess to create a healthier lifestyle. From this exposé a space for women and others has emerged in which to constructively communicate their feelings, thoughts and actions within relationships with the therapist-researcher, others and self.

Theme 4: Participating in creative arts and handiwork

Integrated Discovery
An individual participant's alternative story, which is to participate in creative arts and handiwork, is mainly described in terms of helping her in combating her overeating process or tornado experience. Positive input from her participation in creative arts and handiwork are as follows: makes her feel that she can cope, helps her to calm down and be peaceful, gives her a sense of joy, helps her through painful experiences since her childhood, helps her to be more in control of her eating habits, makes her feel better about herself, it is a safe, nurturing, relaxing and special place where she can express her thoughts and feelings, she feels that she can take on the world and that she can accomplish many things and she can allow herself to be like a child sometimes while doing the work.

Discussion

Torrance (1967) describes creativity as a natural human process, where human needs are involved in each stage of the process. This process gives room for the specifying of products. The behavioural perspective of the construct of creativity proposes that creative behaviour demonstrates uniqueness and value in the product delivered by a specific person (Parnes, 1972). This discovery could be summarised as a child-like joyful place to be when the individual participant participates in creative arts. Creative arts are particularly helpful in expressing herself on an emotional level of psychological functioning and to be more in control of her eating habits.

Theme 5: Taking initiative in business

Integrated Discovery
An individual participant's alternative story, which is to take initiative in business, is mainly described in terms of linking it to how she can apply business principles to her combating her overeating process. Positive input from her taking the initiative in business is as follows: marketing her business and believing in her handiwork, having a feeling of being in control, she dislikes being dependent on others, do unto others as you would have them do unto you, aesthetic value is important, take care of yourself and others, perseverance is sometimes the only option, having faith in God is a nessasary asset with regards to success, treat people with respect, keep employees happy and then she will receive happiness or good will come back from the employees, loyalty and good judgement are very important and to be strong and to cope no matter what.

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Discussion

According to Erikson (1963) the positive pole of the psychosocial challenge of the pre-school period is initiative. Interesting to note that this participant has very constructive ideas in taking care of her business, whereas the possibility exists that if she could extrapolate her business skills and knowledge to her relationship with food in excess and apply this knowledge, a new-old story could develop. The assumption of human nature that an individual has more stories than just an obese story and that the obese story could be part of the fuller description of the individual's self, is applicable.

Theme 6: Personal abilities in action

Integrated Discovery
Depicted from data the participants and researcher-participant described their personal abilities as follows: stubbornness and perseverance to become fit, self-assertiveness in discerning that overeating is not a safe place, she has creative and problem solving skills, belief in herself, self-confidence, inner strength that comprises happiness, love, patience and new perspectives on life, faith in God that He accepts her for who she is, self-acceptance, self-love, self-awareness, to use her sense of humour with regard to her relationship with food in excess, taking responsibility, to assume an emotional distance from her dysfunctional patterns in her family of origin, uniqueness as a special quality she has, being a people's person, to be caring and sharing with others, being a go-getter, sense of courage, standing up for herself, honesty and open communication.

Discussion

Depicted from this discovery is a wide range of personal abilities participants and researcher-participant have that could be constructive in helping them attain a healthy and happy lifestyle. In doing research on personal abilities of women it is possible that the list of abilities within context could become endless. As stated in literature, within the narrative therapeutic setting O'Hanlon (1994) argues that if narrative therapists do not believe wholeheartedly, that people are not their problem and that their difficulties are social and personal constructions, then they will not see these transformations.

Theme 7: Story before marriage when I was fit and thin

Integrated Discovery
An individual participant's alternative story is described in the context of before marriage when she was fit and thin. In this context she described the following characteristics she knew about herself as her having perseverance, love for life, self-belief that she can do it and being stubborn. Being fit

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resulted in her having a feeling of accomplishment, feeling better spiritually and physically and proud of herself. The main reason for becoming fit and eating healthy was the realisation that she can do it, will do it and that it will be good for her health.

Discussion

This discovery is set in a past context when this participant was fit and thin before marriage. It is possible that the positive and constructive pay-offs or gains she received at this time could be a situation she desires to regain or re-live as an opposite to her experience of obesity. By exploring this desired past context of fitness and thinness could lead to new-old avenues of fitness and thinness in this participants' married life. The telling of this alternative story portrays her personal abilities and the effect fitness and thinness had on her wellbeing as a person.

Theme 8: Participating in alternative ways of taking care of myself

Integrated Discovery
Depicted from data the participants and researcher-participant described their participation in alternative ways of taking care of themselves as follows: planning her time spent on nurturing herself with healthier ways than food, keeping a reflexive journal with regards to her own thoughts and feelings with regards to her relationship with food in excess, dealing with her emotions is a peacemaking process in trying to accept the things she cannot change, daily planning of food intake and exercise, she commits herself for low fat food, when she feels emotional about the loss of her mother she takes a walk in the garden, looks at old photos or merely asks "why is it nessasary to put something in my mouth if I am really not hungry?", she decided to stand still and take time for herself when there is too much pressure and stress, she allows herself to have more resting times in shorter periods of time, taking care of herself firstly gives her more room to take care of her family and to take walks helps her to feel more relaxed and to release her pent-up energy and to be more focussed, time out in her room now and then, writing, drawing or taking a prayer retreat.

Discussion

Becoming your own primary nurturer or caregiver in different ways than overeating is the main focus of this discovery. The nurturing and comforting role of excessive and unhealthy foods is replaced with different emotional expressions, physical and cognitive outlets than before. Research on generating new ideas instead of being nurtured by food could be very interesting and innovative.

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Theme 9: Prospective healthy lifestyle

Integrated Discovery
From the axial coding the participants and researcher-participant described their decision to choose a healthy lifestyle, as; if she is in control of her eating habits and more self-confident she can cope better with stress, to eat healthy during her second pregnancy is important, she feels some freedom from her struggles with food and she believes she has the choice in what she eats and when she eats it and in which context, she wants and is responsible for a healthy lifestyle not only for her benefit but also for her children, she feels better about herself when she is physically fit, exercise and eat healthy food, fitness relieves hunger pains and fills an emotional void, a healthy lifestyle is more important than just to focus on losing her extra weight, she wants to lose weight to be healthy, she wants to fit into her clothes, have more lust for life, lose bad habits, healthy eating means to cut out sugar and to eat more vegetables, knowledge about health risks with regards to overweight helps her to realise the importance of going for a medical check-up, her happiness and health are the greatest reasons for her to lose weight, she is changing her thoughts from "I must" to "I want to lose weight", being in contact with her body's voice that she is unhealthy and sometimes in pain, she decided to follow a weight management program to the best of her ability with responsibility, she eats to be healthy and to have quality of life, having balance in eating and exercise, she has a healthier outlook and experience of her body space.

Discussion

Depicted from this discovery *a healthy lifestyle is more important than just to focus on losing extra weight*. From literature, obesity is seen as a medical problem, as an illness and could be the cause of other diseases. Furthermore, Rothblum (1999) argues that the power relations within the health businesses at play are nested in the billions of dollars that are at stake and many companies would lose revenue or go bankrupt if women became satisfied with their bodies to the point of not joining health clubs, not undergoing plastic surgery, or wearing comfortable clothing that was unrelated to the annual changing fashion dictates.

From literature, on an individual level, self-esteem appears to be related to positive mental health or psychological well-being (Mruk, 1995). As Bednar, Wells and Peterson (1989) say, for instance, "It has been repeatedly demonstrated that self-esteem and psychological health are related to favourable psychological consequences in a variety of psychological situations" (p. 190). Also stated, a holistic approach to the care being provided to the client should include a focus on health and well-being, not weight. This approach needs to encompass not only health outcomes, but also needs to take into account each individual's perspective on success, health status, weight history

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and goals related to appearance and body size, and that nurses must refuse to participate in cultural stereotypes related to fatness and challenge the sexist bias inherent in the cultural ideal for women's bodies (Allan, 1994).

Theme 10: Prospect of taking care of physical appearance

Integrated Discovery
From the axial coding the participants and researcher-participant described their decision to take care of their physical appearance, as that she is now motivated to take care of herself, to look pretty, to make new clothes, because she wants to take care of her physical appearance, when her physical appearance improved she felt that she showed people her real self, an alternative meaning for her experience of overweight is that she is beautiful but that she just has to go to extra trouble to beautify herself, she is taking care of her body more often and this makes her feel better about herself.

Discussion

These participants and researcher-participant taking care of their physical body and appearance as alternative discovery; could have developed within the narrative therapeutic setting where their bodies where given voices to communicate in relationship to the emotive, cognitive, spiritual and behavioural parts of the self. The assumption is that each individual's physical need is also important in relation to other parts of human functioning.

Concluding reflections

As reported by Bruner and Kalmar (1998) self grows in an environment of its own making. The events and circumstances that shape self are themselves constructed, products of self-generated meaning making shaped to fit our growing conceptions of selves and the events we encounter are coded and filtered at the very entry port by our perception of the world (Bruner, 1973, 1992; Neisser, 1988; Niedenthal & Kitayama, 1994). So while the experienced world may produce self, self also produces the experienced world, all of which suggests that the self is not only constructed, but also that it's mode of construction is massively hermeneutic. Perhaps it is this interpretive feature of self-construction that imposes certain conceptual structures upon self (Bruner & Kalmar, 1998). As stated, the defining processes of participants' selves are co-constructed between the researcher-therapist and an individual participant. In this study the subjective nature of therapeutic conversations allowed for unique constructions of selves, which in itself is possibly larger than the description given regarding an obese person or obesity. With this statement in mind, it is evident

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from the data that psychological functioning could form part of the defining process of women's selves which have been co-constructed between the researcher-therapist, each participant and the world around them.

Linking literature with the integrated discourses and alternative stories discoveries, contribute to the trustworthiness of this study. In this letter the integrated discourse discoveries from the text of therapeutic conversations and reflexive diary of researcher-participant; as well as an existing literature on obesity; are used as the first two steps in the data triangulation process. The psychological aspects of obesity in existing literature comprise mainly self-esteem issues, psychological disturbance, intrapsycic- and interpersonal factors. Although there were several similarities from literature and these discoveries, specifically on psychological, environmental and developmental functioning of obese women; each similarity had deeper and fuller descriptions within the narrative context. The main similarities where found in the constructs such as body-image constructed as body perceptions; inner beliefs constructed as internalised beliefs; overeating in action and socio-cultural voices and power. The main differences between literature and discoveries were focussed more on the emotional functioning of participants in terms of constructs such as anger, frustration, fear, loneliness, rejection, love / hate, comfort, sadness, hurt, guilt, inferiority and mistrust. There is a gap in literature on these areas of psychological functioning, which highlights this study's valuable contribution to the field of research. Another gap found in literature and presented by these discoveries is the references to traumatic experiences such as the experience of sexual abuse and loss being a trigger for overeating. Furthermore, there were small nuances in difference between existing literature and this study's discoveries in terms of familial themes, which gave a richer and fuller description. One of the main nuances was the emphasis on discussion of sexuality being a taboo subject in families. Also another area of difference and a gap in literature is the integrated discovery of communication in action, whereas the main focus is on the participants having difficulty to communicate in a constructive manner with significant others. Finally, one of the interesting phenomenon's that emerged from data was the participants having an overweight identity as if they are born and bred to be overweight without the possibility of change.

From the integrated alternative discoveries it is important to note that each participant has similar as well as unique preferred stories which could be related to their specific and unique way of thinking, feeling and acting, as well as meaningful opportunities presenting themselves in specific situations and in a specific time frame. Within a narrative therapeutic framework during the process of deconstructing questioning of existing discourses; alternative stories emerged from the data evidence. Within this study's context participant's personal agency, where alternative stories are

put into action could be explained within the context of exploring obese women's psychological functioning. Possibly this discovery emphasises the opening up of space for women's voices to be heard with regard to their internalised world experiences during the meaning making process of discourses and especially within the context of discovering relevant alternative stories within a narrative therapeutic setting.

In this letter the integrated alternative stories discoveries from the text of therapeutic conversations and reflexive diary of researcher-participant; as well as an existing literature on obesity; are also used as the first two steps in the data triangulation process. The main alternative stories in literature emphasises weight loss as a cure for obesity seen as an illness according to the medical model. Weight loss is seen as a direct result for magically making the obese women healthy and to psychologically feel better about herself in so doing she is declared a healthy person. This study's alternative stories highlighted psychological functioning within the narrative therapeutic context. Specific themes seen as unique outcomes for individual participants were as follows; participating in creative arts and handiwork, taking initiative in business, story before marriage when she was fit and thin. Several participants had similar alternative stories, such as personal abilities in action, participating in alternative ways of taking care of themselves. Some themes emerged as prospective alternative stories (meaning a decision that could be practiced in the future), such as specific externalised decisions, experiencing self-love and self-worth more often, having a prospective healthy lifestyle and the prospect of taking care of their physical appearance.

Important to note that the participants processes of integrating these alternative stories on a psychological level could be explained as the co-construction process within a specific time-frame, for example, during the therapeutic process, within therapeutic conversations, in between and thereafter. Possibly during this time some of the alternative stories could become lived experiences now and in the future, old stories turn into new-old stories, which could give personal agency to an individual to affect the environment and developmental functioning as being a re-authored story.

Based on narrative work done by Zimmerman and Dickerson (1994) some effects are considered in the discoveries presented in this study. It is clear that each participant's story makes sense; in fact, it is inevitable in the context in which it evolved. These stories also have some limiting effects for person's lives; they are not irrelevant to the interactional process. By following the implications of these stories in conversations, more space seems to be created for the participants and researcher-participant to notice other possibilities for themselves and about their significant others. Another effect is the richness of the experiences brought forth, experiences full of affect and images; the

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narratives of people's lives are dynamic responses to questions reflecting the therapist's theoretical constructions. By following Zimmerman and Dickerson (1994), from a narrative perspective, there are certain effects for the participants and the researcher-participant that allow us to notice and reconstitute our lives along lines we may prefer, and to develop more preferred versions of ourselves. This study is a valuable contribution to the limited research on the psychological functioning of obese women and their relationship with food in excess.

Possibly the usage of qualitative methods such as narrative inquiry as research design and content analysis in data analysis have sufficiently answered the research question such as exploring the various meanings that women could construct with regards to their relationships with food in excess. From discoveries it is clear that future studies, focussing on psychological functioning, could be helpful in deriving fuller and richer descriptions and refining theoretical statements and so on in an ever-growing circle of understanding. As stated, this study contributes to a first level of interpretation and could serve as a basis for future studies by generating hypotheses and theories while reading and analyzing the narratives, and in a circular motion as proposed by Glaser and Strauss's (1967) construct of 'grounded theory', can enrich further reading.

In telling and re-telling the un-preferred and preferred stories
Co-author and researcher

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VI - Letter of discoveries through drawings

More ways of looking at food stories

Dear reader

Celebration feasts mostly represent the giving and receiving of more than one gift. Discovering the content of more than one gift is a journey in itself. The aim of this letter is to present further discoveries of the data analysis which include the self-expressions of four participants through drawing a self-portrait and co-constructed drawings of reflections upon four conversations with each participant in conjunction with the researcher-therapist.

Some of the discoveries through drawings presented are the researcher's account and some are the researcher-therapist and the participants' co-constructed accounts of there experiences of themselves in relationship with food in excess.

Series of drawings and discoveries

Rather than being employed for objective diagnostic and interpretive purposes, both expressive arts therapy (Weller, 1993) and narrative therapy invite clients to make meaning of their own expressions. The therapist takes a stance of curiosity and facilitates the expansion of preferred meanings for the client, rather than offering an expert opinion on her artistic productions. The performance of a new meaning or story that includes other realms of expression solidifies the new experience (Freeman, Epston & Lobovits, 1997). Furthermore, Freeman et al. (1997) reason that one do not have to be an artist or be specifically trained to use the expressive arts in combination with narrative therapy. There are straightforward ways to broaden expression.

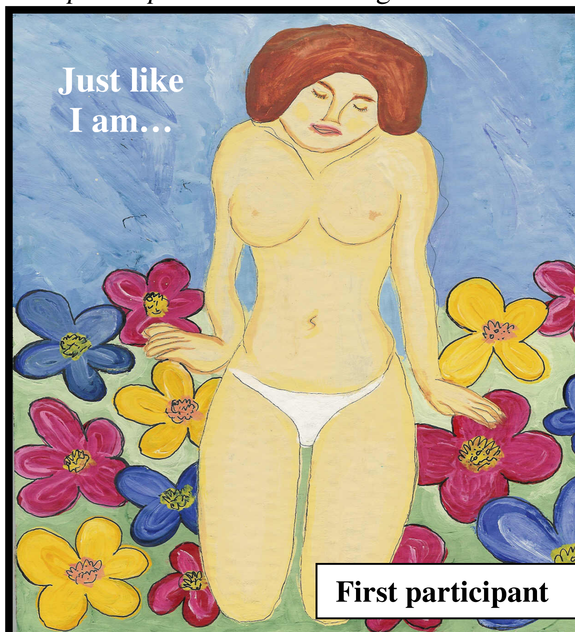
As stated above, the series of drawings used as projective means in communicating data in this study are presented as drawings and described as discussion of discoveries, as follows:

- self-expressions of four participants through drawing a self-portrait;
- co-constructed drawings of reflections upon four conversations with each participant in conjunction with the researcher-therapist.

Drawings as discoveries: self-expressions of four participants through drawing a self-portrait

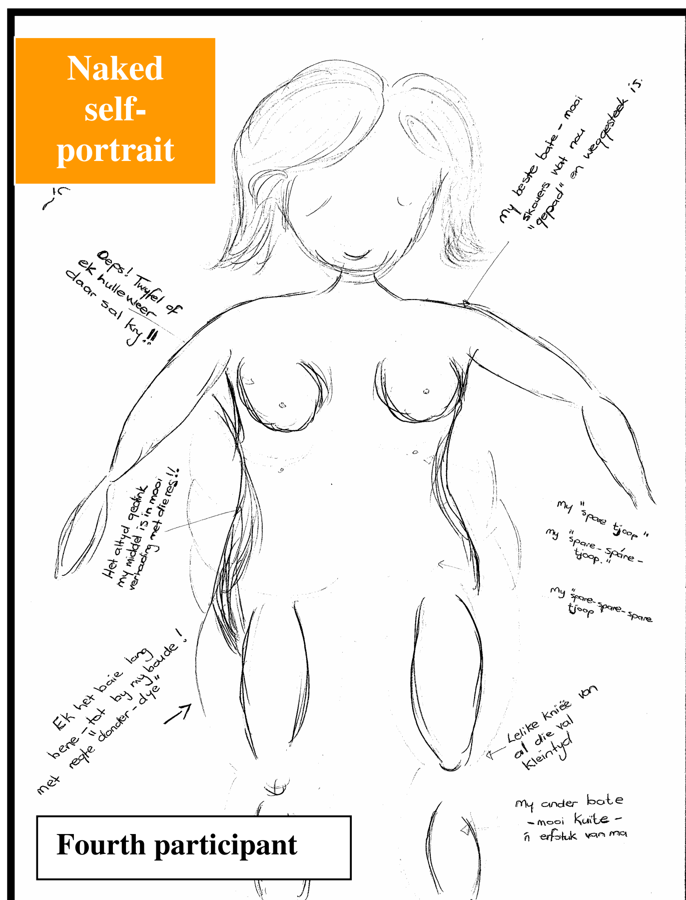
The first, third, fourth and fifth participant partook in drawing self-portraits. The second participant did not partake in drawing a self-portrait, but rather decided to write a story presented earlier in this study.

First participant: Her drawing is entitled: "Just like I am" which according to her depicts her vulnerability as an adult survivor of sexual abuse in childhood. Being the most overweight (more than 70kg) of the participants, she finds it hard to be vulnerable before anyone. When telling the story surrounding her drawing, she talks about how often she has hidden herself away from others and that she finds it more comfortable to be with and by herself. This drawing represents her vulnerability during the therapeutic conversations as an adult and as a child, the difference being that the flowers surrounding her are very colourful, smell wonderful and she feels at peace, as well as safe with another human being (therapist). Drawing herself in this way made her realise how beautiful she really is and after a discussion about this drawing she desired to experience her beauty more often in safe places.



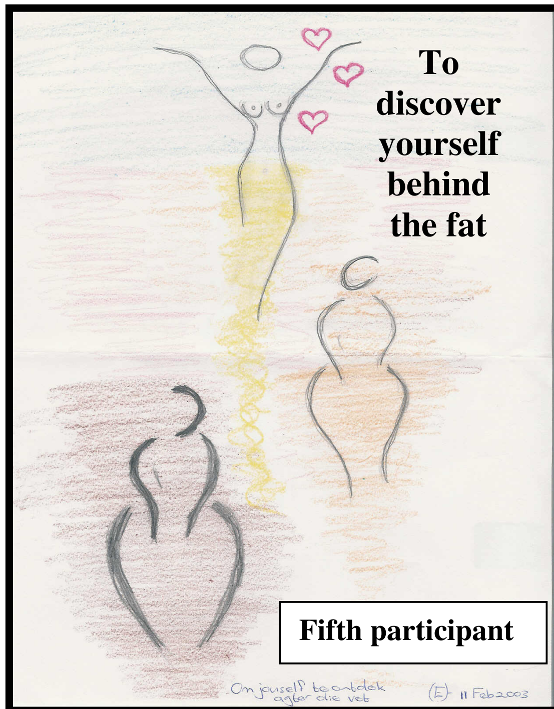
Third participant: Her drawing is entitled: "I like nice food and I invite everyone to come and celebrate with me!" which according to her depicts her love for good and delicious food. It is interesting to note the circumstances in which she drew this drawing; it was at a nursery school where the children and the teachers made comments about her drawing. The children described her picture as a party or feast. Some teachers said that it looked like the invitation to a romantic dinner. This discussion

with children and teachers led her to believe that there are other overweight women that would really want to talk about their relationship with food in excess too. She also learnt that the thinner teachers could not understand why she would want to talk about her overweight experiences, because she just needs to control her eating habits and exercise plans. She came to the conclusion that she loves food and that she has the right to talk about her experiences and that there are other overweight women that feel the same way that she does, concluding that she is not alone in her struggle with overweight and that she is acceptable. Her self-portrait story specifically opened up more stories about socio-cultural and familial perceptions and the effect it had on her, such as "Other's think that thin people have control over their lifestyle and eating habits, which make them more acceptable and successful in the workplace", "Thin people think that overweight people must be ashamed of themselves and are not supposed to talk about their experiences with regards to their relationship with food in excess, because they are fat", "I experience group pressure from other overweight women to be fat with them, so that we won't be alone" and ; "I believe my mother-in-law when she says that we both need to lose weight before our husbands get other wives".



Fourth participant: Her drawing is entitled: "Naked self-portrait" which according to her depicts her body-image at this point in time. When talking about her drawing she immediately described her physical strengths and weaknesses step by step. She wondered about the old expression that says "there is a thin woman inside of me, struggling to come out", where she reasoned that she doesn't struggle like this, because she is anyway inside of herself and she knows how to dress appropriately and feel good about herself regardless of her weight. She specifically stated that she did not want to draw eyes, because she struggles to draw eyes, but she did think about the symbolic meaning of this and did not come up with a meaning. She decided to rather focus on drawing a mouth, because she wanted to draw a smile on her face. In talking about the reason why

she drew a mouth that smiles, she also explained that she has much more depth as a person than just being a happy and friendly person. According to her, her drawing is about a thin and a fat woman within the same space.



Fifth participant: Her drawing is entitled: "To discover yourself behind the fat" which according to her depicts her meaning making process regarding the loss of her mother in childhood and how her relationship with food in excess impacted on her becoming like her mother. She explained that she discovered that she could be a separate person from her mother if she discovers herself behind the fat. Thus she is more than just a person with a fat body. However, her drawing moves between a fat to a thin body-image in the process of her discovering herself behind the fat.

Discussion of discoveries: self-expressions of four participants through drawing a self-portrait

As stated in literature, Wadison (1973), in discussing the techniques used in art therapy, offered two interesting ideas on its benefits. One is the idea that the art performed in therapy offers the client the ability to make a self-portrait. The second idea is that of permanence, therefore, the work that they do in therapy serves as a visual reminder to them. From the descriptions of the discussion involving each participant's self-portrait, it is clear that a fuller and richer description in combination with the previous discourse and alternative story discoveries in this study emerged. Here the importance of data triangulation comes into play. As stated, triangulation allows illumination from multiple standpoints, reflecting a commitment to thoroughness, flexibility and differences of experience (Tindall, 1994). **Themes** that emerged from these drawings are listed as follows:

Theme 1: In relationship to a traumatic experience with specific reference to sexual abuse

Theme 2: In relationship to vulnerability on a bodily experience level

Theme 3: In relationship to fear, rejection and loneliness

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Theme 4: In relationship to avoidance of experiencing her physical body, sensuality or beauty

Theme 5: In relationship to experiencing love and nurturance when overeating

Theme 6: Being connected to and experiencing group pressure to belong to a fat peoples' group

Theme 7: Socio-cultural voices specifically from thin people toward fat people as being unsuccessful

Theme 8: Contrasting relationship between sexual overtones found in the drawing itself of being naked and their bodily experience specifically with reference to body disparagement

These thematic discoveries through drawings could be linked to the previous integrated discourse discoveries from axial and selective coding, whereas theme 3 (in relationship to fear, rejection and loneliness) and theme 5 (in relationship to experiencing love and nurturance when overeating) overlaps and confirms previous themes. In theme 5 the participant's relationship to experiencing love and nurturance when overeating are linked to a celebration feast where everyone is invited, which implies the overeating of food happens during a social gathering with friends and family. In the Afrikaans cultural context this could be an indication of her hospitality and social overeating that take place. A fuller and richer description, complimenting previous data, could be found in theme 1 where the participant's relationship to traumatic experience is with specific reference to sexual abuse. This participant's drawing is physically revealing as well as depicting a sense of hopelessness and vulnerability in the stature of the self portrait.

A combination of similar themes (2, 4 and 8) emerged. These themes from the data through drawings are depicted in terms of the participants' bodily experience of themselves. In theme 2 the focus is on her relationship to vulnerability on a bodily experience level, with specific reference to sexual abuse in childhood where physical boundaries were overstepped by significant others in their adulthood. In theme 4 the construct of avoidance was specifically set within the context of participants' experiencing loss of a loved one or sexual abuse. Theme 8 emerged from the drawings itself, whereas the contrasting relationship between sexual overtones found in the drawing itself of being naked and their bodily experience specifically with reference to body disparagement found in the movement between fat and thin pictures of themselves. For example, participant experiencing while drawing her self-portrait a thin and fat person within the same space or excluding the eyes from her face in not wanting to see or deal with her body perception. In theme 6 specific references is made to participants being connected to and experiencing group pressure to belong to a fat peoples' group. According to Baron and Byrne (1997) groups often exert powerful

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effects upon their members. Baron and Byrne (1997) construct belonging to a group or being a member of a group as being interdependent in some manner – what happens to one must affect what happens to others. In the narrative context these participants experience a sense of belongingness by being part of this study and having an opportunity to share their experiences of their relationships with food in excess with others. The danger in this is that the participants and researcher-participant could become too involved in their own ideas or meanings of their experiences that members of the fat group start assuming that the group can't be wrong, that all members must support the decision strongly, and that any information contrary to it should be rejected (Janis, 1982). In this theme there are many research possibilities in the social psychological field.

In theme 7, socio-cultural voices specifically from thin people toward fat people being unsuccessful, the participants experience thin people as discriminating against them. As stated, literature conveys that stigma produces prejudice and discrimination (Drury & Louis, 2002). There is a possible link between theme 6 and 7 where discrimination from thin people towards fat people could force fat people to stay in the fat group where they find acceptance but also to experience group anger towards society or thin people. This fat group anger could become a destructive power in families and society in perpetuating overeating behaviour as a rebellious act against others not experiencing obesity.

In conclusion, the self-portraits that the women drew opened some previously closed avenues to explore for researcher-therapist and each participant. As participants draw who they think they are, the therapist will get a good sense of the story of their identity. Within a narrative therapeutic context these self-portraits serve as a helpful tool to look back on (reflexive stance), as the client's relationship with the problem changes. Through their drawings, they were able to tell their story about their new identity and the changes they had made. This also served as a way for them to rehearse their new story and to tie their progress to the past, present and future story.

Drawings as discoveries: co-constructed drawings of reflections upon four conversations with each participant in conjunction with the researcher-therapist

Closure and reflection upon the narrative therapeutic process with individual participants were the primary focus of the co-constructed drawings. These co-constructed drawings add value to narrative therapy in practise with the aim of the termination of a narrative therapeutic process with a specific participant or client. Although these drawings don't directly add to the previous

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description of discourses and alternative stories discoveries with regard to women's relationship with food in excess, the data from text and drawings depict that the narrative therapeutic process added value to each participant's life, for example: it was a means to freedom and growth; a walked through process; a learning experience; and a lesson in life.

This drawing activity has been developed for this study by making use of ideas with regards to the construct of "hope" in an article by Kathy Weingarten (2000). In this study the adapted instructions were as follows:

- Researcher-therapist and each participant dyad draw together in silence on a single sheet.
- Each one gets a turn to use a single colour and draw something about the topic.
- The topic being reflection upon four conversations and the meaning it had for each one in the dyad.
- Drawings may be separate entities or be responsive and add to previous drawings.
- Draw for about 15 minutes until all have had an equal number of opportunities.
- An individual gets an opportunity to explain what she drew and shares how it was experienced and voice the ideas evoked through drawing.
- The other member of the dyad then reflects upon the sharer's experience and the effect it had on this member.
- Each member of the dyad gets the opportunity to share and reflect.

As stated, a researcher's reflections of self in the research process needs to be explicitly linked to political practice and researcher reflexivity should address the interactional, relational and power dynamics of the research at hand, rather than focusing on a confession of emotional or discursive positioning of the individual researcher (MacLeod, 2002). It is important to note that the researcher-therapists' reflections are not mentioned in the following discoveries, notwithstanding the meaningful contributions the researcher-therapist made during this drawing and discussion process and that I was part of the process and not just an objective observer. From literature, the social constructionist perspective shifts from the therapist as primary mover to therapist as participant (Mills & Sprenkle, 1995). Furthermore, social construction theory posits an evolving set of meanings that emerge unendingly from the interactions between people. These meanings are part of a general flow of constantly changing narratives (Hoffman, 1990).

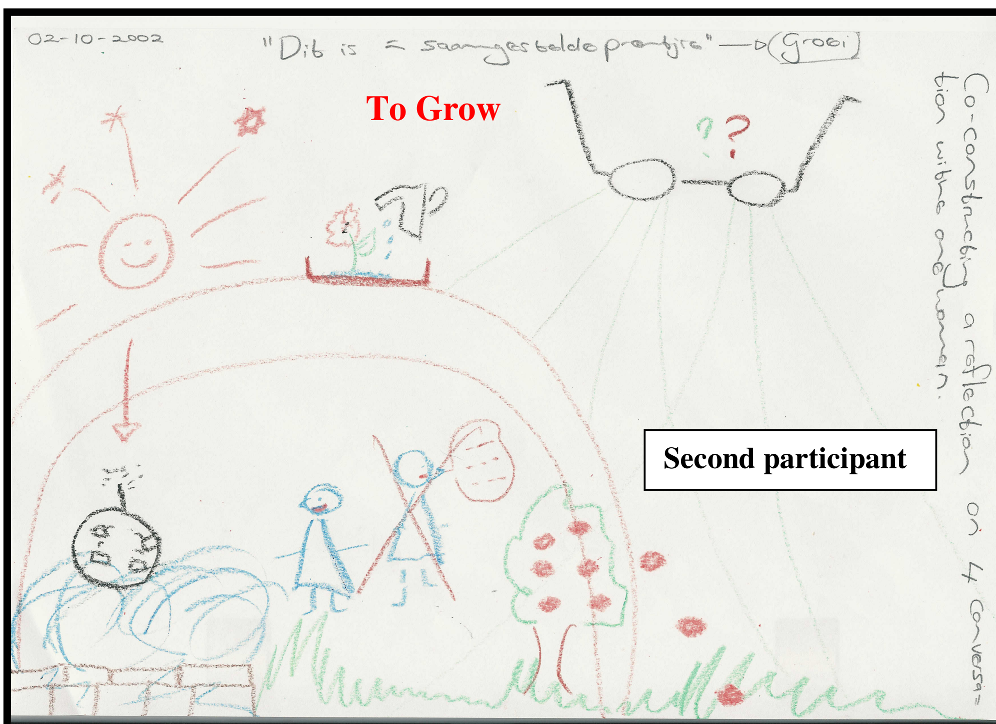
Due to a large volume of text on this matter the decision was made to include the participants' part of the reflections in this co-constructed drawing, because their focus is more on their relationship experiences with food in excess, whereas the researcher-therapist's focus and learning experiences

was more on being a therapist in relationship with each participant. Possibly by not including the therapists' reflections on the process could be valuable information lost to the process of reflection, deconstructing questioning and other therapeutic techniques in narrative conversations through art expressions. Furthermore, if this information where included more research possibilities in theory and practice in a narrative setting could be discovered. In the light of excluding the researcher-therapists' reflections the following reflections of the participants are described.

First participant's description: This co-constructed drawing is entitled: "Freedom". I was in a hole in my personal life, now I am out of this hole. I think I have found myself again. We are going on holiday to the coast and I feel that our family is being put first above friends and my broader family. The meaning I have for your drawing of the shark is that a person always has some fears that bother you. I assume that this is a treasure chest that you drew? A treasure chest for me is my family and my children and here you ask me where the tornado is? Hopefully it is dead. I don't like the tornado! I don't want to have to do anything with it. Here you ask me where I am heading in life. This is all my fears and the rest is the time I spend with my family and my husband and children. I must say that my husband spends much more time with me and the children and we are both aware of how important family time is. Time will tell how we come together and spend time together as family, because it is still a problem, but we are aware of this. This is my parents who are always part of my family's life, but we try to make one another happy. I still feel that I don't always do what and how they want me to do things, but they were there for me always when I needed them. I strive for hope, happiness and I hope everything that is beautiful for all of us. The footprints represent our path to happiness. I feel that this process has clarified a lot for me. One thing that I want to highlight is that I don't hide away anymore from

others and from myself, I don't try to please others so much anymore. I will tell others what I want and why I want it. This drawing means freedom to me, because every person has their struggles in life and we as people need to make an effort to move towards freedom. I have a choice to walk the right way, but there are many roads and I don't always know what is going to happen, but this is what I strive for. At this moment in time I eat healthy and don't overeat. I can't remember when last I had a binging spree. I think it is because I am more mature now and take responsibility for my actions. These conversations were painful, but I am glad that we did talk.

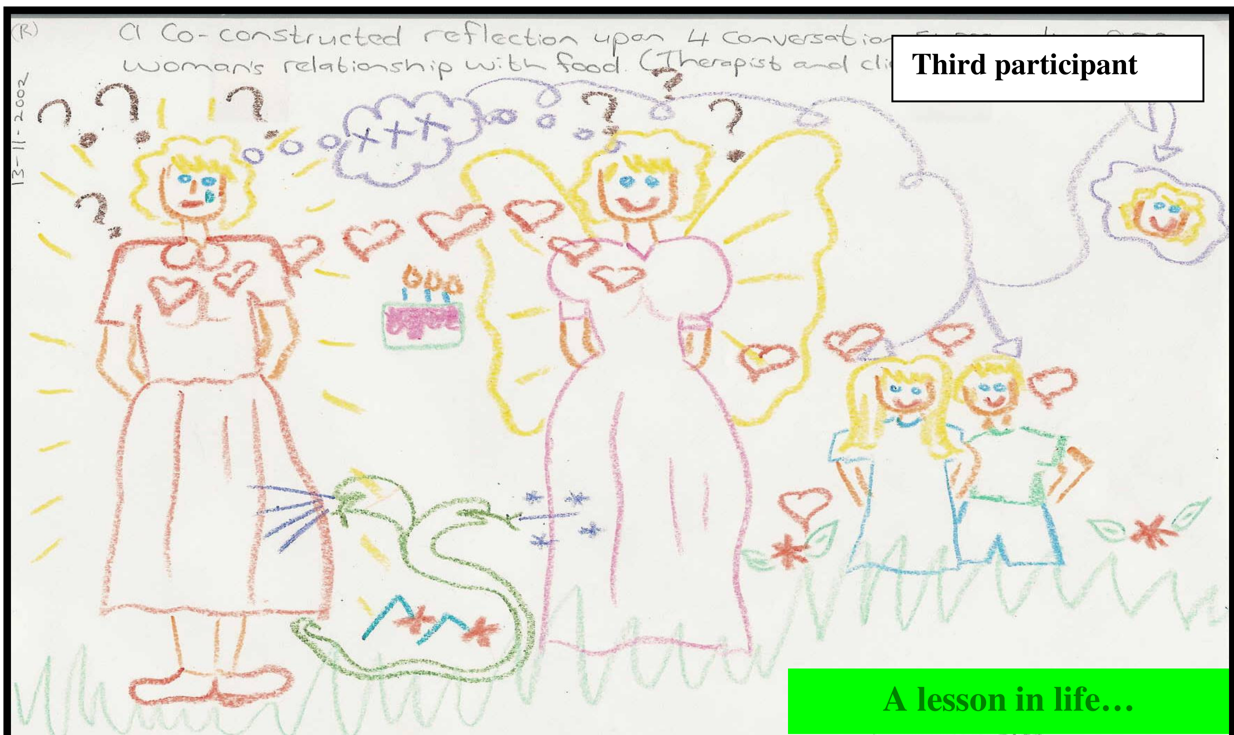
Second participant and researcher-therapist: This co-constructed drawing is entitled: "To grow".



It was like a process of expressing myself so that I could grow. It felt like I was a time bomb in the beginning as if I needed to express myself and that through talking about my experiences and feelings, the time bomb could explode (this is why I drew some stars) in a controlled and safe environment. So where it actually could have been destructive, it was like a breaking open of my experiences. There was growth in that flower with the water and with the grass that was growing there was also some growth. With this drawing I have decided that I am not going to allow other people to dictate to me, because I am on my own. What other people think does not matter anymore. This is a drawing depicting rest and growth. I wondered about the spectacles that you drew and I added some question marks, because why must I feel as if I am being watched. And your drawing of the fruit was precisely what I wanted to do next. I felt as if you understood. What did your drawing of the wall mean? O, yes, the explosion that the time-bomb had been a joyous event. I also think that the spectacles that you drew meant the perception that people are watching me, what am I going to do next, what am I going to eat next, she says that she

is going to lose weight and is she going to do this? The big brother effect; that everybody is watching you. I wanted to draw a cross through your spectacles, but I am careful not to hurt others purposefully. You know the media are going to stay, the perception of other people is going to stay, but it does not have to influence me so much anymore. The dome you drew helped me to put everything together. Another thing that I am thinking of the time bomb now is what would it be like if we take away the fuse? I think that I am bigger than this, that I can do it, without all these issues having an influence. I also think that there is a possibility to break down the wall you drew through talking about it. I think that this blue part you drew could mean water and portray growth. After drawing this picture I realize that I have grown as a person and how easy it is for me to forget what happened to me and I think that this picture just confirmed to me the important work we have done in my life.

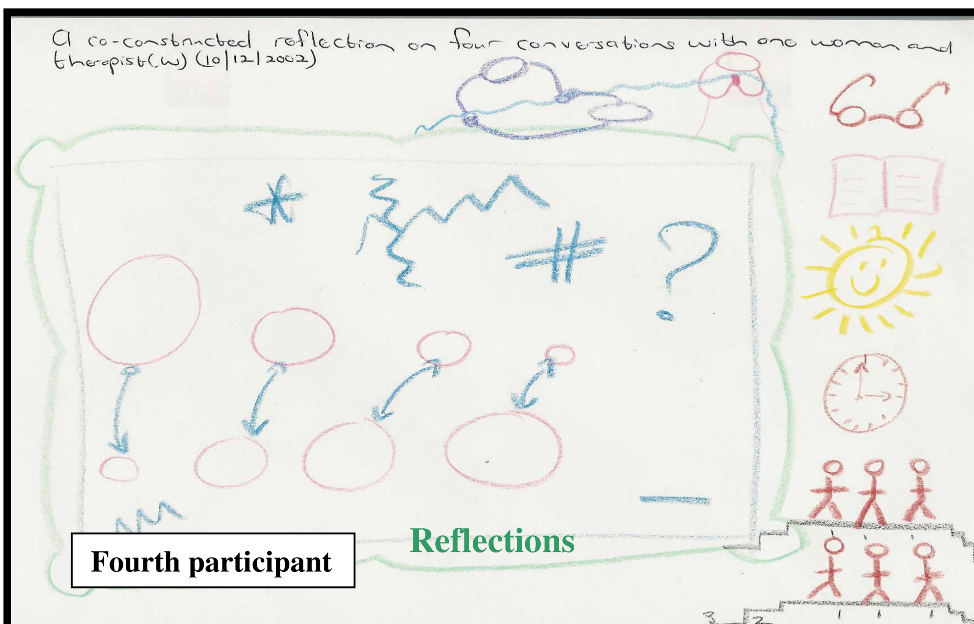
Third participant and researcher-therapist: This co-constructed drawing is entitled: "A lesson in



life". I drew the first picture, where I felt very sad. Before we started with this whole story, I was very sad and unhappy. I did not see anything other than being fat, ugly and sad. And as we started this journey I realised so much more about who I am and I realised that I am more than being fat. I am a person that is pretty and I mean a lot to others and I live for my children and for my family. I must love myself. I moved from the one to the other and that food sometimes made me very sad and unhappy, but that I actually accepted myself later on. So even if the food is there and I eat it, I will still love myself. This is where I say that I am not such an ugly person. And the snakes I

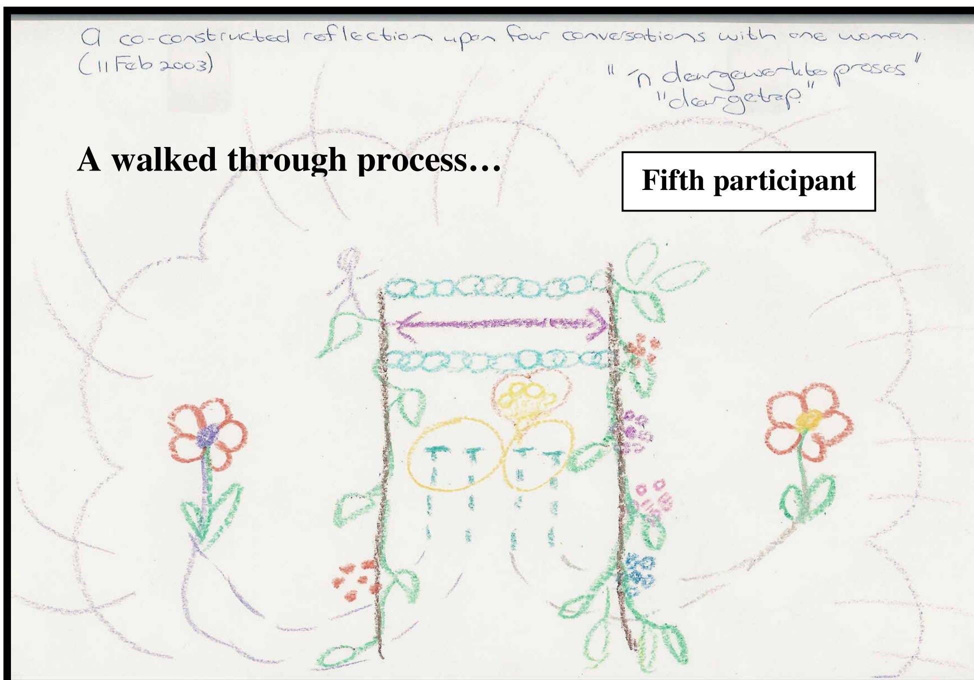
would explain as that when I was so sad it felt like the whole world was spitting on me. And since I have accepted myself, there was still some critique against me, but it is like I have made peace with who I am. The first picture is like the dark side of this old life and the second picture is where I am happier and I have found out who I am. I interpreted your drawing of the snakes as the world's perception of me as a fat person. And with your drawing of the hearts I interpreted it as if you where saying that I am still the same person and I need to love myself and not just the new me, because the old self is still there. And the cloud over there makes me think that it is the same thoughts of both my selves. Therefore there will be times that I am still feeling sad and other times I will feel better about myself. With your drawing of the question marks I interpreted it as if you were asking me to see things from different angles. Everything boils down to the fact that I feel much happier. O, yes, this over here is two flowers that are dying. This is how I felt over there and here I feel so much prettier. I think that these beams wanted to show that it stood out that I was a sad person. Concerning the snakes, I would say, that the stripes could mean that the world wants to say you are bad because you are overweight and at the other snake there are still people that will say to you what they want and how they want. But now I have accepted myself, even though they are saying negative things. It is not poisonous anymore. In the first picture where I was sad it was like how I and the whole world saw me. In the second picture I see myself as a prettier person on an internal and external level, even though I am fat. I really feel like a better person and the wings symbolise that this is a journey that I have started with my Lord, not that I am angel, but I have grown in His word.

Fourth participant and researcher-therapist: This co-constructed drawing is entitled: "Reflections". I think that the first drawing of the circles that I made meant that there was a process happening of things decreasing in my life like things that I have to give up; things



that I see differently. And on the other hand the circles that mean that I have grown. I have started to take things for myself and make them my own; things that I now take full responsibility for. It is like an equal becoming less and becoming more process in my life. And then I drew that it happened in this year within a certain context, where there were lightning, questions and difficulties that weren't always easy for me. What I am the most proud of is that I have decided at the end of this year to take action. This can mean that I am in relationship with the Lord, because I know that if He is not going to give me strength to do it, I cannot do it. I have made a commitment to myself to lose weight step by step. Here I pray alongside the water, because it is calm and peaceful. This part I interpreted as that each person does live their life in a certain way and this is ok. Everyone is a winner with his way of losing weight. In this frame I think everything comes together as a bigger picture, this is with the more and less things process. This is related to each other. I think it is this process that kept me from saying that there is a thin person that wants to climb out of a fat person. You see it is like this, if it isn't about health then I still do like my fat body. My body is not always equally pretty, but do you know some of my features are ok for me. It would be wonderful to have beautiful shoulders again, but I never had pretty knees. It won't become pretty all of a sudden, when I become thin again. I accept my body at this weight and accept myself for who I am.

Fifth participant and researcher-therapist: This co-constructed drawing is entitled: "A walked through process". This was very difficult for me to do. I started by drawing those two lines. I actually wanted to draw a prettier picture of myself over there, but this is how it was for me. It is what we talked about, how my life was is that I stood there at a distance away from others and at the one side of a deep hole. There was just a deep hole, something that was gone, something that I needed and how I tried to use chains to get to the other side and how I could not bring the links together to come to the



other side. In this time that it took me and it took me a long time and how I could finally take the links and put together the chain to get to the other side. This is why I drew flowers on this side. There where first flowers on this side, there wasn't flowers for me on the other side. Initially I wanted to draw leaves on the other side, on the side with the flowers and then you drew it and the timeframe it took me to get to the other side. This was a good experience; it helped me to grow, because if there was nothing inside of me I don't believe that I would have made it to the other side. When you drew the two faces with the tears I experienced it that you understood me. This is what it was all about, because for me to put the links into the chain was for me like working through the death of my mother and father. To work through it to finally find myself as individual. This took time and here I tried to draw corn seeds that are tied together and these circles within the corn seeds symbolises my family, because we are four in the family. The heart stands for my families support through my losses. And then off course the food, but I have not drawn anything about food, because I don't want to. I don't want to see food as an emotional aid anymore. This was a worked through process. This made me see my life from a different perspective. I tried the whole time to work through these losses, but I failed and now I feel so much better about myself and more empowered.

Discussion of discoveries: co-constructed drawings of reflections upon four conversations with each participant in conjunction with the researcher-therapist

The aim of this drawing activity was to co-construct the meanings in reflection of the therapeutic process as a whole, thus the principle of co-construction in understanding the therapeutic relationship (Carlson, 1997). Freeman et al. (1997) argues that the very process of drawing evokes a visceral sense of the problem as located for reflection outside of the self. The act of expression in this sense is often reported as beneficial in itself. From literature, the historical reflection on ourselves is answered in the question; what are we today (Foucault, 1988). Narrative therapy then calls to service that which is useful at a certain point in time. As stated, reflection and experimentation mean considering outcome and the ends to which therapy might be put (Amundson, 2001). From literature, narrative therapy emphasises unique outcomes as a way to help families realise times when they were able to decline the invitation to cooperate with the problem (White, 1993; White & Epston, 1990). Within the narrative therapeutic framework of this study the focus of these co-constructed drawings was to help participants realize times when they were able to decline the invitation to cooperate with the problem.

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From the participants' explanations of their experiences of drawing together with the therapist it was clear that the drawing in itself and the discussion thereafter brought closure for them in their time spent during the narrative conversations and the meanings they could make out of their food experiences told. Giving a name to the co-constructed drawing and discussion of the experience at the end of this conversation brought a sense of courage and hope for them as individuals to live out their preferred stories in the future.

Concluding reflections upon the series of drawings and discoveries

Possible implications for narrative conversations in this thesis-context arise when we consider the complexities of perceiving and making sense of these participants' food-story experiences. Freeman et al. (1997) explain that the map of verbal description does not fully represent the territory of lived experience, including the richness of visual symbolic processes, feelings, emotions and sensations. Expressive arts therapies directly engage auditory, visual and kinaesthetic senses, as well as emotions. When we pay attention to non-verbal cues and facilitate expression through a variety of arts that evoke different senses, new dimensions of experience arise that are aesthetically rewarding as well as effective in these narrative conversations (Freeman et al., 1997).

The main discovery in using expressive arts is that various new and creative narrative ways of exploring participant's relationship with food in excess emerged. Self-portraits gave a fuller description of an individual's identity at a certain point in time during and after therapy. Co-constructed drawings at the end of the therapeutic process served as reflection upon the process by all parties involved and brought closure to the research process with each individual. These various expressive drawings could be used as examples of narrative documents in future research and as a validation tool for participant's decisions in living preferred narratives as discoveries in this thesis and in their future life.

In reflected conclusion, these drawings added value in reaching a fuller description of the meanings these participants made of their experiences with their relationship with food in excess and to the description and discussion of the discoveries in the light of this thesis as a whole.

With added value
Co-author and researcher

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VII - Letter of reflections

The pantry door re-opened…

Dear reader

Like Strause (2001), I had no idea at the start of my thesis what would be created in the research process. As author I have lived the experience of never being able to be separate from that which I was observing. My research also became a part of my daily life. Sometimes it did amount to re-searching for things I had lost or gained during my training as therapist, researcher and role of woman with my own relationship with food in excess. Upon reflection, notwithstanding the different literary voices, in the different participant voices that we have heard, new meanings have been created. Griffith and Griffith (1994) reflect:

> The use of the reflecting position…is in essence a political act whose function is to distribute power among all the different voices in the discourse, dominant and non-dominant (p.166).

The notion that there are multiple ways to describe a particular event or relationship comes to life in the practice of reflecting from different perspectives (Freedman & Combs, 1996). Davis and Lax (1991) state:

> The power of the reflecting idea is not in the switching of rooms, but in the switching of perspectives (p.1).

Acknowledgement is given that there could be shortcomings concerning the possibility that from other theoretical frameworks or paradigms different discoveries could have emerged. Although the relationship framework within the narrative context from which content analysis within a narrative inquiry research design was done, is a valid way of answering the research question. Therefore the research question emphasises an exploration of meaning that women make of their experiences of their relationships with food in excess, with regards to discourses and alternative stories within a narrative context. In the narrative context unique outcomes can be translated as sparkling moments or in this study a co-constructed term could be meaningful discoveries, where there was movement from a discourse to alternative story in the meaning-making process. Within a narrative setting of this thesis and the qualitative methods used, a description of the reflected possibilities in research follows.

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Reflected possibilities

As stated by Wiggens et al. (2001) psychological research into eating practices has focused mainly on attitudes and behaviour towards food, and disorders of eating. Using experimental and questionnaire-based designs, these studies place an emphasis on individual consumption and cognitive appraisal, *overlooking the interactive context in which food is eaten.* Furthermore, Rodin et al. (1984) suggested that while daily conversations and popular press clearly indicate the importance of weight in women's lives, psychological research has largely neglected the issue.

Upon reflection, re-visiting the main discoveries of this study sheds light on the valuable contributions this study makes to the field of research. As stated, the integrated discourse discoveries from the text of therapeutic conversations and reflexive diary of researcher-participant; as well as an existing literature on obesity; are used as the first two steps in the data triangulation process. As stated, the psychological aspects of obesity in existing literature comprise mainly self-esteem issues, psychological disturbance, intrapsycic- and interpersonal factors. Linking literature with the integrated discourses and alternative stories discoveries, contribute to the trustworthiness of this study. Although there were several similarities from literature and these discoveries, specifically on psychological, environmental and developmental functioning of obese women; each similarity had deeper and fuller descriptions within the narrative context. The main similarities where found in the constructs such as body-image constructed as body perceptions; inner beliefs constructed as internalised beliefs; overeating in action and socio-cultural voices and power. The main differences between literature and discoveries were focussed more on the emotional functioning of participants in terms of constructs such as anger, frustration, fear, loneliness, rejection, love / hate, comfort, sadness, hurt, guilt, inferiority and mistrust. There is a gap in literature on these areas of psychological functioning, which highlights this study's valuable contribution to the field of research. Another gap found in literature and presented by these discoveries is the references to traumatic experiences such as the experience of sexual abuse and loss being a trigger for overeating. As reported, one of the main nuances was the emphasis on discussion of sexuality being a taboo subject in families. Also another area of difference and a gap in literature is the integrated discovery of communication in action, whereas the main focus is on the participants having difficulty to communicate in a constructive manner with significant others. Finally as stated, one of the interesting phenomenon's that emerged from data was the participants having an overweight identity as if they are born and bred to be overweight without the possibility of change.

Furthermore as stated, the integrated alternative stories discoveries from the text of therapeutic conversations and reflexive diary of researcher-participant; as well as an existing literature on obesity; are also used as the first two steps in the data triangulation process. As stated, the main alternative story in literature emphasises weight loss as a cure for obesity seen as an illness according to the medical model. Weight loss is seen as a direct result for magically making the obese women healthy and to psychologically feel better about herself in so doing she is declared a healthy person. This study's alternative stories highlighted psychological functioning within the narrative therapeutic context. As stated, specific themes seen as unique outcomes for individual participants were as follows; participating in creative arts and handiwork, taking initiative in business, story before marriage when she was fit and thin. Several participants had these similar alternative stories, such as personal abilities in action, participating in alternative ways of taking care of themselves. Some themes emerged as prospective alternative stories (meaning a decision that could be practiced in the future), such as specific externalised decisions, experiencing self-love and self-worth more often, having a prospective healthy lifestyle and the prospect of taking care of their physical appearance.

As reported, the integrated discoveries from the text of therapeutic conversations and reflexive diary of researcher-participant; existing literature on obesity; as well as drawings are used as complete steps in the data triangulation process. As stated, the main discovery in using expressive arts is that various new and creative narrative ways of exploring participant's relationship with food in excess emerged. Self-portraits gave a fuller description of an individual's identity at a certain point in time during and after therapy. Contributing to filling the gap in literature is a combination of themes from the data through drawings, as depicted in terms of the participants' bodily experience of themselves with sexual undertones. A further contribution to the research field is the theme highlighting women's hopelessness and vulnerability in the stature of the self-portrait. Furthermore, two other themes highlighted that there where discrimination from thin people towards fat people forcing them to stay in the fat group where they find acceptance but also to experience group anger towards society or thin people. Therefore more research in the social psychological field could be done.

Upon reflection this thesis reflects my understanding of the immensely practical application of the post-modern, social constructionist and specifically the narrative therapeutic approach to psychology. The possible implication could be that the narrative therapeutic input in this study opened up space to study psychological functioning of the obese at grass roots level. In the final analysis, the discoveries in this thesis could lead to endless research possibilities specifically in

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terms of psychological, environmental and developmental, as well as spiritual functioning of the obese person. Furthermore, a description of the reflected limitations in research follows.

Reflected limitations

At this point of reflection it is important to note Neuman's (2000) argument that in qualitative research the emphasis has been on finding patterns and analysing events to present what is found in data. In this study the emphasis on narrative and content analysis within a post-modern, social constructionist and specifically the narrative therapeutic approach, have been evident. Neuman (2000) describes how things or discoveries that are not in the data can be important for analysis.

Negative evidence

Neuman (2000) states that when re-reading notes and coding data, it is easy to forget about things that do not appear, and it is hard to learn how to think about things that are not in the data but are important. For example, I use comparison as a technique in this reflection upon my study; many women are in a relationship with obesity as defined by professionals and society and defined as having relationships with food in excess in this study. Does this mean that men, adolescents and children do not engage with obesity or have relationships with food in excess? If not, why not?

Lewis and Lewis (in Neuman, 2000) provide seven kinds of negative evidence to consider as more reflections on the limitations of this study, as follows:

- *Events that do not occur*: Some events are expected to occur on the basis of past experience, but do not. A wide range of research shows that there is a possible positive effect weight-loss has on an obese persons' self-esteem. In this study the importance or non-importance of weight-loss is viewed in different ways, but not necessarily as the outcome of a higher self-esteem in women.
- *Events of which the population is unaware*: The fact that members or participants in a setting are unaware of an issue does not mean that a researcher should ignore it or fail to look for its influence. For example, in reflection, two issues like these come to mind; the unexplored territory of obese people's or women's experience of their sexuality in relation to a significant other person, especially with reference to using having intercourse or not as a power tool within an intimate relationship and the possible role self-pity could play in keeping people or women in justifying their need to overeat.

- *Events the population wants to hide*: People may misrepresent events to protect themselves or others. For example, adult obese people often refuse to talk about taboo subjects like sexual molestation or incest during childhood, because what does this have to do with them being overweight? Likewise, in an overview of literature the subject of loss of a significant other at a young age seen as a taboo subject in relation to possible reasons for explaining overweight in part, has not been discussed or researched.
- *Overlooked commonplace events*: Everyday, routine events set expectations and create a taken-for-granted attitude. For example, many self-help books on how to lose weight are available in popular literature, which do describe certain areas of people's psychological experiences of their relationship with food in excess, only someone who likes reading popular literature (one participant in this study insisted that I read two books on this subject in popular literature) becomes aware of different ways of making meaning of their experiences of obesity.
- *Effects of a researcher having preconceived notions*: Strong prior notions of where to look and what data is relevant may inhibit a researcher from noticing other relevant or disconfirming evidence. For example, in this study I expected to find discourses that related to women experiencing anger in their relationship with food in excess towards others and I noticed this immediately, but I possibly failed to see the anger they feel towards themselves for overeating, by justifying that overeating is OK, because I comfort myself with food.
- *Unconscious non-reporting*: Some events appear to be insignificant and not worthy of being reported in the mind of the researcher. Yet, if detailed observations are recorded, a critical re-reading of notes looking for negative cases may overlook events. For example, at first I did not consider the essence of overweight making a person very visible to others to be important. However, after re-reading data notes and careful consideration, I realised that the visibility of overweight women could possibly be a symbolic sign of their attention seeking from others or the heavy emotional burdens they carry. Another limitation of the data analysis is that the researcher did not specifically search for discourses or alternative stories that pertain to spiritual meaning. After re-reading the data again the researcher did come across some participants specifically describing spiritual meaning associated with their experiences in relationship with food in excess.
- *Conscious non-reporting*: Researchers may omit aspects of the setting or events to protect individuals or relations in the setting. To my knowledge I have adhered to ethical research procedures in this study and did not consciously not report any discoveries to protect individuals.

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Final reflection

On reflecting upon the meaning of this thesis, the meaning ascribed to this thesis would depend on the questions asked to determine this meaning (Watzlawick, 1990). If you have already decided that this thesis does not contain the meaning you wish it to, your questions are aimed at eliciting just that (Van Rooyen, 1995). Perhaps, were we to regard this thesis as meaningless to start with, there can be no frustration at this thesis withholding that which it doesn't inherently contain (Watzlawick, 1990). Straus (2001) comments that the thesis itself does not contain meaning; this can only be created in relationship with the reader. In agreement, this thesis will have as many meanings as there are readers.

Greetings
Co-author and researcher

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Appendix A: Informed consent

I the undersigned, acknowledge the following:

1. I approached Lieuwkje for counseling and requested that she assist me in dealing with my problem.
2. She has explained the counseling procedures to me and I fully understand the implications. Lieuwkje has provided me with an explanation about the nature of the counseling and I fully understand what it is all about.
3. While fully understanding that Lieuwkje will try her best to help me resolve my problem(s) or my symptom(s), I understand that there is no guarantee that the treatment will be successful.
4. I fully understand that Lieuwkje may refer me to a professional person (psychologist or medical doctor) for treatment should she consider it advisable. However, it is my prerogative to either adhere to the advice given during counseling sessions, I shall have neither legal nor any other claim against Lieuwkje.
5. I understand that, should it be considered advisable, the counseling session may be audio or video taped or both for my own protection as well as the protection of Lieuwkje and that these audio or video tapes will be kept confidential by Lieuwkje.
6. I understand that memory is imperfect and research has shown that there is no guarantee that all information revealed during or after sessions may be accurate. However, I understand that whatever information is revealed during the counseling sessions, will be used entirely and solely for my benefit.
7. I understand that I have the right to terminate treatment whenever I wish should I feel that no progress is being made. I also understand that Lieuwkje may terminate the therapy if she feels that I am not co-operating.
8. If the outcome of the counseling is not what I expect it to be, I hereby agree that I will not have legal cause of action against Lieuwkje based on her counseling and competent use of relevant counseling methods with me.
9. I understand that the information relevant to my case and supplied by me to Lieuwkje during counseling sessions shall be treated as confidential and will not be disclosed to anyone else.
10. I declare that this informed consent given by me to Lieuwkje was given of my own free will.
11. I approached Lieuwkje of my own free will and was not forced by anyone to seek counseling.

Signed __________ Date___________

Referred __________ Date___________ To__________

Appendix B: Discourses and alternative stories from open coding

Discourses (D)

1 - First participant

D1 - Anger about my husband's work load and peer pressure from his colleagues affects my relationship with my husband on a regular basis.

D2 – I am angry on a regular basis and this does not feel nice.

D3 – I blame my husband for not spending enough time with me and my child.

D4 – I feel guilty for fighting with my husband when he comes late from work.

D5 – My husband and I don't know how to communicate with one another with regards to his work situation.

D6 – I overeat because my husband doesn't spend time with me or my child.

D7 – I am afraid of being alone.

D8 – I am afraid to sleep alone and that's why my husband must come home in time.

D9 – I blame my husband for enjoying his life with friends and I am suffering alone at home.

D10 – A child – my child comes first at all costs even though that would mean that I come last, but blaming my child is unacceptable. Children come first no matter what!

D11 – I married a man who is just like my father.

D12 – I believe that if a girl becomes pregnant before marriage she has to marry the father of the baby.

D13 – Circumstances surrounding the wedding prevented me from sitting still and thinking about what I was doing or getting myself into. When I reflect upon this time period I wonder how I did it and I have a sense of disillusionment, thus a sense of passively giving into the greater pressure of circumstances never mind my feelings on the matter.

D14 – It is the right of my husband not to have sex during my pregnancy, because of my weight gain during pregnancy, this made me eat more.

D15 – I blame my husband for my overweight.

D16 – I feel that my voice is not being heard, I demand to be heard by others.

D17 – I blame my husband for not having sex with me even though I don't have sex with him or don't want to have sex with him for long periods of time.

D18 – I believe that men cannot be trusted when women don't give them sex and they will find it elsewhere.

D19 – I am happy or sad depending on how my husband experiences himself and relates to me in a non- stressful, peaceful and happy way or not.

D20 – Everything will be ok between myself and my husband although I do not believe this is true.

D21 – I blame my husband for my fear with regards to my possible failure in the workplace.

D22 – My husband must know me and understand what I am saying even though I don't know or want to know myself.

D23 – I mistrust my husband and this gives me the right to overeat.

D24 – When I relate how I think and feel, my husband does not respond in a way that I feel heard or listened to.

D25 – I am not good enough in my husband's eyes and this makes me feel rejected.

D26 – I think that many people think that "Men are kings, women are slaves".

D27 – My husband and father both want me to serve them and this is ok because my mother served my father and this is what women do.

D28 – I must do things for my husband, things that I really don't want to do, but I do it anyway.

D29 – My mother's voice:" a man is the boss and a woman is the slave".

D30 – I think that women buy into being servants of men, even though they don't want to.

D31 – I think I want to trust my husband, I tell myself that I do and I must, but I don't really trust him, because he does not live up to my very strict expectations.

D32 – Confrontations are futile, therefore I do not have to take part in a confronting situation, because it does not help anyway.

D33 – My feelings and thoughts are not important to my husband.

D34 – I overeat to avoid conflict in my relationship with my husband.

D35 – My husband always knows more or better and therefore he must take the responsibility for making me feel better about myself.

D36 – I overeat when under stress then I have the right to not stop and think about my feelings, thoughts and actions in the moment.

D37 – I must protect my children against adults that don't care for them.

D38 – I want my relationship with my husband to be perfect like it was in the beginning.

D39 – I want my husband to be my knight in shining armour.

D40 – I am not allowed to let myself be heard because my husband is more important than I am.

D41 – I believe that loving my husband means to sacrifice myself so that he will love me back.

D42 – When I experience doubts and mistrust in various areas of my relationship with my husband, it is necessary to just go on even to my own detriment and unhappiness.

D43 – I like to mother my husband with regards to his responsibility in the household.

D44 – I overeat because of financial difficulty and not communicating with my husband about finances.

D45 – I want to be loved and accepted for who I am by my husband.

D46 – If my husband doesn't love me in a certain way, I don't allow him sexual intercourse.

D47 – I think that if I lose weight my husband will change his attitude towards me, but why should I?

D48 – I expect my husband to change before I will change my eating pattern.

D49 – I have tried different coping skills like ignorance, confrontation and the silent treatment and talking nicely in relationship to my husband and none of them were helpful and this makes me feel helpless.

D50 – I want my husband to love me for who I am, but feel as if I am nothing special and am being treated like a doormat.

D51 – I am angry when my husband's friends convince him that I sit on his head.

D52 – It frustrates me when my husband believes that he must put their needs above mine.

D53 – I believe that family time is of the utmost importance and cannot be bought or compromised by material things, but it is important to spend time together.

D54 – I will not lose weight because my husband pressures me to lose weight by saying:" Are you eating again?"

D55 – I believe that the standard for spiritual connectedness between a man and a woman means to spend time together by just talking and being close but not sexually intimate.

D56 – I overeat when my husband does not respect me and treat me like a queen.

D57 - My husband's needs are more important than my own.

D58 – I believe that the sign of a happy family is the presence of a consistent and steadfast mother figure, even though the mother stands alone.

D59 – I have the right to know where my husband is.

D60 – I don't know if I can trust my husband because I think he could have had an affair.

D61 – I am very angry when my husband spends time away from me.

D62 – I believe in my husband's mother's voice: Men can look on the menu, but they must eat at home.

D63 – I think that all men are alike with regards to their sexual desires.

D64 – I overeat when I see my husband lusting after other women.

D65 – I feel disillusioned in my marriage and I blame my husband for that.

D66 – I overeat when my husband does not do what I expect of him.

D67 – I fear people to be close to me because often they gossip about me and then I feel hurt.

D68 – I don't want everyone to see my feelings of hurt.

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D69 – My child is a source of support and companionship.

D70 – It is important to be in control of people and my circumstances.

D71 – I feel taken for granted.

D72 – It is important what other people think of me.

D73 - When other people have negative feelings toward me, I feel bad about myself.

D74 – I feel guilty when I refuse to lose weight when others try and force me.

D75 – In the context of visiting the Gynaecologist I just need to go even though I am ashamed of my weight.

D76 – I try to hide myself behind an iron curtain or behind a cupboard rather than interacting with others.

D77 – I think I am fat and ugly.

D78 – Sometimes it is better to be withdrawn from others and be by myself, because this place is not so lonely.

D79 – It is too painful to re-experience and fully express my thoughts and feelings surrounding the molestation during my childhood.

D80 – It is better to forget and not talk about the painful molestation experience.

D81 – As a child I had no control over the molestation, because I was so small and now as an adult I sometimes feel out of control when unforeseen things happen.

D82 – I feel anxious when talking about painful experiences.

D83 – I don't want to talk or feel the painful experience again, I want to forget by overeating.

D84 – I link the molestation to a 'tornado' being my overeating process as a rush where I cannot sit down and take time to think about what I am doing.

D85 – I cannot make meaning out of my childhood molestation experience, because it is meaningless what happened to me.

D86 – I think that my fear of rejection and being alone could be related to what happened in my childhood.

D87 – When being molested I felt left just like this and that is it.

D88 – I experienced social pressure to lose weight from family, school and dieticians since my childhood.

D89 – I have been struggling with being overweight since my childhood.

D90 – I feel guilty to weigh myself at the gynaecologist.

D91 – I am afraid of accumulating more weight during pregnancy.

D92 – I feel guilty and ashamed being overweight.

D93 – I believe that something bad will happen to my unborn child, because I am overweight.

D94 – I am afraid that the gynaecologist will tell me to stop eating because I am too fat.

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D95 – I believe that my thyroid gland has an influence on me being overweight.

D96 – I believe that genetics has caused me to be overweight, because there are many in our family who are overweight.

D97 – I have a lot of information about different diets and methods of weight-loss, but feel that diets have failed me in the past and that surgical procedures are dangerous and not a solution.

D98 – I believe that my family and I can lose weight, but we have to restrict ourselves highly with food intake to accomplish this.

D99 – I believe that it is hard work to lose weight.

D100 – I believe I cannot lose weight, but I want to lose weight, but all those salads and gym discourages me.

D101 – I don't have the time to lose weight, because there are more important things in life than losing weight.

D102– I passively overeat while spending time with my child and in front of the TV.

D103 – After I have overeaten it results in physical and emotional pain.

D104 – I blame myself, feel guilt and then feel angry after overeating and this feels not so nice.

D105 – I overeat when I feel afraid when my husband is late from work.

D106 – After I have overeaten I experience anger towards myself.

D107 – I comfort myself with food.

D108 – During the process of the binge my brain works overtime, eating happens automatically, over active thinking process, and this leads to worry.

D109 – At the end of the eating process I feel guilty and blame myself.

D110 – When I am afraid of being alone I overeat.

D111 – Overeating is a basic refuge or a comfort so that I will feel better for a short while.

D112 – The effect of the overeating process is that I feel worse about myself, therefore overeating is a discomfort and not a refuge

D113 – Overeating could be a friend or an enemy.

D114 – I feel guilty every time I overeat and then I overeat even more.

D115 – During the overeating process my brain works overtime.

D116 – Overeating process leads to confusion in thought patterns and there is a period of blankness in my mind.

D117 – Overeating is like a tornado experience…like a wind that twirls.

D118 – The chaos of the tornado has an overwhelming effect on me…it numbs me and renders me helpless.

D119 – The tornado has always been there, linking it to something that happened to me when I was very small.

D120 – When circumstances are chaotic I sit down and overeat and then experience anger about the amount that I have eaten and I have eaten to get rid of thoughts that stress me.

D121 – Ideal times for overeating bouts are when I put myself down or sacrifice my own time for others.

D122 – During overeating I experience a fear of being alone and the food keeps me company.

D123 – Every time I have been upset in my life the tornado has been there for me.

D124 – When I experience stress and think of past painful experiences I need to overeat.

D125 – I overeat, because sometimes I feel taken for granted.

D126 – When I feel helpless, I try to focus my thoughts on other things by eating in excess.

D127 – I think that other people think that if you overeat you are out of control and therefore not coping.

D128 – I feel overwhelmed and restless when I am out of control with regards to my eating habits.

D129 – Passive activities, like watching TV makes me want to overeat.

D130 – Overeating makes me feel better about myself just for a moment.

D131 – I overeat when people come late for their appointments, because it makes me feel discouraged.

2 - Second participant

D1 – Anger towards husband's expectations for me to lose weight just like his mother before he will accept me, unlike my child's unconditional acceptance for who I am no matter how much I weigh.

D2 – My husband thinks that my child will become ashamed of me if I do not lose my weight and this angers me.

D3 – I am jealous and angry with my husband because he is allowed to become fit and thereby have control over his weight and I am not allowed to spend time exercising, because of my responsibilities towards the children.

D4 – Afrikaner, Christian men are the head of the household and he can come and go as he pleases, while the wife is the mother and caregiver to the children.

D5 – It angers me when I make excuses for my husband to my own detriment.

D6 – It is important to place my own needs below the needs of my husband.

D7 – In my marriage I am everybody's caregiver to the detriment of myself.

D8 – I blame my husband for not taking my needs into consideration.

D9 – I am angry with my husband when he takes me for granted, but I realise that I am the one that gives into his demands and this makes me angry with myself.

D10 – It is important not to show my anger towards my husband when he takes me for granted, because men should be held in high regard at all times.

D11 – I sometimes don't understand my husband for only thinking of himself and his needs, because I believe that others' needs are more important than your own.

D12 – It is important to please others and my husband to the detriment of myself.

D13 – I blame my husband and myself for not helping me to have a healthy lifestyle since my marriage and pregnancies.

D14 – I am a married woman and therefore I must now do what my husband wants me to do.

D15 – My mother's voice with regards to others being overweight makes me feel that I am at an unacceptable weight; and therefore I am unacceptable as a person.

D16 – Accept me for whom I am, and not just for how I look, but for who I am.

D17 – My body image is only a by-product, but it is not who I really am, but it is the inner me that counts in relationship to others.

D18 – I am judged by others in terms of what I look like and this makes me unacceptable.

D19 – I am judged by others within my work environment according to how I look, because it is part of my work image to present a good body image.

D20 – Other people have the perception that I cannot do my work adequately, because I don't fit into my uniform.

D21 – Constant feedback from others with regards to my fat body makes me believe that I am unacceptable as a person and that I cannot do my work.

D22 – It is unacceptable for me when some people tease other fat people about their weight.

D23 - I feel angry and hurt for others in the same fat predicament as me.

D24 – When some people make subtle comments about other fat people I become angry, because I know that if they do it to them they will do it to me too, because I am fat too.

D25 – People in general are judgemental towards fat people.

D26 – My mother's voice that she was always right about how fat I am, is a confirmation of others' negative critique with regards to my overweight.

D27 – I am over sensitive to other's perception of my overweight.

D28 - I believe that others have negative perceptions of me in general.

D29 – Even though I want people to accept me for who I am and not for how I look, I am very conscious of the fact that I am very visible.

D30 – Society expects from me to hear their negative comments about me, but they don't want to listen how painful and hurtful their comments are.

D31 – I have to always be the one in relationships to hear others' opinions, once again I am the one that has to listen to them without anyone hearing my opinions.

D32 – It angers me when society has the perception that a fat person is stupid or is not fit to do a certain job.

D33 – It angers me when society expects a fat person to use wonder treatments to lose weight.

D34 – The Afrikaners are fat, because they love eating meat.

D35 – I am angry when fat people are being exploited in beauty pageants as if they are in a circus and people have the right to make fun of them.

D36 – I hate it when thin people or slightly overweight people have the audacity to express how fat they feel, but they don't have the faintest idea how it feels to be fat.

D37 – I am not allowed to tell others that I am frustrated and angry that they don't hear me.

D38 – In my struggle to believe that I am acceptable, I blame the media and society for making me believe that I am unacceptable for being a fat person.

D39 – It is important to show people that I can eat right and be fit.

D40 – Other people's opinions are more important than mine.

D41 – I use my children as an excuse to not have a healthy lifestyle.

D42 – It is important to take care of my children even though I do not allow myself to blame them for my unhealthy lifestyle.

D43 – My responsibilities as a mother causes me to lose control over my healthy lifestyle.

D44 – I am a bad mother if my children aren't with me the whole day.

D45 – I have to take other people into consideration to the detriment of myself and therefore I feel powerless and out of control.

D46 – It is an Afrikaner tradition that the "Wife is submissive towards her husband and it is expected of the wife to be at home when her husband comes home from work and then everything must be under control in the household".

D47 – My mother needed to push aside many of her dreams in early years of her marriage and therefore I am pushing many of my dreams aside at the moment.

D48 – Sometimes when I want to express my opinion about a certain subject in a group of people, I prevent myself from doing so because I feel ashamed of my overweight body.

D49 – Sometimes low self-worth can be a hindrance to my self-confidence.

D50 – Example of who I am, is different to how I look: Who I am – I would like to participate in fun and games (physical activities), but how I look influences the fact that I prefer not to participate because of being ashamed of my fat body.

D51 – I am discouraged when I look at my body, because I don't like what I see and I know that I can look better.

D52 – My children changed my life to the extent that I feel trapped in the sense that I can no longer come and go as I please.

D53 – I sometimes use my responsibility towards my children as an excuse to choose not to exercise and eat healthy, because I am afraid of failure.

D54 – My fear of failure immobilises me to not start exercising and eating healthy again.

D55 – I am not good enough because I don't know how to do things right in the eyes of significant others and that is why I rather won't do things with reference to a healthy lifestyle.

D56 – I believe that I am not really good enough, because I am a failure.

D57 – My head tells me that when somebody tells me I cannot do something, I respond by saying then I shall show you I cannot do it, when they say I can't do it, then I can't and I won't even take the time to try to do it, because I also believe that I can't do it.

D58 – I am rebellious against the voice of society that says that I have to be thin in order to be successful.

D59 – My voice of rebellion says "I don't want to, because I don't want to, because I don't want to lose weight, just because others expect it from me."

D60 – I am very careful in new situations so that I will not shame myself.

D61 – I know that I have high standards for myself, because I mistrust my intuition, because sometimes when I did trust my intuition others criticised me and then I believe that I am judged according to others expectations of me.

D62 – Feedback I get from my work environment about my overweight makes me feel ashamed, humiliated, unacceptable and bad about myself.

D63 – My mother's voice that certain types of clothes make me look fatter in the eyes of others angers me.

D64 – In the context of being the youngest child in my family of origin, certain responsibilities were often taken out of my hands, simply because it was easier to allow the older children or my parents to take the responsibility. This left me with an angry feeling of if you think I cannot do it, I will show you that I cannot do it.

D65 – I experienced pain when others did not believe that I can't do certain tasks in my childhood and this made me believe that they are right.

D66 – I experience fear of failure and feelings of guilt, the moment I am challenged by others to take responsibility for my own health.

D67 – I don't achieve or start working on my goals to take responsibility for my own health, because I expect too much of myself and I am very hard on myself to perform perfectly.

D68 – Other things are always more important to do than to take responsibility for my eating patterns and exercising.

D69 – I want others to accept my reasons for not wanting to lose weight, because it is very obvious that I am trying to lose weight.

D70 – In the era of the 1970 and 80's a person's sexuality was considered a taboo subject.

D71 – I sometimes experience intellectual understanding of my painful experiences, but expression of my emotions are hindered by my thinking that my mothers' family do not cry or show appropriate emotions during painful experiences, therefore I do not show my emotions easily to others.

D72 – It angers me when others take control out of my hands in doing tasks without me giving them the permission to do so, therefore it is their entire fault if I do not complete or attempt to do the tasks.

D73 – I don't trust others to help me with difficult tasks, thus I don't need others to tell me how I must reach a healthy lifestyle.

D74 – Children cannot complete tasks as adequately as adults.

D75 – In the context of loss of my two week old brother in my childhood I experienced that it is a taboo subject and that it does not help to cry about his death or talk about his death, we must just go on with our lives.

D76 – In 1970 children were allowed to be seen but not heard and family members didn't talk about painful experiences or express their emotions, but now in 1990 families communicate more and children's voices are allowed to be heard.

D77 – In the context of my father being a pastor I believed that my needs were less important than the congregation that he was serving, therefore considering others and serving others is an important Christian virtue.

D78 – Crying in front of others makes you vulnerable to their judgement and they can take advantage of you.

D79 – I do not show my emotions, but this does not mean that I do not experience emotions.

D80 – I feel guilty when I think bad things about others and when I am angry with them.

D81 – I become very angry when some people treat fat people unfairly.

D82 – I am afraid of being alone.

D83 – The feeling that I am not being heard and loneliness makes me feel tied down and in a cocoon.

D84 – I am irritated with myself for not choosing to eat healthy.

D85 – To have control over my life equals to have control over my food habits and exercise habits.

D86 – I need to put a switch on in my mind to be able to start with a healthy lifestyle.

D87 – I am angry at myself for allowing myself to place my husband and my children's needs above my own.

D88 – Most of the time I don't know how to express myself or how to communicate with others about how I am feeling and thinking about certain situations, people and myself.

D89 – I have confidence in what I can do and in my own abilities, but I don't have confidence in my physical appearance, therefore my self-worth is low.

D90 - I link my self-confidence to who I am and my self-worth to how I look.

D91 – I want to be thin, but I am not prepared to work at it, in fear of unwanted attention from men and also from myself that I am sexually attractive.

D92 – It often frustrates me when I can't connect my intuition and intellectual reasoning to my emotional expression of painful experiences.

D93 – I yield to procrastination in fear of failure.

D94 – After my wedding I accumulated a lot of weight especially during my two pregnancies.

D95 – Fat is unacceptable and thin is acceptable.

D96 – My children are not supposed to have an issue with me as their mother being overweight, because they must be very accepting.

D97 – Fat is unacceptable, Fat is ugly, Fat is wrong, Fat restricts your activities.

D98 – It angers me when people ask whether my overweight is caused by my genetic make up and they ask what do your brothers and sisters look like?

D99 – Since an early age I matured faster than my peers which gave the impression to others and me that I was fatter than I really was.

D100 – Others perception that I am not necessarily fat, but that certain clothing or eating a piece of cake would make me fatter in essence gave the message that I am fatter than I am.

D101 – To lose weight is a conscious process, but I will rather want it to be unconscious so that I am not reminded of the fact that I am overweight all the time.

D102 - To be pregnant and to have children gives me the right to overeat.

D103 – Depression leads to overeating.

D104 – Overeating habits aren't as important to change as to have good exercise habits.

D105 – Overeating makes me feel out of control.

D106 – If I do not express how I feel and think on a regular basis, it leads to anger and frustration with myself and then I feel depressed and overeat.

D107 – I overeat in the context where others and my own expectations are too demanding for me to reach plausible goals with regards to a healthy lifestyle.

D108 – In the context of a childhood sexual exploration experience with my brother and making sense of it in a therapeutic context in the past leads me to thinking that I am not allowed to focus attention on me being unjustly treated by men thus the unwanted attention of men translates for me to the needed emotional and nurturing attention that I am not allowed to give myself. This forces me to find nurturance and comfort in my relationship with food in excess, because the attention is then on food and not on myself.

D109 – When I experience strong emotions I escape them without expressing them through my overeating patterns.

D110 – By controlling my emotions, I am controlling the expression of my emotions in front of others so that I allow myself to be out of control with my eating habits.

D111 – Overeating is a way of treating me after ignoring myself and my need to express my emotions like anger and hurt.

D112 – I overeat when I feel guilty about thinking bad things about others.

3 - Third participant

D1 – Anger and blame towards my husband for not accepting me with regards to my overweight in the context of my first pregnancy and that he was not ready to be a father when I became a mother affected me to pick up 40kg.

D2 – It angers me when my husband equates thinness with beauty.

D3 – I am not sexually pleasing enough for my husband, because of my overweight and therefore I am not good enough as a person.

D4 – I withhold sexual intercourse from my husband, because I am not as bad as those bad girls on TV.

D5 – I believe that sex should be seen by men as a holy and a beautiful thing between a husband and a wife and not as something filthy and disgusting.

D6 – I think that I cannot communicate my sexual needs and sexual experiences that give me pleasure, because women are seen by men as sex objects.

D7 – I believe that women are supposed to eat less than men and men have the right to judge women if they eat the same amount or just as much as them.

D8 – When my husband's voice demands that I must eat less than him, I eat anyway, because I think "who are you, I will eat anyway."

D9 – I am angry at my husband for setting certain rules for what I should or should not eat.

D10 – I believe that my husband doesn't love me as he used to, because even he thinks and says that I must watch out because I have become fat.

D11 – Nobody can love like I can love.

D12 – I mistrust my husband's love for me in the context of painful experiences.

D13 – Communicating with my husband is like a scale that goes up the one way and down the other way, therefore I wonder if it is worth even to try communicating with him.

D14 – I withdraw and submit to my husband thereby keeping the peace in conflict situations.

D15 – I believe that I must be submissive to my husband and this angers me.

D16 – I think that my husband thinks that I only look pretty when I lose weight and when I am thin.

D17 – I think my husband does not think that I can lose the excess weight, whereas in fact I also don't believe I can.

D18 – I am someone that wants to hear my husband say that he believes I can lose weight, but I experience that he doesn't believe I can.

D19 – Although I know that losing weight to be healthy is important, I rather want to lose weight so that my husband will accept me more and find me more attractive.

D20 – Sometimes I feel disgusted with regards to my body image and I feel even more disgusted in myself when I consider how disgusting my husband perceives me and my body.

D21 – I will not lose weight for my husband because he expects me to.

D22 – I believe that my husband could easily find a nicer and prettier woman and therefore I threaten him and myself to lose weight just so that I could take revenge on him for not accepting me just as I am.

D23 – I believe that during pregnancy it is allowed for women to eat for two, to gain a lot of weight, because after the baby's birth you will lose the weight again.

D24 – Other's think that thin people have control over their lifestyle and eating habits, which make them more acceptable and successful in the workplace.

D25 – Others need to accept me for my inner being more and not judge me according to my physical appearance.

D26 – I think that men treat women like sexual objects.

D27 – I think that if I am round and fat everything is going happy and well in my life.

D28 – We have a family routine to eat in front of the TV so that we could escape from our daily stress and life.

D29 – I believe it is better to be the least when there is conflict.

D30 – When I am the least in relationship to others, it is a privilege because I am carrying others' burdens this gives me the power of "holiness".

D31 – I am in control when I am the peacekeeper, because others depend on me so that they won't fall apart.

D32 – My fear that my daughter will also struggle with overweight gives me the right to overly control her eating habits.

D33 – Significant others must support me in my weight-loss endeavour, because I can't do it by myself.

D34 – I feel sad and discouraged that others have not listened to my deepest feelings and thoughts in the past.

D35 – I believe my mother-in-law when she says that we both need to lose weight before our husbands get other wives.

D36 – I am afraid that I will die early, because of my family's medical history of early deaths.

D37 – Thin people think that overweight people must be ashamed of them and are not supposed to talk about their experiences with regards to their relationship with food in excess, because they are fat.

D38 – All thin people are judgemental towards fat people.

D39 – I experience group pressure from other overweight women to be fat with them, "so that we won't be alone".

D40 – Sometimes I feel that others judge me according to which clothes I wear and how I look, rather than seeing me as a beautiful person. Others judge beauty according to my attire and not for who I am.

D41 – I am angry when my mother says that my dress makes me look thinner and therefore I look pretty.

D42 – In the context of my life before my marriage I did not ever think that I will become fat, because I never had a problem with my weight.

D43 – I tell myself sometimes that I am ugly and nobody will love me, because I am fat.

D44 – I believe that I am not worthy to be loved.

D45 – I sometimes think that everybody is superior to me, because I don't have any control over food or any other areas of my life.

D46 - Food is my boss.

D47 – My inner being is more important than my physical appearance.

D48 – If I am not thin I am not beautiful.

D49 – The experience of overweight is a day to day struggle, one day I have a good and the next day I have a bad body image

D50 – I am the type of person who loves to eat good food.

D51 – After I overeat I feel guilty about going overboard.

D52 – In the context of stress I sit in front of the TV and overeat so that I will feel better about myself.

D53 – I often feel that I stand alone with all my problems and this gives me a reason to overeat.

D54 – I overeat and blame my self, because nobody listens to what I need or sees me for who I am.

D55 – I am the peacemaker in our family where I am always the one that places others needs above my own.

D56 – To have a strong will power will give me more control over my unhealthy eating habits.

D57 – I cannot live without nice food.

D58 – Clothes sometimes hide away who I am and it makes me feel that people don't see me as a person but see my clothes as beautiful. Therefore people could just as well have the clothes.

D59 – Impatience during weight-loss discourages me so that I give up easily in trying to lose weight.

D60 – Overweight with the accompanying health risks are part of my family of origin's history with diets, overeating and exercise patterns.

D61 – Health risks in my family of origin include; high blood pressure, cholesterol and heart attacks.

D62 – Diets and diet pills promise to give you better control over your eating habits.

D63 – I do not diet, because life is too short to live everyday according to rules and regulations with regards to food restriction.

D64 – Only after I gained 40 kg I started worrying about my weight.

D65 – If I want to lose weight I need to draw the line somewhere.

D66 – My overweight is not so unacceptable in comparison to other people's overweight and therefore I just have to lose a few kilograms to feel better about myself.

D67 – Family history of health risks with regards to overweight makes me fearful to keep on being overweight, but not fearful enough to take action.

D68 – I must do something about my overweight for fear of health risks.

D69 – My genetic make-up excuses me to stay overweight.

D70 – Guilt surrounding my relationship with food in excess has a negative influence on my daughter's relationship with food.

D71 – I am waiting for something to happen to trigger me to start to lose weight and this makes me wonder whether I must or must not do it.

D72 – I mistrust myself to lose big amounts of weight and to get to goal weight.

D73 – I believe I am a happy overweight person and this stops me from losing weight.

D74 – I always have tomorrow to start to lose weight.

D75 – Please God, if I can't be thin, please make my friends fat.

D76 – I know that I will never be thin but please don't let me be the only fat person.

D77 – I stop myself from losing weight, because I am not ready for it now.

D78 – Something external must happen for me to have the motivation to lose weight.

D79 – My experience of up and down feelings allows me to not take control of my eating habits.

D80 – I overeat to comfort myself.

D81 – When I am under a lot of stress and feel I have a lot of problems I tend to overeat to try to instantly feel better about myself.

D82 – I overeat in times where my husband and I experience difficulties in our sexual relationship.

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D83 – I overeat when I am stressed out by my children's misbehaviour and I want to escape it and comfort myself with food.

D84 – When I am overstressed at work and home I feel powerless to make my own decisions about healthy food choices and rather often overeat.

D85 – When I feel pressurised by the restrictions diets place on me, I break away and overeat.

D86 – When women become pregnant they should eat for two.

D87 – I feel guilty after overeating and then I feel and look like a pig and then I feel negative about myself.

D88 – I overeat away my problems.

D89 – I reward myself with food.

D90 – Overeating calms me down for a moment.

D91 – After overeating the "feeling better about me" is more important to me than the guilt.

D92 – After overeating negative self-talk triggers me into overeating again.

D93 – The type of food in terms of its taste triggers my overeating.

D94 – When I overeat in secret where nobody can see me, I am afraid that I might be caught.

D95 – When I keep quiet to the detriment of myself, I overeat, because it is like I punished myself and therefore I must be comforted.

D96 – At social gatherings I want the freedom to eat fatty and unhealthy foods and not to restrict myself with unhealthy foods and thereby feel punished.

D97 – People say that we always eat with our eyes so if the food table looks pretty and full of unhealthy food, we tend to overeat.

4 - Fourth participant

D1 – Shame and embarrassment affect me in not communicating with my husband about my experience of my overweight body in relation to him, because "I wanted to be dignified at all times".

D2 – I choose not to wear revealing clothing because I am ashamed of what my husband might think of me in the presence of others when I do so.

D3 – I prefer not to have sexual intercourse with my husband, because I am fat, which makes it more difficult.

D4 – I am angry towards others with regards to their unrealistic judgements toward me just because I am fat.

D5 – "My self-image is more important than my body image" and therefore I have the right to cover my body with big dress sizes.

D6 – My mother taught me to dress properly and dignified at all times even though I stop myself to experiencing my body in a physical sense.

D7 – Although I am rebellious toward the thinking "Proper women" in the "proper" sense of the word are supposed to not show or experience their bodies as sensual and attractive, I buy into it.

D8 – I think that society thinks that "If you are fat, you are not supposed to wear revealing clothing".

D9 – I deem myself more privileged than others with regards to me having a high self-image regardless of my attitude of my body image.

D10 – Media portrays a "thin is beautiful" message and this influences overweight people to dissociate with or have negative feelings about their body image.

D11 – Society rejects fat people with regards to providing ugly, bigger sized clothing.

D12 – Clothing for thin people is always of a better quality and prettier than for fat people.

D13 – Beautiful people I define primarily as being beautiful within their personality, therefore being comfortable with you and this makes people O.K.

D14 – Thin people anger me when they make a big deal about a few extra kilograms in the light of my overweight in extreme.

D15 – I don't understand why I need to lose weight if other people like me just the way I am.

D16 – Others must accept me for who I am and not for how I look.

D17 – Fat people are judged more on their looks than thin people.

D18 – Fat people are judged with negative rather than positive attributes.

D19 – I demand that society sees me for who I am and not for how I look, but on the other hand I am showing society that I do not respect my own body by being overweight.

D20 – I am angry that society does not acknowledge the fact that even though I am overweight, I am more acceptable than other people that have abnormal eating habits. Thus, binging is the better of the two.

D21 – I am happy that I don't have a closet-problem like others thus overweight is an acceptable way of dealing with emotional problems and is not as bad a disorder, in fact everybody does it so therefore I do it.

D22 – A person can rather be unhealthy by overeating than being unhealthy in striving for thinness.

D23 – I am automatically disrespected with regards to my overweight body, because people see the fat first before they see me.

D24 – Talking about my overweight body makes others uncomfortable because it's supposed to be a taboo subject.

D25 – I am angry with society's attention upon me because of my physical visibility, therefore I want to divert their attention away from me.

D26 – By being physically visible to others I am more "sane" than thin people who have skeletons in their closets.

D27 – My mother modelled overeating behaviour as a comfort in times of stress and work pressure.

D28 – I have decided to nurture myself with food just like my mother nurtured herself with food and this is O.K.

D29 – In the context of my overweight body and bodily cells becoming ill, I recognise the fact that other overweight friends are becoming sick just like me, if we continue overeating.

D30 – Overweight people don't have respect for their bodies.

D31 – My need to be acknowledged as a good enough daughter for my mother in the role of the caregiver in my family of origin, gave me full licence to nurture myself with food.

D32 – I often felt misunderstood and unheard by my parents and others.

D33 – Other people's needs are more important than my own.

D34 – I must work myself to death to please everyone.

D35 – I please others and take care of them so that they will acknowledge me as a good enough person.

D36 – I demand that others must sort things out through talking and if this does not happen, I am angry and therefore overeat.

D37 – Other's think that thin people are successful, therefore fat people are failures.

D38 – I continue to buy bigger dress sizes and accept them because I am dignified and have self-respect and will look professional and pretty in bigger sized dresses, because my dignity is more important than to implement a healthy lifestyle.

D39 – My dignity with regards to accepting bigger dress sizes is more important than honesty about my actual overweight.

D40 – I want to hide my overweight body because it is not pretty for me.

D41 – I do not face my overweight body image because regardless of what the media and society expect of me in terms of how I must look, I accept my inner self but I still reject my overweight body image.

D42 – My maturity and wisdom with regards to my age is more important to me than my physical appearance.

D43 – I give myself permission to put some weight on each year, because the older a woman is, being fat is more socially acceptable.

D44 – Since childhood I have been less intent on caring for my physical appearance than other children.

D45 – There was a time that I felt that I am nothing, whereas I now feel that I am nearly pretty.

D46 – It is better to be a plain and uncomplicated person rather than a highly sophisticated, sexually attractive person.

D47 – Since my childhood physical activity has been unfamiliar to me and therefore unwanted.

D48 – Since my childhood I have become set in my unhealthy eating and exercise patterns, therefore I will always be fat.

D49 – I value being a dreamer and passive more than being active and more physically attractive.

D50 – On a self-image level I associate myself more with a kiwi-fruit or a strawberry but on a body-image level I associate myself more with a creampuff.

D51 – The image of my whole self is that I am a fresh fruit within.

D52 – I demand to be heard that there is a thin person within me waiting to come out.

D53 – It is in my personal make-up to leave an idea/venture/task if I cannot do it perfectly, therefore if I am not 5000% committed to a healthy diet, I just let go of it and then start binging.

D54 – I am not fat and friendly because I have more depth than just friendliness to share with others.

D55 – Weighing me on a scale isn't good for me, because this triggers me to try and achieve the perfect body weight.

D56 – My mother and I often dieted together while I was growing up, where there were definite times when we restricted ourselves from certain foods.

D57 – I have learnt to have love for food from my mom.

D58 – My high cholesterol problem does not trigger me to eat healthier because diets do not guarantee a healthy lifestyle.

D59 – The all or nothing thinking with regards to diets makes me angry.

D60 – All female teenagers through all centuries can tell stories about diets and their unhealthy effects on you as an individual and others around you, where you lose a little bit of weight in a week's time and then the following week you binge again.

D61 – Diets are a death sentence.

D62 – In my head I feel that there is a lot of time still to work on my unhealthy eating habits, before cholesterol will be detrimental to my health.

D63 – In the light of my belief that there is still a lot of time for me to work on my unhealthy eating habits, I do not start losing weight and keep on overeating.

D64 – The perfect, unscarred physical appearance defines whether you are regarded as beautiful or not, therefore overweight people are not beautiful.

D65 – I am angry to be labelled as a person with a fuller figure thus implying that I am in the fat category.

D66 – Since childhood I have preferred to be passive with regards to physical activities, I will rather read or sit and think about things which are less active in nature than exercise.

D67 – Passive activities are not only relaxing but also a way for me to be slower and to live slower, therefore it is more important than physical activity.

D68 – Since childhood I experienced that my overweight stood in the way of boys liking me and this made me feel as if I am nothing therefore I did not take care of my physical appearance.

D69 – I experience a more negative image of myself when I am fat.

D70 – Round and bulging fat is not healthy.

D71 – I am often jealous when another overweight person loses a lot of weight, therefore "leaving me behind", leaving me with a feeling of being alone and a feeling of anger towards them in the questions "how could you leave me alone, what is wrong with me?"

D72 – I love food.

D73 – Food is one of my greatest friends.

D74 – Food has so many nuances.

D75 – Food has so many possibilities.

D76 – Food helps me to entertain and to share and to take care of others.

D77 – Food helps me to do something special for someone else.

D78 – I use food in my life and in my relationships because I love food and food is pretty and nice.

D79 – Food is very special to me, it is really like a gift from the Lord that I enjoy very much.

D80 – Food can be compared to perfume which I also love.

D81 – Restricting my food-intake during certain periods of my life was terrible because I just wanted to overeat afterwards.

D82 – I comfort myself with food.

D83 – I don't like diet-food therefore I overeat.

D84 – I overeat in times of my anger-reaction to restrictions on my food intake.

D85 – As soon as I overeat once during a period of dieting, it triggers me into a cycle of overeating because I give in to the notion that I trespassed the staunch restrictions.

D86 – The all or nothing discourse with regards to eating restrictions becomes a punishment either way.

D87 – Restrictions with regards to dieting cause an individual to have an unrealistic, unhealthy, and unnatural relationship with food.

D88 – The all or nothing discourse with regards to dieting triggers binge eating, as if you unconsciously prepare yourself for it to happen.

D89 – The all or nothing discourse with regards to overeating is all inclusive therefore restricting your health, your lust for life, your quality of life, because I am not healthy.

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D90 – If I do not follow a specific diet to the letter, it triggers me to leave the diet and overeat, therefore definitely being a winning recipe for failure.

D91 – There is not enough incentive for me to have a healthy lifestyle, even though I suffer from cholesterol, because the price to pay in terms of delicious food is too high.

D92 – Passivity triggers overeating.

D93 – I use a quick fix by overeating in times of tiredness and stress, thereby experiencing a short-lived energy spurt.

D94 – In the context of my high work-ethics, I allow myself to nurture and comfort myself with food.

D95 – In the context of the social discourse that all girls must partake in ballet, I did not fit the physical requirements therefore I started nurturing myself with food.

D96 – In the context of growing up in the midst of financial difficulty, I started pitying myself and therefore nurtured myself with food.

D97 – I use overeating as an escape for day to day stresses, "it is as if I escaped into a fantasy world whenever everything got too much", and therefore I have been eating secretively since my childhood.

D98 – Today I still carry the burden of the pain of my whole family of origin, I still take care of this family and food takes care of me.

D99 – Taking care of my family of origin angers me and gives me the right to blame them and after that myself, which triggers binge eating, after which the eating cycle continues with no time limit.

D100 – When self-pity visits me I overeat.

D101 – One of the biggest reasons I overeat is "I overeat for my mother". Therefore I console myself when my mother does not console me or take care of me.

D102 – When I am especially angry with my mother, it is my normal pattern to overeat.

D103 – Frustration and anxiety tricks me into overeating.

D104 – Overeating is a behavioural pattern, which can be altered into a healthier behavioural pattern, but I unfortunately have a nose and a tongue for food for smelling and eating.

D105 – The overeating process is an instant gratification for my unmet emotional needs.

D106 – I am dependant on food just like an alcoholic is dependant on alcohol.

5 - Fifth participant

D1 – When I feel taken for granted by my husband, I tend to do too much for other people, while neglecting my husbands' needs and him expecting of me to be there exclusively for him.

D2 – It angers me when my husband doesn't consider me, my feelings, thoughts and needs.

D3 – It angers me when my husband doesn't listen to my feelings and thoughts and in so doing he does not understand me.

D4 – In the context of my mother passing away when I was thirteen years old, my family of origin wanted to lessen their guilt feelings about me losing my mother at such a young age and then tried to comfort me with food.

D5 – I try to fulfil my mother's role in my family of origin, by preparing the same food as my mother did in the same way that she did, without straying from her way of doing things when my family comes to visit.

D6 – When I prepare the same food my mother did in the same way, I am comforting myself and others by recalling her presence and touch with food at family gatherings when my mother was still alive.

D7 – Preparing food like my mother did, makes me feel that something of her person has stayed behind with me as if I am still reaching out to be touched and comforted by her.

D8 – I spoil my children and myself with food because children must be spoiled by a grandmother whose place I have taken.

D9 – I feel guilty that I was not a good enough daughter for my mother. I therefore feel it is my right to reprimand others when they don't treat their parents in a correct way.

D10 – Others don't understand my emotional experience with regards to the loss of my mother.

D11 – It is important to me what others think about me.

D12 – Others' needs are more important than my own.

D13 – I take care of others, but nobody will look after me like I can do for them.

D14 - I help other people with all my heart without thinking what the consequences will be.

D15 – I am a very soft person and others easily take advantage of me.

D16 – I easily feel sorry for others and in so doing help them because I want to make it easier for them in life. But I think that sometimes this is the wrong thing to do because people need to help themselves to be strong, but I do it anyway.

D17 – In the context of my younger brother being an alcoholic it angers me when I allow him to sit passively and misuse me with regards to financial support.

D18 – It angers me when others don't reciprocate my never-ending love and devotion to them, therefore believing that they can't do it as good as I can.

D19 – When helping others I blame them for making me feel guilty when I don't help them.

D20 – I hate it when others are dishonest with me about how I look.

D21 – I hate it when my brother has unrealistic expectations of me without him knowing what's happening in my life. This makes me feel that what I'm doing is not good enough and that I am not good enough.

D22 – It is important to have a soft nature even though others misuse me.

D23 – If my mother was still alive everything would have been perfect but now it is my fate to be like my mother.

D24 – It is difficult to say no to others even to the detriment of myself and my family.

D25 – The loss of my mother was a painful experience which I tried to numb by comforting myself with food.

D26 – I feel guilty when I consider myself, my children and husband's needs less important than others.

D27 – It angers me when I allow myself to waste my energy on guilt feelings.

D28 – I dislike family gatherings because it allows for my family of origin to reminisce about the good times when my mother and father were still alive and this leads to me being very emotional, guilty and angry for not having a mother and father anymore.

D29 – I don't like it when my brothers and sisters still cry about the death of my mother and father because it does not help me or them to come to terms with it.

D30 – I feel powerless in the presence of my family of origin's tears and crying because I cannot comfort them, and more so, I don't know how to comfort myself.

D31 – I was not comforted by my family after losing my mother because nothing can comfort you after such a loss.

D32 – I need to help other people so that I can feel better about myself.

D33 – I help people as far as I can, but if I can't help them anymore, then it is a very bad experience for me.

D34 – Just like my brother being an alcoholic and dependant on alcohol to comfort him, I am an overeater to comfort myself with food. Thus I will always be an overeater.

D35 – I will keep my employees, even though times are financially tough, because others' financial needs are more important than my own.

D36 – I fear to be alone in the context of the loss of my mother, because who will worry about me, who will love me?

D37 – In the context of the death of my mother "just forget and accept that your loved one has passed away and move on" angers me so that I want to escape the painful experience by overeating.

D38 – When I am pregnant I can overeat and become fat and this is ok because I am a mother.

D39 – My mother was supposed to warn me to not overeat because it is not good for me, but she did not do that.

D40 – In the context of me being left behind as the youngest in my family of origin after my mother passed away, I feel alone and I feel less privileged than my brothers and sisters.

D41 – Society believes that fat people are to be blamed because they are fat.

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D42 – I am sad because I never shared my emotions with my mother and she did not teach me how to handle my emotions.

D43 – It is difficult to separate myself being and doing like my mother since my mother past away, because this will make me feel lonely.

D44 – It is more important to help others and be there for others rather than for my family and for myself.

D45 – I could lose something if I cannot help someone fully but only to a certain point, when I am not continuously involved in their lives.

D46 – After the death of my mother I started to live in the shadow of my mother, meaning to strive to be like her and in the process losing myself.

D47 – Financial security gives me a sense of self-worth.

D48 – I blame myself for indulging in food and then realising that I am fat and feeling bad about myself.

D49 – I think I am ugly, because I am fat.

D50 – I have become like my mother and this makes me feel close to her.

D51 – I, like my mother, like to surprise people, to do something special for someone else and never for myself.

D52 – I, like my mother, always have a solution for problems, I love my husband and I work very hard and will sacrifice everything I have for others.

D53 – I, like my mother, don't take care of myself just so that everybody around me will be happy.

D54 – I, like my mother, love the Lord and will do everything for the church.

D55 – I, like my mother, make sure that my family of origin come together and experience everything as it was in the past.

D56 – The voice of my emotions and thoughts is more important than my physical body.

D57 – I have always thought that I must close my body with clothes and that I must hide it from the world.

D58 – Since my childhood I have been comforted with food by others.

D59 – I think that my mother felt very guilty because I was her last born and the only one left at home and she felt that she owed me something, therefore I was very spoilt, mostly with food. Now I feel guilty eating too much.

D60 – I started to become overweight only after the birth of my first child and I link this to me missing my mother during this time.

D61 – Overeating is not such a big psychological problem and need not be talked about.

D62 – Unhealthy food is an important crutch in stressful times.

D63 – I overeat so that my father, mother and siblings will feel that they provided me with comfort through food.

D64 – I allow myself to overeat in reaction to the loss of my mother.

D65 – It triggers me to overeat after my siblings leave family gatherings where I feel left with pain when they say they love me and I am just like my mother.

D66 – I overeat when my siblings demand from me to prepare food like our mother used to, because I don't want to be their mother and also miss her.

D67 – Guilt feelings about considering others more important than me and my family leads to me being emotional without knowing why I am emotional and then I overeat.

D68 – It is better to overeat than to misuse alcohol because all that happens to me is that I grow fat with no detriment to others.

D69 – I overeat to escape my painful experiences rather than to come to terms with it.

D70 – Tension and stress with regards to finances pressurises me into a corner and forces me to overeat and in so doing escaping my fear of failure in business.

D71 – An entrepreneurial lifestyle forces me to have to do something, to have to perform and I think this has an influence in me comforting myself with food.

D72 – Financial uncertainty makes me very emotional, especially at the end of the month, thereby leading to a two-week binge-eating spree.

D73 – While overeating I don't think what I'm doing.

D74 – In times of overeating I think of how nice the food is, at least the food is nice, something that I can hold onto.

D75 – I think that an alcoholic and an overeater have the same reason for their problem. Food or alcohol gives persons courage again to go on in uncertain times or during painful experiences.

D76 – Overeating allows me to escape for a moment and then to go on in the midst of difficult or painful experiences.

D77 – Stressful times gives me a reason to pick up a lot of weight.

D78 – During times of menstruation I tend to overeat more.

D79 – Food as my comforter tells the lie of "just one more piece of bread, don't worry it won't make you fat. Just keep on eating; you can't actually make a difference to your physical size".

D80 – As soon as I am challenged to go and sit down and plan how to eat healthier, it triggers me to over-eat even more.

D81 – I overeat because all the nice times that I spent with my mother were in the kitchen busy preparing food or around the table.

D82 – Food makes the missing of my mother less.

D83 – I feel powerless in the face of food being my comforter.

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R – Researcher- participant: Reflected upon discourses during the study and therapeutic process

D1 – I could not hate food, because whenever times are tough or easy I tend to nurture myself with food.

D2 - Food calms me down and comforts me like when I was a new born infant drinking my bottle in my mother's arms.

D3 - Anger visits me when society expects that weight-loss is the only success story for obese women in their relationship with food in excess.

D4 – I overeat because of emotional reasons, I want to comfort myself with food.

D5 – I overeat because of my own fear of failure or the fear that I may not be good enough as a doctoral student.

D6 - I ate more and had a few binge eating sessions during the time I compiled my D-proposal, which allows me to make the link that binge eating is a form of comfort in times of stress. Naming the discourse that binge eating is a form of comfort in times of stress exposed to me how I allowed myself to emotionally overeat.

D7 – There is a right time to talk about women's relationships with food.

D8 - I can identify with the experience of the "tornado" where "binge eating" has paralysed me to a stand still, where I could just space out and not take responsibility for what I am feeling.

D9 - I am wondering about the "hurt feelings" or "emotions" involved as the cause and sometimes in my case the outcome of this "tornado" experience.

D10 - Is it the "tornado" or the hurt feelings or emotions that paralyse me? I would say that in my case it is both – like a vicious circle!

D11 - "How I look is more important than who I am".

D12 – In the context of one client's discourse: Client agrees with others that she cannot do something and she listens to "being spiteful" when she does not prove others wrong. My discourse: I like to prove others wrong if they judge me about something.

D13 – I don't just accept positive feedback all the time.

D14 - In the unveiling of my food story I realise daily the love – hate relationship I have with food, as if my emotions of "sadness", "anger", "fear of rejection" are like monsters constantly needing to be fed by food – junk food – sweets and fatty foods!!!

D15 - I overeat sometimes so that I can protect myself from others' negative onslaughts and this makes me more holy than others, because I do not act out my anger towards them but towards my own body. This leads to a point where "overeating" numbs me in such a way that I choose to not let

myself be heard. Therefore rather than blaming others, I start listening to self-pity and then I need comfort by overeating…

D16 - "Sexuality" has been a "taboo subject" from way back in my larger family circle. In an era in which my grandparents and parents grew up, "sexuality" was a "taboo subject" to many people they associated with.

D17 - What others think of me and their perception of my ability to lose weight were so often so important that this skewed my reasons for losing weight.

D18 – Reason for losing weight: "I'll show my mother and father I can lose a lot of weight, just because they simply don't believe I can do it."

D19 - Reason for losing weight: "I'll lose weight so that I can look good in my clothes and make other women jealous and make men desire me."

D20 - Reason for losing weight: "I'll lose weight so that I would look good in a certain dress for a certain occasion."

D21 - Reason for losing weight: "I'll lose weight for my husband, because I live in fear of him leaving me or looking at other women and I want his attention."

D22 - Reason for losing weight: "I'll lose weight so that I can win a competition between girl friends."

D23 - Reason for losing weight: "I'll lose weight so that my son won't be shy of me at school."

D24 – I blame others and myself for my overweight and excessive eating habits.

D25 - I know and have experienced in the past how easily the "all or nothing" discourse can keep me from losing weight in a healthy way and it could force me or push me to obsess about losing weight so that I lose perspective on why I started to lose weight in the first place.

D26 – Beauty is the way we share caring attitudes and things with others.

D27 - Overeating was a very safe place and loving place for me for many years.

D28 – Like one of my clients, I also "eat for my mother".

D29 - Being hard on myself and not taking time out can have the outcome of quick fixes disguised as substitutes for my "overeating being the comforter" like "going on a spending spree for new clothes" or "eating out and making wrong food choices and then punishing myself with strict diets and an overload of digestive pills".

D30 – I relate the quick fix as the answer to my pain or anger, but translate it to myself as "I am feeling better about myself, because "I look good in these clothes" or "when I punish myself with dietary foods, I may have nice food now and then".

D31 - During the past 18 to 20 years quick fixes for my pain and hurt and anger have been just as detrimental as the "overeating of food". As a matter of fact I think the quick fixes were part of the trap to sort of excuse my "overeating habits" as permissible and good for me.

D32 - My taking responsibility for my relationship with food got stuck in mistrust in myself that I would stay forever at the point of a see-saw with my weight.

D33 - One thing that stood out from my whole reflected story was that I had a deep need, even as a 16 year old to express my relationship with my body. This is after the incident where I sat on my father's lap at 14 years of age and then the mind – body split happened and eating food in excess became my protection against unwanted attention from my father, other men and from myself. My main purpose in life started to be "to protect my holiness" and this resulted in my body becoming mute for nearly 18 years now.

D34 - Working with my discourse of "proving others wrong if they say I cannot do something". The first thing that comes to my mind is that this discourse is somehow linked to the need I have to be recognised by others and even to be complimented by other people as "I am a good person" and that "I deserve to be treated as someone that can do things and are good at tasks". I am thinking of the discourse "I must always be the role model in all situations".

D35 - I learnt from my mother's voice that I must always be good and "proving" to her always that I will be a good little girl and sister towards my brother even if I do not want to do this with all my heart, because of hurt feelings towards my brother. So I justified this self-abuse by ways of overeating and pacifying my anger and comforting my hurt feelings.

D36 - My discourse – "not just accepting positive feedback all the time" is a voice of my father (my ever optimistic and positive and trusting father) that sometimes was cheated by other people and felt hurt and disappointed, but then quoted how positive and optimistic he is as to his saying "Always look at the bright side of life!"

D37 – For many years I believed that "my family cannot live without me". I must rescue them and comfort them.

D38 - The "unwanted attention from men" is part of my blaming game towards the male gender for declaring as a male dominated society to me at the age of twelve that males are better or more superior to females. I then decided that I could start blaming men for looking at my body as being desirable. In my mind this made men "unholy" and I was allowed to overeat to keep myself being the "holy one", thus the superior gender.

D39 - The "poor, poorer and poorest me", "ag shame, look how terrible everything and everyone is to me" and "I am the victim and everyone must know that I am the victim and this makes me holier than others"; are all discourses when I look at my relationship with "self-pity".

D40 - I have allowed "self-pity" to put me down as the victim in relationship with my husband and this has led to me blaming others and in so doing taking over the persecutor role.

D41 - "I am going to eat myself to the death, because you do not listen to me".

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D42 – When I am thin and attractive, guilt tells me that I am a wonton sex goddess and this makes me a bad, bad girl.

D43 - I was told by society that men were better at everything and I hated it with a passion.

D44 - I will be better than boys or men at being holy.

Alternative stories (A)

1 - First participant

A1 – When I am creative in painting and needlework it helps me to deal with the tornado experience and it makes me feel that if I am productive I can cope.

A2 – When I am creative I don't experience the chaos caused by the tornado.

A3 – Creative arts help me to calm down and be peaceful.

A4 – Working with my hands gives me a sense of joy.

A5 – The new-old story: creative arts have helped me through painful experiences since my childhood.

A6 – Talking about this new-old story of creative arts makes the tornado smaller.

A7 – Creative arts helps me to be more in control of my eating habits.

A8 – If I am in control of my eating habits, it means that I am coping better with stress.

A9 – It makes me feel better about myself if I can busy myself with creative things and thereby express myself.

A10 – When I turn self-hate into self-love I feel nurtured.

A11 – Self-love and acceptance helps me to explore alternative ways of comforting myself.

A12 – After talking about my overeating process, I feel more in control, because when I feel the need to overeat I find something else (creative arts) to do.

A13 – To do something physically with my hands helps to stop the tornado.

A14 – When other people compliment my handy work, I feel better about myself and I feel worthwhile.

A15 – I protect myself from negative feedback by not telling other people that I have done a specific creative product, thus I feel safe.

A16 – New-old story: I am used to being praised for my creative abilities.

A17 – Creative expression through needlework and painting is a safe, nurturing, relaxing and special place where I can express my thoughts and feelings.

A18 – My creative expression results in me feeling as if I can take on the world and I feel that I can accomplish many things.

A19 – Talking about my feelings and thoughts helps me to stand up against the tornado

A20 – I have plans to market my art works and to start my own business because I believe in my handiwork.

A21 – Talking about my creative abilities rekindles my passion to create.

A22 – A horse from my childhood was a great comfort to me and he made me feel safe.

A23 – Running my own business gives me a feeling of being in control.

A24 – In business I dislike being dependant on others.

A25 – In business do unto others as you would have them do unto you.

A26 – Aesthetic value is important in business.

A27 – It is important to take care of yourself and others in business.

A28 – To persevere in business is sometimes the only option.

A29 – Having faith in God is a nessasary asset with regards to success in business.

A30 – It is important to treat people with respect in business.

A31 – It is important to keep employees happy in business, and then I will receive happiness or good will comes back from the employees.

A32 – Loyalty and good judgement are very important in business.

A33 – My good judgement tells me that the tornado is a really big problem and I am busy thinking about different possibilities in dealing with this tornado rather than just sitting and worrying about it.

A34 – I am now pregnant with my second child and have the desire unlike my first pregnancy to eat healthy and look after myself.

A35 – I am now motivated to take care of myself and to look pretty and to make new clothes, because I want to take care of my physical appearance.

A36 – I am very proud of myself.

A37 – I have decided to think twice before I act impulsively and to be calm in relationship to my husband and the tornado.

A38 – In business I am strong and I am not allowed to be weak and I just have to cope there is no other alternative. When the focus is on my own personal life and feelings I tend to be helpless.

A39 – It is good to talk to or about my inner child and to be reconciled to her.

A40 – To talk about painful experiences can be healing.

A41 – Talking about painful experiences can be like an open wound.

A42 – If I look after myself on different levels everything will fall into place.

A43 – I am learning that I have a perception of other people's perception of me, so I can choose to believe differently than negatively about myself.

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A44 – These conversations have helped me to be more patient in my relationship with my husband, we also communicate more.

A45 – If I think twice about what to say or not to say to my husband, we communicate better and understand each other more.

A46 – I have learnt that I have a relationship with the tornado and that I can overcome it.

A47 – I can allow myself to be like a child sometimes in the context of creative arts and in relationships where I have fun more often.

A48 – I have learnt that my childhood friend, a horse meant a lot to me and he helped through my painful experiences by comforting me. This means that I was not alone.

A49 – Creative arts have been an emotional outlet for me during my painful experiences as a child.

A50 – It means a lot to me that my child, dolls, friend, horse and sometimes my husband love me.

A51 – By talking about my relationship with the tornado I could find myself again.

A52 – I hope that after these conversations that our family and I will have hope and happiness.

A53 – These conversations have helped me to allow my voice and opinions to be heard.

A54 – These conversations have helped me to stop running away from my problems and not to hide away anymore, but to face myself and others.

A55 – It is not important anymore to try and please others the whole time, thus my opinion is important.

A56 – I feel some freedom from my struggles with food and I believe that I have the choice in what I eat and when I eat it and in which context.

A57 – I think I have become more mature and have taken responsibility for my actions.

A58 – It has been helpful to talk about my painful experiences, although I was afraid to do so in the beginning.

A59 – I have learnt that I still have a fear for my husband's drinking problem.

A60 – I have learnt that I have a deep need to be loved by myself and others, but that it starts with self-love.

A61 – I want to have a healthy lifestyle, not only for my benefit but also for my children. This is my reason for losing weight in the long run.

2 - Second participant

A1 – Believing in the definition of hope is helpful and gives me hope and openness to others and myself.

A2 – I feel better about myself when I am physically fit, exercise and eat healthy food.

A3 – My stubbornness made me want to show other people that I can accomplish becoming fit and in so doing feel better about myself.

A4 – I have perseverance when I decide to become fit.

A5 – Fitness relieves hunger pains and fills an emotional void.

A6 – Being fit resulted in me feeling better about myself, feeling proud of myself, having a feeling of accomplishment and feeling better physically and spiritually.

A7 – When my physical appearance improved I felt that I showed people the real me, thus being thin and fit makes me want to show myself more often to others.

A8 – I have the ability to think creatively and in a different way than usual, thus I am a good problem solver.

A9 – The switch to take control of my life in a healthy way happens when I have an overload of others perceptions that I am fat and then I want to prove them wrong.

A10 – Just before my marriage where I was fit and thin is the context for the following characteristics I know about myself, namely: Perseverance, spitefulness, stubbornness, love for life, belief that I can do it, belief in myself. These characteristics could help me to start again with a healthy lifestyle, because I cannot expect my husband to change. I want to take the responsibility for my own health.

A11 – The main reason why I decided to take control of my life through exercise and eating healthy was the realisation that I can do it and will do it and that it will be good for my health.

A12 – The belief in myself that I am worthy allows me to prove to others that I can live a healthy lifestyle.

A13 – In the context of me leaving home as a young adult I started to take responsibility for my own health and wellbeing, because I developed the need to prove to myself that I can do it by myself thereby rekindling my characteristic of perseverance in finishing a task that I have started in the first place.

A14 – In the context of previous therapeutic conversations before this study I learnt that it is important not to be stuck in the past but to focus on the future by living daily in the here and the now, thus opening new ways of thinking about the importance of taking responsibility for my own health.

A15 – I am remembering how important it is to set goals for myself and to work on my goals, because I cannot change the past for it is the past.

A16 – Some of my goals are to start communicating my health needs with my husband again and to join a gym and to actually go.

A17 – Perseverance helps me to sort out difficult problems and intellectual and emotional stumbling blocks.

A18 – The belief in myself since childhood that I can accomplish tasks if only I persevere and put my mind to it, gives me courage and hope.

A19 – The belief that crying as a form of expressing your emotions makes you more human and approachable to others.

A20 – I have the courage to talk to my family of origin about past taboo subjects, thus courage is a friend of mine.

A21 – I have initiative to share with my family of origin my experiences of our taboo subjects to the benefit of more intimate relationships amongst family members.

A22 – Self-forgiveness and self-acceptance helps me to stop blaming others and myself for being fat or overeating.

A23 – Being more self assertive is helpful in discerning that overeating is not such a safe place.

A24 – In the context of my work environment I decide to stand up for myself and to express my opinion.

A25 – In a safe place I can express my emotions of anger.

A26 – As an adult and a mother I have a better understanding and mercy for my mother's pain.

A27 – It is more important to change my eating habits into a healthy lifestyle rather than to just focus on losing my extra weight.

A28 – I have talked about my relationship with food in excess and this made me grow as a person.

A29 – Being self-aware of my thoughts and feelings and actions with regards to my relationship with food in excess allows me to make meaning from my experiences, thereby getting to know myself better and feeling more in control.

A30 – I am learning that I want to hear myself more often so that I can get perspective with regards to my relationship with food in excess.

A31 – I am learning that talking about painful experiences with others and my family of origin can be healing not only for myself but also for them, therefore lessening my need to overeat as a safe place to emotionally express myself.

A32 – I am learning that to have courage to change my lifestyle to a healthy one means to put the courage into practise by taking responsibility for my exercise and eating habits.

A33 – I am learning that the media and society's opinions with regards to people who are overweight will always be there, but I have the choice to allow it to influence me or not.

A34 – I am learning that there are more stories to describe myself and my experiences than only with regards to my fat story.

A35 - I felt good about myself when I was thin.

3 - Third participant

A1 – In the context of previous therapeutic relationship with the researcher-therapist I have learnt how to love myself, to accept myself, to accept and forgive people that I love, to talk to significant others about my problems; thereby giving expression to my emotions.

A2 – My decision in the context of the previous therapeutic relationship with the researcher-therapist was to take control of my feelings of depression and to stand up against the feelings of powerlessness and to open myself up again just to be me in a unique way.

A3 – Self-worth and self-acceptance helps me to change my perception of other people's negative perception of me being fat and ugly.

A4 – My changed perception that I am beautiful even though I am fat makes me more approachable to others.

A5 – Believing in myself helps me to be self-confident and visa versa.

A6 – It is my responsibility to listen to myself and to accept myself.

A7 – Inner strength helps me to listen and nurture my emotional needs without using food as a comfort.

A8 – Open communication between my husband and I concerning sex and emotions is helpful to strengthen our intimacy.

A9 – I take more time to spend with my husband and children and this helps me to feel more loved and accepted.

A10 – I feel prettier as a woman when I communicate my feelings and thoughts with my husband.

A11 – Self-acceptance and others' acceptance of me enables me to feel better about myself and this makes me feel pretty.

A12 – My husband and I standing together in our discipline towards our children is helpful for me to feel a better mother and motivates me to look after my physical appearance better and to take care of my health. This has a positive effect on my children as well.

A13 – Inner strength comprises happiness, love, patience and new perspectives on life.

A14 – Inner strength gives me a new perspective like even though I am fat I am still a beautiful person.

A15 – I don't need anything from other people to make myself feel better about myself, even though I am overweight I can be pretty.

A16 – To think and hear that I have lost weight makes me feel good about myself.

A17 – I don't want to be round and fat, because it does not make me happy to be overweight and unhealthy and I want to be healthy therefore I want to lose weight.

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A18 - Self-acceptance helps me to deal with negative comments in a more constructive manner, because the comments don't bother me so much anymore.

A19 - I have decided that my happiness does not depend on others, only on myself, and this will be my motto in life.

A20 – I don't allow other people's negative opinions of me to oppress me, because I want to be a winner!

A21 – My relationship with God has given me a better understanding of His fruit of the Spirit such as; patience, love, self-control, self-confidence; and this helps me to accept and love myself more.

A22 – My faith in God helps me to understand that although I have contributed to having an overweight body, God is my creator, I am His child and He accepts me for who I am, therefore I do not have the right to not accept myself and neither do others.

A23 – My relationship with God is of great value in the fact that I believe I love and accept myself in looks and personality.

A24 - My communication with people and God whom I trust about my relationship with food in excess is helpful.

A25 – My experience of God's grace, mercy and love has made me more thankful for who I am just like I am at the moment.

A26 – I could gain health, feel better about myself, fit into my clothes and have more lust for life; from losing weight.

A27 – I could lose my bad habits such as the habit of overeating all day, being unfit; from losing weight.

A28 – I could gain a sense of self control and it helps me to be a better and healthier person, from losing weight.

A29 – When I set the goal to eat healthy on a daily basis I feel powerful and in control of my eating habits and this result in to me saying, "Yes, I can if I want to."

A30 – I have decided to communicate my needs even if it means to not keep the peace so that they could carry the burdens with me.

A31 – It is important that we sit around the table and eat our dinner together as a family and use the time to communicate about our day.

A32 – It is important to eat less and healthy. Healthy eating means to cut out sugar, and to eat more vegetables.

A33 – Knowledge about health risks with regards to overweight helps me to realise that overweight could be very dangerous and therefore I am going for a full medical check-up.

A34 – I am responsible for myself and my family to set a pattern in our household of a healthy lifestyle.

A35 – I am taking responsibility to break the unhealthy habits chain in my family by taking care of what, how much and when my family and I eat certain foods and to replace very unhealthy foods with healthier but nice alternatives.

A36 – Self-acceptance allows me to experience other's acceptance of me on a more regular basis.

A37 – Self-acceptance helps me to accept others just as they are.

A38 – It is more important to lose weight for myself and my health rather than for my husband or my children.

A39 – My happiness and health are the greatest reasons for me to lose weight.

A40 – I am going to make use of spiritual support from God, emotional support from friends and family to lose weight and live a healthy lifestyle, not only for myself, but also for my family.

A41 – I have the right to allow my voice to be heard because I am worth being listened to with regards to my experiences of my relationship with food in excess.

A42 – When I have self-confidence, self-respect, self-love then I do not worry about what others think about me anymore.

A43 – My inner strength helps me to allow my voice to be heard, because I am a person in my own right.

A44 – Others' positive remarks about how I look also gives me inner strength.

A45 – I have decided that people must take me or leave me just as I am even if they accept it or not, I am who I am.

A46 – I choose to eat healthy and not to punish myself with must lose weight by changing my thoughts to "I want to lose weight".

A47 – The "I want to lose weight" is a more peaceful way to prepare myself to lose the weight and I am more willing to do it.

A48 – I am deciding to lose weight and therefore I will do it on my own time, but I will do it without punishing myself.

A49 – I am learning that there is a flipside to the comforting function overeating has in the long run, because the bad pattern brings sadness and fat.

A50 – I am learning that all the perceptions I have of others' negative perceptions of me are all in my mind and therefore I can change my perception at any given moment.

A51 – I am learning that to be healthy is one of the main reasons to lose weight.

A52 – I am learning that my inner strength comes directly from my spiritual relationship with God.

A53 – I am learning that emotional support from others is helpful in me realising my accomplishment in self-acceptance in my relationship with food in excess.

A54 – I am learning that even though I am married and have children, I am responsible to take care of myself.

A55 – Talking about my experiences of my relationship with food in excess opens up space for other overweight people to disclose their experiences, therefore resulting in the feeling of belonging somewhere.

A56 – When I allow my voice to be heard surrounding my experiences with my relationship with food in excess, it brings hope to others with similar experiences but have not yet let their voices be heard on this matter.

A57 – It is important to continue to talk about my experiences of my relationship with food in excess, so that I will reach a healthy lifestyle.

A58 – I am learning that when I change my motive from "must" to "want to" lose weight, I am more in control and I am choosing then to lose the weight.

A59 – I am learning that I am not totally where I want to be with regards to my weight, I would like to lose some weight but I have made peace with myself.

4 - Fourth participant

A1 – To have a healthy lifestyle is the crux of combating overweight.

A2 – A few years ago I made a calculated decision that I will never ever pay someone again to help me to become thin, because quick-fixes and other solutions are not the answer to a healthy lifestyle, because the answer to a healthy lifestyle is within me.

A3 – Since a few years ago I do not settle for the all or nothing discourse rather the all and nothing. The all implies the overeating and/or to stick to your diet no matter what. The nothing implies to never diet again and/or to decide to never follow a diet again. Thinking in this way, where I decided that I am just going to accept myself, has not worked because since the decision I have picked up even more weight. To change my overweight condition to a more healthy weight, I need to make a lifestyle change, therefore something that really works for me on all sides is to take responsibility for my healthy eating habits as good as possible. On the nothing side is to be free of restrictions of society-driven diets.

A4 – Others' unhealthy relationships with food gives me a wake-up call with regards to how necessary it is to take responsibility for a definitive lifestyle change to health and well-being.

A5 – Being in contact with my body's voice with regards to cholesterol and overweight having detrimental effects, help me to take responsibility to have a healthy lifestyle.

A6 – Self-acceptance of myself and body image helps me to take responsibility for a healthy lifestyle.

A7 – I don't need to lose weight because by dressing myself professionally I like how I look.

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A8 – I have the ability to create a verbal space for women to allow their voices to be heard with regards to their experiences with their relationship with food in excess.

A9 – Self-assertiveness helps me to say that I have the right to say to society-driven diets and the media:" Do not exploit my fat!"

A10 – I vote for the value of exercise and find it enjoyable.

A11 – Physical exercise is helpful to prevent medical illness and enriches the quality of my life and therefore doing exercise is an important element to have a healthy lifestyle.

A12 – I have the knowledge and the responsibility to take charge of my unhealthy eating patterns because I will then be less depressed and more relaxed and have quality of life.

A13 – I am striving to have a healthier relationship with food by nurturing myself with healthy food, because I love the richness and variety of food. When all else is said and done I want to come back to what I said to you in the first place: "I am passionate about food, man!"

A14 – I accept myself when I am professionally dressed and take care of my physical appearance, even though I am overweight.

A15 – An alternative meaning for my experience of overweight is that I am beautiful; I just have to go to extra trouble to beautify myself.

A16 – I equate fat to being unhealthy, therefore a total health image is more important than physical beauty.

A17 – In the context of believing that I have freedom of choice in anything I think, feel or do, I feel happier if I choose a healthy lifestyle.

A18 – I am accountable and responsible in practicing my choice of how much food I consume and how much exercise I do.

A19 – I have the ability to use sense of humour and problem-solving skills with regard to my relationship with food in excess.

A20 – I have the ability to hear my own and others' blaming games, which helps me to take responsibility for not nurturing myself with food but rather to talk about it, to reach alternative solutions.

A21 – I have the ability to recognise the bottom line concerning my relationship with food in excess "the buck stops here".

A22 – When I take an emotional distance from my dysfunctional patterns with regards to my relationship with food in excess within my relationship with my mother, I am more in control of a healthy lifestyle.

A23 – I have the ability to plan my time spent on nurturing myself with healthier ways than food.

A24 – I have decided to take responsibility for my weight problem and not to make my mother the scapegoat, because I recognise the fact that my mother has control over her eating habits, therefore the buck stops here.

A25 – I have the choice to eat or not to eat healthy foods.

A26 – I have decided to go to a dietician and to be committed to lose weight for health reasons and for health reasons only.

A27 – I am keeping a reflexive journal with regards to my own thoughts and feelings surrounding my relationship with food in excess.

A28 – I am dealing with my emotions to help myself to get a grip on my unhealthy eating patterns, because I realise that some of the things that I am angry about towards my mother, will never change. This is a peacemaking process for me to try to accept the things I cannot change.

A29 – Limited options in larger dress sizes brings the reality to me that I need to lose weight, but more so, overweight is unhealthy and I don’t want to be unhealthy and this is the right time to lose weight.

A30 – I am very motivated to lose weight after hearing and experiencing various success stories with regards to overweight people’s great weight-loss.

A31 – My definition of success in terms of weight-loss is as follows:” A good day for me is when I didn’t overeat to satisfy my emotions, when I use more fat free products to combat high cholesterol or have a moderate fat intake”.

A32 – I have decided to not have any rules for myself anymore because it doesn’t work for me. So the only rule for me is “low fat – healthy – low fat – healthy”.

A33 – Everyday I plan my time, food intake and exercise, step by step, morning to morning. That’s what I commit myself for. In general I commit for low fat.

A34 – Being in contact with my body’s voice that I am unhealthy and sometimes in pain, is my friend more than my enemy and one of the greatest reasons why I am choosing a healthy lifestyle, because I don’t want to die soon.

A35 – My fear of dying caused by my unhealthy lifestyle motivates me to strive for quality of life and a healthy lifestyle, because my family is important to me.

A36 – I am learning that my anger towards media and society with regards to their prejudices about fat people is a good excuse for me not to take responsibility in cultivating a healthy lifestyle. Not taking the responsibility makes me realise that I don’t have respect for my own body and I inflict pain upon my body by overeating, when I ignore my high cholesterol, eat until I can’t anymore and to be obese.

A37 – I am learning that the term self-respect, not only pertains to my self-image but also to having respect for my body.

A38 – I am learning in the context of being in contact with my body, that my body's overweight is too heavy to carry, therefore I want to lose weight to lighten my body's burden.

A39 – I am learning that I do not need to nurture my mother and myself with food because I am responsible only for myself, my own happiness and health.

A40 – I am learning in the context of my self-portrait, that I am a fat and thin person. Thus there is a thin woman inside of me that struggles to come out.

A41 – I am learning that the crux of maintaining my unhealthy lifestyle is the feeling I have had for a long time that this is life and I cannot stop living just because I am so fat, therefore I think I tried to live with the right clothes, activities or whatever and then to pretend that my overweight never bothered me. Now I know I just used this as a cover up.

5 - Fifth participant

A1 – Saying no and setting boundaries to others is helpful when they want to take me for granted and misuse me.

A2 – I am listening to myself, children and husband with regards how to set boundaries to ensure that my families and my own needs are met.

A3 – My faith in God helps me to realise that it is not good to overeat.

A4 – It doesn't help blaming affirmative action for my financial stress, but it is my responsibility to have an entrepreneurial lifestyle.

A5 – Praying to God has helped me to eat less during times of financial insecurity.

A6 – I acknowledge the fact that God helps me in determining financial success, thus leaving me feeling more in control of my eating habits.

A7 – My mother's voice "too much of a good thing isn't good anymore" allows me to re-evaluate my eating habits and to commit to a healthy lifestyle.

A8 – Making my mother part of my life again helps me to take my thoughts away from overeating all the time and this works for me.

A9 – I have started to look for alternative ways to comfort myself emotionally with regards to the loss of my mother, for instance, to walk in the garden or to look at her photo or just to ask myself the question "why is it necessary to put something in my mouth if I am not really hungry?"

A10 – Rekindling memories of my mother has made me realise that I do not need food anymore to make me feel close to my mother again.

A11 – I have decided not to pity myself anymore but to focus on the good things and characteristics that I have.

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A12 – I have decided that I have worked through the loss of my mother and I can handle it better emotionally by incorporating my mother in my life again.

A13 – I am exploring new ways of thinking about who I am and what I want to be, because I have considered too many people's feelings as more important than my own, therefore keeping quiet and not allowing my voice to be heard.

A14 – I am more self-confident and more in control of my eating habits because I now know what I want out of life.

A15 – I decide what healthy food choices to make by weighing the advantages and disadvantages.

A16 – I remember a time before my mother passed away where I was self-confident because I knew I wanted to do things in a certain way and I wouldn't allow anyone to change my mind. Whereas I think my mother would be more influenced because she had less self-confidence.

A17 – I have made peace with the fact that my mother wasn't there in times where I really wanted her to be there because I believe that she would have been there if she could.

A18 – For the first time in many years I feel that I have discovered myself as an individual again, separate from my mother.

A19 – I have taken my uniqueness as a special quality I have.

A20 – I am exploring who I am and I know that I would like to be just who I am and not like others want me to be.

A21 – I know that I am a people's person, I mean I can adapt to other people and talk to anyone.

A22 – I know that I am a caring and sharing person and this is how I want to be rather than snobbish and not caring.

A23 – I want to be involved with other people's lives and if I can help other people I would like to do that but not to the detriment of myself.

A24 – I make more time now to spend with my family and myself, thus family and personal time is very important.

A25 – I have decided to accept myself.

A26 – Positive self-talk helps me to be in control of my eating habits.

A27 – I am stopping myself to be a steam-roller, to just decide I cannot go further, I have to stand still and take time for myself in deciding what to do next, therefore taking care of my emotions and thoughts, rather than overeating to feel better about myself.

A28 – I am taking care of my body and plan a healthy lifestyle more often on a daily basis to feel better about myself and my body.

A29 – I am comforting my body by physically holding my body in times of stress.

A30 – Self-awareness allows me to be more in touch with my body.

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A31 – I have decided to allow my body to speak to me more often and I would like to hear what she has to say.

A32 – Being a go-getter and having love for myself, helps me to overeat less.

A33– I am allowing myself to have more resting times in shorter periods of time.

A34 – Taking care of myself firstly, gives me more room than before to take care of my family and others.

A35 – I am experiencing myself in a new way, by being more in touch with my body, emotions and thoughts than before.

A36 – The loss of my mother has taught me that life is precious and must not be taken for granted.

A37 – I am learning that when I help others to the detriment of myself, both parties are disadvantaged.

A38 – I am learning to have authority when I say no to someone without losing my softness as a woman.

A39 – I am learning how to set boundaries with regards to what I am prepared to do for others or not.

A40 – I am learning that my mother is always with me and that I am important and good enough for her just like I am. This helps me to lessen my pain and my bad eating habits when I have periods of missing her tremendously.

A41 – Experiencing my mother's comforting message in a therapeutic context brings healing and comfort to me.

A42 – I can actually handle anything in life when I share the good and the bad experiences with someone I can trust; and if I think about it I can see things differently and learn from my experiences.

A43 – I am learning that it is not necessary for me to be like my mother anymore and there are some good things about my mother that I still want to cherish.

A44 – I am learning that it has a positive influence on my relationship with my family when I set boundaries in helping others.

A45 – I am allowed to not feel good, to feel sick, to be tired and to acknowledge it to others and then to take care of myself.

A46 – I am learning that I also have a physical body and that I need to incorporate my body into my thoughts and emotions.

A47 – When I acknowledge the fact that my body is also important to acknowledge in having a voice, I experience my body to be thankful and to be more a part of me.

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R – Researcher-participant: Reflected upon alternative stories during the study and therapeutic process

A1 – Interpersonal sharing relieves my lonely struggle to find what food means to me.

A2 - My desire is to find comfort not in food but in my belief or knowledge that I am good enough and worthy, just because I am who I am and it does not matter what others say, I can only learn from this experience.

A3 - I am thinking of what my mother used to say when she was drenched in cancer – "No matter what happens to you in your life, it is how you handle it that makes the difference"!!! I have decided to make this learning my own.

A4 - I can turn a negative experience into a positive experience by giving voice to my belief that I did my best and I am good enough academic wise "no matter what the learned panel" says and most of all "no matter what fear of rejection shouts and tantrums about".

A5 - I also realised that I do have a choice in times of stress to overeat or not to overeat.

A6 - It is a challenge for me to figure out in which other ways I can combat stress and comfort myself at the same time. Something familiar to me is to go for a walk or for several walks when I feel stressed or upset. Walking helps me to feel more relaxed and to release my pent-up energy. After walking my mind is clearer and I feel better and I can focus on what is important.

A7 - My choice is thus to use externalisation of my "problems" and to go for many walks in times of stress, more often.

A8 - I sense that my motive of wanting to be healthy will help me to rather externalise my problems and walk than to binge eat.

A9 - I have come to the realisation that "who I am" is in part portrayed by "how I look" or how I present my body and my body's adornments or defects to others. "Who I am" could be much more than "how I look" and it could also be less than "how I look". "How I look" could be seen from other people and my own point of view. Each one of us could have a different opinion on "how I look".

A10 - The choice I have is in the reaction to and creation of "how I look" translated partly into "who I am". I am now wondering about how to integrate the two concepts in my own perception of what I choose to be and to become.

A11 - As a child of nine years and older I started to question my father's "always" trusting and positive attitude. I have decided that "I am not going to accept positive feedback from myself or others all the time."

A12 - I want to know my fears and conquer them, I am taking full responsibility for my past hurts and I want to break free from my own "blaming game" that causes me to recycle my relationship with food in excess.

A13 - The period of change to be more open about my "sexuality" was from 1987 to 1993, where I developed from a young teenager into a young adult. Since 1995, being married to my husband and experiencing sexual intercourse, I have realised the importance of talking about "sexuality".

A14 - The way I am starting to see it now, my sexuality is an integral part of my being healthy or unhealthy in my body, mind and soul. "My sexuality" is such a great gift to me being a woman and being human.

A15 - My choice is to talk about "sexuality" in my family and in safe places. As a therapist I have seen and heard myself express themes about "sexuality" to clients and colleagues. I am happy about this, because it helps me to celebrate my "sexuality" as being part of my womanhood.

A16 - I discovered two years ago the main reason for me to lose my weight and to maintain a healthy weight for the rest of my life. This reason is; or the need or the desire is: "I want (freedom of choice) to lose weight so that I can be healthier in mind, body and soul. My health is my choice and my responsibility to myself and my children. This is my legacy…"

A17 - One thing I have noticed about the freedom of choice is that it is an act of my will to carry out my decision about something. I think that if I connect or link my will to lose weight to my reason for being healthy, it could have a long lasting effect.

A18 - Unwanted male attention could become unwanted attention towards myself, specifically towards my image of a thin body. The unwanted attention towards myself allows "guilt" like "I am a bad girl" and "I need to become holier than men" to push me to excessive eating habits. The learning is to be aware of this.

A19 - So I have decided to lose 52kg "as good as I can with responsibility", thus to follow my weight management program 80% and above.

A20 - I decided that I have a choice to be healthy or not to be healthy and that my so called diet can only become a healthy lifestyle pattern of eating, if I "free myself from society-driven diets", where Weigh- less expects from me to go to their group meeting once each week. I don't like the group meetings and decided that I will not go to the group meetings, but to weigh-in each week is non-negotiable. I decided that the strict weighing of food will only be for one month and for new foods that are unknown to me, so that I could learn how to lead a normal and balanced life and have a good eating pattern. I want to enjoy healthy food in a new way.

A21 - Something I learned since my 21st birthday is that life or society sets people up to compare themselves to others and themselves on different levels and roles they have. I have discovered that I am unique, even though some people are better or worse at some things than me.

A22 – I have decided that my relationship with food translated as "I eat for my mother" will not ring true anymore. Thus "I eat to be healthy and have quality of life".

A23 - My "tornado" experience or binge eating has become small, so very small and I thank the clients for helping me in describing my own story about my "tornado" experiences with food.

A24 - I have re-learned the power of "giving yourself permission to think about yourself or to nurture yourself" by listening clearly to this client's story about possible solutions for a more balanced lifestyle in mind, body, soul and emotions.

A25 - I am aware of the healing factor of the possibility of staying in my room to deal with my sadness or anger or stress and to specifically give myself permission to take time out just for me. I also am familiar with the fact that this possibility to listen to myself is hard and difficult, because of the whisperings of fear sometimes that I am lazy or I am not supposed to be sick or feeling tired, that I am supposed to be superwoman and supposed to expect others to have super powers too; thus being very hard on myself for being good to myself.

A26 - I am searching for more sustainable "nurturing places" for myself and have found that time out with myself in thinking in my room for a whole day or two, writing, drawing or taking a prayer retreat away from home have been difficult places, but very helpful and liberating.

A27 – I have realised that making healthy choices in my life means that "the buck does stop here".

A28 - I am responsible for the amount and type of food I take in daily.

A29 - I like what Covey says about balance:" Balance is not either/or, but it is **and**." This brings me back to my client's and my discourse surrounding "all or nothing". I am realising daily now that my taking of responsibility for my healthy lifestyle will be a lifetime process and that the choice to live healthy is up to me and it is a daily decision. My overall reason to lose weight and then to maintain my goal weight can only be to be healthy and hopefully this is a sustainable reason.

A30 – I take with me a sense of and the knowledge of that "the buck stops here", thus I am responsible for my own unhealthy or healthy lifestyle now and in the future.

A31 - I have re-learned that my body needs to voice her opinion in relation to my mind, emotions and soul, thus my body has a voice.

A32 - I have re-learned about my sense of hope in the experience that even though my mother has past away, she is with me every step of the way and that I am a person in my own right.

A33 – By describing and understanding my discourses more clearly I hope to enrich myself as a person in my relationship with food in excess in the context of being holistically healthier.

A34 – It is important to grow into a healthier person in my relationship with food.

A35 - I would like to see my own growth and others growth to a healthier body and mind.

A36 - I acknowledge that I have a more whole or/and healthier outlook and experience of my body space.

A37 - Talking about my relationship with my body opens up so many different avenues or areas in my life and especially it's relation to my relationship with food in excess.

A38 - In the process of my studies I have allowed myself to allow my body to have a similar voice as to my mind and as to my emotions.

A39 - If I choose to allow my body's voice to be heard in a significant time, space and relationship; it allows the whole me to have intimacy in physical pleasure, joy and sorrow or praise and worship.

A40 - I realise that it is my responsibility to help my body to fulfil its rightful place in my personality make up.

A41 - I am experiencing a blooming friendship and reconciliation between my body, my mind and my soul. And I feel more whole than ever before.

A42 - I have a sense of "courage", "taking of responsibility" and "standing up for myself"!

A43 – I have learnt that my family have outgrown my rescuing act and this makes me feel a sense of loss, but at the same time a sense of release and relief.

A44 - I am becoming my own mother and comforter as I want to take responsibility to fulfil my own needs.

A45 - I realise now that "self-pity" and her gifts is not my friend, because she wants me to be like her, always doubting others and myself to such an extent that I will shrivel up and die eventually. My decision is to say goodbye to "self-pity" and hello to new friends who really appreciate me and want to be honest and truthful with me about my "bad" feelings…friends that would look out for me in times of trouble, so that I would be healthy. Self-awareness could be one of my new friends.

A46 - I am learning that my choice is to be more open about my relationship with "self-pity" and to not allow "self-pity" to intrude upon my relationship with "honesty towards myself and others" about my relationship with food in excess.

A47 - I have a great sense of hope in the knowledge that I am not alone in this world. I did have a "good enough mother", but most of all I was a "good enough daughter" during the thirty years I had the privilege to know her while she was still alive. My mother taught me so many good things. She did try her best to make me happy. I am re-learning and have learnt the importance of scouting out my own talents and to believe in myself that I can do it.

A48 - I would like to know what it means to have a healthy body and I would like to explore more ways to look after myself emotionally in the long run of my life's journey. I want substance in body, mind and soul in maintenance and growth.

A49 – In relation to the threat "I am going to eat myself to the death, because you do not listen to me"; eating myself to the death is not an option anymore.

A50 - My decision is to be healthy by accepting that I am a beautiful woman inside and out – body, mind and soul. Self acceptance is my friend and ally against "unwanted male attention" and "strife

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to be seen as equal to the male gender". I know and accept the fact that I am unique in certain ways. I celebrate my womanhood! In knowledge of my physical beauty and attractiveness I decide to be me.

A51 - Consuming food is important for us as people/human beings to stay alive, thus to survive.

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Appendix C: Discourses and alternative stories according to various themes from axial coding

Discourses (D) according to themes

1 - First participant

Theme 1: In relationship to anger and frustration

D1 – Anger about my husband's work load and peer pressure from his colleagues affects my relationship with my husband on a regular basis.

D2 – I am angry on a regular basis and this does not feel nice.

D47 – I think that if I lose weight my husband will change his attitude towards me, but why should I?

D51 – I am angry when my husband's friends convince him that I sit on his head.

D52 – It frustrates me when my husband believes that he must put their needs above mine.

D61 – I am very angry when my husband spends time away from me.

D106 – After I have overeaten I experience anger towards myself.

Theme 2: In relationship to fear, loneliness and rejection

D7 – I am afraid of being alone.

D8 – I am afraid to sleep alone and that's why my husband must come home on time.

D86 – I think that my fear of rejection and being alone could be related to what happened in my childhood.

D91 – I am afraid of accumulating more weight during pregnancy.

D94 – I am afraid that the gynaecologist will tell me to stop eating because I am too fat.

D122 – During overeating I experience a fear of being alone and the food keeps me company.

Theme 3: In relationship to love / hate and comfort

D41 – I believe that loving my husband means to sacrifice myself so that he will love me back.

D45 – I want to be loved and accepted for who I am by my husband.

D46 – If my husband doesn't love me in a certain way, I don't allow him sexual intercourse.

D69 – My child is a source of support and companionship.

D107 – I comfort myself with food.

D111 – Overeating is a basic refuge or a comfort so that I will feel better for a short while.

D123 – Every time I have been upset in my life the tornado has been there for me.

Theme 4: In relationship to sadness and hurt

D67 – I fear people to be close to me because often they gossip about me and then I feel hurt.

D68 – I don't want everyone to see my feelings of hurt.

D103 – After I have overeaten it results in physical and emotional pain.

Theme 5: In relationship to guilt

D4 – I feel guilty for fighting with my husband when he comes late from work.

D74 – I feel guilty when I refuse to lose weight when others try and force me.

D75 – In the context of visiting the Gynaecologist I just need to go even though I am ashamed of my weight.

D90 – I feel guilty to weigh myself at the gynaecologist.

D92 – I feel guilty and ashamed being overweight.

D109 – At the end of the eating process I feel guilty and blame myself.

D114 – I feel guilty every time I overeat and then I overeat even more.

Theme 6: In relationship to inferiority

D25 – I am not good enough in my husband's eyes and this makes me feel rejected.

D33 – My feelings and thoughts are not important to my husband.

D35 – My husband always knows more or better and therefore he must take the responsibility for making me feel better about myself.

D50 – I want my husband to love me for who I am, but feel as if I am nothing special and am being treated like a doormat.

D57 - My husband's needs are more important than my own.

D71 – I feel taken for granted.

D73 - When other people have negative feelings toward me, I feel bad about myself.

D112 – The effect of the overeating process is that I feel worse about myself; therefore overeating is a discomfort and not a refuge.

D121 – Ideal times for overeating bouts are when I put myself down or sacrifice my own time for others.

D125 – I overeat, because sometimes I feel taken for granted.

Theme 7: In relationship to mistrust

D18 – I believe that men cannot be trusted when women don't give them sex and they will find it else- where.

D20 – Everything will be ok between me and my husband although I do not believe this is true.

D23 – I mistrust my husband and this gives me the right to overeat.

D31 – I think I want to trust my husband, I tell myself that I do and I must, but I don't really trust him, because he does not live up to my very strict expectations.

D42 – When I experience doubts and mistrust in various areas of my relationship with my husband, it is necessary to just go on even to my own detriment and unhappiness.

D60 – I don't know if I can trust my husband because I think he could have had an affair.

Theme 8: Internalised beliefs

D14 – It is the right of my husband not to have sex during my pregnancy, because of my weight gain during pregnancy, this made me eat more.

D38 – I want my relationship with my husband to be perfect like it was in the beginning.

D39 – I want my husband to be my knight in shining armour.

D55 – I believe that the standard for spiritual connectedness between a man and a woman means to spend time together by just talking and being close but not sexually intimate.

D59 – I have the right to know where my husband is.

D63 – I think that all men are alike with regards to their sexual desires.

D72 – It is important what other people think of me.

D93 – I believe that something bad will happen to my unborn child, because I am overweight.

D99 – I believe that it is hard work to lose weight.

D100 – I believe I cannot lose weight, but I want to lose weight, but all those salads and gym discourages me.

Theme 9: Body perceptions

D77 – I think I am fat and ugly.

Theme 10: Voices of control

D13 – Circumstances surrounding the wedding prevented me from sitting still and thinking about what I was doing or getting myself into. When I reflect upon this time period I wonder how I did it and I have a sense of disillusionment thus a sense of passively giving into the greater pressure of circumstances never mind my feelings on the matter.

D19 – I am happy or sad depending on how my husband experiences himself and relates to me in a non- stressful, peaceful and happy way or not.

D48 – I expect my husband to change before I will change in my eating pattern.

D54 – I will not lose weight because my husband pressures me to lose weight by saying:" Are you eating again?"

D70 – It is important to be in control of people and my circumstances.

D88 – I experienced social pressure to lose weight from family, school and dieticians since my childhood.

D101 – I don't have the time to lose weight, because there are more important things in life than losing weight.

D118 – The chaos of the tornado has an overwhelming effect on me…it numbs me and renders me helpless.

D127 – I think that other people think that if you overeat you are out of control and therefore not coping.

D128 – I feel overwhelmed and restless when I am out of control with regards to my eating habits.

Theme 11: Overeating in action

D6 – I overeat because my husband doesn't spend time with me or my child.

D34 – I overeat to avoid conflict in my relationship with my husband.

D44 – I overeat because of financial difficulty and not communicating with my husband about finances.

D56 – I overeat when my husband does not respect me and treat me like a queen.

D64 – I overeat when I see my husband lusting after other women

D66 – I overeat when my husband does not do what I expect of him.

D84 – I link the molestation to a tornado being my overeating process as a rush where I cannot sit down and take time to think about what I am doing.

D102– I passively overeat while spending time with my child and in front of the TV.

D105 – I overeat when I feel afraid when my husband is late from work.

D108 – During the process of the binge my brain works overtime, eating happens automatically, over active thinking process, and this leads to worry.

D110 – When I am afraid of being alone I overeat.

D113 – Overeating could be a friend or an enemy

D115 – During the overeating process my brain works overtime.

D117 – Overeating is like a tornado experience…like a wind that twirls.

D126 – When I feel helpless, I try to focus my thoughts on other things by eating in excess.

D129 – Passive activities, like watching TV makes me want to overeat.

D130 – Overeating makes me feel better about myself just for a moment.

D131 – I overeat when people come late for their appointments, because it makes me feel discouraged.

D116 – Overeating process leads to confusion in thought patterns and there is a period of blankness in my mind.

Theme 12: Communication in action

D5 – My husband and I don't know how to communicate with one another with regards to his work situation

D16 – I feel that my voice is not being heard, I demand to be heard by others.

D22 – My husband must know me and understand what I am saying even though I don't know or want to know myself.

D24 – When I relate how I think and feel, my husband does not respond in a way that I feel heard or listened to.

D32 – Confrontations are futile, therefore I do not have to take part in a confronting situation, because it does not help anyway.

D40 – I am not allowed to let myself be heard because my husband is more important than I am.

D49 – I have tried different coping skills like ignorance, confrontation and the silent treatment and talking nicely in relationship to my husband and none of them were helpful and this makes me feel helpless.

D76 – I try to hide myself behind an iron curtain or behind a cupboard rather than interacting with others.

D78 – Sometimes it is better to be withdrawn from others and be by myself, because this place is not so lonely.

Theme 13: Blaming in action

D3 – I blame my husband for not spending enough time with me and my child.

D9 – I blame my husband for enjoying his life with friends and I am suffering alone at home.

D15 – I blame my husband for my overweight.

D17 – I blame my husband for not having sex with me even though I don't have sex with him or don't want to have sex with him for long periods of time.

D21 – I blame my husband for my fear with regards to my possible failure in the workplace.

D65 – I feel disillusioned in my marriage and I blame my husband for that.

D104 – I blame myself, feel guilty and then feel angry after overeating and this feels not so nice.

Theme 14: In relationship to stressful situations

D36 – I overeat when under stress, and then I have the right to not stop and think about my feelings, thoughts and actions at the moment.

D120 – When circumstances are chaotic I sit down and overeat and then experience anger about the amount that I have eaten and I have eaten to get rid of thoughts that stress me.

D124 – When I experience stress and think of past painful experiences, I need to overeat.

Theme 15: In relationship to traumatic experiences

D79 – It is too painful to re-experience and fully express my thoughts and feelings surrounding the molestation during my childhood.

D80 – It is better to forget and not talk about the painful molestation experience.

D81 – As a child I had no control over the molestation, because I was so small and now as an adult I sometimes feel out of control when unforeseen things happen.

D82 – I feel anxious when talking about painful experiences.

D83 – I don't want to talk or feel the painful experience again, I want to forget by overeating.

D85 – I cannot make meaning out of my childhood molestation experience, because it is meaningless what happened to me.

D87 – When being molested, I felt left just like this and that is it.

D119 – The tornado has always been there, linking it to something that happened to me when I was very small.

Theme 16: Familial themes and voices

D10 – A child – my child comes first at all costs even though that would mean that I come last, but blaming my child is unacceptable. Children come first no matter what!

D11 – I married a man who is just like my father.

D27 – My husband and father both want me to serve them and this is ok because my mother served my father and this is what women do.

D28 – I must do things for my husband, things that I really don't want to do, but I do it anyway.

D29 – My mother's voice:" a man is the boss and a woman is the slave".

D37 – I must protect my children against adults that don't care for them.

D43 – I like to mother my husband with regards to his responsibility in the household.

D53 – I believe that family time is of the utmost importance and cannot be bought or compromised by material things, but it is important to spend time together.

D58 – I believe that the sign of a happy family is the presence of a consistent and steadfast mother figure, even though the mother stands alone.

D62 – I believe in my husband's mother's voice: Men can look on the menu, but they must eat at home.

D98 – I believe that my family and I can lose weight, but we have to restrict ourselves highly with food intake to accomplish this.

Theme 17: Socio-cultural power and voices

D12 – I believe that if a girl becomes pregnant before marriage she has to marry the father of the baby.

D26 – I think that many people think that "Men are kings, women are slaves".

D30 – I think that women buy into being servants of men, even though they don't want to.

Theme 18: Living with an overweight identity

D89 – I have been struggling with being overweight since my childhood.

D95 – I believe that my thyroid gland has an influence on me being overweight.

D96 – I believe that genetics has caused me to be overweight, because there are many in our family who are overweight.

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D97 – I have a lot of information about different diets and methods of weight-loss, but feel that diets have failed me in the past and that surgical procedures are dangerous and not a solution.

2 - Second participant

Theme 1: In relationship to anger and frustration

D1 – Anger towards husband's expectations for me to lose weight just like his mother before he will accept me, unlike my child's unconditional acceptance for who I am no matter how much I weigh.

D2 – My husband thinks that my child will become ashamed of me if I do not lose my weight and this angers me.

D3 – I am jealous and angry with my husband because he is allowed to become fit and thereby have control over his weight and I am not allowed to spend time exercising, because of my responsibilities towards the children.

D5 – It angers me when I make excuses for my husband to my own detriment.

D9 – I am angry with my husband when he takes me for granted, but I realise that I am the one that gives into his demands and this makes me angry with myself.

D22 – It is unacceptable for me when some people tease other fat people about their weight.

D23 - I feel angry and hurt for others in the same fat predicament as me.

D24 – When some people make subtle comments about other fat people I become angry, because I know that if they do it to them they will do it to me too, because I am fat too.

D32 – It angers me when society has the perception that a fat person is stupid or is not fit to do a certain job.

D33 – It angers me when society expects a fat person to use wonder treatments to lose weight.

D35 – I am angry when fat people are being exploited in beauty pageants as if they are in a circus and people have the right to make fun of them.

D63 – My mother's voice that certain types of clothes make me look fatter in the eyes of others angers me.

D64 – In the context of being the youngest child in my family of origin, certain responsibilities were often taken out of my hands, simply because it was easier to allow the older children or my parents to take the responsibility. This left me with an angry feeling of if you think I cannot do it, I will show you that I cannot do it.

D72 – It angers me when others take control out of my hands in doing tasks without me giving them permission to do so, therefore it is their entire fault if I do not complete or attempt to do the tasks.

D81 – I become very angry when some people treat fat people unfairly.

D84 – I am irritated with myself for not choosing to eat healthy.

D87 – I am angry at myself for allowing myself to place my husband and my children's needs above my own.

D92 – It often frustrates me when I can't connect my intuition and intellectual reasoning to my emotional expression of painful experiences.

D98 – It angers me when people ask whether my overweight is caused by my genetic make up and they ask what do your brothers and sisters look like?

Theme 2: In relationship to fear, loneliness and rejection

D53 – I sometimes use my responsibility towards my children as an excuse to choose not to exercise and eat healthy, because I am afraid of failure.

D54 – My fear of failure immobilises me to not start exercising and eating healthy again.

D82 – I am afraid of being alone.

D91 – I want to be thin, but I am not prepared to work at it, in fear of unwanted attention from men and also from myself that I am sexually attractive.

D93 – I yield to procrastination in fear of failure.

Theme 3: In relationship to love / hate and comfort

D36 – I hate it when thin people or slightly overweight people have the audacity to express how fat they feel, but they don't have the faintest idea how it feels to be fat.

D108 – In the context of a childhood sexual exploration experience with my brother and making sense of it in a therapeutic context in the past leads me to thinking that I am not allowed to focus attention on me being unjustly treated by men thus the unwanted attention of men translates for me to the needed emotional and nurturing attention that I am not allowed to give myself. This forces me to find nurturance and comfort in my relationship with food in excess, because the attention is then on food and not on me.

Theme 4: In relationship to sadness and hurt

D30 – Society expects from me to hear their negative comments about me, but they don't want to listen how painful and hurtful their comments are.

D65 – I experienced pain when others did not believe that I can't do certain tasks in my childhood and this made me believe that they are right.

D78 – Crying in front of others makes you vulnerable to their judgement and they can take advantage of you.

D79 – I do not show my emotions, but this does not mean that I do not experience emotions.

Theme 5: In relationship to guilt

D48 – Sometimes when I want to express my opinion about a certain subject in a group of people, I prevent myself from doing so because I feel ashamed of my overweight body.

D60 – I am very careful in new situations so that I will not shame myself.

D66 – I experience fear of failure and feelings of guilt, the moment I am challenged by others to take responsibility for my own health.

D67 – I don't achieve or start working on my goals to take responsibility for my own health, because I expect too much of myself and I am very hard on myself to perform perfectly.

D80 – I feel guilty when I think bad things about others and when I am angry with them.

Theme 6: In relationship to inferiority

D6 – It is important to place my own needs below the needs of my husband.

D7 – In my marriage I am everybody's caregiver to the detriment of myself.

D11 – I sometimes don't understand my husband for only thinking of himself and his needs, because I believe that others' needs are more important than your own.

D12 – It is important to please others and my husband to the detriment of myself.

D40 – Other people's opinions are more important than mine.

D49 – Sometimes low self-worth can be a hindrance to my self-confidence.

D55 – I am not good enough because I don't know how to do things "right" in the eyes of significant others and that is why I rather won't do things with reference to a healthy lifestyle.

D56 – I believe that I am not really good enough, because I am a failure.

D57 – My head tells me that when somebody tells me I cannot do something, I respond by saying then I shall show you I cannot do it, when they say I can't do it, then I can't and I won't even take the time to try to do it, because I also believe that I can't do it.

Theme 7: In relationship to mistrust

D61 – I know that I have high standards for myself, because I mistrust my intuition, because sometimes when I do trust my intuition others criticised me and then I believe that I am judged according to others expectations of me.

D73 – I don't trust others to help me with difficult tasks, thus I don't need others to tell me how I must reach a healthy lifestyle.

Theme 8: Internalised beliefs

D10 – It is important not to show my anger towards my husband when he takes me for granted, because men should be held in high regard at all times.

D14 – I am a married woman and therefore I must now do what my husband wants me to do.

D28 - I believe that others have negative perceptions of me in general.

D39 – It is important to show people that I can eat right and be fit.

D59 – My voice of rebellion says "I don't want to, because I don't want to, because I don't want to lose weight, just because others expect it from me."

D69 – I want others to accept my reasons for not wanting to lose weight, because it is very obvious that I am trying to lose weight.

D71 – I sometimes experience intellectual understanding of my painful experiences, but expression of my emotions is hindered by my thinking that my mothers' family do not cry or show appropriate emotions during painful experiences; therefore I do not show my emotions easily to others.

D74 – Children cannot complete tasks as adequately as adults.

D86 – I need to put a switch on in my mind to be able to start with a healthy lifestyle.

D102 - To be pregnant and to have children gives me the right to overeat.

D104 – Overeating habits aren't as important to change as to have good exercise habits.

Theme 9: Body perceptions

D17 – My body image is only a by-product, but it is not who I really am, but it is the inner me that counts in relationship to others.

D19 – I am judged by others within my work environment according to how I look, because it is part of my work image to present a good body image.

D29 – Even though I want people to accept me for who I am and not for how I look, I am very conscious of the fact that I am very visible.

D50 – Example of who I am, is different to how I look: Who I am – I would like to participate in fun and games (physical activities), but how I look influences the fact that I prefer not to participate because of being ashamed of my fat body.

D51 – I am discouraged when I look at my body, because I don't like what I see and I know that I can look better.

D89 – I have confidence in what I can do and in my own abilities, but I don't have confidence in my physical appearance, therefore my self-worth is low.

D97 – Fat is unacceptable, Fat is ugly, Fat is wrong, Fat restricts your activities.

Theme 10: Voices of control

D27 – I am over sensitive to other's perception of my overweight.

D45 – I have to take other people into consideration to the detriment of myself and therefore I feel powerless and out of control.

D52 – My children changed my life to the extent that I feel trapped in the sense that I can no longer come and go as I please.

D68 – Other things are always more important to do than to take responsibility for my eating patterns and exercising.

D85 – To have control over my life equals to have control over my food habits and exercise habits.

D105 – Overeating makes me feel out of control.

D110 – By controlling my emotions, I am controlling the expression of my emotions in front of others so that I allow myself to be out of control with my eating habits.

Theme 11: Overeating in action

D103 – Depression leads to overeating.

D107 – I overeat in the context where others and my own expectations are too demanding for me to reach plausible goals with regards to a healthy lifestyle.

D109 – When I experience strong emotions I escape them without expressing them through my overeating patterns.

D111 – Overeating is a way of treating me after ignoring myself and my need to express my emotions like anger and hurt.

D112 – I overeat when I feel guilty about thinking bad things about others.

Theme 12: Communication in action

D21 – Constant feedback from others with regards to my fat body makes me believe that I am unacceptable as a person and that I cannot do my work.

D31 – I have to always be the one in relationships to hear others' opinions, once again I am the one that has to listen to them without any one hearing my opinions.

D37 – I am not allowed to tell others that I am frustrated and angry that they don't hear me.

D62 – Feedback I get from my work environment about my overweight makes me feel ashamed, humiliated, unacceptable and bad about myself.

D83 – The feeling that I am not being heard and loneliness makes me feel tied down and in a cocoon.

D88 – Most of the time I don't know how to express myself or how to communicate with others about how I am feeling and thinking about certain situations, people and myself.

D106 – If I do not express how I feel and think on a regular basis, it leads to anger and frustration with myself and then I feel depressed and overeat.

Theme 13: Blaming in action

D8 – I blame my husband for not taking my needs into consideration.

D13 – I blame my husband and myself for not helping me to have a healthy lifestyle since my marriage and pregnancies.

D38 – In my struggle to believe that I am acceptable, I blame the media and society for making me believe that I am unacceptable for being a fat person.

Theme 14: In relationship to stressful situations

No relevant discourses.

Theme 15: In relationship to traumatic experiences

D75 – In the context of loss of my two week old brother in my childhood I experienced that it is a taboo subject and that it does not help to cry about his death or talk about his death, we must just go on with our lives.

Theme 16: Familial themes and voices

D15 – My mother's voice with regards to others being overweight makes me feel that I am at an unacceptable weight; and therefore I am unacceptable as a person.

D41 – I use my children as an excuse to not have a healthy lifestyle.

D42 – It is important to take care of my children even though I do not allow myself to blame them for my unhealthy lifestyle.

D43 – My responsibilities as a mother causes me to lose control over my healthy lifestyle.

D44 – I am a bad mother if my children aren't with me the whole day.

D47 – My mother needed to push aside many of her dreams in early years of her marriage and therefore I am pushing many of my dreams aside at the moment.

D96 – My children are not supposed to have an issue with me as their mother being overweight, because they must be very accepting.

Theme 17: Socio-cultural power and voices

D4 – Afrikaner, Christian men are the head of the household and they can come and go as they please, while the wife is the mother and caregiver to the children.

D18 – I am judged by others in terms of how I look and this makes me unacceptable.

D20 – Other people have the perception that I cannot do my work adequately, because I don't fit into my uniform.

D25 – People in general are judgemental towards fat people.

D26 – My mother's voice that she was always right about how fat I am, is a confirmation of others' negative critique with regards to my overweight.

D34 – The Afrikaners are fat, because they love eating meat.

D46 – It is an Afrikaner tradition that the "Wife is submissive towards her husband and it is expected of the wife to be at home when her husband comes home from work and then everything must be under control in the household".

D58 – I am rebellious against the voice of society that says that I have to be thin in order to be successful.

D70 – In the era of the 1970 and 80's a person's sexuality was considered a taboo subject.

D76 – In 1970 children were allowed to be seen but not heard and family members didn't talk about painful experiences or express their emotions, but now in 1990 families communicate more and children's voices are allowed to be heard.

D77 – In the context of my father being a pastor I believed that my needs were less important than the congregation that he was serving, therefore considering others and serving others is an important Christian virtue.

D95 – Fat is unacceptable and thin is acceptable.

Theme 18: Living with an overweight identity

D16 – Accept me for whom I am, and not just for how I look, but for who I am.

D90 - I link my self-confidence to who I am and my self worth to how I look.

D94 – After my wedding I accumulated a lot of weight especially during my two pregnancies.

D99 – Since an early age I matured faster than my peers which gave the impression to others and me that I was fatter than I really was.

D100 – Others perception that I am not necessarily fat, but that certain clothing or eating a piece of cake would make me fatter in essence gave the message that I am fatter than I am.

D101 – To lose weight is a conscious process, but I will rather want it to be unconscious so that I am not reminded of the fact that I am overweight all the time.

3 - Third participant

Theme 1: In relationship to anger and frustration

D1 – Anger and blame towards my husband for not accepting me with regards to my overweight in the context of my first pregnancy and that he was not ready to be a father when I became a mother affected me to pick up 40kg.

D2 – It angers me when my husband equates thinness with beauty.

D9 – I am angry at my husband for setting certain rules of what I should or should not eat.

D15 – I believe that I must be submissive to my husband and this angers me.

D41 – I am angry when my mother says that my dress makes me look thinner and therefore I look pretty.

D58 – Clothes sometimes hide away who I am and it makes me feel that people don't see me as a person but see my clothes as beautiful. Therefore people could just as well have the clothes.

Theme 2: In relationship to fear, loneliness and rejection

D32 – My fear that my daughter will also struggle with overweight gives me the right to overly control her eating habits.

D36 – I am afraid that I will die early, because of my family's medical history of early deaths.

D67 – Family history of health risks with regards to overweight makes me fearful to keep on being overweight, but not fearful enough to take action.

D68 – I must do something about my overweight for fear of health risks.

D94 – When I overeat in secret where nobody can see me, I am afraid that I might be caught.

Theme 3: In relationship to love / hate and comfort

D10 – I believe that my husband doesn't love me as he used to, because even he thinks and says that I must watch out because I have become fat.

D11 – Nobody can love like I can love.

D44 – I believe that I am not worthy to be loved.

D80 – I overeat to comfort myself.

D89 – I reward myself with food.

D90 – Overeating calms me down for a moment.

D95 – When I keep quiet to the detriment of myself, I overeat, because it is like I punished myself and therefore I must be comforted.

Theme 4: In relationship to sadness and hurt

D34 – I feel sad and discouraged that others have not listened to my deepest feelings and thoughts in the past.

Theme 5: In relationship to guilt

D51 – After I overeat I feel guilty about going overboard.

D70 – Guilt surrounding my relationship with food in excess has a negative influence on my daughter's relationship with food.

D87 – I feel guilty after overeating and then I feel and look like a pig and then I feel negative about myself.

Theme 6: In relationship to inferiority

D3 – I am not sexually pleasing enough for my husband, because of my overweight and therefore I am not good enough as a person.

D30 – When I am the least in relationship to others, it is a privilege because I am carrying others' burdens this gives me the power of "holiness".

D45 – I sometimes think that everybody is superior to me, because I don't have any control over food or any other areas of my life.

Theme 7: In relationship to mistrust

D12 – I mistrust my husband's love for me in the context of painful experiences.

D72 – I mistrust myself to lose big amounts of weight and to get to goal weight.

Theme 8: Internalised beliefs

D4 – I withhold sexual intercourse from my husband, because I am not as bad as those bad girls on TV.

D5 – I believe that sex should be seen by men as a holy and a beautiful thing between a husband and a wife and not as something filthy and disgusting.

D7 – I believe that women are supposed to eat less than men and men have the right to judge women if they eat the same amount or just as much as them.

D16 – I think that my husband thinks that I only look pretty when I lose weight and when I am thin.

D17 – I think my husband does not think that I can lose the weight, whereas, in fact I also don't believe I can.

D19 – Although I know that losing weight to be healthy is important, I rather want to lose weight so that my husband will accept me more and find me more attractive.

D21 – I will not lose weight for my husband because he expects me to.

D22 – I believe that my husband could easily find a nicer and prettier woman and therefore I threaten him and myself to lose weight just so that I can take revenge on him for not accepting me just as I am.

D23 – I believe that during pregnancy it is allowed for women to eat for two, to gain a lot of weight, because after the baby's birth you will lose the weight again.

D25 – Others need to accept me for my inner being more and not judge me according to my physical appearance.

D26 – I think that men treat women like sexual objects.

D27 – I think that if I am round and fat everything is going happy and well in my life.

D38 – All thin people are judgemental towards fat people.

D40 – Sometimes I feel that others judge me according to which clothes I wear and how I look, rather than seeing me as a beautiful person. Others judge beauty according to my attire and not for who I am.

D42 – In the context of my life before my marriage I did not ever think that I would become fat, because I never had a problem with my weight.

D47 – My inner being is more important than my physical appearance.

D50 – I am the type of person who loves to eat good food.

D57 – I cannot live without nice food.

D65 – If I want to lose weight I need to draw the line somewhere.

D74 – I always have tomorrow to start to lose weight.

D75 – Please God, if I can't be thin, please make my friends fat.

D76 – I know that I will never be thin but please don't let me be the only fat person.

D77 – I stop myself from losing weight, because I am not ready for it now.

D91 – After overeating the feeling better about me is more important to me than the guilt.

Theme 9: Body perceptions

D20 – Sometimes I feel disgusted with regards to my body image and I feel even more disgusted in myself when I consider how disgusting my husband perceives me and my body

D43 – I tell myself sometimes that I am ugly and nobody will love me, because I am fat.

D48 – If I am not thin I am not beautiful.

D49 – The experience of overweight is a day to day struggle, one day I have a good and the other day I have a bad body image.

Theme 10: Voices of control

D31 – I am in control when I am the peacekeeper, because others depend on me so that they won't fall apart.

D33 – Significant others must support me in my weight-loss endeavour, because I can't do it by myself.

D46 - Food is my boss.

D56 – To have a strong will power will give me more control over my unhealthy eating habits.

D71 – I am waiting for something to happen to trigger me to start to lose weight and this makes me wonder whether I must or must not do it.

D78 – Something external must happen for me to have the motivation to lose weight.

D79 – My experience of up and down feelings allows me to not take control of my eating habits.

D84 – When I am over stressed at work and home I feel powerless to make my own decisions about healthy food choices and rather often overeat.

Theme 11: Overeating in action

D8 – When my husband's voice demands that I must eat less than him, I eat anyway, because I think "who are you, I will eat anyway."

D53 – I often feel that I stand alone with all my problems and this gives me a reason to overeat.

D82 – I overeat in times where my husband and I experience difficulties in our sexual relationship.

D85 – When I feel pressurised by the restrictions diets place on me, I break away and overeat.

D88 – I overeat away my problems.

D92 – After overeating negative self-talk triggers me into overeating again.

D93 – The type of food in terms of its taste triggers my overeating.

Theme 12: Communication in action

D6 – I think that I cannot communicate my sexual needs and sexual experiences that give me pleasure, because women are seen by men as sex objects.

D13 – Communicating with my husband is like a scale that goes up the one way and down the other way, therefore I wonder if it is worth even to try communicating with him.

D14 – I withdraw and submit to my husband thereby keeping the peace in conflict situations.

D18 – I am someone that wants to hear my husband say that he believes I can lose weight, but I experience that he doesn't believe I can.

D29 – I believe it is better to be the least when there is conflict.

Theme 13: Blaming in action

D54 – I overeat and blame myself, because nobody listens to what I need or see me for who I am.

Theme 14: In relationship to stressful situations

D52 – In the context of stress I sit in front of the TV and overeat so that I will feel better about myself.

D81 – When I am under a lot of stress and feel I have a lot of problems I tend to overeat to try to instantly feel better about myself.

D83 – I overeat when I am stressed out by my children's misbehaviour and I want to escape it and comfort myself with food.

Theme 15: In relationship to traumatic experiences

No relevant discourses.

Theme 16: Familial themes and voices

D28 – We have a family routine to eat in front of the TV so that we could escape from our daily stress and life.

D35 – I believe my mother-in-law when she says that we both need to lose weight before our husbands get other wives.

D55 – I am the peacemaker in our family where I am always the one that places others needs above my own.

D61 – Health risks in my family of origin include; high blood pressure, cholesterol and heart attacks.

Theme 17: Socio-cultural power and voices

D24 – Other's think that thin people have control over their lifestyle and eating habits, which makes them more acceptable and successful in the workplace.

D37 – Thin people think that overweight people must be ashamed of themselves and are not supposed to talk about their experiences with regards to their relationship with food in excess, because they are fat.

D39 – I experience group pressure from other overweight women to be fat with them, "so that we won't be alone".

D86 – When women become pregnant they should eat for two.

D96 – At social gatherings I want the freedom to eat fatty and unhealthy foods and not to restrict myself with unhealthy foods and thereby feel punished.

D97 – People say that we always eat with our eyes so if the food table looks pretty and full of unhealthy food, we tend to overeat.

Theme 18: Living with an overweight identity

D59 – Impatience during weight-loss discourages me so that I give up easily in trying to lose weight.

D60 – Overweight with the accompanying health risks is part of my family of origin's history with diets, overeating and exercise patterns.

D62 – Diets and diet pills promise to give you better control over your eating habits.

D63 – I do not diet, because life is too short to live everyday according to rules and regulations with regards to food restriction.

D64 – Only after I gained 40 kg I started worrying about my weight.

D66 – My overweight is not so unacceptable in comparison to other people's overweight and therefore I just have to lose a few kilograms to feel better about myself.

D69 – My genetic make up excuses me to stay overweight.

D73 – I believe I am a happy overweight person and this stops me from losing weight.

4 - Fourth participant

Theme 1: In relationship to anger and frustration

D4 – I am angry towards others with regards to their unrealistic judgements toward me just because I am fat.

D14 – Thin people anger me when they make a big deal about a few extra kilograms in the light of my overweight in extreme.

D20 – I am angry that society does not acknowledge the fact that even though I am overweight, I am more acceptable than other people that have abnormal eating habits. Thus, binging is the better of the two.

D25 – I am angry with society's attention upon me because of my physical visibility, therefore I want to divert their attention away from me.

D59 – The all or nothing thinking with regards to diets makes me angry.

D65 – I am angry to be labelled as a person with a fuller figure thus implying that I am in the fat category.

Theme 2: In relationship to fear, loneliness and rejection

D71 – I am often jealous when another overweight person loses a lot of weight, therefore "leaving me behind", leaving me with a feeling of being alone and a feeling of anger towards them in the questions "how could you leave me alone, what is wrong with me?"

Theme 3: In relationship to love / hate and comfort

D31 – My need to be acknowledged as a good enough daughter for my mother in the role of the caregiver in my family of origin, gave me full licence to nurture myself with food.

D35 – I please others and take care of them so that they will acknowledge me as a good enough person.

D72 – I love food.

D73 – Food is one of my greatest friends.

D74 – Food has so many nuances.

D75 – Food has so many possibilities.

D76 – Food helps me to entertain and to share and to take care of others.

D77 – Food helps me to do something special for someone else.

D78 – I use food in my life and in my relationships because I love food and food is pretty and nice.

D79 – Food is very special to me, it is really like a gift from the Lord that I enjoy very much.

D80 – Food can be compared to perfume which I also love.

D82 – I comfort myself with food.

D94 – In the context of my high work-ethics, I allow myself to nurture and comfort myself with food.

D95 – In the context of the social discourse that all girls must partake in ballet, I did not fit the physical requirements therefore I started nurturing myself with food.

D96 – In the context of growing up in the midst of financial difficulty, I started pitying myself and therefore nurtured myself with food.

D98 – Today I still carry the burden of the pain of my whole family of origin, I still take care of this family and food takes care of me.

D101 – One of the biggest reasons I overeat is "I overeat for my mother". Therefore I console myself when my mother does not console me or take care of me.

Theme 4: In relationship to sadness and hurt

No relevant discourses.

Theme 5: In relationship to guilt

D1 – Shame and embarrassment affect me in not communicating with my husband about my experience of my overweight body in relation to him, because "I wanted to be dignified at all times".

D2 – I choose not to wear revealing clothing because I am ashamed of what my husband might think of me in the presence of others when I do so.

Theme 6: In relationship to inferiority

D33 – Other people's needs are more important than my own.

D45 – There was a time that I felt that I was nothing, whereas I now feel that I am nearly pretty.

Theme 7: In relationship to mistrust

No relevant discourses.

Theme 8: Internalised beliefs

D3 – I prefer not to have sexual intercourse with my husband, because I am fat, which makes it more difficult.

D7 – Although I am rebellious toward the thinking "proper women" in the "proper" sense of the word are supposed to not show or experience their bodies as sensual and attractive, I buy into it.

D9 – I deem myself more privileged than others with regards to me having a high self-image regardless of my attitude to my body image.

D12 – Clothing for thin people is always of a better quality and prettier than for fat people.

D13 – Beautiful people I define primarily as being beautiful within their personality, therefore being comfortable with you and this makes people O.K.

D15 – I don't understand why I need to lose weight if other people like me just the way I am.

D16 – Others must accept me for who I am and not for how I look.

D17 – Fat people are judged more on their looks than thin people.

D18 – Fat people are judged with negative rather than positive attributes.

D19 – I demand that society sees me for who I am and not for how I look, but on the other hand I am showing society that I do not respect my own body by being overweight.

D21 – I am happy that I don't have a closet-problem like others thus overweight is an acceptable way of dealing with emotional problems and is not as bad a disorder, in fact everybody does it so therefore I do it.

D22 – A person can rather be unhealthy by overeating than being unhealthy in striving for thinness.

D23 – I am automatically disrespected with regards to my overweight body, because people see the fat first before they see me.

D26 – By being physically visible to others I am saner than thin people who have skeletons in their closets.

D30 – Overweight people don't have respect for their bodies.

D34 – I must work myself to death to please everyone.

D38 – I continue to buy bigger dress sizes and accept them because I am dignified and have self-respect and will look professional and pretty in bigger sized dresses, because my dignity is more important than to implement a healthy lifestyle.

D39 – My dignity with regards to accepting bigger dress sizes is more important than honesty about my actual overweight.

D42 – My maturity and wisdom with regards to my age is more important to me than my physical appearance.

D43 – I give myself permission to put some weight on each year, because the older a woman is, being fat is more socially acceptable.

D46 – It is better to be a plain and uncomplicated person rather than a highly sophisticated, sexually attractive person.

D49 – I value being a dreamer and passive more than being active and more physically attractive.

D51 – The image of my whole self is that I am a fresh fruit within.

D54 – I am not fat and friendly because I have more depth than just friendliness to share with others.

D55 – Weighing myself on a scale isn't good for me, because this triggers me to try and achieve the perfect body weight.

D61 – Diets are a death sentence.

D62 – In my head I feel that there is a lot of time still to work on my unhealthy eating habits, before cholesterol will be detrimental to my health.

D67 – Passive activities are not only relaxing but also a way for me to be slower and to live slower, therefore it is more important than physical activity.

D70 – Round and bulging fat is not healthy.

D86 – The all or nothing discourse with regards to eating restrictions becomes a punishment either way.

D87 – Restrictions with regards to dieting causes an individual to have an unrealistic, unhealthy, and unnatural relationship with food.

D89 – The all or nothing discourse with regards to overeating is all inclusive therefore restricting your health, your lust for life, your quality of life, because I am not healthy.

D91 – There is not enough incentive for me to have a healthy lifestyle, even though I suffer from cholesterol, because the price to pay in terms of delicious food is too high.

D104 – Overeating is a behavioural pattern, which can be altered into a healthier behavioural pattern, but I unfortunately have a nose and a tongue for food for smelling and eating.

D106 – I am dependant on food just like an alcoholic is dependant on alcohol.

Theme 9: Body perceptions

D5 – "My self-image is more important than my body image" and therefore I have the right to cover my body with big dress sizes.

D40 – I want to hide my overweight body because it is not pretty for me.

D41 – I do not face my overweight body image because regardless of what the media and society expect of me in terms of how I must look, I accept my inner self but I still reject my overweight body image.

D50 – On a self-image level I associate myself more with a kiwi-fruit or a strawberry but on a body-image level I associate myself more with a creampuff.

D64 – The perfect, unscarred physical appearance defines whether you are regarded as beautiful or not, therefore overweight people are not beautiful.

D69 – I experience a more negative image of myself when I am fat.

Theme 10: Voices of control

No relevant discourses.

Theme 11: Overeating in action

D53 – It is in my personality make-up to leave an idea/venture/task if I cannot do it perfectly, therefore if I am not 5000% committed to a healthy diet, I just let go of it and then start binging.

D63 – In the light of my belief that there is still a lot of time for me to work on my unhealthy eating habits, I do not start losing weight and keep on overeating.

D83 – I don't like diet-food therefore I overeat.

D84 – I overeat in times of my anger-reaction to restrictions on my food intake.

D85 – As soon as I overeat once during a period of dieting, it triggers me into a cycle of overeating because I give in to the notion that I trespassed the staunch restrictions.

D88 – The all or nothing discourse with regards to dieting triggers binge eating, as if you unconsciously prepare yourself for it to happen.

D90 – If I do not follow a specific diet to the letter, it triggers me to leave the diet and overeat, therefore definitely being a winning recipe for failure.

D92 – Passivity triggers overeating.

D97 – I use overeating as an escape for day to day stresses, "it is as if I escaped into a fantasy world whenever everything got too much", and therefore I have been eating secretively since my childhood.

D100 – When self-pity visits me I overeat.

D102 – When I am especially angry with my mother, it is my normal pattern to overeat.

D103 – Frustration and anxiety tricks me into overeating.

Theme 12: Communication in action

D24 – Talking about my overweight body makes others uncomfortable because it's supposed to be a taboo subject.

D32 – I often felt misunderstood and unheard by my parents and others.

D36 – I demand that others must sort things out through talking and if this does not happen, I am angry and therefore overeat.

D52 – I demand to be heard that there is a thin person within me waiting to come out.

Theme 13: Blaming in action

D99 – Taking care of my family of origin angers me and gives me the right to blame them and after that myself, which triggers binge eating, after which the eating cycle continues with no time limit.

Theme 14: In relationship to stressful situations

D93 – I use a quick fix by overeating in times of tiredness and stress, thereby experiencing a short-lived energy spurt.

Theme 15: In relationship to traumatic experiences

No relevant discourses.

Theme 16: Familial themes and voices

D6 – My mother taught me to dress properly and dignified at all times even though I stop myself experiencing my body in a physical sense.

D27 – My mother modelled overeating behaviour as a comfort in times of stress and work pressure.

D28 – I have decided to nurture myself with food just like my mother nurtured herself with food and this is O.K.

D56 – My mother and I often dieted together while I was growing up, where there were definite times when we restricted ourselves from certain foods.

D57 – I have learnt to have love for food from my mom.

Theme 17: Socio-cultural power and voices

D8 – I think that society thinks that “If you are fat, you are not supposed to wear revealing clothing”.

D10 – Media portrays a “thin is beautiful” message and this influences overweight people to dissociate with or have negative feelings about their body image.

D11 – Society rejects fat people with regards to providing ugly, bigger sized clothing.

D37 – Other’s think that thin people are successful, therefore fat people are failures.

D60 – All female teenagers through all centuries can tell stories about diets and their unhealthy effects on you as an individual and others around you, where you lose a little bit of weight in a week’s time and then the following week you binge again.

Theme 18: Living with an overweight identity

D29 – In the context of my overweight body and bodily cells becoming ill, I recognise the fact that other overweight friends are becoming sick just like me, if we continue overeating.

D44 – Since childhood I have been less intent on caring for my physical appearance than other children.

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D47 – Since my childhood physical activity has been unfamiliar to me and therefore unwanted.

D48 – Since my childhood I have become set in my unhealthy eating and exercise patterns, therefore I will always be fat.

D58 – My high cholesterol problem does not trigger me to eat healthier because diets do not guarantee a healthy lifestyle.

D66 – Since childhood I have preferred to be passive with regards to physical activities, I will rather read or sit and think about things which are less active in nature than exercise.

D68 – Since childhood I experienced that my overweight stood in the way of boys liking me and this made me feel as if I was nothing therefore I did not take care of my physical appearance.

D81 – Restricting my food-intake during certain periods of my life was terrible because I just wanted to overeat afterwards.

5 - Fifth participant

Theme 1: In relationship to anger and frustration

D2 – It angers me when my husband doesn't consider me, my feelings, thoughts and needs.

D3 – It angers me when my husband doesn't listen to my feelings and thoughts and in so doing he does not understand me.

D17 – In the context of my younger brother being an alcoholic it angers me when I allow him to sit passively and misuse me with regards to financial support.

D18 – It angers me when others don't reciprocate my never-ending love and devotion to them, therefore believing that they can't do it as well as I can.

D27 – It angers me when I allow myself to waste my energy on guilt feelings.

D37 – In the context of the death of my mother "just forget and accept that your loved one has passed away and move on" angers me so that I want to escape the painful experience by overeating.

Theme 2: In relationship to fear, loneliness and rejection

D36 – I fear to be alone in the context of the loss of my mother, because who will worry about me, who will love me?

D40 – In the context of me being left behind as the youngest in my family of origin after my mother passed away, I feel alone and I feel less privileged than my brothers and sisters.

D43 – It is difficult to separate myself being and doing like my mother since my mother past away, because this will make me feel lonely.

Theme 3: In relationship to love / hate and comfort

D6 – When I prepare the same food my mother did in the same way, I am comforting myself and others by recalling her presence and touch with food at family gatherings when my mother was still alive.

D7 – Preparing food like my mother did, makes me feel that something of her person has stayed behind with me as if I am still reaching out to be touched and comforted by her.

D20 – I hate it when others are dishonest with me about how I look.

D21 – I hate it when my brother has unrealistic expectations of me without him knowing what's happening in my life. This makes me feel that what I'm doing is not good enough and that I am not good enough.

D31 – I was not comforted by my family after losing my mother because nothing can comfort you after such a loss.

D58 – Since my childhood I have been comforted with food by others.

D71 – An entrepreneurial lifestyle forces me to have to do something, to have to perform and I think this has an influence on me comforting myself with food.

D79 – Food as my comforter tells the lie of "just one more piece of bread, don't worry it won't make you fat. Just keep on eating; you can't actually make a difference to your physical size".

Theme 4: In relationship to sadness and hurt

D42 – I am sad because I never shared my emotions with my mother and she did not teach me how to handle my emotions.

Theme 5: In relationship to guilt

D9 – I feel guilty that I was not a good enough daughter for my mother. I therefore feel it is my right to reprimand others when they don't treat their parents in a correct way.

D26 – I feel guilty when I consider myself, my children and husband's needs less important than others.

D59 – I think that my mother felt very guilty because I was her last born and the only one left at home and she felt that she owed me something, therefore I was very spoilt, mostly with food. Now I feel guilty eating too much.

D67 – Guilt feelings about considering others more important than me and my family leads to me being emotional without knowing why I am emotional and then I overeat.

Theme 6: In relationship to inferiority

D1 – When I feel taken for granted by my husband, I tend to do too much for other people, while neglecting my husbands' needs and him expecting of me to be there exclusively for him.

D12 – Others' needs are more important than my own.

D15 – I am a very soft person and others easily take advantage of me.

D24 – It is difficult to say no to others even to the detriment of myself and my family.

D35 – I will keep my employees, even though times are financially tough, because others' financial needs are more important than my own.

Theme 7: In relationship to mistrust

No relevant discourses.

Theme 8: Internalised beliefs

D10 – Others don't understand my emotional experience with regards to the loss of my mother.

D11 – It is important to me what others think about me.

D13 – I take care of others, but nobody will look after me like I can do for them.

D14 - I help other people with all my heart without thinking what the consequences will be.

D16 – I easily feel sorry for others and in so doing help them because I want to make it easier for them in life. But I think that sometimes this is the wrong thing to do because people need to help themselves to be strong, but I do it anyway.

D22 – It is important to have a soft nature even though others misuse me.

D23 – If my mother was still alive everything would have been perfect but now it is my fate to be like my mother.

D32 – I need to help other people so that I can feel better about myself.

D33 – I help people as far as I can, but if I can't help them anymore, then it is a very bad experience for me.

D34 – Just like my brother being an alcoholic and dependant on alcohol to comfort him, I am an overeater to comfort myself with food. Thus I will always be an overeater.

D39 – My mother was supposed to warn me not to overeat because it is not good for me, but she did not do that.

D44 – It is more important to help others and be there for others rather than for my family and for myself.

D45 – I could lose something if I cannot help someone fully but only to a certain point, when I am not continuously involved in their lives.

D47 – Financial security gives me a sense of self-worth.

D56 – The voice of my emotions and thoughts is more important than my physical body.

D61 – Overeating is not such a big psychological problem and need not be talked about.

D68 – It is better to overeat than to misuse alcohol because all that happens to me is that I grow fat with no detriment to others.

D75 – I think that an alcoholic and an overeater have the same reason for their "problem". Food or alcohol gives persons courage again to go on in uncertain times or during painful experiences.

Theme 9: Body perceptions

D49 – I think I am ugly, because I am fat.

D57 – I have always thought that I must close my body with clothes and that I must hide it from the world.

Theme 10: Voices of control

D30 – I feel powerless in the presence of my family of origin's tears and crying because I cannot comfort them, and more so, I don't know how to comfort myself.

D83 – I feel powerless in the face of food being my comforter.

Theme 11: Overeating in action

D63 – I overeat so that my father, mother and siblings will feel that they provided me with comfort through food.

D64 – I allow myself to overeat in reaction to the loss of my mother.

D65 – It triggers me to overeat after my siblings leave family gatherings where I feel left with pain when they say they love me and I am just like my mother.

D66 – I overeat when my siblings demand from me to prepare food like our mother used to, because I don't want to be their mother and also miss her.

D69 – I overeat to escape my painful experiences rather than to come to terms with it.

D73 – While overeating I don't think what I'm doing.

D74 – In times of overeating I think of how nice the food is, at least the food is nice, something that I can hold onto.

D76 – Overeating allows me to escape for a moment and then to go on in the midst of difficult or painful experiences.

D78 – During times of menstruation I tend to overeat more.

D80 – As soon as I am challenged to go and sit down and plan how to eat healthier, it triggers me to overeat even more.

D81 – I overeat because all the nice times that I spent with my mother were in the kitchen busy preparing food or around the table.

Theme 12: Communication in action

No relevant discourses.

Theme 13: Blaming in action

D19 – When helping others I blame them for making me feel guilty when I don't help them.

D48 – I blame myself for indulging in food and then realising that I am fat and feeling bad about myself.

Theme 14: In relationship to stressful situations

D62 – Unhealthy food is an important crutch in stressful times.

D70 – Tension and stress with regards to finances pressurises me into a corner and forces me to overeat and in so doing escaping my fear of failure in business.

D72 – Financial uncertainty makes me very emotional, especially at the end of the month, thereby leading to a two-week binge-eating spree.

D77 – Stressful times give me a reason to pick up a lot of weight.

Theme 15: In relationship to traumatic experiences

D25 – The loss of my mother was a painful experience which I tried to numb by comforting myself with food.

D46 – After the death of my mother I started to live in the shadow of my mother, meaning to strive to be like her and in the process losing myself.

Theme 16: Familial themes and voices

D4 – In the context of my mother passing away when I was thirteen years old, my family of origin wanted to lessen their guilt feelings about me losing my mother at such a young age and then tried to comfort me with food.

D5 – I try to fulfil my mother's role in my family of origin, by preparing the same food as my mother did in the same way that she did, without straying from her way of doing things when my family comes to visit.

D8 – I spoil my children and myself with food because children must be spoiled by a grandmother whose place I have taken.

D28 – I dislike family gatherings because it allows for my family of origin to reminisce about the good times when my mother and father were still alive and this leads to me being very emotional, guilty and angry for not having a mother and father anymore.

D29 – I don't like it when my brothers and sisters still cry about the death of my mother and father because it does not help me or them to come to terms with it.

D38 – When I am pregnant I can overeat and become fat and this is ok because I am a mother.

D50 – I have become like my mother and this makes me feel close to her.

D51 – I, like my mother, like to surprise people, to do something special for someone else and never for myself.

D52 – I, like my mother, always have a solution for problems, I love my husband and I work very hard and will sacrifice everything I have for others.

D53 – I, like my mother, don't take care of myself just so that everybody around me will be happy.

D54 – I, like my mother, love the Lord and will do everything for the church.

D55 – I, like my mother, make sure that my family of origin come together and experience everything as it was in the past.

Theme 17: Socio-cultural power and voices

D41 – Society believes that fat people are to be blamed because they are fat.

Theme 18: Living with an overweight identity

D60 – I started to become overweight only after the birth of my first child and I link this to me missing my mother during this time.

R - Researcher-participant

Theme 1: In relationship to anger and frustration

D3 - Anger visits me when society expects that weight-loss is the only success story for obese women in their relationship with food in excess.

Theme 2: In relationship to fear, loneliness and rejection

D5 – I overeat because of my own "fear of failure" or the "fear that I may not be good enough" as a doctoral student.

Theme 3: In relationship to love / hate and comfort

D1 – I could not hate food, because whenever times are tough or easy I tend to nurture myself with food.

D2 - Food calms me down and comforts me like when I was a new born infant drinking my bottle in my mother's arms.

D4 – I overeat because of emotional reasons, I want to comfort myself with food.

D14 - In the unveiling of my food story I realise daily the love – hate relationship I have with food, as if my emotions of "sadness", "anger", "fear of rejection" are like monsters constantly needing to be fed by food – junk food – sweets and fatty foods!!!

D27 - Overeating was a very safe place and loving place for me for many years.

Theme 4: In relationship to sadness and hurt

D9 - I am wondering about the "hurt feelings" or "emotions" involved as the cause and sometimes in my case the outcome of this "tornado" experience.

D10 - Is it the "tornado" or the hurt feelings or emotions that paralyse me? I would say that in my case it is both – like a vicious circle!

Theme 5: In relationship to guilt

D42 – When I am thin and attractive, guilt tells me that I am a wonton sex goddess and this makes me a bad, bad girl.

Theme 6: In relationship to inferiority

No relevant discourses.

Theme 7: In relationship to mistrust

D32 - My taking responsibility for my relationship with food got stuck in mistrust in myself that I would stay forever at the point of a see-saw with my weight.

Theme 8: Internalised beliefs

D11 - “How I look is more important as to who I am”.

D12 – In the context of one client’s discourse: Client agrees with others that she cannot do something and she listens to “being spiteful” when she does not prove others wrong. My discourse: I like to prove others wrong if they judge me about something.

D13 – I don’t just accept positive feedback all the time

D17 - What others think of me and their perception of my ability to lose weight were so often so important that this skewed my reasons for losing weight.

D18 – Reason for losing weight: “I’ll show my mother and father I can lose a lot of weight, just because they simply don’t believe I can do it.”

D19 - Reason for losing weight: “I’ll lose weight so that I can look good in my clothes and make other women jealous and make men desire me.”

D20 - Reason for losing weight: “I’ll lose weight so that I would look good in a certain dress for a certain occasion.”

D21 - Reason for losing weight: “I’ll lose weight for my husband, because I live in fear of him leaving me or looking at other women and I want his attention.”

D22 - Reason for losing weight: “I’ll lose weight so that I can win a competition between girl friends.”

D23 - Reason for losing weight: “I’ll lose weight so that my son won’t be shy of me at school.”

D25 - I know and have experienced in the past how easily the “all or nothing” discourse can keep me from losing weight in a healthy way and it could force me or push me to obsess about losing weight so that I lose perspective on why I started to lose weight in the first place.

D26 – Beauty is the way we share caring attitudes and things with others.

D29 - Being hard on myself and not taking time out can have the outcome of quick fixes disguised as substitutes for my “overeating being the comforter” like “going on a spending spree for new clothes” or “eating out and making wrong food choices and then punishing myself with strict diets and an overload of digestive pills”.

D30 – I relate the quick fix as the answer to my pain or anger, but translate it to myself as “I am feeling better about myself, because “I look good in these clothes” or “when I punish myself with dietary foods, I may have nice food now and then”.

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D31 - During the past 18 to 20 years quick fixes for my pain and hurt and anger have been just as detrimental as the "overeating of food". As a matter of fact I think the quick fixes were part of the trap to sort of excuse my "overeating habits" as permissible and good for me.

D34 - Working with my discourse of "proving others wrong if they say I cannot do something". The first thing that comes to my mind is that this discourse is somehow linked to the need I have to be recognised by others and even to be complimented by other people as "I am a good person" and that "I deserve to be treated as someone that can do things and are good at tasks". I am thinking of the discourse "I must always be the role model in all situations".

D39 - The "poor, poorer and poorest me", "ag shame, look how terrible everything and everyone is to me" and "I am the victim and everyone must know that I am the victim and this makes me holier than others"; are all discourses when I look at my relationship with "self-pity".

D44 - I will be better than boys or men at being holy.

Theme 9: Body perceptions

No relevant discourses.

Theme 10: Voices of control

No relevant discourses.

Theme 11: Overeating in action

D8 - I can identify with the experience of the "tornado" where "binge eating" has paralysed me to a stand still, where I could just space out and not take responsibility for what I am feeling.

D15 - I overeat sometimes so that I can protect myself from others' negative onslaughts and this makes me more holy than others, because I do not act out my anger towards them but towards my own body. This leads to a point where "overeating" numbs me in such a way that I choose to not let myself be heard. Therefore rather than blaming others, I start listening to self-pity and then I need comfort by overeating…

Theme 12: Communication in action

D7 – There is a right time to talk about women's relationships with food.

D33 - One thing that stood out from my whole reflective story was that I had a deep need, even as a 16 year old to express my relationship with my body. This is after the incident where I sat on my father's lap at 14 years of age and then the mind – body split happened and eating food in excess became my protection against unwanted attention from my father, other men and from myself. My main purpose in life started to be "to protect my holiness" and this resulted in my body becoming mute for nearly 18 years now.

D41 - "I am going to eat myself to the death, because you do not listen to me".

Theme 13: Blaming in action

D24 – I blame others and myself for my overweight and excessive eating habits.

D38 - The "unwanted attention from men" is part of my blaming game towards the male gender for declaring as a male dominated society to me at the age of twelve that males are better or more superior to females. I then decided that I could start blaming men for looking at my body as being desirable. In my mind this made men "unholy" and I was allowed to overeat to keep myself being the "holy one", thus the superior gender.

D40 - I have allowed "self-pity" to put me down as the victim in relationship with my husband and this has lead to me blaming others and in so doing taking over the persecutor role.

Theme 14: In relationship to stressful situations

D6 - I ate more and had a few binge eating sessions during the time I compiled my D-proposal, which allows me to make the link that binge eating is a form of comfort in times of stress. Naming the discourse that "binge eating is a form of comfort in times of stress" revealed to me how I allowed myself to emotionally overeat.

Theme 15: In relationship to traumatic experiences

No relevant discourses.

Theme 16: Familial themes and voices

D16 - "Sexuality" has been a "taboo subject" from way back in my larger family circle. In an era in which my grandparents and parents grew up, "sexuality" was a "taboo subject" to many people they associated with.

D28 – Like one of my clients, I also "eat for my mother".

D35 - I learnt from my mother's voice that I must always be good and "proving" to her always that I will be a good little girl and sister towards my brother even if I do not want to do this with all my heart, because of hurt feelings towards my brother. So I justified this self-abuse by overeating and pacifying my anger and comforting my hurt feelings.

D36 - My discourse – "not just accepting positive feedback all the time" is a voice of my father (my ever optimistic and positive and trusting father) that sometimes was cheated by other people and felt hurt and disappointed, but then quoted how positive and optimistic he is as to his saying "Always look at the bright side of life!"

D37 – For many years I believed that "my family cannot live with out me". I must rescue them and comfort them.

Theme 17: Socio-cultural power and voices

D43 - I was told by society that men were better at everything and I hated it with a passion.

Theme 18: Living with an overweight identity

No relevant discourses.

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Alternative stories (A) according to themes

1 - First participant

Theme 1: In relationship to self-worth, self-love and love from others

A10 – When I turn self-hate into self-love I feel nurtured.

A11 – Self-love and acceptance helps me to explore alternative ways of comforting myself.

A14 – When other people compliment my handy work, I feel better about myself and I feel worthwhile.

A22 – A horse from my childhood was a great comfort to me and he made me feel safe.

A36 – I am very proud of myself.

A50 – It means a lot to me that my child, dolls, friend, horse and sometimes my husband love me.

A60 – I have learnt that I have a deep need to be loved by myself and others, but that it starts with self-love.

Theme 2: Learning experience and externalised decision

A33 – My good judgement tells me that the tornado is a really big problem and I am busy thinking about different possibilities in dealing with this tornado rather than just sitting and worrying about it.

A37 – I have decided to think twice before I act impulsively and to be calm in relationship to my husband and the tornado.

A41 – Talking about painful experiences can be like an open wound.

A42 – If I look after myself on different levels everything will fall into place.

A43 – I am learning that I have a perception of other people's perception of me, so I can choose to believe differently than negatively about myself.

A46 – I have learnt that I have a relationship with the tornado and that I can overcome it.

A48 – I have learnt that my childhood friend, a horse meant a lot to me and he helped through my painful experiences by comforting me. This means that I was not alone.

A52 – I hope that after these conversations that our family and I will have hope and happiness.

A55 – It is not important anymore to try and please others the whole time, thus my opinion is important.

A57 – I think I have become more mature and have taken responsibility for my actions.

A59 – I have learnt that I still have a fear for my husband's drinking problem.

Theme 3: Constructive communication in action

A12 – After talking about my overeating process, I feel more in control, because when I feel the need to overeat I find something else (creative arts) to do.

A15 – I protect myself from negative feedback by not telling other people that I have done a specific creative product, thus I feel safe.

A16 – I am used to being praised for my creative abilities.

A19 – Talking about my feelings and thoughts helps me to stand up against the tornado.

A21 – Talking about my creative abilities rekindles my passion to create.

A39 – It is good to talk to or about my inner child and to be reconciled to her.

A40 – To talk about painful experiences can be healing.

A44 – These conversations have helped me to be more patient in my relationship with my husband, we also communicate more.

A45 – If I think twice about what to say or not to say to my husband, we communicate better and understand each other more.

A51 – By talking about my relationship with the tornado I could find myself again.

A53 – These conversations have helped me to allow my voice and opinions to be heard.

A54 – These conversations have helped me to stop running away from my problems and not to hide away anymore, but to face myself and others.

A58 – It has been helpful to talk about my painful experiences, although I was afraid to do so in the beginning.

Theme 4: Participating in creative arts and handiwork

A1 – When I am creative in painting and needlework it helps me to deal with the tornado experience and it makes me feel that if I am productive I can cope.

A2 – When I am creative I don't experience the chaos caused by the tornado.

A3 – Creative arts helps me to calm down and be peaceful.

A4 – Working with my hands gives me a sense of joy.

A5 – Creative arts have helped me through painful experiences since my childhood.

A6 – Talking about the helpfulness of creative arts in being more in control of my life makes the tornado smaller.

A7 – Creative arts help me to be more in control of my eating habits.

A9 – It makes me feel better about myself if I can busy myself with creative things and thereby express myself.

A13 – To do something physically with my hands helps to stop the tornado.

A17 – Creative expression through needlework and painting is a safe, nurturing, relaxing and special place where I can express my thoughts and feelings.

A18 – My creative expression results in me feeling as if I can take on the world and I feel that I can accomplish many things.

A47 – I can allow myself to be like a child sometimes in the context of creative arts and in relationships where I have fun more often.

A49 – Creative arts has been an emotional outlet for me during my painful experiences as a child.

Theme 5: Taking initiative in business

A20 – I have plans to market my art works and to start my own business because I believe in my handiwork.

A23 – Running my own business gives me a feeling of being in control.

A24 – In business I dislike being dependant on others.

A25 – In business, do unto others as you would have them do unto you.

A26 – Aesthetic value is important in business.

A27 – It is important to take care of yourself and others in business.

A28 – To persevere in business is sometimes the only option.

A29 – Having faith in God is a nessasary asset with regards to success in business.

A30 – It is important to treat people with respect in business.

A31 – It is important to keep employees happy in business, and then I will receive happiness or good will comes back from the employees.

A32 – Loyalty and good judgement are very important in business.

A38 – In business I am strong and I am not allowed to be weak and I just have to cope there is no other alternative.

Theme 6: Personal abilities in action

Not applicable.

Theme 7: Story before marriage when I was fit and thin

Not applicable.

Theme 8: Participating in alternative ways of taking care of myself

Not applicable.

Theme 9: Prospective healthy lifestyle

A8 – If I am in control of my eating habits, it means that I am coping better with stress.

A34 – I am now pregnant with my second child and have the desire unlike my first pregnancy to eat healthy and look after myself.

A56 – I feel some freedom from my struggles with food and I believe that I have the choice in what I eat and when I eat it and in which context.

A61 – I want to have a healthy lifestyle, not only for my benefit but also for my children. This is my reason for losing weight in the long run.

Theme 10: Prospect of taking care of physical appearance

A35 – I am now motivated to take care of myself and to look pretty and to make new clothes, because I want to take care of my physical appearance.

2 - Second participant

Theme 1: In relationship to self-worth, self-love and love from others

A12 – The belief in myself that I am worthy allows me to prove to others that I can live a healthy lifestyle.

A22 – Self-forgiveness and self-acceptance help me to stop blaming others and myself for being fat or overeating.

Theme 2: Learning experience and externalised decision

A1 – Believing in the definition of hope is helpful and gives me hope and openness to others and myself.

A9 – The switch to take control of my life in a healthy way happens when I have an overload of others perceptions that I am fat and then I want to prove them wrong.

A14 – In the context of previous therapeutic conversations before this study I learnt that it is important to not be stuck in the past but to focus on the future by living daily in the here and the now, thus opening new ways of thinking about the importance of taking responsibility for my own health.

A15 – I am remembering how important it is to set goals for myself and to work on my goals, because I cannot change the past for it is the past.

A17 – Perseverance helps me to sort out difficult problems and intellectual and emotional stumbling blocks.

A18 – The belief in myself since childhood that I can accomplish tasks if only I persevere and put my mind to it, gives me courage and hope.

A19 – The belief that crying as a form of expressing your emotions makes you more human and approachable to others.

A26 – As an adult and a mother I have a better understanding and mercy for my mother's pain.

A29 – Being self-aware of my thoughts and feelings and actions with regards to my relationship with food in excess allows me to make meaning from my experiences, thereby getting to know myself better and feeling more in control.

A30 – I am learning that I want to hear myself more often so that I can get perspective with regards to my relationship with food in excess.

A32 – I am learning that to have courage to change my lifestyle to a healthy one means to put the courage into practise by taking responsibility for my exercise and eating habits.

A33 – I am learning that the media and society's opinions with regards to people who are overweight will always be there, but I have the choice to allow it to influence me or not.

A34 – I am learning that there are more stories to describe myself and my experiences than only with regards to my fat story.

Theme 3: Constructive communication in action

A16 – Some of my goals are to start communicating my health needs with my husband again and to join a gym and to actually go.

A20 – I have the courage to talk to my family of origin about past taboo subjects, thus courage is a friend of mine.

A21 – I have initiative to share with my family of origin my experiences of our taboo subjects to the benefit of more intimate relationships amongst family members.

A24 – In the context of my work environment I decide to stand up for myself and to express my opinion.

A25 – In a safe place I can express my emotions of anger.

A28 – I have talked about my relationship with food in excess and this made me grow as a person.

A31 – I am learning that talking about painful experiences with others and my family of origin can be healing not only for myself but also for them, therefore lessening my need to overeat as a safe place to emotionally express myself.

Theme 4: Participating in creative arts and handiwork

Not applicable.

Theme 5: Taking initiative in business

Not applicable.

Theme 6: Personal abilities in action

A3 – My stubbornness made me want to show other people that I can accomplish becoming fit and in so doing feel better about myself.

A4 – I have perseverance when I decide to become fit.

A8 – I have the ability to think creatively and in a different way than usual, thus I am a good problem solver.

A23 – Being more self assertive is helpful in discerning that overeating is not such a safe place.

Theme 7: Story before marriage when I was fit and thin

A6 – Being fit resulted in me feeling better about myself, feeling proud of myself, having a feeling of accomplishment and feeling better physically and spiritually.

A10 – Just before my marriage where I was fit and thin is the context for the following characteristics I know about myself, namely: Perseverance, spitefulness, stubbornness, love for life, belief that I can do it, belief in myself. These characteristics could help me to start again with a healthy lifestyle, because I cannot expect my husband to change. I want to take the responsibility for my own health.

A11 – The main reason why I decided to take control of my life through exercise and eating healthy was the realisation that I can do it and will do it and that it will be good for my health.

A13 – In the context of me leaving home as a young adult I started to take responsibility for my own health and wellbeing, because I developed the need to prove to myself that I can do it by myself thereby rekindling my characteristic of perseverance in finishing a task that I have started in the first place.

A35 - I felt good about myself when I was thin.

Theme 8: Participating in alternative ways of taking care of myself

Not applicable.

Theme 9: Prospective healthy lifestyle

A2 – I feel better about myself when I am physically fit, exercise and eat healthy food.

A5 – Fitness relieves hunger pains and fills an emotional void.

A27 – It is more important to change my eating habits into a healthy lifestyle rather than to just focus on losing my extra weight

Theme 10: Prospect of taking care of physical appearance

A7 – When my physical appearance improved I felt that I showed people the real me, thus being thin and fit makes me want to show myself more often to others.

3 - Third participant

Theme 1: In relationship to self-worth, self-love and love from others

A3 – Self-worth and self-acceptance help me to change my perception of other people's negative perception of me being fat and ugly.

A6 – It is my responsibility to listen to myself and to accept myself.

A9 – I take more time to spend with my husband and children and this helps me to feel more loved and accepted.

A11 – Self-acceptance and others' acceptance of me enables me to feel better about myself and this makes me feel pretty.

A18 - Self-acceptance helps me to deal with negative comments in a more constructive manner, because the comments don't bother me so much anymore.

A21 – My relationship with God has given me a better understanding of His fruit of the Spirit such as; patience, love, self-control, self-confidence; and this helps me to accept and love myself more.

A23 – My relationship with God is of great value in the fact that I believe I love and accept myself in looks and personality.

A25 – My experience of God's grace, mercy and love has made me more thankful for who I am just like I am in the moment.

A36 – Self-acceptance allows me to experience other's acceptance of me on a more regular basis.

A37 – Self-acceptance helps me to accept others just as they are.

A41 – I have the right to allow my voice to be heard because I am worth being listened to with regards to my experiences of my relationship with food in excess.

A42 – When I have self-confidence, self-respect, self-love then I do not worry about what others think about me anymore.

Theme 2: Learning experience and externalised decision

A4 – My changed perception that I am beautiful even though I am fat makes me more approachable to others.

A15 – I don't need anything from other people to make myself feel better about myself, even though I am overweight I can be pretty.

A19 - I have decided that my happiness does not depend on others, only on myself, and this will be my motto in life.

A20 – I don't allow other people's negative opinions of me to oppress me, because I want to be a winner!

A38 – It is more important to lose weight for myself and my health rather than for my husband or my children.

A39 – My happiness and health are the greatest reasons for me to lose weight.

A40 – I am going to make use of spiritual support from God, emotional support from friends and family to lose weight and live a healthy lifestyle, not only for myself, but also for my family.

A45 – I have decided that people must take me or leave me just as I am even if they accept it or not, I am who I am.

A47 – The "I want to lose weight" is a more peaceful way to prepare myself to lose the weight and I am more willing to do it.

A48 – I am deciding to lose weight and therefore I will do it on my own time, but I will do it without punishing myself.

A49 – I am learning that there is a flipside to the comforting function overeating has in the long run, because the bad pattern brings sadness and fat.

A50 – I am learning that all the perceptions I have of others' negative perceptions of me are all in my mind and therefore I can change my perception at any given moment.

A51 – I am learning that to be healthy is one of the main reasons to lose weight.

A52 – I am learning that my inner strength comes directly from my spiritual relationship with God.

A53 – I am learning that emotional support from others is helpful in me realising my accomplishment in self-acceptance in my relationship with food in excess.

A54 – I am learning that even though I am married and have children, I am responsible to take care of myself.

A58 – I am learning that when I change my motive from must to want to lose weight, I am more in control and I am choosing then to lose the weight.

A59 – I am learning that I am not totally where I want to be with regards to my weight, I would like to lose some weight but I have made peace with myself.

Theme 3: Constructive communication in action

A1 – In the context of previous therapeutic relationship with the researcher-therapist I have learnt how to love myself, to accept myself, to accept and forgive people that I love, to talk to significant others about my problems; thereby giving expression to my emotions.

A2 – My decision in the context of the previous therapeutic relationship with the researcher-therapist was to take control of my feelings of depression and to stand up against the feelings of powerlessness and to open myself up again just to be me in a unique way.

A8 – Open communication between my husband and I concerning sex and emotions is helpful to strengthen our intimacy.

A10 – I feel prettier as a woman when I communicate my feelings and thoughts with my husband.

A12 – My husband and I standing together in our discipline towards our children is helpful for me to feel a better mother and motivates me to look after my physical appearance better and to take care of my health. This has a positive effect on my children as well.

A16 – To think and hear that I have lost weight makes me feel good about myself.

A24 - My communication with people and God whom I trust about my relationship with food in excess is helpful.

A30 – I have decided to communicate my needs even if it means to not keep the peace so that they could carry the burdens with me.

A31 – It is important that we sit around the table and eat our dinner together as a family and use the time to communicate about our day.

A44 – Others' positive remarks about how I look also gives me inner strength.

A55 – Talking about my experiences of my relationship with food in excess opens up space for other overweight people to disclose their experiences, therefore resulting in the feeling of belonging somewhere.

A56 – When I allow my voice to be heard surrounding my experiences with my relationship with food in excess, it brings hope to others with similar experiences but that have not yet let their voices be heard on this matter.

A57 – It is important to continue to talk about my experiences of my relationship with food in excess, so that I will reach a healthy lifestyle.

Theme 4: Participating in creative arts and handiwork

Not applicable.

Theme 5: Taking initiative in business

Not applicable.

Theme 6: Personal abilities in action

A5 – Believing in myself helps me to be self-confident and visa versa.

A7 – Inner strength helps me to listen and nurture my emotional needs without using food as a comfort.

A13 – Inner strength comprises happiness, love, patience and new perspectives on life.

A14 – Inner strength gives me a new perspective like even though I am fat I am still a beautiful person.

A22 – My faith in God helps me to understand that although I have contributed to having an overweight body, God is my creator, I am His child and He accepts me for who I am, therefore I do not have the right to not accept myself and neither do others.

A43 – My inner strength helps me to allow my voice to be heard, because I am a person in my own right.

Theme 7: Story before marriage when I was fit and thin

Not applicable.

Theme 8: Participating in alternative ways of taking care of myself

Not applicable.

Theme 9: Prospective healthy lifestyle

A17 – I don’t want to be round and fat, because it does not make me happy to be overweight and unhealthy and I want to be healthy therefore I want to lose weight.

A26 – I could gain health, feel better about myself, fit into my clothes and have more lust for life; from losing weight

A27 – I could lose my bad habits such as the habit of overeating all day, being unfit; from losing weight.

A28 – I could gain a sense of self control and it helps me to be a better and healthier person, from losing weight.

A29 – When I set the goal to eat healthy on a daily basis I feel powerful and in control of my eating habits and this result in to me saying, "Yes, I can if I want to."

A32 – It is important to eat less and healthy. Healthy eating means to cut out sugar, and to eat more vegetables.

A33 – Knowledge about health risks with regards to overweight helps me to realise that overweight could be very dangerous and therefore I am going for a full medical check-up.

A34 – I am responsible for myself and my family to set a pattern in our household of a healthy lifestyle.

A35 – I am taking responsibility to break the unhealthy habits chain in my family by taking care of what, how much and when my family and I eat certain foods and to replace very unhealthy foods with healthier but nice alternatives.

A39 – My happiness and health are the greatest reasons for me to lose weight.

A46 – I choose to eat healthy and not to punish myself with must lose weight by changing my thoughts to I want to lose weight.

Theme 10: Prospect of taking care of physical appearance

Not applicable.

4 - Fourth participant

Theme 1: In relationship to self-worth, self-love and love from others

A6 – Self-acceptance of myself and body image helps me to take responsibility for a healthy lifestyle.

A14 – I accept myself when I am professionally dressed and take care of my physical appearance, even though I am overweight.

Theme 2: Learning experience and externalised decision

A1 – To have a healthy lifestyle is the crux of combating overweight.

A2 – A few years ago I made a calculated decision that I will never ever pay someone again to help me to become thin, because quick-fixes and other solutions are not the answer to a healthy lifestyle, because the answer to a healthy lifestyle is within me.

A3 – Since a few years ago I do not settle for the all or nothing discourse rather the all and nothing. The all implies the overeating and/or to stick to your diet no matter what. The nothing implies to never diet again and/or to decide to never follow a diet again. Thinking in this way, where I decided that I am just going to accept myself, has not worked because since the decision I have

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picked up even more weight. To change my overweight condition to a more healthy weight, I need to make a lifestyle change; therefore something that really works for me on all sides is to take responsibility for my healthy eating habits as good as possible. On the nothing side is to be free of restrictions of society-driven diets.

A4 – Others' unhealthy relationships with food gives me a wake-up call with regards to how necessary it is to take responsibility for a definitive lifestyle change to health and well-being.

A7 – I don't need to lose weight because by dressing myself professionally I like how I look.

A12 – I have the knowledge and the responsibility to take charge of my unhealthy eating patterns because I will then be less depressed and more relaxed and have quality of life.

A16 – I equate fat to being unhealthy, therefore a total health image is more important than physical beauty.

A17 – In the context of believing that I have freedom of choice in anything I think, feel or do, I feel happier if I choose a healthy lifestyle.

A24 – I have decided to take responsibility for my weight problem and not to make my mother the scapegoat, because I recognise the fact that my mother has control over her eating habits, therefore the buck stops here.

A25 – I have the choice to eat or not to eat healthy foods.

A26 – I have decided to go to a dietician and to be committed to lose weight for health reasons and for health reasons only.

A29 – Limited options in larger dress sizes brings the reality to me that I need to lose weight, but more so, overweight is unhealthy and I don't want to be unhealthy and this is the right time to lose weight.

A30 – I am very motivated to lose weight after hearing and experiencing various success stories with regards to overweight people's great weight-loss.

A31 – My definition of success in terms of weight-loss is as follows:" A good day for me is when I didn't overeat to satisfy my emotions, when I use more fat free products to combat high cholesterol or have a moderate fat intake".

A32 – I have decided to not have any rules for myself anymore because it doesn't work for me. So the only rule for me is "low fat – healthy – low fat – healthy".

A35 – My fear of dying caused by my unhealthy lifestyle motivates me to strive for quality of life and a healthy lifestyle, because my family is important to me.

A36 – I am learning that my anger towards media and society with regards to their prejudices about "fat" people is a good excuse for me not to take responsibility in cultivating a healthy lifestyle. Not taking the responsibility makes me realise that I don't have respect for my own body and I inflict

pain upon my body by overeating, when I ignore my high cholesterol, eat until I can't anymore and to be obese.

A37 – I am learning that the term self-respect, not only pertains to my self-image but also to having respect for my body.

A38 – I am learning in the context of being in contact with my body, that my body's overweight is too heavy to carry, therefore I want to lose weight to lighten my body's burden.

A39 – I am learning that I do not need to nurture my mother and myself with food because I am responsible only for myself, my own happiness and health.

A40 – I am learning in the context of my self-portrait, that I am a fat and thin person. Thus there is a thin woman inside of me that struggles to come out.

A41 – I am learning that the crux of maintaining my unhealthy lifestyle is the feeling I have had for a long time that this is life and I cannot stop living just because I am so fat, therefore I think I tried to live with the right clothes, activities or whatever and then to pretend that my overweight never bothered me. Now I know I just used this as a cover up.

Theme 3: Constructive communication in action

A8 – I have the ability to create a verbal space for women to allow their voices to be heard with regards to their experiences with their relationship with food in excess.

A20 – I have the ability to hear my own and others' blaming games, which helps me to take responsibility for not nurturing myself with food but rather to talk about it, to reach alternative solutions.

Theme 4: Participating in creative arts and handiwork

Not applicable.

Theme 5: Taking initiative in business

Not applicable.

Theme 6: Personal abilities in action

A9 – Self-assertiveness helps me to say that I have the right to say to society-driven diets and the media:" Don't exploit my fat!"

A19 – I have the ability to use sense of humour and problem-solving skills with regard to my relationship with food in excess.

A21 – I have the ability to recognise the bottom line concerning my relationship with food in excess "the buck stops here".

A22 – When I take an emotional distance from my dysfunctional patterns with regards to my relationship with food in excess within my relationship with my mother, I am more in control of a healthy lifestyle.

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Theme 7: Story before marriage when I was fit and thin

Not applicable.

Theme 8: Participating in alternative ways of taking care of myself

A23 – I have the ability to plan my time spent on nurturing myself with healthier ways than food.

A27 – I am keeping a reflexive journal with regards to my own thoughts and feelings surrounding my relationship with food in excess.

A28 – I am dealing with my emotions to help myself to get a grip on my unhealthy eating patterns, because I realise that some of the things that I am angry about towards my mother, will never change. This is a peacemaking process for me to try to accept the things I cannot change.

A33 – Everyday I plan my time, food intake and exercise, step by step, morning to morning. That's what I commit myself for. In general I commit for low fat.

Theme 9: Prospective healthy lifestyle

A5 – Being in contact with my body's voice with regards to cholesterol and overweight having detrimental effects help me to take responsibility to have a healthy lifestyle.

A10 – I vote for the value of exercise and find it enjoyable.

A11 – Physical exercise is helpful to prevent medical illness and enriches the quality of my life and therefore doing exercise is an important element to have a healthy lifestyle.

A13 – I am striving to have a healthier relationship with food by nurturing myself with healthy food, because I love the richness and variety of food. When all else is said and done I want to come back to what I said to you in the first place: "I am passionate about food, man!"

A18 – I am accountable and responsible in practising my choice of how much food I consume and how much exercise I do.

A34 – Being in contact with my body's voice that I am unhealthy and sometimes in pain, is my friend more than my enemy and one of the greatest reasons why I am choosing a healthy lifestyle, because I don't want to die soon.

Theme 10: Prospect of taking care of physical appearance

A15 – An alternative meaning for my experience of overweight is that I am beautiful; I just have to go to extra trouble to beautify myself.

5 - Fifth participant

Theme 1: In relationship to self-worth, self-love and love from others

A25 – I have decided to accept myself.

A29 – I am comforting my body by physically holding my body in times of stress.

A41 – Experiencing my mother's comforting message in a therapeutic context brings healing and comfort to me.

Theme 2: Learning experience and externalised decision

A4 – It doesn't help blaming affirmative action for my financial stress, but it is my responsibility to have an entrepreneurial lifestyle.

A6 – I acknowledge the fact that God helps me in determining financial success, thus leaving me feeling more in control of my eating habits.

A7 – My mother's voice "too much of a good thing isn't good anymore" allows me to re-evaluate my eating habits and to commit to a healthy lifestyle.

A8 – Making my mother part of my life again helps me to take my thoughts away from overeating all the time and this works for me.

A10 – Rekindling memories of my mother has made me realise that I do not need food anymore to make me feel close to my mother again.

A11 – I have decided not to pity myself anymore but to focus on the good things and characteristics that I have.

A12 – I have decided that I have worked through the loss of my mother and I can handle it better emotionally by incorporating my mother in my life again.

A13 – I am exploring new ways of thinking about who I am and what I want to be, because I have considered too many people's feelings as more important than my own, therefore keeping quiet and not allowing my voice to be heard.

A17 – I have made peace with the fact that my mother wasn't there in times where I really wanted her to be there because I believe that she would have been there if she could.

A18 – For the first time in many years I feel that I have discovered myself as an individual again, separate from my mother.

A20 – I am exploring who I am and I know that I would like to be just who I am and not like others want me to be.

A23 – I want to be involved with other people's lives and if I can help other people I would like to do that but not to the detriment of myself.

A24 – I make more time now to spend with my family and myself, thus family and personal time is very important.

A35 – I am experiencing myself in a new way, by being more in touch with my body, emotions and thoughts than before.

A36 – The loss of my mother has taught me that life is precious and must not be taken for granted.

A37 – I am learning that when I help others to the detriment of myself, both parties are disadvantaged.

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A38 – I am learning to have authority when I say no to someone without losing my softness as a woman.

A39 – I am learning how to set boundaries with regards to what I am prepared to do for others or not.

A40 – I am learning that my mother is always with me and that I am important and good enough for her just like I am. This helps me to lessen my pain and my bad eating habits when I have periods of missing her tremendously.

A43 – I am learning that it is not necessary for me to be like my mother anymore and there are some good things about my mother that I still want to cherish.

A44 – I am learning that it has a positive influence on my relationship with my family when I set boundaries in helping others.

A46 – I am learning that I also have a physical body and that I need to incorporate my body into my thoughts and emotions.

A47 – When I acknowledge the fact that my body is also important to acknowledge in having a voice, I experience my body to be thankful and to be more a part of me.

Theme 3: Constructive communication in action

A1 – Saying no and setting boundaries to others is helpful when they want to take me for granted and misuse me.

A2 – I am listening to myself, children and husband regarding how to set boundaries to ensure that my families and my own needs are met.

A5 – Praying to God has helped me to eat less during times of financial insecurity.

A26 – Positive self-talk helps me to be in control of my eating habits.

A31 – I have decided to allow my body to speak to me more often and I would like to hear what she has to say.

A42 – I can actually handle anything in life when I share the good and the bad experiences with someone I can trust; and if I think about it I can see things differently and learn from my experiences.

Theme 4: Participating in creative arts and handiwork

Not applicable.

Theme 5: Taking initiative in business

Not applicable.

Theme 6: Personal abilities in action

A3 – My faith in God helps me to realise that it is not good to overeat.

A16 – I remember a time before my mother passed away where I was self-confident because I knew I wanted to do things in a certain way and I wouldn't allow anyone to change my mind. Whereas I think my mother would be more influenced because she had less self-confidence.

A19 – I have taken my uniqueness as a special quality I have.

A21 – I know that I am a people's person; I mean I can adapt to other people and talk to anyone.

A22 – I know that I am a caring and sharing person and this is how I want to be rather than snobbish and not caring.

A30 – Self-awareness allows me to be more in touch with my body.

A32 – Being a go-getter and having love for myself, helps me to overeat less.

Theme 7: Story before marriage when I was fit and thin

Not applicable.

Theme 8: Participating in alternative ways of taking care of myself

A9 – I have started to look for alternative ways to comfort myself emotionally with regards to the loss of my mother, for instance, to walk in the garden or to look at her photo or just to ask myself the question "why is it necessary to put something in my mouth if I am not really hungry?"

A27 – I am stopping myself to be a steam-roller, to just decide I cannot go further, I have to stand still and take time for myself in deciding what to do next, therefore taking care of my emotions and thoughts, rather than overeating to feel better about myself.

A33 – I am allowing myself to have more resting times in shorter periods of time.

A34 – Taking care of myself firstly, gives me more room than before to take care of my family and others.

A45 – I am allowed to not feel good, to feel sick, to be tired and to acknowledge it to others and then to take care of myself.

Theme 9: Prospective healthy lifestyle

A14 – I am more self-confident and more in control of my eating habits because I now know what I want out of life.

A15 – I decide what healthy food choices to make by weighing the advantages and disadvantages.

Theme 10: Prospect of taking care of physical appearance

A28 – I am taking care of my body and plan a healthy lifestyle more often on a daily basis to feel better about myself and my body.

R - Researcher-participant

Theme 1: In relationship to self-worth, self-love and love from others

A2 - My desire is to find comfort not in food but in my belief or knowledge that I am good enough and worthy, just because I am who I am and it does not matter what others say, I can only learn from this experience.

A44 - I am becoming my own mother and comforter as I want to take responsibility to fulfil my own needs.

A50 - My decision is to be healthy by accepting that I am a beautiful woman inside and out – body, mind and soul. Self acceptance is my friend and ally against "unwanted male attention" and "strive to be seen as equal to the male gender". I know and accept the fact that I am unique in certain ways. I celebrate my womanhood! In knowledge of my physical beauty and attractiveness I decide to be me.

Theme 2: Learning experience and externalised decision

A1 – Interpersonal sharing relieves my lonely struggle to find what food means to me.

A3 - I am thinking of what my mother used to say when she was drenched in cancer – "No matter what happens to you in your life, it is how you handle it that makes the difference"!!! I have decided to make this learning my own.

A5 - I also realised that I do have a choice in times of stress to overeat or not to overeat.

A7 - My choice is thus to use externalisation of my problems and to go for many walks in times of stress, more often.

A9 - I have come to the realisation that "who I am" is in part portrayed by "how I look" or how I present my body and my body's adornments or defects to others. "Who I am" could be much more than "how I look" and it could also be less than "how I look". "How I look" could be seen from other people and my own point of view. Each one of us could have a different opinion on "how I look".

A10 - The choice I have is in the reaction to and creation of "how I look" translated partly into "who I am". I am now wondering about how to integrate the two concepts in my own perception of what I choose to be and to become.

A11 - As a child of nine years and older I started to question my father's "always" trusting and positive attitude. I have decided that "I am not going to accept positive feedback from myself or others all the time."

A12 - I want to know my fears and conquer them, I am taking full responsibility for my past hurts and I want to break free from my own blaming game that causes me to recycle my relationship with food in excess.

A14 - The way I am starting to see it now, is my sexuality is an integral part of my being healthy or unhealthy in my body, mind and soul. "My sexuality" is such a great gift to me being a woman and being human.

A16 - I discovered two years ago the main reason for me to lose my overweight and to maintain a healthy weight for the rest of my life. This reason is; or the need or the desire is: "I want (freedom of choice) to lose weight so that I can be healthier in mind, body and soul. My health is my choice and my responsibility to myself and my children. This is my legacy…"

A17 - One thing I have noticed about the freedom of choice is that it is an act of my will to carry out my decision about something. I think that if I connect or link my will to lose weight to my reason for being healthy, it could have a long lasting effect.

A18 - Unwanted male attention could become unwanted attention towards myself, specifically towards my image of a thin body. The unwanted attention towards myself allows "guilt" like "I am a bad girl" and "I need to become holier than men" to push me to excessive eating habits. The learning is to be aware of this.

A21 - Something I learned since my 21st birthday is that life or society sets people up to compare themselves to others and themselves on different levels and roles they have. I have discovered that I am unique, even though some people are better or worse at some things than me.

A24 - I have re-learned the power of "giving yourself permission to think about yourself or to nurture yourself" by listening clearly to this client's story about possible solutions for a more balanced lifestyle in mind, body, soul and emotions.

A27 – I have realised that making healthy choices in my life means that "the buck does stop here".

A28 - I am responsible for the amount and type of food I take in daily.

A30 – I take with me a sense of and the knowledge of "the buck stops here", thus I am responsible for my own unhealthy or healthy lifestyle now and in the future.

A31 - I have re-learned that my body needs to voice her opinion in relation to my mind, emotions and soul, thus my body has a voice.

A32 - I have re-learned about my sense of hope in the experience that even though my mother has past away, she is with me every step of the way and that I am a person in my own right.

A34 – It is important to grow into a healthier person in my relationship with food.

A35 - I would like to see my own growth and others growth to a healthier body and mind.

A40 - I realise that it is my responsibility to help my body to fulfil its rightful place in my personality make-up.

A41 - I am experiencing a blooming friendship and reconciliation between my body, my mind and my soul. And I feel more whole than ever before.

A43 – I have learnt that my family have outgrown my rescuing act and this makes me feel a sense of loss, but at the same time a sense of release and relief.

A47 - I have a great sense of hope in the knowledge that I am not alone in this world. I did have a "good enough mother", but most of all I was a "good enough daughter" during the thirty years I had the privilege to know her while she was still alive. My mother taught me so many good things. She did try her best to make me happy. I am re-learning and have learnt the importance of scouting out my own talents and to believe in myself that I can do it.

A48 - I would like to know what it means to have a healthy body and I would like to explore more ways as how to look after myself emotionally in the long run of my life's journey. I want substance in body, mind and soul in maintenance and growth.

A49 – In relation to the threat "I am going to eat myself to the death, because you do not listen to me"; eating myself to the death is not an option anymore.

A51 - Consuming food is important for us as people/human beings to stay alive, thus to survive.

Theme 3: Constructive communication in action

A4 - I can turn a negative experience into a positive experience by giving voice to my belief that I did my best and I am good enough academic wise "no matter what the learned panel" says and most of all "no matter what fear of rejection shouts and tantrums about".

A13 - The period of change to be more open about my "sexuality" was from 1987 to 1993, where I developed from a young teenager into a young adult. Since 1995, being married to my husband and experiencing sexual intercourse, I have realised the importance of talking about "sexuality".

A15 - My choice is to talk about "sexuality" in my family and in safe places. As a therapist I have seen and heard myself express themes about "sexuality" to clients and colleagues. I am happy about this, because it helps me to celebrate my "sexuality" as being part of my womanhood.

A25 - I am aware of the healing factor of the possibility of staying in my room to deal with my sadness or anger or stress and to specifically give myself permission to take time out just for me. I also am familiar with the fact that this possibility to listen to myself is hard and difficult, because of the whisperings of fear sometimes that I am lazy or I am not supposed to be sick or feeling tired, that I am supposed to be superwoman and supposed to expect others to have super powers too; thus being very hard on myself for being good to myself.

A33 – By describing and understanding my discourses more clearly I hope to enrich myself as a person in my relationship with food in excess in the context of being holistically healthier.

A37 - Talking about my relationship with my body opens up so many different avenues or areas in my life and especially it's relation to my relationship with food in excess.

A38 - In the process of my studies I have allowed myself to allow my body to have a similar voice to my mind and to my emotions.

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A39 - If I choose to allow my body's voice to be heard in a significant time, space and relationship; it allows the whole me to have intimacy in physical pleasure, joy and sorrow or praise and worship.

Theme 4: Participating in creative arts and handiwork

Not applicable.

Theme 5: Taking initiative in business

Not applicable.

Theme 6: Personal abilities in action

A42 - I have a sense of "courage", "taking of responsibility" and "standing up for myself"!

A45 - I realise now that "self-pity" and her gifts are not my friend, because she wants me to be like her, always doubting others and myself to such an extent that I will shrivel up and die eventually. My decision is to say goodbye to "self-pity" and hello to new friends who really appreciate me and want to be honest and truthful with me about my "bad" feelings…friends that would look out for me in times of trouble, so that I would be healthy. Self-awareness could be one of my new friends.

A46 - I am learning that my choice is to be more open about my relationship with "self-pity" and to not allow "self-pity" to intrude upon my relationship with "honesty towards myself and others" about my relationship with food in excess.

Theme 7: Story before marriage when I was fit and thin

Not applicable.

Theme 8: Participating in alternative ways of taking care of myself

A6 - It is a challenge for me to figure out in which other ways I could combat stress and comfort myself at the same time. Something familiar to me is to go for a walk or for several walks when I feel stressed or upset. Walking helps me to feel more relaxed and to release my pent-up energy. After walking my mind is clearer and I feel better and I can focus on what is important.

A26 - I am searching for more sustainable "nurturing places" for myself and have found that time out with myself in thinking in my room for a whole day or two, writing, drawing or taking a prayer retreat away from home have been difficult places, but very helpful and liberating.

Theme 9: Prospective healthy lifestyle

A19 - So I have decided to lose 52kg "as good as I can with responsibility", thus to follow my weight management program 80% and above.

A20 - I decided that I have a choice to be healthy or not to be healthy and that my so-called diet can only become a healthy lifestyle pattern of eating, if I "free myself from society-driven diets", where Weigh- less expects from me to go to their group meeting once each week. I don't like the group meetings and decided that I will not go to the group meetings, but to weigh in each week is non-negotiable. I decided that the strict weighing of food will only be for one month and for new foods

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that are unknown to me, so that I can learn how to lead a normal and balanced life and have a good eating pattern. I want to enjoy healthy food in a new way.

A22 – I have decided that my relationship with food translated as “I eat for my mother” will not ring true anymore. Thus “I eat to be healthy and have quality of life”.

A23 - My “tornado” experience or binge eating has become small, so very small and I thank the clients for helping me in describing my own story about my “tornado” experiences with food.

A29 - I like what Covey says about balance:” Balance is not either/or, but it is **and**.” This brings me back to my client’s and my discourse surrounding “all or nothing”. I am realising daily now that my taking of responsibility for my healthy lifestyle will be a lifetime process and that the choice to live healthy is up to me and it is a daily decision. My overall reason to lose weight and then to maintain my goal weight can only be to be healthy and hopefully this is a sustainable reason.

A36 - I acknowledge that I have a more whole or/and healthier outlook and experience of my body space.

Theme 10: Prospect of taking care of physical appearance

Not applicable.