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CHAPTER I

INTRODUCTION

General Introduction and orientation

The impact of socio-economical factors on the society and the patient suffering from morbid obesity is mediocre if compared to the emotional impact that obese patients have to endure. Stigmatisation, obesity bias and discrimination can even start during childhood and continue through adolescence into adulthood. Psychological, physical and social prejudices within the contemporary society may contribute to the prevalence of eating disorders, mood and various body image disturbances amongst obese people (Myers & Rosen, 1999; Puhl & Brownell, 2001 & Buchwald, 2005).

Several studies have documented the social and economic impact associated with obesity and its increasing prevalence (James, Leach & Shayeghi, 2001; Buchwald, 2005). A cross-sectional study amongst normal and obese city workers by Bungum, Satterwhite, Jackson, & Morrow (2003) concluded that obesity, according to the Body Mass Index (BMI) measurement, predicts higher annual healthcare costs and absence from work. This study implies that obesity not only has health implications for the obese person, but also has a major impact on the economy (financial) and the work sector of a community.

With the ongoing increase in the number of people suffering from obesity, bariatric surgery has gained major attention and popularity. Bariatric surgery, also referred to as Weight Loss Surgery (WLS), does not cure morbid obesity, but provides patients with a means to keep their weight under control, if used correctly. According to a “2004 Consensus Conference Statement” prepared by a panel of broadly based and experienced experts on the state of bariatric surgery for morbid obesity (American Society for Bariatric Surgery), an independent report by Buchwald (2005) concluded that bariatric surgery is the most effective therapy available

for people suffering from morbid obesity. The recent conclusive findings by Buchwald were also indicated by much earlier research done by Brolin (1996). Buchwald further commented that markedly lower body weight reverses or ameliorates the myriad of obesity co-morbidities, therefore improving quality of life expectancies of morbid obese patients.

Maintenance of the positive effects of bariatric surgery, in general, requires that bariatric patients be emotionally prepared pre-surgically, while post-surgical aftercare should be paramount to truly transform the patient. Transformation within this context implies a lifelong commitment to self care and healthy choices. In order for these patients to maintain healthy choices and self care, patients would need to have the motivation, resources and ability to adhere to a new "relationship" with, amongst others, food.

From the researcher's experience in a private practice, there is a tendency to label and exploit morbid obese patients. In order to help these patients to rebuild their lives after a traumatic event, it is necessary to create a "safe environment". Nurturance, support and safety are considered essential features in the abuse-focused therapeutic environment of patients exposed to prolonged childhood trauma (Briere & Scott, 2006).

The researcher also observed that the majority of these patients present with symptoms typical to the symptom constellation of Complex Posttraumatic Stress Disorder (CPTSD) or also known as Disorder of Extreme Stress not otherwise specified (DESNOS). The concept of early traumatic experiences among obese patients has been well described in recent literature (Lilliamson, Thompson, Anda, Dietz, & Felitti, 2002; Van Hanswijck de Jonge, Waller, Fiennes, Rashid, & Lacey, 2003; Stefaniak, Babinska, Trus, & Vingerhoets, 2007; Selway, 2006; Oppong, Nickels, & Sax, 2006; Noll, Zeller, Trickett, & Putnam, 2007; Mitchell & Mazzeo, 2005; Mazzeo & Espelage, 2002; Laitinen, Ek, & Sovio, 2002; Goodwin & Stein, 2004; Gunstad, Paul, Spitznagel, Cohen, Williams, Kohn, et al., 2006; Grilo, Masheb, Brody, Toth, Burke-Martindale & Rothschild, 2005; Gustafson & Sarwer, 2004; Grilo & Masheb, 2001). The researcher has to date assessed,

psychologically prepared and supported more than 400 bariatric patients for bariatric surgery. Observations by the researcher in dealing with bariatric patients also showed discrimination towards obese patients. This form of discrimination implies various types of bullying in the workplace, interpersonal relationships and even among medical professionals who treat these patients.

No research could be found within the South African context regarding the topic of bullying that specifically refers to morbid obese patients seeking bariatric surgery. The term bullying in this context is, according to the researcher, synonymous with totalitarian control and victimisation; and is considered a prerequisite for the development of Complex PTSD. It is therefore proposed that direct and/or indirect "totalitarian control" due to childhood trauma or abuse within this context, can exacerbate the Complex Trauma symptoms already present in some bariatric patients seeking surgery.

Ebert & Dyck (2004) are of the opinion that forms of totalitarian control undermine identity by causing change in four identity domains. These domains include:

- Totalitarian control that causes the victim to act and live in ways inconsistent with his/her core beliefs, assumptions and values, that can lead to discontinuity of identity as reflected in shame and guilt during and after traumatic exposure;
- Totalitarian control causes the victim to perceive others differently and diminish a person's capacity to trust and become attached to others;
- Totalitarian control causes changes to a person's view of the world and includes stereotyped negative perceptions of social order, justice and safety; and finally
- The changes caused by totalitarian control to the identity of the person, changes his/her behaviour in such a way that continuity is lost between pre-trauma and post-trauma patterns of behaviour and consequently the perception of the self.

From the researcher's observations in a private practice, most of these changes in the identity of the controlled person are prominent amongst morbid obese patients and are supported by Herman's (1992a,1992b) view of the pathologic changes in identity due to totalitarian control.

Explaining the title

The terms used in this title: **The impact of early traumatic experiences on bariatric patients: A Qualitative exploration of their “voices”** will now be briefly explained.

The “impact of early traumatic experiences” refers to the traumatic contributing factors to the development of obesity. Although the contributing factors associated with morbid obesity can be enormous, the focus will be on the recalled experiences of bariatric patients, as perceived during childhood. For the purposes of this study, “early traumatic experiences” in terms of age will refer to any child or adolescent up to the age of 18 years who is either dependent and is directly or indirectly linked to his/her parental unit. There are various forms of abuse and this study will focus on neglect, separation, emotional abuse, physical abuse, sexual abuse, witnessing alcohol or drug abuse and parental conflict/trauma during childhood and adolescence as categorised by Van der Kolk (2001). The researcher’s interpretations of patients’ early traumatic experiences will be supported by literature and his own experiences in the field of psychology.

“Bariatric surgery” is a term derived from the Greek word “baros” meaning “weight” and from there the concept “Weight Loss Surgery” (WLS), which refers to bariatric surgery, originated. For the purposes of this study, bariatric patients refer to people who underwent weight loss surgery due to obesity, in order to preserve a better quality of life. Van Hout, Van Oudheusden & Van Heck (2004) described bariatric surgery as a “forced behaviour modification”, a term appropriate for the purposes of this study.

The wide array of literature associated with obesity, bariatric surgery, the contributing factors (medical and psychological) and predictors of post surgery outcomes, pose an impossible task to be addressed by this study. The researcher therefore decided to focus on specific aspects associated with bariatric surgery. In order to focus on such aspects, the researcher had to find a way to narrow down the exploration and decided to focus on existing research among obese patients who had to endure a form/s of childhood abuse. The various classifications in the field of traumatic stress and obesity will be discussed critically in Chapter 2.

Although “voices” refer to the verbal expressions of sound, for the purposes of this study, “voices” refers to the data gathered that patients verbally expressed during the course of their engagement in this research. Ultimately this study will expose the psychological coping mechanisms that this group of bariatric patients use to cope with an early history of trauma within the context of an invasive and forced behaviour modification, such as weight loss surgery.

Descriptions of key concepts

Body Mass Index and morbid obesity

Body Mass Index (BMI) or Quetelet Index is a method used to express the relationship between height and weight at any given age, and include both genders. This form of measurement was invented between 1830 and 1850 by Adolphe Quetelet, a Belgian polymath, during the course of developing “social physics”. This formula is widely used as a universal measurement in medicine as a unit of measure (kg/m^2), and can be calculated by dividing the patient’s weight in kilograms (kg) by the square of their height in metres (m) (Birmingham & Beumont, 2004/2005).

The National Center for Health Statistics from the Centers for Disease Control (CDC) in the United States of America (USA) suggested a BMI-for-age chart in order to differentiate

between age/BMI classifications (Birmingham & Beumont, 2005). In recent years the debates on whether there should be separate cut-off points for different ages, different ethnic groups, morphology and stature due to percentage of body fat and body fat distribution across ethnic groups, therefore increasing health risks above the cut-off points of 25 kg/m² that defines overweight in the current World Health Organization (WHO) classification, is ongoing. The International Classification of adult underweight, overweight and obesity according to BMI (Table 1) reflects on the proposed additional cut-off points. The WHO: Expert Consultation Group concluded with recommendations that the current BMI “principal cutoff points” (Table 1) should be retained as the international classification of choice (World Health Organization, 2004).

Table 1: International Classification of adult underweight, overweight and obesity according to BMI

Classification	BMI(kg/m ²)	
	Principal cutoff points	Additional cutoff points
Underweight	<18.50	<18.50
Severe thinness	<16.00	<16.00
Moderate thinness	16.00 - 16.99	16.00 - 16.99
Mild thinness	17.00 - 18.49	17.00 - 18.49
Normal range	18.50 - 24.99	18.50 - 22.99
		23.00 - 24.99
Overweight	≥25.00	≥25.00
Pre-obese	25.00 - 29.99	25.00 - 27.49
		27.50 - 29.99
Obese	≥30.00	≥30.00
Obese class I	30.00 - 34.99	30.00 - 32.49
		32.50 - 34.99
Obese class II	35.00 - 39.99	35.00 - 37.49
		37.50 - 39.99
Obese class III	≥40.00	≥40.00

Source: (World Health Organization, 2004)

For the purposes of this study, the principal cutoff points, as proposed by the World Health Organization (Table 1), will be used as an indicator for the different classifications of obesity.

In this study, patients with a BMI measure of more than 35 points are considered obese and those with a BMI of more than 40 points are considered morbid obese (Class II and III, according to the WHO's classification). The reference to obesity thus refers to "Class II and III, although other researchers prefer to refer to morbid obesity (Class III) as "severe obesity". For the purposes of this study, the term obesity and morbid obesity will be used interchangeably, depending on the topic and intensity of the issues under discussion. In general, the researcher will refer to "obesity".

Bariatric surgery

Bariatric surgery refers to surgical procedures used to alter or remove parts of the stomach or small intestines. The rationale behind invasive surgical procedures like weight loss surgery (WLS) is to enable the morbid obese person to lose weight in a safe and controlled manner. The procedures fall into three major categories. The aim of these descriptions is to introduce the reader to the various categories of surgery used to enable the patient to lose weight. The various procedures used by surgeons will not be a focus of this study and the following descriptions, based on the work of Mitchell, Swan-Kremeier, & Myers, (2007), will serve as the only descriptions of the procedures used.

The first of the three categories is the *restrictive* procedures. In these operations, the surgeon creates a pouch about the size of a walnut at the top of the stomach where the food enters from the esophagus. The lower outlet of the pouch is a tiny outlet that slows the emptying of food from the pouch to the larger area of the stomach. With this very little food, it creates a prolonged sense of fullness. Adjustable gastric banding surgery is a type of restrictive procedure and is considered less invasive and one of the safest weight loss surgical approaches.

The *malabsorptive* procedure shortens the digestive tract to limit the number of calories and nutrients that can be absorbed. Biliopancreatic diversion (BPD) is a known malabsorptive procedure in which the lower portion (three fourths) of the stomach is removed and the small pouch that remains is stapled directly to the small intestines. This procedure greatly reduces nutrient absorption and caloric intake and is used less often than adjustable gastric banding and even gastric bypass (described below), due to the risks involved in nutrient deficiency, complications and mortality rates associated with this procedure.

The third category is the *combined restrictive/malabsorptive* procedure and is most commonly used. This procedure restricts the amount of food one can eat and reduces the amount of calories the body absorbs. This procedure is referred to as gastric bypass (also known as Roux-en-Y gastric bypass). A small stomach pouch that can hold only limited amounts of food is created by the surgeon. Then a Y-shaped section of the small intestine is cut and attached to the pouch to allow food to bypass to the lower stomach entirely and to the first two sections of the small intestine. This procedure results in a reduced amount of calories and nutrients absorbed by the body.

All of the above procedures can be done through laparoscopic surgery (this technique eliminates large incisions and involve small incisions made which allow the surgeon to pass a light, camera and special surgical instruments into the abdomen). The small incisions result in less loss of blood, shorter hospitalisation and faster recovery as well as fewer post-operative complications when compared to traditional/“open” surgery.

Motivation for the study

Bauchowitz, Gonder-Frederick, Olbrisch, Azarbad, Ryee, Woodson, et al. (2005) who conducted a survey of present Psychological Practices, evaluating bariatric surgery candidates,

urge that there is a need to identify psychological, behavioural, cognitive and social characteristics that are predicative of bariatric surgery outcomes. They also indicated that professionals are expected to make decisions about the suitability of bariatric candidates for surgery without the necessary empirical support. According to their survey, the impact of important variables (knowledge and expectations) about bariatric surgery is still unknown. Based on this assumption, the researcher's observations in dealing with these patients clearly indicated the need for a more defined description of the true experiences these patients have to endure.

A term coined by Judith Herman (1992a, 1992b), called Complex Posttraumatic Stress Disorder (Complex PTSD), is an example of a set of symptoms found among obese people who had to endure early traumatic experiences. Observations by the researcher in working with bariatric patients, clearly display the symptomatology of Complex PTSD as described by Herman (1992a). No specific research could be found that describe Herman's classification of symptoms among bariatric patients.

The researcher also intends to give "voice" to those suffering from obesity in order to make a meaningful transformation from the emotional ridicule and trauma these patients endure in order to achieve a better understanding of their chronic illnesses (morbid obesity). In the process of exploring the "voices" of the patients, it is suggested that better insight into the "typical" emotional world of bariatric patients will assist psychologists dealing with these patients to develop optimal strategies in the compilation of a psychological treatment regimen for bariatric patients who have a history of complicated traumatic experiences.

For the researcher, an in-depth exploration of the "voices" of bariatric patients, holds the key to the development of a "psychological support programme", truly unique to the South African context of bariatric surgery. The eventual process of developing a "psychological support programme", based on the in-depth experiences of bariatric patients, might also have added value to the lived experiences of the support systems of these patients. This study will not

attempt to design a “psychological support programme” for bariatric surgery, but considers the perceptions as reflected by this study, as an aid in future when designing such a programme.

Aim and rationale of the study

Relevance

It is suggested that the focus of research needs to be extended beyond the traditional preoccupation with the obese patient and be aimed at the lived experiences of obese patients who had to endure prolonged early childhood traumatic experiences. Analysing and describing themes according to the living experiences of these bariatric patients can primarily contribute to a better understanding of the complexity of obesity and the full impact of bariatric surgery on them. The proposed study can increase understanding and improve support to patients suffering from obesity together with their professionals in the journey of finding “a road map” to a better quality of life. Ultimately, this study will expose the lived experiences and various psychological coping mechanisms used by bariatric patients in the course of treatment pre- and post- operatively.

This study will furthermore be described according to the aim and rationale with specific reference to the patient, and the impact on the field of psychology.

The bariatric patient

To be heard and acknowledged for the suffering that obese patients have to endure, giving them a “voice” is seen as valuable in terms of validation, an emotional need which most bariatric patients are desperate for. The researcher also aims to use the information and themes that evolved from this research by giving back to other prospective candidates who need to go for bariatric surgery. A clearer view on the process of dealing with the various emotional issues associated with bariatric surgery will hopefully add value to other patients. Although the research

subjects used for this study would not reap the full benefits of the information gathered during the research process, it is believed that those candidates who might follow their example will have the benefits in terms of a better psychological treatment regimen and understanding of the psychological impact of early traumatic experiences on the bariatric patient.

The results emanating from this study might clearly serve as an indication for the identification and typology of high risk bariatric patients, and alternatives to an invasive intervention like bariatric surgery may arise from these explorations. The ability to understand the patients' lived experiences of obesity within the "early traumatic experience-context" might enable the psychologists/psychiatrists dealing with bariatric patients to make alternative suggestions to lose weight in an appropriate manner which address the desperate emotional needs that are found amongst obese patients, if they are declined for surgery.

In this study, the researcher will attempt to shed more light on the role of support systems for bariatric patients. This information could then be used to guide the support systems of the bariatric patient in dealing with the patient pre- and post-operatively in a more effective way.

The field of psychology

The researcher will attempt to add value to the field of psychology by utilising the results from this study in guiding other therapists in terms of potential pitfalls and interventions that pose to be effective or damaging in dealing with bariatric patients. To date no research about the qualitative experiences of bariatric patients within a South African context could be found. Shared information about the true experience of bariatric patients also creates opportunities for therapists to improve on these findings and assist in supporting these patients in a more understanding and knowledgeable manner.

Theoretical framework

An in-depth exploration of the theoretical underpinnings that form the basis of this research will be discussed in Chapter 2.

Research design

A detailed description of the qualitative research motives within a social constructivist approach will form the basis of the researcher's research process. Sampling and data analysis will be done according to the principles of thematic content analysis, as discussed in more detail in Chapter 3.

Focus of study

The wide array of information available on obesity, bariatric surgery and post-surgery outcomes forced the researcher to narrow down the broad field of information pertaining to the study. This was done by focusing on observed behavioural and emotional patterns among the experiences of bariatric patients. The main focus of the study is the exploration of early traumatic exposure, the development of obesity and ultimately making sense of a forced behavioural intervention like bariatric surgery.

Epistemological framework

The researcher's epistemological and theoretical approach to the study is based on social constructionist ideas. The researcher applies ideas within a social constructionist context in order to capture the full impact of early traumatising on bariatric patients.

A detailed layout of the researcher's epistemological approach to social constructivism will be discussed in Chapter 3.

A qualitative methodology is suggested for this study because of the rich emphasis placed on the meaning that people attach to their experiences. This statement is supported by Miles and Huberman's (1994) notion that qualitative data is suitable for uncovering meanings, perceptions and assumptions that people have regarding their worlds. A qualitative exploration of this nature also has the potential to give "voice" to obese people's suffering, and eventually guide professionals in dealing with bariatric patients in a more effective way.

More appropriate than positivistic research methods, qualitative research procedures and principles will broadly be used for the purposes of this study. The interconnection between qualitative research methods and social constructionist ideas will be referred to throughout this research.

Ethical considerations

Due to the vulnerability of the patients involved in the study, the researcher will be guided by the code of ethics as proposed in the layout of "Ethics relating to Social Science Research with victims of violence and other vulnerable groups" (Artz & Themba Lesizwe, 2005) as proposed within the South African context. The four basic principles that govern research include:

Respect for the individual: encompassing respect for autonomy and protection of vulnerable participants; Non-harm: minimising harm to research participants; Beneficence: maximising research benefits for research participants; and Justice: balancing the risks with the benefits.

Due to the vulnerability of these patients, the researcher will make a follow-up phone call a week after the final semi-structured interview to assure that the participants are emotionally

stable and not in emotional discomfort due to the exploration of their intimate lives during the final interview. If any participant feels that he or she was traumatised during the interview, the researcher will be available to support and contain such a patient. All the participants in this research are existing patients of the researcher and it is his therapy policy that in case of emotional crisis, patients have full access to him.

Emergent design

The initial motivation for conducting the research was to explore the research issues relevant to the process of bariatric surgery and its impact on the obese patient. The aim was to enable the researcher to have a better understanding of patients who have to endure the process of bariatric surgery. Becoming more aware of the impact of early traumatic experiences among these patients, the researcher was guided into exploring the impact of traumatic experiences as a major contributing factor in the development of morbid obesity. Therefore, the focus of the initial research shifted away from the impact of bariatric surgery, to the contributing factors and specifically the early traumatic experiences and the role of their psychological coping mechanisms in dealing with the impact of bariatric surgery, as the core focus of the research.

The contributing factors pertaining to obesity (medical and psychological), some of the predictors of outcome, various assessment techniques and methods, basic therapeutic interventions and indicators of success among bariatric patients will only briefly be discussed in Chapter 2. Although the focus will be on the traumatic issues related to obesity and the impact of bariatric surgery, it will be an incomplete reflection on the full process of bariatric surgery if other pertaining factors are excluded from the literature review. These factors will therefore be mentioned as part of a complete and exhausted literature review.

Format of the study

The proposed study is presented by means of the following chapters:

Chapter 1 focuses on the introduction and basic layout of the chapters to follow.

Chapter 2 comprises of a literature review on the broad field of childhood trauma, contextualising obesity within the context of bariatric surgery and eventually concluding with the interrelatedness of trauma, obesity and outcomes after bariatric surgery. Although aspects of the patient's body image, the perceptions of medical professionals about bariatric surgery, the role of the bariatric team and various therapeutic approaches do not form the core of the discussion, the literature review is incomplete without the supportive information pertaining to the full spectrum of the lived experiences of the bariatric patient. The chapter concludes with an examination of all the aspects under discussion.

Chapter 3 introduces the reader to the methodology and epistemological stance in the process of understanding and exploring the traumatic experiences of bariatric patients. A layout of the core concepts of Social Constructivism and the applicability of these concepts to the study are explained. The various methods used to obtain the information are also explained and qualified. A detailed description of the data collection process and procedures used to obtain the relevant information is included. As part of explaining the rationale for the proposed methods used, the chapter includes an objective evaluation of the research methods.

Chapter 4 explores the "voices" of Subject A

Chapter 5 explores the "voices" of Subject B

Chapter 6 explores the "voices" of Subject C

Chapter 7 explores the "voices" of Subject D

Chapter 8 explores the "voices" of Subject E

Chapter 9 is organised around the reconstruction of the “voices” of the subjects’ experiences and the link with obesity and bariatric surgery. The chapter is structured around the core themes identified among the “voices” of subjects A to E (Chapter 4 to 8). The “voices” of the subjects in terms of recurring themes and patterns are then linked to the relevant literature.

Chapter 10 as the concluding chapter reflects on the total study, along with possible future applications to be used in dealing with bariatric patients. Finally, the strengths and limitations from this research are discussed and recommendations for future research are made.

Abbreviations

The following list of abbreviations was used in this research:

- **BAROS** (Bariatric Analysis and Reporting Outcome System)
- **BED** (Binge Eating Disorder)
- **BMI** (Body Mass Index)
- **BN** (Bulimia Nervosa)
- **BPD** (Biliopancreatic Division)
- **BPD** (Borderline Personality Disorder)
- **CBT** (Cognitive Behavioural Therapy)
- **CPTSD** (Complex Posttraumatic Stress Disorder)
- **DESNOS** (Disorders of Extreme Stress not otherwise specified)
- **DID** (Dissociative Identity Disorder)
- **DSM** (Diagnostic and Statistical Manual)
- **GBS** (Gastric Bypass Surgery)
- **GHB** (Gamma-Hydroxybutyric acid)
- **MCMII** (Millon Clinical Multiaxial Inventory)

- **NES** (Night-eating Syndrome)
- **NPY** (Neuropeptide Y)
- **POCM** (Pro-opiomelanocortin)
- **PTSD** (Posttraumatic Stress Disorder)
- **TCI** (Temperament and Character Inventory)
- **VMH** (Ventromedial Hypothalamus)
- **WHO** (World Health Organization)
- **WLS** (Weight Loss Surgery)

Conclusion

The information contained in this chapter serves as an introduction to the exploration into the array of knowledge captured by literature. Based on the emergent design, as briefly described in this chapter, the researcher is able to elaborate and explore the basic foundations of this study, building a repertoire of experiences that may add value to patients, mental health professions and in particular assist surgeons to make a more informed decision, based on evidence, that could make bariatric surgery the ultimate safe intervention (psychologically) for bariatric patients.

CHAPTER 2

LITERATURE REVIEW

When conducting a literature review for exploratory studies, it is relevant to organise the literature according to a theme or construct, as has been pointed out by Mouton (2001). The aim of this study will not be to test a specific theory, but rather to explore different and similar classifications or typologies according to the research themes.

When exploring the “voices” of bariatric surgery patients, three basic themes of research literature are implied, namely: the mechanisms underlying the development of obesity; the effect of early traumatic childhood exposure on the obese person; and finally the experience of a forced behavioural intervention like bariatric surgery on the patient. To date, no specific research could be found that link the symptom constellation of Complex Trauma (due to early and prolonged childhood trauma) to the experiences of bariatric patients. The researcher will attempt to link and explore these three main areas of research, separately and conjoint, to build a literature repertoire of the issues under discussion.

Underlying mechanisms (factors) promoting and ameliorating the development of obesity

The following section will highlight some of the predisposing risk factors (mechanisms) and biological markers, which may be aspects of endophenotypes or merely consequences of obesity. Obesity can develop when energy intake exceeds expenditure, and for the majority of obese people this becomes a permanent condition once it develops. Gottesman & Gould (2003) defined endophenotypes as an internal phenotype discovered by technology such as biochemical tests and/or microscopic examinations, therefore filling the gap between observable behaviours and descriptors of the underlying disease process. They also state that endophenotypes may be environmental, epigenetic or multifactorial in origin. Extrinsic and intrinsic genetic vulnerabilities,

environmental and developmental factors associated with obesity as well as specific eating pathology have been implicated in various forms of eating pathology and may produce biological changes as observed among the obese.

The underlying neuro-endocrine responses to eating and genetic factors do not form the basis of this research and therefore only justifies a brief focus on the core elements associated with obesity and eventual bariatric surgery. Although Bulimia Nervosa (BN) and Binge Eating Disorder (BED) may be present in normal weight individuals, these forms of eating pathology as well as Night Eating Syndrome (NES) are more commonly observed and overlapping among severely obese patients (Treasure & Collier, 2005 and Herzog & Eddy, 2007), and will therefore interchangeably be highlighted in the following literature review.

Psychobiological influences and genetic risk factors

Levin (2005, p.633) states that “obese-prone individuals are born with a genetically raised threshold for sensing a variety of hormonal and metabolic signals which normally inhibit weight gain by acting on the network of metabolic sensing neurons which control energy homeostasis”. Therefore a constant neural, metabolic and hormonal interaction between the brain and periphery (peripheral cues of hunger and satiety are cues involving parts of the body’s physiology other than the central nervous system) underlies the defence of a given level of adiposity (Logue, 1986/1991) and (Levin, 2005). Adipose cells store fat and when these cells are “full” there is less hunger, while when they are less “full” there is more hunger. Therefore, a person whose body has stored a certain amount of fat in a particular number of adipose cells would feel hungrier than someone whose body has stored the same amount of fat in fewer adipose cells (Logue, 1986/1991). Some major peripheral factors as determinants of hunger include stomach contractions, oral stimulation, stomach distention, temperature regulation, glucostatic, lipostatic, blood amino acid levels, food-water ratio in the stomach and small intestines as well as gut hormone mechanisms.

One of the first experiments to localise the site in the brain that control satiety began in earnest around 1940 and according to Hetherington & Ranson (1940), as cited in Logue (1986/1991), this pointed to the “ventromedial hypothalamus” (VMH) as the most likely place in the brain, if lesioned, to result in obesity among rats. According to Logue, later studies indicated that the mechanisms involved that resulted in obesity among lesioned VMH rats are much more complicated and that the VMH are more sensitive to glucose, while destruction of the glucoreceptors might affect the VMH’s information about blood sugar levels, resulting in obesity. In reaction to Hetherington & Ranson’s experiment, Berthoud (2002) indicated that the control of energy intake, expenditure and storage is a very complex process and is regulated by a distributed network of central neurons.

Two of the most important mediators of energy homeostasis in the brain are neuropeptide Y (NPY) and pro-opiomelanocortin (POMC). These neurons alter their activity in response to changes in ambient glucose, fatty acid, leptin and insulin levels. Both these hormones are located in the hindbrain and hypothalamus and have been best characterised with regard to their role in the regulation of energy homeostasis. The NPY anabolic peptide is considered the most important for survival of the species since there is little need for a catabolic brake during times of energy surfeit and/or scarcity. Therefore, when food is only intermittently available, it is in the individual’s interest to be able to ingest and store calories as a possible buffer during later periods of energy deficit. A hypothetical genetic trait termed “thrifty genotype” allows the individual to maximise the ability to consume and store calories. Unfortunately this trait predisposes the individual to become obese when there is a constant excess of obtainable food with little need for energy expenditure (Neel, 1962 as cited in Levin, 2005; Levin, 1999; and Berthoud, 2002).

A study by Sorensen and Stunkard (1993) concluded that human obesity (measured by body mass index) is under genetic control, whereas the childhood family environment has little, if any, influence on obesity in adults. They found no relationship in silhouette scoring between

adoptees and adoptive parents and indicated a strong relationship between the adult adoptees and their biological mothers, and between the adoptees and their biological full siblings reared by the biological parents. A weaker, non-significant relationship was found for the biological fathers and for the maternal and paternal half-siblings. Although the role of genetic control over obesity cannot be denied, various other researchers, in contradiction to Sorensen and Stunkard's study, indicated that a range of other factors (e.g. socio-economic inequality, gender, age, ethnic differences and the impact of childhood maltreatment), apart from genetic control, can also predispose the occurrence and maintenance of obesity (Lilliamson, Thompson, Anda, Dietz, & Felitti, 2002; Van Hanswijck de Jonge, Waller, Fiennes, Rashid, & Lacey, 2003; Stefaniak, Babinska, Trus, & Vingerhoets, 2007; Selway, 2006; Oppong, Nickels, & Sax, 2006; Noll, Zeller, Trickett, & Putnam, 2007; Mitchell & Mazzeo, 2005; Mazzeo & Espelage, 2002; Laitinen, Ek, & Sovio, 2002; Goodwin & Stein, 2004; Gunstad et al., 2006; Grilo et al., 2005; Gustafson & Sarwer, 2004; Grilo & Masheb, 2001; Zhang & Wang, 2004). A genetic component is not the same as complete genetic determination and other factors like the environment also play a role in the determination of obesity. To simply know that there is a genetic component does not tell us about the mechanisms by which that genetic component exerts its effect (Atkinson, Lindzey, & Thompson, 1986/1991).

Environmental and developmental risk factors

Genetic variations and environmental exposure might be a possible mechanism that underpins the various types of eating behaviour which may have independent or interacting effects that produce changes in the brain and behaviour. Treasure and Collier (2005) hold the opinion that biological factors contribute to and interact with the various tiers of environmental input, interpersonal, society and various cultures, to offer a broad array of unhealthy eating and nutritional balances. According to them, the pathophysiology of appetite, eating, satiation and the metabolism are all disrupted among those suffering from eating disorders and those who have issues with body composition. Whether these disturbances are primary or secondary, hunger

seems to be a key drive in all living organisms. Eating as a basic primary force has, among others, an impact on basal emotional tone, producing pleasure. Therefore the regulation of emotions and eating is considered intimately connected.

Bouchard and Perusse (1993) estimated that at least 60% of human obesity occurs in those with a genetic predisposition. Epidemiological research by Ravelli, Stein, and Susser (1976) suggests that the prenatal environment can have an enormous impact on the development of obesity, particularly in those who are genetically predisposed to obesity. They further concluded that maternal nutritional deprivation during the first trimester of pregnancy or maternal obesity throughout gestation and lactation (Levin, 2000), can increase the risks of obesity in offspring. Animal studies, however, provide more direct evidence that factors within the perinatal environment can promote the development of obesity, often observed in association with altered brain development. Levin, Magnan, Migrenne, Chua, and Dunn-Meynell (2005) indicated that offspring with an obesity-prone genotype during gestation and lactation promotes the development of obesity in adult life; therefore it is considered likely that both gestation and postnatal factors contribute to obesity. Animal studies among rats after administration of insulin to dams during the third trimester produce obese offspring (Jones, Pothos, Rada, Olster, & Hoebel, 1995), as does maternal undernutrition during the first and third trimester of pregnancy (Plagemann, Rittel, Waas, Harder, & Rohde, 1999). Plagemann and co-workers also indicated that some of these manipulations can result in altered development of the hypothalamic neurotransmitter and peptide systems that are associated with the regulation of energy homeostasis. Cross-fostering obesity resistant offspring to obese dams during the postnatal period, according to a study by Reifsnyder, Churchill, and Leiter (2000), can also promote obesity.

As an ameliorating factor, postnatal studies, whereby raising pups in large litters or cross-fostering obese-prone pups by lean dams, can reduce body weight and insulin resistance in adult life (Faust, Johnson, & Hirsch, 1980). Raising pups in small litters (Reifsnyder, Churchill, &

Leiter, 2000) or artificially rearing pups on a high carbohydrate diet apart from their dams also produce adult obesity, and according to West, Diaz, and Woods (1982) can be carried over into the next generation of offspring. The perception is therefore reinforced that maternal obesity begets offspring obesity (Vadlamudi, Kalhan, & Patel, 1995). This confirms that a relatively high fat diet from weaning provided to juvenile pups can produce obesity, and as indicated by Levin, Triscari, and Sullivan (1986), this can occur even amongst obesity-resistant individuals. This also implies that manipulation carried out during the active brain developmental period can alter the development of and even cause permanent changes in the neural circuits that are involved in the process of energy homeostasis. The presence or absence of leptin and insulin (both have neurotropic properties) during development, may be important mediators of these sometimes permanent changes in body mass (Ahima, Bjorbaek, Osei, & Flier, 1999).

A study by Patterson and Levin (2004) emphasised that intervening during the period of active brain development by means of exercise (during the immediate post-weaning period) can lead to long-term reduction in adiposity and even be “permanent”, outlasting termination of exercise, even in obesity-prone individuals on high fat diets. The beneficial effects of exercise on adiposity do not persist once exercise is terminated in adults, unlike the effect of early onset exercise (Bi, Scott, Hyun, Ladenheim, & Moran, 2005). In rats (Belke & Wagner, 2005), as rewarding as exercise is on adiposity by running on wheels, for obese humans (Tremblay, Despres, & Bouchard, 1984) exercise seem less rewarding to reduce levels of adiposity due to the high levels of exercise needed to accomplish the same results. However, there are the rare obese individuals who maintain chronic weight loss by means of exercise (Klem, Wing, McGuire, & Hill, 1997). Thus, a number of environmental manipulations beginning in utero, and extending through adult life, can promote and maintain obesity, limiting ameliorating factors to a few interventions or conditions, aside from illness, surgical procedures (like bariatric surgery) or high levels of permanent stress to lower the defended body weight (Strader et al., 2005).

A population-based cross-sectional study (The Hordaland Health Study) by Bjorvatn, Sagen, Oyane, Waage, Fetveit, Pallesen, et al. (2007), indicated that Body Mass Index (BMI), cholesterol, triglycerides, systolic and diastolic blood pressure (hypertension) were associated with short sleep duration. These findings also correlate with a study (Beebe, Lewin, Zeller, McCabe, MacLeod, Daniels, et al., 2007) amongst overweight adolescents where there was a direct indication that being overweight is associated with more sleep symptoms, sleep-disordered breathing, later sleep onset, shorter sleep time as well as more disrupted sleep than the control group. According to the above findings, it is therefore concluded that excessive weight is associated with sleep problems.

The risk factors (mechanisms) which were discussed in the section above have been proven by various studies to influence the occurrence of obesity, whether it is genetic or environmental in nature.

Contextualising childhood maltreatment

In this section, the occurrence of childhood maltreatment is situated and contextualised in order to assess the symptoms and cause of eating disorders.

As pointed out by Schwartz & Cohn (1996), Herman's (1992a) view on a specific constellation of symptoms following prolonged childhood trauma and the inclusion of childhood sexual abuse or maltreatment as well as the inescapable stress as syndromes capable of resulting in Complex PTSD, dissociation, revictimisation and susceptibility to compulsive re-enactment (frequently found amongst eating disorder symptomatology), are important advancements in the field of eating disorders and early traumatic experiences. Additionally, because of Schwartz & Cohn's perceptions that sexual abuse is a form of extreme boundary violation, it is not surprising that some patients exhibit symptoms of self-injury to the body, of which eating disorders are considered one of those self-inflicting acts. Furthermore, this extreme

form of self-inflicting punishment when sexual abuse has occurred, could imply that the body and sex organs become the “enemy” of the distorted survival mechanisms the child uses to maintain the belief that adults are “safe” and therefore the “body” deserves punishment, for being “bad”. More specifically, in the case of females’ body size inferences as to men, being “feminine” and to make the body unacceptable (overweight/obese) protects the self from the incapacity to say “no”.

For some women, the internal damages due to childhood abuse cause them to feel that the body “becomes the only reason a man would approach them”, and the only way to escape being alone is by making the body more attractive; this can become an obsession (as often observed among anorexia patients), according to Schwartz & Cohn (1996). They further concluded that food, in this context, serves as a transitional object when internal schemas for safety are disrupted and parents and living objects are too scary to trust. They further commented that fasting and overeating can then be utilised by abused children to alter their mood by “numbing” the terrified child or alerting when the child is too numb to react to direct and/or indirect associations with the exposed trauma.

The relative absence of research recognising the interconnection between childhood trauma, dissociation and eating disorders is partially due to what Schwartz & Cohn (1996) called the clinician’s or researcher’s “blind spot” - to know and see. They suggest that managing reality amongst these patients should include their beliefs in personal invulnerability and a perception of the world as meaningful and comprehensible. To maintain this illusion amongst patients, the clinician sometimes needs “not to know or see”. Whether memories of childhood abuse are accurate or not, they are and will be a controversial issue in the process of understanding the true impact of childhood atrocities among the abused. Because of the child’s developmental limitations in information processing and resultant interpretation and attribution, developmental distortions have the tendency to make abuse more injurious.

It is also true that not all patients suffering from eating disorders were sexually or physically abused or neglected. Eating disorders are determined by a multitude of syndromes and factors associated with eating disorders, either directly or indirectly related. Therefore, this study will focus specifically on adults who were maltreated as children, consequently suffering from obesity within the remedial context of bariatric surgery as a forced behavioural intervention.

To fully comprehend the context of childhood maltreatment, this section will shed some light on the prevalence and impact of childhood maltreatment with the intent to introduce the reader to the proposed link between childhood maltreatment and the symptom constellation, known as “Complex Trauma”.

Prevalence and impact of childhood maltreatment

Herman, Perry, & Van der Kolk (1989) considered childhood abuse and neglect as having a profound and lifelong effect on the physical and mental health abilities of the victim. Sexual abuse is considered more destructive and more prevalent and often more prolonged than physical abuse. The combination of sexual and physical abuse can be more severe and can include symptoms like adjustment disorders; alcohol abuse; other substance abuse; personality disorders; dissociative identity disorders; anxiety disorders; psychotic disorders; and psychosexual dysfunctions according to Bryer, Nelson, Miller & Krol (1987). Symptoms like compulsive sexual behaviour; substance abuse; sadomasochistic fantasies; problems with sexual identity; low energy or chronic fatigue and loss of interest in sex are especially likely to indicate a history of sexual abuse.

Moeller, Bachman, & Moeller (1991) observed that a third of the women with a history of sexual abuse during childhood who participated in their research, reported sexual mistreatment in adulthood, compared to women with no history of childhood sexual abuse who reported sexual abuse as an adult, which represented only 1% of their research population.

Spinazzola, Blaustein, Kisiel, & Van der Kolk B.A. (2001) revealed that the developmental period during which the patient was exposed to trauma, played a more critical role in adult outcomes related to Disorder of Extreme Stress not otherwise specified (DESNOS) than specific type(s) of trauma. Luxenberg, Spinazzola, & Van der Kolk (2001) also indicated that the exposure to multiple forms of trauma and the lack of safety and competence as an adaptive function and protection during early childhood, poses a key indicator of poor prognosis as an adult survivor of early traumatisation.

The importance of the developmental period during which the maltreatment took place as to the type of trauma, guided the researcher into a less detailed discussion on the various forms of childhood trauma. This notion is supported by Caporino, Murray, & Jensen (2003), who indicated that researchers are more interested in distinguishing between different types of trauma and their subsequent short- and long-term impact on the child, not always bearing in mind that the process is complicated by frequent coexistence of many types of trauma and the potential secondary effects of trauma. They also considered the secondary effects of trauma as changes that occur in the aftermath of trauma that can include alteration of the core relationship, separation from a particular family/caretaker, changes in the socio-economic status of the family and the involvement of legal or police systems.

The child's response to traumatic events can both be internalising symptoms and externalised through behaviour at different times during post-traumatic exposure and can be circular or reciprocal. The child's behaviour and reaction to the internalised symptoms can change over time as both cognitions and reactivity change and therefore it is very difficult to assess as causal reactions to trauma or symptoms and behaviour of the traumatic exposure itself (Caporino, Murray, & Jensen, 2003).

Men and woman may react differently to exposure to trauma during childhood, and as a generalisation females develop internalising symptoms that present in a more passive form of behaviour. Men tend to externalise their emotions and turn to activity and aggression. On a physiological level, females tend to dissociate as a primary defence mechanism against the intrusive experiences of trauma while white adult men become more prone to use an active emergency response (fight-and-flight response), displaying hyper-aroused reactions to suppressed childhood emotional trauma (Perry, Pollard, Blakeley, Baker, & Vigilante, 1995). There are exceptions to the above-mentioned notion, as indicated by Hennessey, Ford, Mahoney, Ko & Siegfried (2004); young children (including males) exposed to maltreatment may dissociate as an adaptive function when they feel powerless in the presence of an offending adult. In addition, females may develop externalised behaviour in addition to the internalised symptoms they experience, evident in the high rate of drug and alcohol abuse among traumatised adult woman.

According to Schwarz & Perry (1994) and the National Institute of Mental Health (NIMH) (2001), children may have different levels of vulnerability and the more severe the traumatic exposure, the longer it lasts (duration), while the more frequent the episodes of traumatic exposure, the greater the impact will be on the child, in specific pertaining to physical abuse, sexual abuse, and neglect. Over time, the chronicity of traumatic exposure is regarded as extremely significant in terms of its impact on, among others, the child's health behaviour (Rodgers, Lang, Laffaye, Satz, Dresselhaus & Stein, 2004)

An earlier study by Wolfe, Gentile, & Wolfe (1989) indicated that in spite of high rates of internalising symptoms as reported by parents of abused children, the abused children themselves did not report elevated levels of negative affect, but instead reported a substantial degree of intrusive thoughts. Accordingly, the majority of the children did not report many feelings of stigmatisation, betrayal, guilt or negative sexualisation. However, they observed that younger children showed greater symptomatology with specific reference to sex-related abuse.

Although their research was limited to a small sample group (71 children) between the ages of 5 and 16 years, comprising of children who disclosed their abuse, the results were contradictory to the predictors that abused children perceive their worlds as “dangerous” and that these children would relate to negative affect. They concluded that the results could be explained due to the child’s beliefs that similar things happen to other children and therefore their experiences may be “comforting”. The ever increasing awareness of child abuse created by the media and society, might explain why earlier studies like these, if duplicated, could portray different results.

The child’s brain adapts to the requirements of the environment, and ongoing traumatic exposure has a subsequent effect on the development of the brain and functioning of the child, resulting in altered responses if compared to normal child development (NIMH, 2001). The child’s need for safety and survival can have an impact on his/her behavioural patterns. A state of chronic helplessness and hyperarousal can therefore result in the skew development of what Schwarz & Perry (1994) referred to as “malignant memories” due to prolonged exposure to childhood trauma, predisposing the child to re-experiencing and various other symptoms related to Posttraumatic Stress Disorder (PTSD).

According to Caporino, Murray, & Jensen (2003, p. 73), evidence points to a few generalisations regarding specific types of trauma and the child’s subsequent responses, and include the following: “Physical abuse tends to be linked most commonly to externalising behaviours, although there is increased risk for anxiety and depression as well; sexual abuse tends to be linked most commonly to internalising symptoms, although externalising behaviours may also occur, particularly with older children and adolescents; severe physical abuse during the preschool period tends to predict externalising behaviour and aggression and; severe neglect during this same period has been associated with internalising symptoms and withdrawal”.

Complex Trauma symptom constellation as a psychological representation of childhood maltreatment

The terms “Complex PTSD” (CPTSD) or “Disorder of extreme stress not otherwise specified” (DESNOS) are perhaps the best known of the non-DSM-IV post-traumatic presentations (Briere, 2004). Disturbances in perception, information processing, affect regulation, impulse control and personality development were up to this point relegated to various other co-morbidities within the trauma research context (Van der Kolk, 2001). The DESNOS construct of diagnosis is therefore merely an attempt to capture the multi-dimensional nature of the breakdown of adaptation within the Complex Trauma context. Complex Posttraumatic Stress Disorder is found among people who have been exposed to prolonged traumatic situations, especially during childhood and usually of an interpersonal nature (Herman, 1992a). As suggested by Judith Herman, children exposed to inescapable stress during childhood will be at risk for compulsivity and re-enactment of trauma by self-abuse syndromes. She also coined the term “Complex Posttraumatic Stress disorder”, referring to a symptom constellation of childhood trauma, especially during childhood. Herman (1992b) suggests that subsequent psychological difficulties are in many cases associated with Axis II disorders. The probable link between the symptom constellation of childhood trauma as a possible personality feature and borderline personality disorder is in relative opposition to the traditional DSM distinction between Axis I and Axis II disorders (Briere, 2004).

The symptom constellation for “Disorder of Extreme Stress” was used in the DSM-IV field trial (1991-1993) to address the wide array of complexities associated with Complex Trauma (Pelcovitz, Van der Kolk, Roth, Mandel, Kaplan and Resick, 1997). The following major categories included in this DSM-IV field trial were: alterations in regulation of affect and impulses; alterations in attention or consciousness; Somatisation; alterations in self-perception; alterations in perception of the perpetrator (this symptom group was eventually eliminated from the final DESNOS criterion set); alterations in relations with others and alterations in systems of meaning.

Although the categories as set out for the DSM-IV trial did not include "reliving", "avoidance", and "hyper arousal" as found under the Posttraumatic Stress Disorder (PTSD) symptom criteria, the term "Complex PTSD" was considered confusing. This confusion was re-mediated when the term DESNOS was used, because it does not refer directly to PTSD. Instead, DESNOS is considered a common co-morbid disorder of PTSD (Jongedijk, Carlier, Schreuder, & Gersons, 1996; Briere, 2004).

In a diverse clinical sample, Ford and Kidd (1998) found that the presence of DESNOS has been shown to be a negative prognostic indicator of PTSD treatment outcomes. DESNOS causes more functional impairment than PTSD and it is suggested that the focus of DESNOS treatment should be shifted to other focus areas like loss of emotional regulation, dissociation and interpersonal problems, compared to the focus (in the case of PTSD), on specific post-traumatic memories (Briere & Spinnazola, 2005; Ford, Courtois, Steele, Van Der Hart, & Nijenhuis, 2005). The World Health Organization (1992) also described the "lasting personality changes following catastrophic stress" as a diagnosis well beyond the classic PTSD criteria; this supports the notion of a more complicated constellation of symptoms experienced from past prolonged exposure to trauma as usually found amongst morbid obese patients seeking bariatric surgery.

Briere (2004) concluded his interpretation on the various terms used for PTSD and DESNOS (or CPTSD) by pointing out that chronic interpersonal violence or maltreatment effects do not reside exclusively in PTSD or Acute Stress Disorder, or even exclusively in Axis I disorders. Most of the symptoms associated with Complex PTSD can be found in Axis II, as proposed unsuccessfully for DSM-IV. In accordance with Briere's conclusion, Pelcovitz et al. (1997) reported earlier that when the prevalence of DESNOS was assessed in a PTSD sample, it was found that the various symptom constellations of DESNOS did not necessarily operate in concert with one another, but rather reflected the wide range of symptoms potentially present in any traumatised individual. Van der Kolk (2001) clearly indicated that the symptom constellation he described as Disorder of Extreme stress not otherwise specified (DESNOS), is associated with

forms of eating pathology among some of the patients with a history of exposure to early traumatic events. This notion is supported by Herman (1992b) and described as Complex PTSD. Van der Kolk and Herman refer to a similar symptom constellation, but differ in terms of the diagnostic label referring to patients with symptoms associated with a history of complicated trauma.

The traumatic stress field has adopted the term “Complex Trauma” to describe the multiple, and/or chronic, prolonged experiences and developmentally adverse traumatic events, most often of an interpersonal nature, commonly due to exposure by the care giving system, with an early life onset (e.g. physical and/or sexual abuse, emotional and/or physical neglect, war and violence).

Therefore, for the purposes of this study, the term “Complex Trauma” is suggested in order to collectively identify the wide range of symptoms potentially present in traumatised patients, which can include PTSD symptoms as well as symptoms associated with CPTSD and DESNOS.

The researcher accepts that not all traumatised patients have eating disorders, but observed while dealing with obese patients seeking surgery that a typical constellation of symptoms associated with Complex Trauma were more commonly found among bariatric patients.

Characteristics of Complex Trauma

The following section will focus on the diagnostic aspects related to the symptomatological constellation of Complex Trauma as derived from the conclusive evidence from the DSM IV-Field trial (Pelcovitz et al., 1997; Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). The final

diagnostic criteria from this Field trial as reflected by Table 2: “Diagnostic criteria for Disorder of extreme stress not otherwise specified”, will be discussed in the following section.

Table 2: Diagnostic criteria for Disorder of extreme stress not otherwise specified

DIAGNOSTIC CRITERIA FOR DISORDERS OF EXTREME STRESS (DESNOS) (A)
<p>I. Alteration in Regulation of Affect and Impulses <i>(A and 1 of B – F required):</i> A. Affect Regulation (2) B. Modulation of Anger (2) C. Self-Destructive D. Suicidal Preoccupation E. Difficulty Modulating Sexual Involvement F. Excessive Risk Taking</p>
<p>II. Alterations in Attention or Consciousness <i>(A or B required):</i> A. Amnesia B. Transient Dissociative Episodes and Depersonalisation</p>
<p>III. Alterations in Self-Perception <i>(Two of A - F required):</i> A. Ineffectiveness B. Permanent Damage C. Guilt and Responsibility D. Shame E. Nobody Can Understand F. Minimising</p>
<p>IV. Alterations in Relations With Others <i>(One of A - C required):</i> A. Inability to Trust B. Revictimisation C. Victimising Others</p>
<p>V. Somatisation <i>(Two of A - E required):</i> A. Digestive System B. Chronic Pain C. Cardiopulmonary Symptoms D. Conversion Symptoms E. Sexual Symptoms</p>
<p>VI. Alterations in Systems of Meaning <i>(A or B required):</i> A. Despair and Hopelessness B. Loss of Previously Sustaining Beliefs</p>
<p>(A) Numbers in parentheses indicate number of subscale items required for endorsement of subscale. Only one item required for endorsement of all other subscales.</p>

Source: (Luxenberg, Spinazzola, & Van der Kolk, 2001)

Affect dysregulation

Both Ford (1999) and Van der Kolk (1996) suggested that affect dysregulation may be the most prominent dysfunction that results from psychological trauma. According to the diagnostic criteria for DESSOS with specific reference to affect regulation, these patients pose difficulty in managing their emotional experiences like overreactions to minor stresses, feeling easily overwhelmed, finding it difficult to calm themselves from even neutral or mild stimuli, and sometimes having compulsive sexual reactions, self-injury, drug use or even eating disorders in an attempt to manage their emotions. These patients also have difficulty in expressing or modulating their emotions like anger and pose a risk to themselves and others due to frequent suicidal preoccupations, sexual preoccupation or heightened risk-taking behaviour and difficulty in modulating and controlling sexual impulses (Felitti, Anda, & Norderberg, 1998; Ford, 1999).

Disturbances in attention or consciousness

It is not uncommon for traumatised individuals to dissociate or separate their experiences to cope with “everyday” activities and perceived consciousness. Dissociation as a psychological defence mechanism serves as a mediator where the traumatised person loses the ability to integrate information into a coherent whole. The normal course of information processing captures experiences in a more or less coherent whole, with most parts of the information readily accessible, unlike when dissociation takes place (Luxenberg, Spinazzola, & Van der Kolk, 2001).

The inability to reconcile traumatic experiences becomes relegated to separate aspects of consciousness that do not impinge on day-to-day consciousness (e.g. experiences that are too overwhelming or traumatic) (Draijer & Langeland, 1999). Visual, emotional and somatic elements of an experience that is too overwhelming, may then be split “off” from the traumatised individual’s own personal narrative; these elements are typically perceptual or sensory, rather than linguistic in nature (Van der Kolk, Van Der Hart, & Marmar, 1996). These “split-off’s”,

predominantly perceptual or sensory traumatic experiences, are often experienced as inexplicable physical sensations that the traumatised person cannot verbally explain or deconstruct. Therefore, it is not unusual for chronically traumatised patients to dissociate from bodily sensations and experiences due to frequent boundary violations of the body (e.g. physical or sexual abuse). The strong association between trauma and the danger or distress inflicted on the body creates a feeling of dissociation and may be perceived as “not in their” bodies.

The chronically traumatised person’s ability to “forget” certain parts of his/her experiences can be intermittent, specifically if confronted with painful emotions or reminders of traumatic experiences. Therefore, for a traumatised individual to have amnesia for significant portions of his/her life (single experiences, whole months or even years) is common. This aspect of amnesia not only can be a source of distress for the traumatised patient, but can complicate history gathering and recall during therapy (Luxenberg, Spinazzola, & Van der Kolk, 2001).

Dissociation in its extreme form, usually due to multiple traumatic experiences, can lead to Dissociative Identity Disorder (DID). A study by Ross (1991) claimed that 1% of the general population suffers from DID and “pathological dissociation” figures of up to 3,3% of the general population sample were displayed in a study by Waller & Ross (1997). These results led to the notion by Ross (1991, p. 515) that Dissociative disorders are “as a group, as common as anxiety and affective disorders”.

Dissociation as a defence mechanism used by the abused child very often prevents the child from capturing the memory of the actual event, and instead the child is left with behavioural or somatic reenactment as clues to the abuse. The incompatible messages sometimes projected by families in terms of meals and the parents’ responsibility to create safety and care as well as the power issues found among a parental figure during mealtimes, can create the association among the abused child that mealtimes are rituals of terror (Schwartz & Cohn, 1996).

Disturbances in self-perception

The child's perception of being "bad" even due to the abuse by adults, in most cases their caregivers, emphatically causes the child to believe that he/she is at "fault". These perceptions spring directly from the way young children interpret their worlds. The child's pre-operational thinking places him/her in the centre of the universe, causing him/her to believe that he/she has "caused" the abuse (Luxenberg, Spinazzola, & Van der Kolk, 2001). These negative views of themselves, due to childhood abuse, lead to negative views of being helpless, not understood, damaged, undesirable to others and as ineffectual (Herman, 1992a).

The structures of the self (body image), internalised images of others and the sense of coherence and purpose are invaded and broken down when chronic and totalitarian control due to childhood abuse occurs. The complicated deformation of identity therefore presents with a malignant and fragmented sense of the self as contaminated, guilty and evil as widely observed among researchers of childhood abuse (Herman, 1992b).

Disturbances in relationships

Luxenberg, Spinazzola, & Van der Kolk (2001, p. 378) argue that "the propensity of chronically traumatised individuals to dissociate from their own bodies also severely constricts their capacity to enter into relationships, as they struggle to know even themselves".

The chronically traumatised (in specific abused children), presents with dysfunctional relationships and are linked to distrust of others, revictimisation and even the victimisation of others (Herman, 1992b). According to Luxenberg, Spinazzola, & Van der Kolk (2001), the lack of a "healthy reference" to healthy interactions often presents in the form of inappropriate behaviour towards others or allowing others to interact with the "self" in an inappropriate manner. The ability to pick up on danger signs such as their own feelings of hurt, anger and unease on another's

part, are often disrupted and enmeshed. This inability explains why chronically traumatised people often engage with people who embarrass, humiliate, upset and confuse them. Prolonged exposure to trauma can cause the victim to lose “touch” with bodily signals (e.g. accelerated heart rate, changes in breathing patterns, the physical urge to flee or gastrointestinal stress) and therefore the victim only feels “alive” when agitated, revictimised or in conflict as a matter of course in a relationship. Luxenberg, Spinazzola, & Van der Kolk (2001) further noted that distrust in others (lack of appropriate social support) and the inability to use appropriate defence mechanisms then creates a feeling of helplessness and powerlessness as often observed among chronically traumatised people.

The frequent need to re-enactment by these patients explains why they sometimes are involved with people who have the potential to, for example, domineer them, the same way they were dominated as a child; or even choose people to engage with, whom they can victimise in the same way they were victimised literally or emotionally as a child (replicate their own traumas). Therapeutic relationship building with these patients can become an arduous process due to the inability to trust and relate on an interpersonal level (Roth, Newman, Pelcovitz, Van der Kolk, & Mandel, 1997; Chu, 1998).

Somatisation

It is not unusual for chronically traumatised patients to present with physical symptoms that often defy medical explanations (Luxenberg, Spinazzola, & Van der Kolk, 2001). Evidence conclusively link the physiological stress response and the release of endogenous stress responsive hormones as evident of repeated traumatic experiences as having an impact on the biological levels on the body (Van der Kolk, 1996; Yehuda, 1999). According to Yehuda (2001), the release of stress hormones acts as a trigger to prepare and mobilise the body to respond to threatening situations and chronic exposure to stress (typical of prolonged exposure to threatening situations like child maltreatment), significantly compromising this physiological

system. Neurohormonal dysregulation and exposure to trauma not only have an effect on the limbic system but also play an important role in the emotional significance of incoming emotional stimuli and the encoding of semantic memory. Prolonged exposure to trauma therefore can have a significant alteration not only to the body's response to trauma but also to the brain's ability to interpret and remember traumatic influences.

Bremner (1995) found that trauma has definite neuroanatomical impacts, evident of smaller hippocampal volume among traumatised patients if compared to non-traumatised patients according to MRI scans, suggesting that chronically traumatised patients have difficulties adjusting their levels of physiological arousal (Yehuda, 2001). This dysregulation of the physiological system suggests that the nervous system has become over responsive to previously innocuous stimuli. This clearly has an impact on the sympathetic and parasympathetic nervous system and reflects on the exaggerated startle response, characteristic of PTSD.

Traumatised individuals respond to various stimuli at a lower threshold, and the overproduction of catecholamines (like norepinephrine) as one of various neurohormones, is a reflection of the traumatised individual's unmodulated response to even minor stressors (Pitman, Orr, Foa, & Claiborn, 1987). This overproduction of catecholamines can result in general feelings of anxiety, hyperarousal (oversensitivity to stimuli and/or difficulty sleeping). The underproduction of serotonin, a neurohormone that mediates the behavioural inhibition system, can create an "emergency" response due to increased reactivity. This overall loss of neuromodulation often reflects in heightened irritability and aggressiveness for the traumatised individual (Coccaro, Siever, Klar, & Maurer, 1989).

Yehuda and colleagues (Yehuda, Southwick, Mason, & Giller, 1990) hold the notion that traumatised individuals with an underproduction of cortisol (Yehuda, 1995) serve as an "anti-stress" hormone by signaling that other stress related responses should be suppressed. The result of reduced glucocorticoid production (of which cortisol is an example), due to the exposure

of chronic stress, leads to the elevation of endogenous opioid production (Pitman, Van der Kolk, Orr, & Greenberg, 1990) that can, according to Wilson, Van der Kolk, Burbridge, Fessler, & Kravitz, (1999) result in analgesia in response to reminders of traumatic exposures. Wilson and co-workers also found a direct link between immune system dysfunction and histories of chronic sexual abuse during childhood, among a group of ten women. Although not yet fully understood, all ten women had increased lymphocyte immune activation; thus it is believed that chronic exposure to trauma may “reset” the body’s physiological functioning in order to prepare the person for the next traumatic event, which may come to be anticipated on a physiological level. It is therefore believed by these researchers that, over time, this may have negative consequences for basic functioning.

Felitti, Anda, & Nordenberg (1998) found that chronically traumatised individuals not only exhibit multiple somatic difficulties but that, as the number of traumas increased, physical health decrease precipitously. As evidence of the findings of Felitti and co-workers, Berkowitz (1998) noticed that traumatised individuals have documented increasing difficulties in their digestive system, cardiopulmonary, and urogenital areas.

In a large-scale survey (Felitti, Anda, & Nordenberg, 1998) of more than 10 000 adults who reported exposure to adverse childhood traumatic experiences, it was found that a dramatic increase in health risks for several of the leading causes of death in adults (heart disease, stroke, diabetes, skeletal fractures and cancer) is evident. They further concluded that traumatised individuals, who reported three or more adverse childhood events, were twice as likely to develop the above-mentioned diseases if compared to their peers without any adverse traumatic exposures.

Appropriately, Van der Kolk (1996) pointed out that emotional pain among traumatised individuals who lost the ability to put words to their traumatic experiences, may display physical symptoms as a symbolic way of communicating their inner emotional distress. Obesity is seen as

a symbolic way of trying to express and protect the core person as commonly observed among those suffering from severe forms of obesity.

Disturbances in meaning systems

Herman (1992b) holds the notion that chronically traumatised individuals often see their world through a very “dark lens” and often they believe that they no longer have a purpose and do not make sense to themselves. To question religious and/or ethical belief structures with which they were raised and their view of any spiritual being or force as actively malevolent or insensitive to human suffering, is considered the norm, rather than the exception. They even adapt to the notion that “every” person is out for him/herself, having a fatalistic view to life, ultimately also holding the belief that they will not be able to make positive alterations in their own existence. This belief system poses a profound, persistent, physical sense of learned helplessness that can affect the ability to make new choices, act on one’s own behalf and even implement changes in one’s life.

This concludes the discussion on the characteristics of Complex Trauma. The following section will highlight the differential diagnosis often associated with Complex Trauma.

Complex Trauma and differential diagnosis

The current diagnosis of DESNOS is anchored in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV) (American Psychiatric Association, 2000) and serves as a guide for both treatment and research of mental illness according to empirical research. The DSM IV as a nosological system endeavours to clarify, confirm or revise clinically and theoretically derived constructs of psychopathology that were initiated with the first edition. This widely used, universal, nosological system has the benefits to develop a common language for mental health practitioners, researchers, policymakers and even patients themselves.

Ultimately, mental health practitioners can become overly reliant on artificial distinctions between disorders and therefore challenge what we know about psychopathology in various clinical populations. This salient issue, when evaluating the presence of Complex Trauma among patients with histories of chronic traumatisation, becomes an important issue when the differential diagnosis of DESNOS frequently emerges. Therefore it is not surprising that high incidences of co-morbid disorders among chronically traumatised patients have been observed between symptom clusters of DESNOS and other Axis I and II disorders, common to this bariatric population. In an attempt to account for symptom presentations typical to DESNOS, clinicians very often misdiagnose the symptoms of DESNOS as atypical symptom formations as established by the DSM IV diagnosis.

The multiple DSM IV diagnosis as assigned to patients who present with symptoms of Complex Trauma, are very often overlapped or confused with PTSD, BPD and Bi-polar II disorders. Diagnostic confusion among mental health professionals are often present when they have to evaluate and treat patients with chronic traumatisation. Darves-Bornoz, Lemperiere, Degio Vanni, & Gaillard (1995) and Mueser, Goodman, Trumbetta, Rosenber, Osher, Vidaver, Auciello, and Foy (1998) reported a high prevalence of histories of chronic traumatisation among populations who present with PTSD, BPD and Bi-polar II disorders.

This potential misdiagnosis excludes co-morbid conditions of DESNOS, PTSD and/or BPD. Results from the DSM IV Field trial (Van der Kolk, Roth, Pelcovitz, & Mandel, 1993) (Blaustein, Spinazzola, Simpsom, & Van der Kolk, 2000) confirmed the common co-occurrences of DESNOS, Simple PTSD and BPD in patients with histories of chronic traumatisation. Some of the common features typical to DESNOS and the differences among PTSD and BPD patients will be discussed in the following section. Apart from the differences, overlapping areas of diagnosis will also be highlighted. This will be done separately according to the diagnostic features typical to PTSD and BPD. Table 3: DESNOS versus PTSD; and Table 4: DESNOS versus BPD will highlight these typical and overlapping diagnostic features. The researcher does not intend to

give a detailed description of PTSD or BPD and only relevant diagnostic features related to DESNOS will be discussed.

Table 3: DESNOS versus/and PTSD

Diagnostic Features	Typical PTSD versus and/or overlapping areas of DESNOS diagnosis features
Etiology	DESNOS is more common among individuals exposed to interpersonal trauma with an early onset and of lasting duration (Van der Kolk, 1996). PTSD is not necessary a precondition for DESNOS (Ford & Kidd, 1998).
Avoidance	Severe avoidance and suppression of trauma-related memories with associated affective numbing and constriction (PTSD Criteria C) are often facilitated by means of self-medication through substance abuse and dependency and are more common to the DESNOS construct of diagnosis than Simple PTSD (Luxenberg, Spinazzola, & Van der Kolk, 2001).
Dissociation	Dissociation as a coping mechanism and defence against intolerable affect as represented by avoidance, numbing and dissociative symptoms, may over time mask the overt intrusive PTSD symptomatology (Criteria B) and therefore will not obviously be typical to the diagnoses of PTSD but rather to DESNOS (Luxenberg, Spinazzola, & Van der Kolk, 2001)
Traumatic intrusion	Trauma patients with severe mental illness are often misdiagnosed due to the focus of and severe manifestation of psychopathology, including paranoid ideations, persecutory delusions and perceptual disturbances. Therefore the presence of flashbacks as a traumatic intrusion common to PTSD are often overlooked because they are experienced within the context of other psychopathology (i.e. bizarre auditory or visual hallucinations) (Luxenberg, Spinazzola, & Van der Kolk, 2001)

The distinction between DESNOS and BPD is perhaps the most challenging differential diagnosis due to the potential overlap or dual diagnosis it poses to the clinician. Luxenberg, Spinazzola, & Van der Kolk (2001) claim that according to their observations, patients who have been diagnosed with the historical concept as “borderline” are, upon more thorough evaluation, better characterised by the DESNOS framework. They also suggest that a thorough trauma history (i.e. developmental adaptation to experiences of childhood trauma), in this case conceptualisation and treatment of these patients, should be paramount before therapeutic interventions are started. Common personality features of the BPD patient, such as hostility, emotional manipulation and deception are often replaced by genuine feelings of sadness, loss and traumatic grief upon further exploration. Empirical research (Van der Kolk, 1996 and

Blaustein, Spinazzola, Simpsons, & Van der Kolk, 2000) claims that overlapping and/or distinct symptom profiles among BPD and DESNOS are commonly found.

Both these disorders (DESNOS and BPD) appear to be quite similar, related to four of the six domains of self regulatory deficits captured by the DESNOS construct (i.e. affect, attention/consciousness, self-perception, and relationships), but in essence BPD represents a disorder of attachment while DESNOS is better understood as a disorder of self regulation (American Psychiatric Association, 2000). The four overlapping, although sometimes different domains of the DESNOS construct versus BPD will be clarified as follows according to Table 4: DESNOS versus BPD.

Table 4: DESNOS versus BPD

Diagnostic Features	Typical BPD versus and/or overlapping areas of DESNOS diagnostic features
Affect regulation	DESNOS patients tend to have a downward affect dysregulation as evident of dysthymia/anxious baseline and profound stages of rage, terror and hopelessness, where BPD patients tend to have an upward affect dysregulation. Greater ranges of emotional spikes (brief excitements, positive anticipation and euphoria associated with transient idealisations of new intimate others) are observed among BPD patients if compared to DESNOS patients. More prominent features of DESNOS patients are their profound deficit to sustain positive emotional states, experience pleasure and become involved in present-focused positive states of awareness (Luxenberg, Spinazzola, & Van der Kolk, 2001).
Relationships	<p>The interpersonal orientation of DESNOS patients is hallmarked by being more passive in nature, characterised by duality of avoidance and revictimisation (i.e. prolonged periods of self-inflicted social isolation and avoidance of intimate contact with others). In contrast, BPD patients' interpersonal orientation is active with an approach-based stance that is characterised by the duality of desire and disillusionment. Unrealistic and untenable relationships characterised by the devaluation, sabotage and oscillation between longing and idealised relationships are more commonly found among BPD patients.</p> <p>DESNOS patients tend to engage in intimate relationships characterised by feelings of being unsafe and out of control. Due to the DESNOS patients' emotional vulnerability to identify danger cues and tolerance for violence and boundary violations, they tend to become targets of others who are drawn to their vulnerabilities. The opposite of this form of re-enactment to become the victim, as evident of childhood trauma, can also include engagement with others who are vulnerable to become victims. When an intimate other person threatens to disengage from the BPD patient, even if the relationship is perceived as unsatisfactory by the patient, the desperate need to maintain this relationship is not</p>

	<p>uncommon among BPD patients. For the BPD patient, the driving force behind this fear is very often the fear of abandonment and rejection as perceived by the BPD patient. The BPD patient is often consumed by vaguely articulated fantasies about new relationships, with the hope that others will fill the emptiness at the core of his/her own being, just to feel the sting of disappointment if they do not fulfil his/her expectations. This pattern of engagement is very often observed by therapists treating BPD patients.</p> <p>In contradiction to BPD patients' relationship perceptions, the DESNOS patients tend to perceive themselves as unworthy of meaningful relationships, and incapable of imagining a future where they can love and be loved by others, free of abuse.</p> <p>Unlike BPD patients, DESNOS patients are less likely to engage in boundary violations and intrusiveness with their therapists and others, therefore rather present with hostility, apprehensiveness and guardedness towards others.</p> <p>(Luxenberg, Spinazzola, & Van der Kolk, 2001)</p>
Dissociation	<p>According to Luxenberg, Spinazzola, & Van der Kolk (2001), dissociative symptoms associated with BPD are characterised by transient responses to stress. Darves-Bornoz, Lemperiere, Degio Vanni, & Gaillard (1995) also observed that BPD patients reported lower levels of Dissociative symptoms than PTSD patients. The presence of dissociative symptomatology is a required criteria for DESNOS and can present in the form of episodic experiences of derealisation to lasting psychogenic amnesia for portions of a traumatic experience to the presence of Dissociative Identity Disorder (DID) (Luxenberg, Spinazzola, & Van der Kolk, 2001).</p>
Type and extent of self-perception	<p>The DESNOS patient experiences a self that has been permanently damaged and alienated from others where the BPD patients' disturbances in self-perceptions involve fundamental confusion about the self.</p> <p>For the BPD patient, the core identity lays in the absence of the self or ego identity and feelings of emptiness associated with the void left by the unformed self. This intolerable black hole or "void" explains the constant consideration to commit suicide as commonly found among BPD patients. Plagued by negative affect states of guilt, shame and ineffectiveness associated with perceptions of the damaged self, DESNOS patients also have the ability to have a basic core sense of identity, even if it presents as a dual identity of victim and/or patient. This dual identity of victim and/or patient can become a source of meaning-making and a source of proof of interpersonal suffering and emotional pain (Luxenberg, Spinazzola, & Van der Kolk, 2001).</p>

In response to persistent traumatisations, DESNOS as a diagnosis encompasses a pervasive pattern of adjustment, reflective of the frequent and numerous types of trauma (prolonged exposure) that disrupt and alter maturing biological and emotional systems, particularly when present during childhood.

Factors associated with childhood maltreatment and obesity

Most studies only focused on women and specifically on the role of sexual abuse on obesity. This section will therefore reflect on some underlying notions related to eating pathology, childhood maltreatment and obesity.

Although evidence of improved psychological status and quality of life exist with significant weight loss after surgery, Rand & Macgregor (1990) argue against the assumption that severe obesity is a psychological defence mechanism and that weight loss causes major psychological disturbances (Vallis & Ross, 1993). Growing evidence about genetic markers that influence central control of energy balance seem to be contrary to the belief that severe obesity is caused by psychological disturbances. A study by Rand & Macgregor (1991) emphasised the benefit of weight loss in which patients would rather prefer to have another handicap or even not be an “obese millionaire” instead of being severely obese. In sharp contradiction to Rand & Macgregors’ (1990) findings, Felitti (1993) and King, Clark, & Pera (1996) found that a subgroup of severely obese patients who were sexually abused may find weight loss threatening and may even sabotage attempts to lose weight due to the inability to defend the core person once he/she is more attractive. Therefore, this strongly indicates that weight in some obese patients serves as a protective mechanism against the inability to protect their intimate space (body).

A strong relationship between binge eating and obesity has been documented (Stunkard & Costello, 2003 and De Zwaan, 2005) and binge eating is thought to precede the development and maintenance of obesity (Felitti, 1991). Several studies suggest that childhood sexual abuse is positively correlated with binge eating (Grilo & Masheb, 2001; Grilo et al., 2005; Grilo, White, Masheb, Rothschild & Burke-Martindale, 2006), therefore conclusively indicating a relationship between childhood sexual abuse, binge eating and eventually obesity in some individuals.

A study by Kaiser Permanente and the Centre for Disease Control (Felitti, Anda, & Norderberg, 1998), reported that of the 17 337 adult respondents to a questionnaire about adverse childhood experiences, including childhood abuse, neglect and family dysfunction, emotional childhood abuse was reported by 11.0% of the respondents, physical abuse by 30.1%, and sexual abuse by 19.9% of the participants. Furthermore, the study reflected on 23.5% being exposed to alcohol abuse, 18.8% to mental illness, 12.5% of the respondents reported witnessing their mothers being battered and 4.9% reported family drug abuse. This study unequivocally confirms the significant relationship between adverse childhood experiences and depression, suicide attempts, alcoholism, drug abuse, sexual promiscuity, domestic violence, tobacco smoking, obesity, physical inactivity, and sexually transmitted diseases. They also reported that there was a direct correlation between the amount of exposure to adverse childhood experiences and the likelihood of a person to develop heart disease, cancer, stroke, diabetes, skeletal fractures and liver diseases.

Earlier studies, amongst those a study by Oppenheimer, Howells, Palmer, & Chaloner (1985), reported sexual abuse during childhood and/or adolescence among eating disorder patients to be as high as 78%. Rorty & Yager (1996) found that women with a complex genesis of eating disorders and a history of sexual and physical abuse during childhood relate more to the development of eating disorders than those who did not present with traumatic experiences during childhood.

Grilo & Masheb (2001) found that 83% of a group of white, well-educated women seeking treatment for binge eating disorders (commonly found among obese individuals), presented with a form of child maltreatment. Williamson, Thompson, Anda, Dietz, & Felitti (2002) indicated that 67% of obese adults present with severe types of abuse. Both studies were limited to self-report measurements and did not discriminate between different forms of abuse during childhood. Williamson et al. (2002) commented that the risk of BMI greater than or equal to 30, or BMI greater than or equal to 40 increased with rising numbers of severe types of abuse. In

contradiction to Williamson's report, Van Hanswijck de Jonge et al. (2003) found among a small sample (ten participants) no difference in BMI or adult weight ranges between the abused and non-abused groups. However, a strong link between unhealthy core beliefs was observed among the abused group, if compared to the non-abused group. The small sample size of this study (Van Hanswijck de Jonge et al. 2003) most probably explains the contradictory results as reflected by Grilo (2001) and Williamson's et al. (2002) observations.

A study by Adolfsson (2004) reflects on the lack of evidence to prove a clear association between obesity and sexual abuse. However, a correlation between older overweight/obese males and a history of sexual abuse was observed in both univariate and multivariate analysis. This study was limited to self-report data and exclusive to a Swedish population. A self-reported, retrospective study with a possible sample bias due to a low response rate (65%) among African-American female military veterans concluded that child maltreatment summary scores did not predict high adult BMI rates (Rogers, Lang & Laffaye, 2004). In contrast to Rogers's results, Grilo et al. (2005) reported from a self-reported retrospective study among extremely obese bariatric surgery candidates (mean BMI 51.1), that 69% of the participants reported child maltreatment. Different forms of child maltreatment were not associated with variability of BMI, binge eating, or eating disorder features. A later study by Grilo, White & Masheb (2006) on extremely obese gastric bypass patients, illustrated by a comparison of eating disorder features, psychological functioning and BMI pre-surgery and 12 months post-surgery, that 69.3% of these patients reported some form of maltreatment. A recent study by Oppong, Nickels & Sax (2006) among bariatric surgery patients indicated, as reflected by a single surgeon, patients' reflections on a self-reported measurement at 12 months and 24 months post-operatively that 27% (91% females) reported a history of sexual abuse. Limitations of this retrospective self-report data reflect mainly on white female bariatric surgery patients.

The only longitudinal study (over a period of ten years) published, linking possible child maltreatment to adult obesity was a Danish study done by Lissau and Sorensen (1994), who

reported children as perceived by teachers as “dirty and neglected” to have a greater likelihood of being obese, as compared to those children perceived as presenting with “average hygiene”.

It is the researcher’s opinion that most of the above-mentioned studies reporting on the association between child maltreatment and adult obesity, pose a variety of limitations as evident by sample size, methodology, data collection (self-report), sample bias, lack of distinguishing markers to identify specific forms of child maltreatment, age and sex of the participants. The results and limitations as reflected by these studies emphasise the complexity of the wide array of variables that affect the impact of child maltreatment, obesity and eventually the “voices” of bariatric patients.

Factors and variables interacting with one another that may play a role in the development of psychological sequelae among sexually and physically abused patients with eating disorders, include: the patients’ functioning prior to the onset of trauma (age and vulnerability at the time of the abuse); family variables and dynamics; severity, nature and extent of the sexual or physical abuse; the initial response to the traumatic experiences (parental reaction) and longer-term reactions like personality development and later triggering of events (Vanderlinden & Vandereycken, 1996).

To fully understand the impact of traumatic exposure and the subsequent effect of obesity during adulthood, aspects of childhood development in relation to dysfunctional influences should be clarified. The focus of this study is not to give a comprehensive literature review of childhood development, but to highlight aspects that might have an effect on the development of complicated trauma reactions due to childhood maltreatment on the development of and maintenance of obesity.

It is believed that developmental trauma sets the stage for subsequent stress, leading to an increase in the use of medical, correctional, social and mental health services, according to a

much earlier study (Drossman, Leserman, & Nachman, Li, Gluck, Toomey, et al., 1990). The following paragraphs will reflect on some of the prominent psychological sequelae, commonly found among obese adult survivors of child maltreatment.

The child's affect, age, psychosocial influences and time of the onset of traumatic exposure are undeniably major factors on the child's continuing development. A child's experiences, symptomatic perception and course of the impact of trauma do have an effect on important childhood developmental issues (Nader, 2001/2004). Among these impacts, the child's appraisals of threat, meanings assigned to aspects of traumatic events, emotional and cognitive coping skills, the ability to address secondary life changes and the capacity to tolerate their own reactions, thus have a major effect on the developing child. Basic trust, interpersonal attachment, cognitive and personality development (James, 1994), morality and conscience (Garbarino, Kostelny, & Dubrow, 1991) as well as aspects of memory (Siegel, 1996) disrupt normal child development. Issues of trust and need for protection as experienced by infants and pre-school children may become more prominent at a later age due to previously unresolved aspects related to traumatic experiences and challenged faith in normal/harmless human responses to the need for safety (Nader, 2001/2004).

During the pre-school age, the child depends on adults for nurturance and safety (Macksound, Dyregrov, & Raundalen, 1993). During this developmental period, more concrete thinking (Lewis, 1995), literal interpretations, animistic thinking, faulty hypotheses and inaccurate associations are more commonly observed (Murray & Son, 1998). According to Piaget (as cited in Nader, 2001/2004), children between the ages of two and seven years do have the ability to mentally represent information as observed, but do not yet have the ability to integrate the information into a logical manner. The child's ability to express "thoughts about thinking" (metacognitive thoughts) between the ages of three and nine years is considered important accomplishments to the integrated personality development, according to Siegel (1996). During this developmental period, the child also learns that the appearance of things, people and objects

is distinct from its reality; others may think differently; simultaneous or multiple emotions can be experienced; thoughts can change while desires associated with emotions influence behaviour. Known to this developmental period is the threat to caregivers/loved ones or to the self, which increases the risk of perceived traumatic experiences (Scheeringa & Zeanah, 1995) and can result in anxious attachments or separation reactions (Macksound, Dyregrov, & Raundalen, 1993).

During the school-age period the child increases his/her objectivity and attempts to bring his/her thinking in line with others, according to Combrinck-Graham (1991). The need to construct an orderly and lawful world and the need to become socialised is a prominent milestone during this developmental phase (Lewis, 1991). A term used by Combrinck-Graham (1991), called "interpersonally accountable, independent competence" describes this developmental period. At this age the child already has the ability to depict, in thought and in play, the wishes that may have occurred during or after traumatic exposure, like the ability to fantasise about possible interventions and/or the ability to escape from the impact of the traumatic exposure. The ability to focus on more than one aspect of a situation at a time and the ability to form a mental picture and describe sequences of events without performing them, as well as the awareness that some actions can be reversed by subsequent actions, become a prominent part of this age-related development (Brodzinsky, Gormly, & Ambron, 1986). The need for acceptance and facilitation of intense and opposing emotions and attitudes can be a prominent feature for children at any age.

During the adolescent phase, issues of dependence/independence, vulnerability/invulnerability, real/ideal, competence/incompetence, relationship of self to others and the transformation from adolescence to adulthood become particularly important. In case of loss of a parent, the adolescent may try to unconsciously seek replacement for the relationship with one or both of the parents, girlfriend or boyfriend or another peer or adult. This need may occur whether the relationship was positive or conflicted (Nader, 2001/2004). This specific form

of cognitive distortion is commonly found among abused children as also observed by the researcher in private practice, dealing with obese patients with a history of early traumatic experiences.

Loss of innocence or a precocious development not only occur in a wide array of reactions due to childhood trauma, but also result in premature knowledge of sexuality and the vulnerability of adults, resulting in the child's emotional perceptions, unfamiliar to children who enjoyed a normal sense of safety (Nader, 2001/2004).

Regression as a form of defence against the impact of traumatic exposure is not uncommon even among adolescents and adults, and may be a spontaneous reaction for the need of safety. Among children, it may be wrongfully interpreted as laziness, sloppiness, defiance or even attention seeking behaviour. Nader (2001/2004) also indicated that a protective mechanism like regression may be a subtle desire for a person, place, or situation that represents an association with feelings of safety, that may be complicated or even exaggerated by symptoms like sleep deprivation, cognitive difficulties, preoccupations and changes in the biochemistry of the person exposed to prolonged or intense trauma.

Traumatic experiences (single or multiple exposures) may challenge the moral development of the traumatised person in various forms and at various ages as illustrated by Stillwell, Galvin, & Kopta's (1991) constructed empirical model of conscience through analysis of normal children in Table 5.

Table 5: An Empirical Model of the development of conscience in normal children

Conscience	Description
External (before age 6)	"Big people know best;" accept limits and punishments; find badness or goodness in actions/objects as defined by external authority; fail to abstract moral rules from experiences.
Brain or heart (modal age 7)	Rules derived from experiences; child consults brain or heart (and often authority figures for certainty); imitation, identification, and obedience to avoid punishment or to be found pleasing.
Heart/mind or personified	As early as age 9, rule-governed moral experience mastered;

(modal age 12)	more attention focused on affective aspects; choices generally remain right or wrong; desire to respond to others' emotions; grown-ups not always right; someone older and wiser - like God - might know better; desire to please and be found pleasing by adults; personified conscience may develop as an internal representation with capacity for relationship, argumentation, inspiration, or generation of fear, shame, and guilt.
Confused (modal age 15)	Characterised by confusion, indecisiveness, and struggles with "grey" areas of good and evil; challenges of peer culture and the popular culture; competition between adult and peer authority.
Integrated (model age 17)	Characterised by flexibility, recognising more than two options; understanding the overlapping of good and evil; a return of confine regarding moral issues; increased modulation of moral motions; understanding, benevolence and optimism.

As reflected in Table 5, even a single traumatic experience may challenge the child's belief that adults are "good" (Nader & Pynoos, 1993). Although Stillwell, Galvin, & Kopta's (1991) model traces "normal" children's moral development from a conscience in which the knowledge and power of adults mature into a conscience with flexibility, the traumatised child's moral development becomes disrupted if compared to the normal child's moral development.

Obesity as an adaptive function to early exposure to trauma

One of the first researchers to study the medical consequences of child maltreatment on adult health was Vincent J Felitti (2002). Felitti and his co-researchers initially observed that a history of past child abuse was common amongst obese patients who dropped out from an obesity programme. They concluded that obesity was a protective mechanism against exposure of childhood trauma. A statement by Felitti (2002) appropriately reflects on the results of this study by summing up the core essence of obesity as a protective mechanism to early traumatic experiences with the following words: "obesity was not their problem; it was their protective solution to problems that previously had never been discussed with anyone".

In an attempt to explain the apparent association between childhood sexual abuse and obesity, Gustafson & Sarwer (2004) hypothesised that among other variables, binge eating may serve as a mediating variable, as well as the notion that obesity serves as an "adaptive function"

in some women with a history of childhood sexual abuse. Wonderlich, Crosby, Mithchell, Roberts, Haseltine, DeMuth, et al. (2000) have suggested that the relationship between childhood sexual abuse and disordered eating may also be mediated by mood and behavioural impulsivity, body image disturbances, drug use, and poor self-esteem; and may even result in psychobiological dysregulation, which may negatively reflect on maladaptive behaviours like eating disorders, specifically if exposed to traumatic sexual abuse.

A history of sexual abuse may trigger posttraumatic stress symptoms for some women who are trying to lose weight, due to the emotional association with “thinness” during the abusive period (King, Clark, & Pera, 1996); according to the description, coined by Weiner & Stephens (1996) as “barrier weights”. Barrier weight implies that the body weight, usually if lower than the current weight, as approached, may produce a great deal of anxiety due to the avoidance of specific weights that correspond to events associated with earlier period/s of abuse. Weiner & Stephens’ (1996) study have some limitations in terms of the highly selective sample (women) and sample size (42 respondents) as well as the methodological limitations and lack of statistical analyses. Nevertheless, the concept (as proposed by these researches) of “barrier weights” as related to sexual victimisation, has some intuitive appeal. Other researchers referred to this critical weight as an adaptive function or self-protecting mechanism against the associated lower body weight (Wiederman, Sansone, & Sansone, 1999). As indicated by Sarwer & Durlak (1996), women who had to endure sexual abuse, experience significantly increased rates of sexual dysfunctions and are at greater risk for subsequent victimisation (Green A.H, 1993) as a protection from sexual advances by sexual partners and/or abusers (Felitti, 1993 and Wiederman, Sansone, & Sansone, 1999). This may explain the lack of correspondence between others’ observations of a weight problem and the resistance to lose weight among some obese women (Sarwer & Thompson, 2002).

A possible method to evaluate the notion of obesity as an “adaptive function” among childhood sexual abused victims might be to look for correlations between histories of abuse and

weight loss treatment outcomes. Evident results of such studies are reflected by King, Clark, & Peras' (1996) observations among obese women enrolled for a weight loss programme using a very-low-calorie diet, indicating those with a history of sexual abuse to lose significantly less weight and reported more non-adherence episodes, if compared to non-abused women. In a similar study by Felitti & Williams (1998) among 190 obese patients in a very-low-calorie diet who lost over 100 pounds, those with a history of sexual abuse as a child had a significantly higher likelihood to regain weight during the 18 months follow-up. Wiederman, Sansone, & Sansones' (1999) exploration among weight loss failure as seen among sexually abused victims, found that obese victims of childhood sexual abuse reported less dissatisfaction and less weight fluctuations during adulthood, if compared to non-abused obese adult women. The study by Felitti (1993) among sexually abused women indicated that 13% of the obese group reported an increase in spousal jealousy as they lost weight. Therefore, giving credibility to the notion that some subset of obese women with a history of childhood sexual abuse compared to non-abused women, often maintain their obesity due to the protective properties of obesity against unwanted romantic or sexual interest.

Most of the studies mentioned above focused on the obese woman's experience of obesity due to childhood sexual abuse and the maintenance of obesity. A study by Mitchell & Mazzeo (2005), unlike the majority of studies among women, conducted an investigation into the mediators of the association between abuse and disordered eating in undergraduate men and found that physical abuse and physical neglect were the only adverse childhood experiences associated with eating pathology among this group of men. They also indicated that depression mediated the association between physical abuse, physical neglect and eating disorder symptomatology (excluding anxiety and alexithymia as significant mediators of the association between abuse and eating pathology). They also found that social support moderated the association between physical neglect and depression and concluded that individuals with high social support were less depressed regardless of their level of physical neglect. The results seem to be different from female samples, highlighting the amount of caution that clinicians

should use when interpreting and treating male and female obese patients due to some subtle differences in terms of the different mediators at play when trying to accommodate the pain (emotional) when suffering from a chronic illness like obesity.

Role of bariatric surgery as a remedial intervention

Psychiatric/Psychological issues in bariatric candidates/patients

In the next section, various psychiatric/psychological issues in bariatric patients are discussed, namely psychiatric co-morbidity, eating-specific psychopathology and psychosocial issues. The aim of this discussion is to reflect on the complexity of some other relating factors that might have an impact on the experience of bariatric surgery as a remedial, forced behavioural intervention.

Psychiatric co-morbidity

A history of Axis I diagnosis is not uncommon among obese bariatric patients and has been reported in 27% - 42% of bariatric surgery patients (Gentry, Halverson, & Heisler, 1984 and Gertler & Ramsey-Stewart, 1986). These researchers also found adjustment disorders, affective disorders, anxiety disorders and eating disorders to be most prominent.

Findings by Larsen (1990) indicated a lifetime history of adjustment disorders (15%), anxiety disorders (14%) and affective disorders (8%) among bariatric surgery candidates. Powers (1992) reported a much higher presence of affective disorders (34%) than Larsen and also less anxiety disorders (9%); additionally, he indicated that the occurrence of substance use disorders were present among 8% of his bariatric surgery candidate sample. Sarwer's (2004) investigation into psychiatric diagnosis and treatment histories among 90 bariatric surgery patients emphasised the prevalence of psychiatric co-morbidity among this group of patients.

Criteria for lifetime Axis I diagnosis were reported by 56 of the 90 interviewed patients and half of this group met the criteria for multiple diagnoses. The most common diagnoses were major depressive disorders, binge eating disorders (BED's) followed by substance use disorders. Approximately 40% of these patients were treated with psychotropic medication as a primary form of intervention. A study by Roberts, Kaplan, Shema, & Strawbridge (2000) and Dong, Sanchez, & Price (2004) confirm these findings and overall, their results also suggested an association between obesity and depression.

Larsen (1990) found that pre-surgical histories of Axis II disorders (Personality disorders) were reported by 22% of bariatric patients. Although Powers (1992) reported similar findings as Larsen (1990), Glinski, Wetzler & Goodman (2001) reported an even higher prevalence of 36% of bariatric patients with Axis II diagnosis. In an attempt to determine if mental status could predict personality profiles 18 months after surgery, Guisado and Vaz (2003b) found according to the Millon Clinical Multiaxial Inventory-II (MCMI-II), significant differences (higher values) on the Schizoid, Paranoid, Histrionic and Delusional disorder scales if compared to a Spanish clinical outpatient population. Therefore, it is concluded that the mental state of obese patients undergoing bariatric surgery do show traits and personality disturbances that impair the personality structure.

According to Glinski, S., & Goodman (2001); Larsen (1990) and Powers (1992), dependent and avoidant personality features are among the most common reported personality diagnosis and therefore a "mixed" personality disorder profile seems to be the most descriptive of the Axis II disorders among bariatric surgery patients.

Larsen & Torgersen (1989) propose that personality may relate to morbid obesity in three different ways: either personality characteristics that predispose to overeating causing weight gain; living with morbid obesity itself and the long-term influences on the personality; or a combination of the two mechanisms. Although most researchers indicated that psychopathology

and personality disorders are common among bariatric patients, the researcher holds the opinion that due to discrimination and biased treatment of obese patients, some of the personality styles observed and reflected by obese individuals can be due to the defensive nature of humans against discrimination and should therefore be carefully interpreted.

According to Alciati, D'Ambrosio, Foschi, Corsi, Mellado & Angst (2007), mood disorders and obesity mainly focus on depression, whereas historic polarity of mood has not previously been assessed in a careful way. In spite of limitations of their study that include the lack of data on normal weight as compared with general medical control groups and the reliance on self-reports, retrospective assessment of the collections of some parameters, indications of a bipolar spectrum disorder amongst 89% of severely obese patients, were observed. With this high prevalence for bipolar II Disorder they found that co-morbidity with Panic Disorders was observed in 30% of the bipolar spectrum patients they observed. In spite of their findings, these researchers caution the interpretation of the substantive findings. Alciati et al. (2007) also pointed out that a hypomanic condition characterised by over-activity is considered a very common occurrence among severely obese patients. Therefore, these results contradict previous evidence of low levels of physical activity amongst morbid obese patients. These researchers also claimed that their data do not allow the formulation of any hypothesis on the relationship between severe obesity and bipolar spectrum illness, and they do suggest further research in the causal associations that might suggest model therapeutic and preventative approaches to these specific health problems.

In a population-based study amongst female twins, the presence of binge eating was examined and associated with a greater risk for medical and psychiatric disorders in obese women (Bulik, Sullivan, & Kendler, 2002). The results of this study implicated that obese women with binge eating behaviour were associated with higher lifetime prevalence of major depression, panic disorders, phobias and alcohol dependency. Neurovegetative symptoms (insomnia, agitation, retardation and obsessive compulsive traits), neuroticism and symptom scales

measuring depression, anxiety and phobia were also associated with binge eating behaviour amongst obese women, according to Bulik, Sullivan, & Kendler (2002). Their findings pose certain limitations due to the interviews that could not be verified independently and the exclusive selection of a Caucasian female group. Both Roberts, Kaplan, Shema, & Strawbridge (2000) and Hsu, Benotti, Dwyer, Roberts, Saltzman, Shikora, et al. (1998) observed that obese individuals have a higher likelihood of developing depression, with an estimate of 29-51% as a lifetime prevalent factor.

Eating-specific psychopathology

Aberrant eating behaviours commonly found among bariatric patients include binge eating disorder (BED), night-eating syndrome (NES) and “grazing” (Ceru'-Bjork, Andersson & Rossner, 2001; Powers, 1999; Kalarchian, Wilson, Brolin, & Bradley, 1998 and Hsu, Betancourt, & Sullivan, 1996).

By definition, BED is described as an uncontrolled eating spree that occurs regularly and is associated with significant distress and frequently occurs with other psychopathological conditions (Devlin, Allison, Goldfein, & Spanos, 2007). A population-based study by Bulik, Sullivan, & Kendler, (2002) also indicated that, despite the presence of anxiety, anger, impulsivity and co-morbid psychiatric diagnoses, there is a direct relationship between BED and lifetime major depression. In support of Devlin and colleagues as well as Bulik and colleagues' research results, Guisado and Vaz (2003a) also indicated that among 140 morbidly obese patients during the 18 months of post bariatric surgery, if compared to a group of binge and non-binge eaters pre-operatively, the post-operative binge eating patients had more eating disturbances (more binge eating, less restriction, more disinhibition and more hunger), and psychopathological characteristics of passive-aggressive traits, aggressive-sadistic traits, manic disorders, alcohol dependency and major depression (according to the Millon Clinical Multiaxial Inventory), if compared. A study among 120 obese women (59 with BED and 61 without BED), compared to

80 healthy controls to determine temperament and character (personality), concluded that according to the Temperament and Character Inventory (TCI), patients with BED have lower scores on the "Self-Directedness" (SD) scale and show higher risk of Personality Disorders (Fassino, Leombruni, Piero, Abbate, Amianto, Rovera, et al., 2002). They also concluded that self-directedness seems to be the strongest predictor for the development of BED.

Results from a study among 50 individuals who responded to advertisements (which can be a limiting factor in terms of representation of a diverse population) for medication treatment for compulsive overeating, concluded that binge eating severity was positively correlated with BMI and personality disorder symptomatology and that the frequency of binge eating episodes, not the binge size, was associated with personality psychopathology. The research by Picot & Lilenfeld (2003) concluded that BMI and personality psychopathology were unrelated and that eating pathology, rather than weight, seems to be related to personality psychopathology. According to a psychotherapy trial among 162 BED patients, Wilfley, Friedman, Douchis, Stein, Welch & Ball (2000) found that the presence of Axis II psychopathology at baseline was significantly related to more severe binge eating and eating disorder pathology. They concluded that the overall presence of Axis II psychopathology did not predict treatment outcomes, although the presence of Cluster B personality disorders did predict significantly higher levels of binge eating one year after treatment.

Mitchell, Swan-Kremeier, & Myers (2007) reported that more than 50% of patients interviewed 13 to 15 years post bariatric surgery admitted to symptoms and behaviour (presurgically) similar to the full criteria for BED. A group of 125 patients presenting for gastric bypass surgery showed, according to a self-report questionnaire, that 33.3% of them have severe binge eating, further associated with grazing behaviour and depression (Saunders, Johnson, & Teschner, 1998). Both Powers (1999) and Hsu, Betancourt, & Sullivan (1996) reported the prevalence rate of binge eating in patients seeking bariatric surgery to be 50% and higher, therefore confirming Mitchell, Swan-Kremeier, & Myers' (2007) later findings.

Bonne, Bashi, & Berry (1996), indicated that marked weight loss, impairment in body image and deterioration are much more prevalent amongst women than in the case of men, although the etiology is similar for both genders. Male patients seem to be more prevalent in aspects related to pre-morbid obesity and sexual identity issues. They concluded that men with a history of pre-morbid obesity and sexual identity problems pose a higher risk for the development of binge eating behaviour post-operatively.

Literature varies on whether binge eating behaviour persists or subsides after surgery, in spite of the fact that binge eating is elevated within the obese patient. Kalarchian, Marcus, Wilson, Labouvie, Brolin & LaMarca (2002) observed that nearly 50% of patients who reported continued difficulties with overeating, resulted in less overall weight loss between two to seven years post-operatively. Binge eating behaviours have a worse post-operative outcome according to the study done by Green, Dymek-Valentine, Pytluk, Le Grange, & Alverdy (2004). Adami, Gandolfo, Meneghelli, & Scopinaro (1996) as well as Stunkard & Costello (2003) found that binge eating subsides following bariatric surgery. According to Saunders (2001), patients with a history of binge eating tend to show post-operative eating disturbances that interfere with optimal weight loss.

A study by Hsu, Mulliken, McDonag, Krupa, Rand, Rairburn, et al. (2002) to determine if BED versus non-BED among extremely obese (BMI higher than 40) individuals (37 people) differ in terms of eating disturbances, psychiatric morbidity and health status, concluded that binge eaters had greater disturbances in eating attitudes and behaviour, have poorer physical and mental health status and possible impairment to control hunger/satiety.

A recent literature review from a Pubmed and Medline search dated after April 2006 to determine the impact of binge eating on the outcome of post bariatric surgery by Niego, Kofman, Weiss, & Geliebter (2007), indicated that patients with pre-surgical binge eating are more likely to retain the eating pathology and to have poorer weight loss outcome post surgery. A study by

Malone & Alger-Mayer (2004) one year post surgery, found that patients with the most severe binge eating behaviour prior to bariatric surgery showed most improvement when assessed one year after surgery. Niego et al. (2007), if compared on face value to Malone's study, seem contradictory, but both reflect negatively on the aspect of binge eating, although Malone's results reflect on the severity of binge eating and the impact on depression and quality of life one year after surgery. Niego et al. (2007) also found that patients who binge eat prior to surgery report continued feelings of loss of control after surgery and they caution clinicians that the bariatric patient's perception that surgery will change the behavioural pattern of binge eating might be a false perception. The researcher, in dealing with bariatric patients, also observed that this "false" expectation among binge eating bariatric patients causes feelings of disappointment post surgery if the issues were not addressed prior to surgery (psycho education). These expectations and others will be discussed in more detail later in this chapter.

Ceru'-Bjork, Andersson & Rossner (2001) indicated that the prevalence rating of NES among obese individuals range from 8% to 64% and among bariatric surgery candidates from 10% to 42% according to Hsu, Betancourt, & Sullivan (1996) and Powers (1999). At present, Night eating syndrome (NES) is not included in DSM-IV-TR (American Psychiatric Association, 2000), and is considered as a variant of eating disorders not otherwise specified. Devlin et al. (2007) reflected on NES as a phase delay in the circadian pattern of eating, nocturnal ingestion or grazing during the night, and in most instances the compulsion to eat is too overwhelming and perceived as necessary in order to fall back to sleep. Many people with NES have no appetite or attempt to restrict their eating the following morning in order to mitigate the effects of their night snacking. Stunkard & Costello (2003) described NES as a stress-related eating, sleeping and mood disorder that is associated with disordered neuroendocrine functions, that, according to preliminary evidence, follows a characteristic circadian pattern according to which patients with NES responded well to agents that enhance serotonin function. De Zwaan (2005) also indicated that controlled treatment studies targeting night-time eating, employing melatonin and sertraline, are ongoing in spite of other preliminary evidence that the use of d-fenfluramine, Gamma-

Hydroxybutyric acid (“GHB” a known social street drug) and oxazepam show some positive but mostly equivocal results in treating this syndrome. Saunders, Johnson, & Teschner (1998) reported “grazing”, “picking” or “nibbling” to be common eating behaviour among bariatric surgery candidates and therefore consider NES and grazing as contributing factors to weight gain, forms of obesity and even as related to obesity-medical conditions.

In conclusion, Hsu, Sullivan, & Benotti’s (1997) reflections on eating pathology in general, indicated that patients with pre-surgically eating disorders may experience short-term improvement in their eating disorders after bariatric surgery that erodes or alter after two years and is related to weight gain. Short-term improvement as evident in a study by White, Masheb, Rothschild, Burke-Martindale, & Grilo (2006), indicated that regular binge eating prior to surgery does not appear to be a negative prognostic indicator at 12 months post bariatric surgery, although they admit to the limitations of their study in terms of long-term outcomes. The length of time from surgery and eating disorders prior to surgery therefore predicts the outcome after bariatric surgery. In support of Hsu’s (1997) findings, Niego et al. (2007) concluded that eating pathology prior to and post-operatively, as well as the perception that surgery alone may fundamentally alter underlying eating pathology, specifically those with binge eating, is merely like putting “a band-aid on a long-term psychological disorder”.

Psychosocial issues

Grilo et al. (2006), unlike Buser (2004) found a statistically higher depression score at 12 months post bariatric surgery and also a higher depression score among sexually abused patients between 5 and 9 months post bariatric surgery, but no differences at the 12 month post bariatric surgery evaluation. The different methodological approaches and sample size between these two studies might explain the opposing result.

Robert & Gabriela (1991) claim that gastric bypass surgery has a dramatic weight loss effect on some patients with concomitant improvement in most aspects of social functioning, but that personality and psychological dimensions post surgery do not change in most cases.

A study by Bond, Evans, DeMaria, Wolfe, Meador, Kellum, et al. (2006) to examine quality of life and physical activity readiness among gastric bypass surgery patients prior to surgery, found positive changes in mental and physical health status as well as physical activity behaviour and related intentions. According to these researchers, the findings might indicate that morbid obese patients who are typically resistant to pharmacologic and behavioural interventions may be more amenable to behavioural changes during the pre-surgical period. They further state that maintenance of physical activity behaviours pre-surgically, might be the ideal point to target prospective bariatric patients. The maintenance of physical activity behaviours post-surgery may therefore potentially contribute to long-term weight maintenance as a conclusion of their results.

Patients' expectations and perceptions

To list all the psychological and medical expectations that bariatric surgery candidates have is way beyond the scope of this research. Therefore, some measurable aspects of outcomes after bariatric surgery in terms of expectations will henceforth be discussed.

Most bariatric patients have expectations to have a better quality of life, less medical problems and improved self-image that will enable them to engage in meaningful relationships (social, work and interpersonal) without the bias, discriminatory and stigmatised attitudes they so often have to endure. The expectations mentioned seem very realistic, but in reality the expectations about the amount of weight they will lose post surgery are not always what they expected. An unrealistic expectation of the course of weight loss after surgery causes their perceptions of bariatric surgery to become less favourable, mainly during the period following surgery. This notion emphasises the need for psycho-education to instate some realistic

expectations and perception changes that need to be taken care of even before surgery. The rationale is to create realistic expectations about outcomes which are believed to be of more value to the patient who enrolled for bariatric surgery.

A study by Walfish & Brown (2006) among 250 female patients pre-operative, indicated that nearly one third of the sample expected to lose between 91-100% of their total weight loss goal within the first year post-operative. A significant portion of patients had 12-month weight loss goals that may be unrealistic. Unfortunately, extrapolating from patients entering non-surgical weight loss programmes, Grave, Molinari, Petroni, Bondi, Compare, Marchesini, et al. (2005) found that patients with the largest expectations within a one year drop in BMI, also had the highest dropout rate from treatment. Therefore, this clearly indicates that realistic goals about expectations post bariatric surgery might counter the disappointment of false perceptions and expectations about outcomes among surgical patients.

Psychological assessment of bariatric candidates

To report on all the psychological assessments currently in use (psychometric instruments, self-report inventories and programmes) to evaluate and support patients going for bariatric surgery is not the focus of this study, and the researcher will only briefly reflect on some of the leading trends. This section will also highlight some of the most prominent predictors of post-surgery outcomes; these reflections will not form the basis of this research, although it is necessary to explain potential pitfalls before, during and after surgery within the context of the experiences of the bariatric patients' "voices".

Mitchell, Swan-Kremeier, & Myers (2007) suggest that a psychological assessment is of paramount importance due to the potential for untoward physical complications and the long-term behavioural changes, necessitated by bariatric surgery. At present, there is no standardised approach to assessment; there is also a lack of agreement regarding what should be included in

such assessments. There is even less agreement in terms of exclusion criteria for adolescent bariatric candidates (LeGarde, 2006). Very few psychological factors are thought to preclude bariatric surgery, even such conditions as psychosis, mental retardation, active substance dependency, excessive impulsivity and severe hypochondrias. In most instances, case-by-case decisions are made by the bariatric team (New IPEG Guideline, 2003) and according to Greenberg, Perna, Kaplan, & Sullivan (2005), due to the high incidence of depression (three to four times higher than lean peers), negative body image, lowered self-esteem, eating disorders and low quality of life in severely obese patients, a comprehensive multi-disciplinary programme that incorporates psychological and behavioural changes is considered of critical benefit in enhancing compliance, outcome and quality of life among bariatric surgery patients. Additionally, Ritz (2006) proposes that the assessment of bariatric candidates should also include factors associated with the onset of obesity, maintenance factors, unusual life stressors, coping skills and psychological resources.

A current comprehensive assessment of past psychological status should include an evaluation of any psychological indicators that may negatively reflect on the outcome of bariatric surgery and should include a review of self-report inventories and face-to-face interviews ideally by a behavioural specialist who works with the rest of the bariatric team. Self-report inventories, as proposed by Mitchell, Swan-Kremeier, & Myers (2007), should assess key topics such as prior weight loss attempts, nutrition history, mood, disordered eating behaviours and beliefs (Kalarchian, Wilson, Brolin, & Bradley, 2000), medical history, knowledge of the surgical procedure and risk, motivation and expectations of surgical outcome, support system and relationships, psychiatric functioning as well as quality of life.

According to surveys about psychological evaluation practices (Bauchowitz et al., 2005), 188 "Bariatric Surgery Programmes" were compared. Eighty-one surveys were returned and according to the results of the surveys there are little consensus about screening procedures or criteria for bariatric patient selections. The results of this survey also indicated that 88% of

programmes require patients to undergo a psychological evaluation and almost 50% require formal standardised psychological assessment for patients before bariatric surgery. Evident to the results of the survey, the inclusion of mental health professionals in the assessment of bariatric patients is rather the norm than the exception. The results also indicated that the most commonly used assessment instruments for bariatric patients were the Beck Depression Inventory (BDI) and Minnesota Multiphasic Personality Inventory (MMPI). According to the researcher, the exclusion criteria for surgery vary greatly among the respondents. Commonly cited indications for bariatric surgery preventing patients from gaining approval for surgery (Sarwer, Fabricatore, & Wadden, 2006), included selected screening for severe depression, untreated or under-treated mental illness associated with psychoses, bulimia nervosa, socially disruptive personality disorders, current illicit drug use that include the use of tobacco, active symptoms of Schizophrenia, severe mental retardation and lack of knowledge of the surgery. The use of tobacco products was considered a contraindication for 36% of the respondents from this survey. From the respondents, 90% considered active depression as a definite or possible contraindication for surgery.

Some of the more prominent pre-surgical psychological assessment and support programmes available for bariatric surgery include: "The Boston Interview for Gastric Bypass" (Sogg & Mori, 2004); "Suggestions for the pre-surgical psychological assessment of bariatric surgery candidates" (Allied Health, October 2004) and "Bariatric Analysis and Reporting Outcome System (BAROS)" (Oria & Moorehead, 1998). The above-mentioned assessment programmes are merely an attempt to find a standardised protocol for the assessment of bariatric candidates. To date little empirical data that specifies successful surgical outcomes are available, therefore more research is needed to conclusively predict patients' long-term adaptation to bariatric surgery (Sogg & Mori, 2004).

Psychological management of bariatric patients

When dealing with obese patients who have been diagnosed with not only complex eating pathology but also Complex Trauma, therapists should be aware of the various philosophical underpinnings of the different approaches for dealing with these patients. Perlman, Reinhold & Nadzam (2007) rightfully states that in order for therapists to deal with traumatic life experiences, they have to understand symptoms in a theoretical context. This theoretical context provides a "map" for understanding the framework for locating their clinical observations. The wide arrays of treatment approaches are therefore not surprising if therapists consider some of the prominent philosophical underpinnings that help them to build theoretical models in treating these patients. To list all the philosophical approaches for treating these patients is beyond the scope of this study, but some of the more prominent philosophical approaches like Cognitive-Behaviourism, Psychoanalysis, Existentialism and the Constructivist's approaches should be seen as a basic foundation. Therapeutic modalities that evolved from these prominent philosophies and its variants include: Cognitive Behavioural therapy (Cognitive Behaviourism), Psychodynamic therapy (Psychoanalysis), Logo therapy (Existentialism) and Narrative therapy (Constructivism).

Psychotherapists who intend to guide bariatric patients through the "minefield" of severe emotional and physical stress need to realise that the majority of these cases need further intervention in order to contain patients' distress. In these cases, the need for a "safe environment" while helping the patient get "psychologically unstuck" from the claws of the severe impact of prolonged exposure to trauma and a chronic illness like severe obesity, can be a very complicated therapeutic effort and knowledge in the form of a typology can be considered a "roadmap" when treating these patients.

In retrospect, the researcher used an integrated philosophical and theoretical approach in dealing with complex obesity-trauma cases, with specific focus on the relationship between patient and therapist. For the researcher, safety, trust and transparency in the therapeutic

relationship are regarded as paramount for positive therapeutic outcomes. Kinzie's (2001) work with massively traumatised refugees is considered the best description of the researcher's approach in dealing with Complex Trauma cases. He placed less emphasis on the various techniques used in therapy and focused more on the importance of the relationship with the patient. Kinzie also suggests four factors required to deal with Complex Trauma cases: 1) The need to tell the trauma story and the therapist's ability to listen; 2) The patient's need for constancy over time and the therapist's ability to stay; 3) The patient's need to give and the therapist's ability to receive from the patient (obviously within ethical boundaries and the context of the therapeutic process); and 4) The problem of evil and the patient's search for sacred and the therapist's ability to believe.

In spite of only a few anecdotal reports and research studies regarding the management of post-operative symptoms among bariatric patients, a single published controlled trial (Tucker, Samo, Rand & Woodard, 1991) of 32 bariatric patients indicated no significant statistical differences among the two randomised assigned groups (minimal versus behavioural intervention) regarding weight loss or ratings of daily caloric intake, frequency of vomiting, stomach pain, and emotional health. The behavioural intervention group received 12 educational packets about eating and lifestyle changes and monthly consultations (for 6 months) following surgery and did report greater physical activity, ate less dietary fat and reported greater family satisfaction than the minimal intervention group.

Although most studies show inconsistent results, available data suggests that surgical outcomes can be enhanced with ongoing therapy and regular attendance post surgery and that supportive and solution-focused pre-surgical intervention can be beneficial to those patients identified with risk factors such as BED (Mitchell, Swan-Kremeier, & Myers, 2007).

The researcher's observations suggest that patients tend to neglect the long-term maintenance of their mental health post surgery, resulting in negative eating habits as evident of the reoccurrence of BED in some cases, two years post-operatively.

Pre-surgical and post-surgical interventions

Detailed descriptions of the various interventions prior to and post surgery is not the main focus of this study and will therefore be briefly discussed in the following section. Bariatric patients usually progress through three phases and interventions should be customised according to the individual's needs (Mitchell, Swan-Kremeier, & Myers, 2007). The first phase is considered the period before the operation, the second phase is the period from the surgery up to six months post-operatively and the third intervention phase is 18 to 24 months post bariatric surgery.

The first phase is characterised by a thorough clinical assessment. Although most patients are excited about the possibility of radical weight loss, some appear to be more apprehensive. A non-judgmental approach similar to the motivational type of interviews designed for substance abuse patients can also be used for bariatric patients (Miller & Rollnick, 1991). Depending on the therapist's approach to the pre-operative phases, psycho-education about the impact of rapid weight loss either/or on the individual and others, possible risks or complications, and if appropriate the patients' partner or support systems' role prior to bariatric surgery is considered an important aspect of the preparation phase for bariatric surgery.

During the second phase (up to 6 months post-operatively), patients usually experience a radical increase in weight loss and improvement in emotional functioning. The lack of commitment to comply with a regular exercise programme also seems to be problematic during this phase and patients should be motivated and supported to adhere to a goal oriented exercise regimen. Kalarchian & Marcus (2003) suggest that the focus during this phase should be to

assist the patient with behavioural adjustments (e.g. to eat slower, chew thoroughly, avoid high-calorie beverages, and learn to respond to the physical sensation of fullness).

Characteristic of the period 18 – 24 months post-operative (third phase), is the decline in psychological functioning and social relationships. Pre-morbid conditions might also re-emerge during this phase and the therapist should follow up on the patient and attempt to motivate those with emotional difficulty to take part in supportive psychotherapy. Marital discord, especially if present before the surgery, might become troublesome for the patient during this period and couples therapy can be of great value to the relationship. As already discussed in this chapter, BED symptoms and behaviour might also reappear and as suggested by Peterson, Mitchell, Engbloom, Nugent, Mussel, Crow, et al. (1998), should be treated with Cognitive Behavioural Therapy (CBT). Some CBT techniques, like the use of distracting activities/behaviour and cognitive restructuring to address problematic and/or self-sabotaging thoughts, seem to be most effective when dealing with BED symptomatology. Advice to the patient to engage in regular eating patterns also seems to be effective. During this third phase, issues with body image distortion, insufficient coping styles and lack of self-assertiveness also seem prominent issues of the long-term adaptation after bariatric surgery.

Possible bias and discrimination towards obese individuals

Clear and consistent discriminatory attitudes and stigmatisation towards obese people appear to affect mostly three important areas of living: employment, education and healthcare (Puhl & Brownell, 2001). It is the researcher's opinion that discrimination and biased attitudes towards obese people can be extended to social and interpersonal relationships and, most importantly, the perception of the obese person towards the "self".

Various experimental studies (Decker, 1987; Klassen, Jasper, & Harris, 1993; Rothblum, Miller, & Garbutt, 1988) suggest that overweight people may be at a disadvantage even before

the work interview process begins. Obese applicants were labeled as lacking self-discipline, having low supervisory potential, and having poor personal hygiene and an unprofessional appearance. Further evidence, as reflected by comprehensive literature reviews by Roehling, (1999) and Paul & Townsend (1995) on employees, indicated that in general, obese employees are assumed to lack self-discipline, are lazy, less conscientious, less competent, sloppy, disagreeable, and emotionally unstable. Furthermore, the perceptions among employers are that obese employees think slower, have poor attendance records, and are poor role models, therefore these stereotypes could affect promotions, wages and even termination.

Grilo, Wilfley, Brownell, & Rodin (1994) concluded that their research indicated that long-term exposure to weight-based teasing during childhood and adolescence was related to more negative self-perceptions of attractiveness and more body dissatisfaction during adulthood. Irving's (2000) research indicated that 91% of overweight children felt ashamed of being overweight, 90% believed that if they lose weight, the teasing and humiliation from peers will stop and 69% believed that they will have more friends if they are thinner. Evident from this study was the perception among overweight children that their low self-esteem was due to their own inability to lose weight and that their weight issues were the reason why they have few friends and are often excluded from games and sports. Both Solovay (2000) and Canning & Mayer (1966) reported stigmatisation to be more overt at higher levels of education, as evident in reports of overweight students receiving poor evaluations and poor college acceptances due to their weight. Furthermore, evidence that despite equivalent application rates and academic performance, obese students, if compared to non-obese peers, are significantly less likely to be accepted for college/university. Moreover, obese men (42%) were accepted more frequently than obese woman (31%) (Solovay, 2000).

Even parental bias seems to be evident of the prejudice and discrimination against the obese student. Crandall (1995) and Puhl & Brownell (2001) indicated that there is a tendency for parents to provide less college support for their overweight than thin children. Stigmatisation,

rejection and harassment of obese children at school due to the attitude of not only peers, but parents and adults, therefore pose an important social problem to the obese person.

According to a study among 400 physicians, rating their feelings of discomfort, reluctance or dislike about patients, Klein, Najman, Kohrman, & Munro (1982) reported that a third of the sample listed obese patients to which they responded negatively. Physicians associated obesity as a condition with poor hygiene, noncompliance, hostility, and dishonesty. A similar study of 318 family physicians, using anonymous questionnaires, found that two thirds of the physicians rated obese patients as lacking self-control and that they consider obese people as lazy (Price, Desmond, Krol, Snyder, & O'Connell, 1987). In another study, examining the attitudes about obese patients among healthcare professionals specialising in nutrition, 88% said that obesity was a form of compensation for lack of love or attention, and 70% had the opinion that obesity is caused by emotional problems. Even among nurses, a study by Maroney & Golub (1992) indicated that 48% of nurses felt uncomfortable caring for an obese patient and 31% preferred not caring for obese patients at all, and even felt "repulsed" by obese patients (24%).

Although not well researched, early indications imply that other forms of discrimination, exclusion and biased behaviour towards obese people are far-reaching, affecting public transport users (e.g. air travel and busses); jury selection in countries where a juror system is used, allocation of and acceptance for housing and even denying obese people the right to adopt (Puhl & Brownell, 2001).

Various other studies (Rand & Macgregor, 1990; Adams, Smith, Wilbur, & Grady, 1993; Olson, Schumaker, & Yawn, 1994 and Fontaine, Faith, Allison, & Cheskin, 1998) also indicated that women tend to be more reluctant to have frequent examinations as their body weight/BMI increase. Body image also makes women less likely to report for pelvic and breast examinations. Even among physicians, one study indicated that 17% reported reluctance in providing pelvic examinations to very obese women, and 83% indicated reluctance if the patient seems reluctant

to have the examination done (Adams et al. 1993). This very attitude, not only from physicians but also patients with weight problems, implies that obese women may not receive the necessary treatment and pre-causative examinations needed in order to prevent other chronic medical illnesses in time. This stance not only causes the severely obese patient to seek medical healthcare to prevent secondary medical conditions that stem from obesity, but also causes the obesity to be untreated, resulting in even more damaging effects on the self-perception (psychologically) of the obese patient. As Myers & Rosen (1999) concluded in their research of stigmatisation and coping among obese individuals: the more frequent the exposure to stigmatisation, the greater the psychological distress; and the more one attempts to cope, the more severe obesity becomes, eventually linking certain coping strategies with greater distress.

More specific, a prior study found that 80% of bariatric surgery patients felt disrespectfully treated by members of the medical profession (Rand & Macgregor, 1990). Another study by Wadden, Anderson, Foster, Bennett, Steinberg & Sarwer (2000) found that 8% of these patients reported that they were usually or always “treated disrespectfully by members of the medical profession” due to their weight and more than half of these 259 women with a BMI of 35.2 kg/m² indicated that their doctor rarely spoke with them about weight control. These extremely different results suggest that in the past decade, doctors’ interaction concerning weight may have improved (Anderson & Wadden, 2004)

A survey-based research study (Perlman, Reinhold, & Nadzam, 2007) indicated that family practitioners thought that only 6% of obese patients will be best controlled surgically, 85% had referred patients for gastric bypass surgery and only 57% were comfortable explaining the procedure. Another study about the beliefs and attitudes of primary care physicians also indicated that 84% of the respondents support the recommendation of gastric bypass surgery for patients who do qualify for the procedure, but there was a significant gender difference with female physicians being less supportive than male physicians (Sansone, MacDonald, Wiederman, & Ferreira, 2007). Furthermore, the most common reason for refusal to refer for

surgery was fear of complications and death. Among the group of respondents, 84% were familiar with gastric bypass, 66% with Lap Band, 33% with vertical banded Gastroplasty and only 5% with duodenal switch procedures. They also believe that nausea was the most common side effect, followed by anemia and fatigue, while 53% believed that bowel obstruction was common. A study among 607 general practitioners in a region of France revealed that 90% of the respondents consider obesity a disease, 42% consider themselves well prepared to manage obesity and 51% find obesity management to be professionally rewarding. The majority of the respondents do not consider collaboration with other health professions like dietitians and psychologists as a priority in managing severely obese patients (Thuan & Avignon, 2005). These results clearly indicate a lack of knowledge and positive attitude towards bariatric surgery. The researcher is of the opinion that the lack of knowledge about some of the procedures might be one explanation for the negative attitude about bariatric surgery among family practitioners. The use of educational programmes might be beneficial to those who are not correctly informed; when dealing with severely obese patients, this would hopefully result in a better understanding of the various procedures and the true risks involved.

Conclusive links between childhood maltreatment, Complex Trauma, obesity and bariatric surgery as a forced behavioural intervention

A comprehensive systematic literature search by Van Hout, Van Oudheusden, & Van Heck, (2004) indicated that morbidly obese patients, and specifically those seeking surgical treatment, are described as depressed, anxious, having poor impulse control, low self-esteem and impaired quality of life. The typical symptoms and behavioural aspects of obese patients, based on their research, indicate a similar constellation of some of the symptoms as described by Herman (1992a) as Complex PTSD and Luxenberg, Spinazzola & Van der Kolk (2001) as DEPNOS, commonly found among patients who present with a complicated form of trauma (Complex Trauma).

Based on the literature review as discussed in this chapter, the researcher came to the conclusion that some obese adults who had to endure prolonged childhood trauma, genetic and psychobiological influences combined with environmental factors (e.g. exposure to various forms of childhood maltreatment), have the potential to present with a psychological symptom constellation, known as Complex Trauma.

The various characteristics of the Complex Trauma constellation of symptoms are commonly found among eating disordered patients and excessive food intake, which can lead to obesity, and acts as an adaptive function to symptoms unique to Complex Trauma.

Although the impact of early traumatic exposure as a leading factor in the development and maintenance of obesity is presented as a negative life stressor, the sometimes traumatic impact of a positive life stressor like a forced behavioural intervention (bariatric surgery) not only serves as a remedial mechanism to a life threatening chronic illness and the co-morbid diseases associated with obesity, but also as an emotional lifesaver from the claws of various associated mental illnesses.

In an attempt to give a “voice” to those who had to endure a procedure like bariatric surgery, the final chapter will link the evidence and conclusive findings as guided by this literature review to the “voices” of bariatric patients. Ultimately, the aim is to reflect on bariatric patients’ “voices” in the search for clarity and understanding of the true experiences these patients had to endure.

CHAPTER 3

RESEARCH PARADIGM, THE EPISTEMOLOGICAL “STANCE” AND METHODOLOGICAL PROCESS

Research paradigm

The term paradigm refers to the researcher's interconnection between his epistemology, ontology and methodological beliefs (Denzin & Lincoln, 1994). This implies that the researcher's beliefs and perceptions will be reflected by the research and the research methods. Garbers (1996, p.337) described a paradigm as follows: “(the) metaphysical, theoretical, conceptual and instrumental convictions of the particular scientist and those of the group, which, in the scientist's discipline, has sanctioned the paradigm as the authorized method of explaining the phenomenon in the field of study”.

Ontology refers to the nature of “reality” or phenomena under observation. The nature of this “reality” is considered dynamic, which can be shaped and reshaped depending on the nature of the context and ecology of the ideas of the problem system. The procedures and steps followed in the observation as part of the research process refer to the methodology (Terre Blanche & Durrheim, 1999).

The epistemology of this researcher is based on social constructionism, interested in the relationship patterns and meaning systems as part of a social interaction process. The researcher's epistemological and theoretical framework not only explains the observations made, but fulfils an important role in the construction and determination of the observed phenomena (Keeney & Morris, 1985).

For the researcher, his research findings will be reflected in terms of his epistemological beliefs and theoretical references, and this is considered non-static. As Keeney (1987) indicated, the mere attempt to describe one's epistemology, already changes his/her assumptions and meaning systems.

Introduction to a qualitative research paradigm

Strauss & Corbins' (1990, p.17) broad definition of qualitative research implies: "any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification". Opposed to quantitative researchers who seek causal determination, prediction, and generalisation of findings, qualitative researchers seek illumination, understanding, and extrapolation to similar situations, therefore qualitative analysis results in a different type of knowledge than quantitative research.

Qualitative methods can be used to understand any phenomena about which little is known in a much better way; these methods are also used to gain new perspectives about things which are known already; or to gain, in contrast to quantitative research, more in-depth information. Qualitative methods of inquiry seem more appropriate in situations where the researcher needs to identify the variables that might later be tested quantitatively first or in cases where the researcher has determined that quantitative measures cannot adequately describe a situation (Strauss & Corbin, 1990).

Lincoln & Guba (1985, p.120) stated that "if you want people to understand better than they otherwise might, provide them information in the form in which they usually experience it". The rich detail and insight into participants' experiences of the world may therefore be more meaningful if presented in a way that is epistemologically in harmony with the reader's experiences.

Characteristics

As pointed out by Patton (1990, p. 59), there are no “absolute characteristics of qualitative inquiry, but rather strategic ideas that provide direction and a framework for developing specific designs and concrete data collection tactics” and that these characteristics are considered “interconnected” (Patton, 1990, p. 40) and “mutually reinforcing” (Lincoln & Guba, 1985, p. 39).

Several authors identified what they consider the most common characteristics/“strategic ideas” (Patton, 1990) of qualitative research (Bogdan & Biklen, 1982; Lincoln & Guba, 1985; Patton, 1990; Eisner, 1991; Schurink, 1998/2000). The following list presents a synthesis of these authors’ descriptions of qualitative research, which forms the basis of this researcher’s qualitative research paradigm:

- The natural setting is used as the source of data, implying that the researcher attempts to observe, describe and interpret settings as they are, therefore maintaining what is known as “empathetic neutrality” (Patton, 1990, p. 55).
- Attempt to develop concepts, insight and understanding from patterns in the data (inductive reasoning).
- The researcher acts as a “human instrument” of data collection.
- Aims at discovering the meaning that events have for the individual who experience them and the interpretations thereof by the researcher (interpretive).
- Aims to understand the meaning that people attach to everyday life, the idiosyncratic as well as the pervasive, seeking the uniqueness of each case (ideographic).
- Reality is regarded as subjective.
- Concepts are based on themes, motives and categories.
- Is more descriptive, incorporating expressive language and as Eisner (1991, p.36) named it “presence of voice in the text”.

- Is more emerging than predetermined in terms of design and the researcher's focus on the emerging process as well as the outcomes of the research.
- Attempt to understand phenomena.
- Data is presented in the form of quotes and words from documents and transcripts.
- A unique research design that is flexible throughout the research process implies no fixed steps that should be followed or exactly replicated.
- Data analysis is done by extracting themes.
- Holistic units of analysis with specific focus on the relationships between elements, context and phenomena, implying that the whole is always more than the sum.
- Information richness of the settings is determined by observations and the types of observations used are modified to enrich understanding.

Trustworthiness and criticism of qualitative inquiry

The unique and distinct approach to examine the world and seeking understanding from it (qualitative research) endured various attacks as laid out by the following charges against naturalistic studies, including qualitative research according to Lincoln & Guba (1985): “the naturalistic inquirer soon becomes accustomed to hearing charges that naturalistic studies are undisciplined; that he or she is guilty of ‘sloppy’ research, engaging in ‘merely subjective’ observations, responding indiscriminately to the ‘loudest bangs or brightest lights’. Rigour, it is asserted, is not the hallmark of naturalism. Is the naturalist inevitable defenceless against such charges? Worse, are they true?” Lincoln & Guba’s reply is a clear “no” as they explain that traditionally in the social science; four criteria are usually used to evaluate the merit of research: internal validity, external validity, reliability and objectivity. Most critics of qualitative research argue that there is no merit to qualitative studies because they do not achieve internal and external validity, and that the validity criteria are an inappropriate measure for evaluating

qualitative research. To rectify the notions of qualitative research critics, Denzin & Lincoln (1994) highlights the concept of “trustworthiness” as a collective term to replace the “validity criteria” for judging qualitative research.

According to Lincoln & Guba (1985), the question of trustworthiness in qualitative research is simple: “how can an inquirer persuade his or her audience that the research findings of an inquiry are worth paying attention to?” (p. 290). To answer this question, they suggested an alternative set of criteria to the typical quantitative (non-qualitative) research in judging qualitative research. The following table (Table 6) will be used to illustrate the comparison of criteria for judging the qualitative versus non-qualitative research with the goal of selecting criteria appropriate for judging the general trustworthiness of qualitative research:

Table 6: Comparison of criteria for judging the quality of non-qualitative versus qualitative research

Non-qualitative versus qualitative research
Internal validity versus Credibility
Discussion: Because you have to know the “precise nature of that reality”, internal validity refers to the extent to which the findings accurately describe reality and if this was already known, there would be no need to test it (Lincoln & Guba, 1985, p. 295). Unlike with internal validity, the naturalistic researcher assumes the presence of multiple realities and attempts to represent these realities adequately, implying that credibility therefore becomes the test for this (Hoepfl, 1997).
External validity/Generalisability versus Transferability
Discussion: External validity within the conventional research domain refers to the ability to generalise across different settings and involves a trade-off between internal and external validity according to Lincoln & Guba (1985). Generalisability allows a semblance of prediction and control over situations and therefore, according to Lincoln & Guba, appears to be an appealing concept. As stated by Cronbach (1975, p. 125), “when we give proper weight to local conditions, any generalization is a working hypothesis, not a conclusion”. For the qualitative researcher, the transferability of findings cannot be specified and can only provide sufficient information that the reader can use to determine whether the findings are applicable to new situations (Lincoln & Guba, 1985). Transferability as a “possibility” that was found in

one context by a piece of qualitative research, and applicable to another context, is encapsulated by Lincoln & Guba's (1985, p. 298) notion that "if there is to be transferability, the burden of proof lies less with the original investigator than the person seeking to make an application elsewhere. The original inquirer cannot know the sites to which transferability might be sought, but the appliers can and do. ...The responsibility of the original investigator ends in providing sufficient descriptive data to make such similarity judgments possible."

Reliability versus Dependability

Discussion: Lincoln & Guba's (1985, p. 316) summary of the essence of qualitative research is considered, according to the researcher, the most appropriate description of the issue related to reliability: "Since there can be no validity without reliability (and thus no credibility without dependability), a demonstration of the former is sufficient to establish the latter". Lincoln & Guba (1985, p. 317) also claim that the use of an "inquiry audit" implying that both the process and the product of research, as judged by the reviewer for consistency, can enhance the dependability of qualitative research.

Objectivity versus Confirmability

Discussion: Although contradictory, Patton (1990, p. 55), when entering the debate on objectivity versus subjectivity, suggests that the researcher should strive for "empathetic neutrality" that implies an attempt by the researcher to be non-judgmental and to report findings in a balanced way. Although qualitative researchers attempt to report findings in a value-free and objective manner, the qualitative researcher relies on interpretations and is value-bound. Within the context of qualitative research, Lincoln & Guba (1985) choose to speak of "confirmability" of research that refers to the degree to which the researcher can demonstrate the neutrality of interpretations through "Confirmability audits". They propose that the researcher can provide an audit trail consisting of 1) raw data; 2) analysis notes; 3) reconstruction and synthesis products; 4) process notes; 5) personal notes; and 6) preliminary developmental information. (pp. 320-321).

As stated by Patton (1990), the credibility of qualitative research relies on the confidence that the reader has in the researcher's ability to be sensitive to the data and the ability to make appropriate decisions in the specific field of research interest as supported by Strauss & Corbin's (1990) notion that theoretical sensitivity comes from various sources, including professional literature, professional experience, and personal experiences.

In general, criticisms of qualitative research mainly focus on the issue that subjectively describe the world of human experiences. Largely this is impossible due to the subjective experience of even the most seasoned of researchers (Myers, 2000), and therefore only an attempt to be objective through various methods as indicated in the above-mentioned discussion, poses helpful.

The epistemological “stance”

To explain the rationale for a qualitative approach to this study, the researcher also needs to expose his own epistemological approach / “stance”.

The inclusion and emphasis of, amongst others, social relationships, as part of the construction of realities, cause social constructivism to be relevant as theory and context within which this specific study is conducted. It does not imply that social constructivism is necessarily a “better” theory, but that it is possibly more appropriate in this specific study. The appropriateness is defined in terms of the focus of this study, namely the combined construction of perceptions and ideas in a problem system. Social constructivism also settles the influence of the greater social-cultural and historical contexts in the construction of realities. A narrative approach to the social sciences fit in with the assumptions and principles of a social constructivist theory. Narrative principles and ideas will accordingly also be used in this study in order to expand upon our grasp of occurrences.

The development of a social constructionist theory

The term social constructivism was developed during the late 1960's. The origin of social constructivism however dates back to the 1920's and the Swiss linguist, Ferdinand De Saussure. He investigated the nature and characteristics of language and consequently the influence of language on our world of experience. De Saussure developed hypotheses which are based on the assumption that our experiences in the social world is dependent on the

language that we use to describe these experiences. He also made the assumption that our observations are not reflecting an external reality, but are only a representation of a reality which is created in language (O' Leary, 2001).

Social constructivism was influenced by various disciplines such as philosophy, sociology, anthropology and linguistics (Gergen, 1991b). Philosophers such as Wittgenstein & Rorty claimed that words and gestures are only used to define and explain other words (O' Leary, 2001). It was only recently that theorists such as Anderson & Goolishian (1988), and Hoffman (1994), began to use these ideas as part of the psychology and psychotherapeutic practice.

A social constructionist theory emphasises language, the co-construction of meaning, as well as multiple realities (Hoffman, 1994). An important contribution of this theory to the psychology is the inclusion and recognition of social, historical and political interpretations as part of the process through which realities and meanings are constructed. These constructions happen by means of language, in interaction with others, and in coordination with the specific social, cultural and historical contexts (Drewery & Mackenzie, 1999).

Social constructivism is accordingly appropriate and useful in psychology since it provides an extensive insight by including aspects such as history, culture and social environment in the description of human behaviour. The emphasis is moved from the studying of the individual in isolation (or only as part of a family), to social descriptions of the individual or problem-system as part of extensive contexts.

Social constructionists are interested in language, but in contrast to their modernistic predecessors, less certain about its meaning. They claim that words only refer to other words. Meanings are filled with inevitable contradictions and are open for perceptual re-evaluation (Doherty, 1991). The solution of problems is not necessarily found in specific answers, but in the quest for meaning.

Social constructivism in context

Accordingly, certain ideas which are subject to a social constructivist theory, will be emphasised:

System of meaning

A basic characteristic of social constructivism is represented by the way in which we understand the world, that is, the meanings that we attribute to certain experiences. Meanings are only descriptions of the world and do not exist as fixed definitions of a so-called "reality" which can be discovered. The meanings that we create, form part of an active, cooperative process of people in relationships and are expressed by means of mutual definitions in language (Gergen, 1985). Anderson & Goolishian (1988, p.372) describe it as follows: "...(we) cannot arrive at or have meaning or understanding until we take communicative action, that is, engage in some meaning-generating discourse or dialogue, within a system for which the communication has reference."

One of the essential ideas connected to social constructivism is that there exist no concrete facts that can be objectively observed. Our observations are dependent on specific interpretations through which meanings are attributed (Hoffman, 1990). These meanings are only temporary and form part of a dynamic communication process where new meanings can potentially develop. Even accordance is continually open for negotiation and dispute (Anderson & Goolishian, 1988).

Meaning only comes to the fore as part of the process of social interaction. Meanings are not created in isolation nor are they maintained; they require a measure of mutual agreement. Hoffman (1994) refers to these partial meanings as "inter-subjectivity" (also called "consensual domain"). Inter-subjectivity in the context of social constructivism implies

that two or more people in a specific conversation agree that they experience the same event in a similar way, thus, social consent is reached by means of negotiation. Shared realities enable us to maintain meaningful contact with one another. It creates a context within which differences will come to the fore and where fixed perceptions will be challenged.

The story metaphor

Stories, as part of a narrative approach, provide a framework within which experiences can be organised, thought through, observed, remembered and lived (Holstein & Gubrium, 1997). This implies that stories create a specific context in which our experiences are interpreted. Meanings are constructed in order to fit with these stories. Stories are a way in which meanings are shared and conveyed. We act in interaction and expose ourselves by means of mutual stories.

Each person has certain dominant or primary stories. That is, specific stories that are chosen as part of the attempts to make sense out of experiences. However, dominant stories are not the only available stories in a system. Underlying this are stories which are dormant ("marginal stories"). This means that certain experiences are emphasised to fit into a specific storyline (dominant stories), while contradictory experiences are under-emphasised or avoided (dormant stories). Accordingly, memories are organised by means of dominant stories. This implies that stories which are used to describe happenings already contain certain meanings. In other words, memories are not necessarily a true representation of happenings, but already contain specific interpretations and meanings in order to fit into a dominant storyline. A story is constructed so that it can be accepted by a person and his/her specific social-cultural environment (Allen & Allen, 1997).

Narrative metaphors are thus not constructed in isolation, but in the shared context of language and relationships (Gergen, 1989). The specific person's individual opinions, as well

as the dominant ecology of ideas in his/her specific social group, influence the way in which stories are formulated. The development of stories happens accordingly within the boundaries of political, economic, social and cultural contexts. The choice of stories does not happen unlimited, but are determined to a large extent by the prescription of the respective contexts within which a person moves (Lax, 1992). The therapeutical conversation forms part of a particular context where members of the problem-system can repeat dominant stories of trauma. A context is created where dormant stories are emphasised, and new stories can consequently be developed.

Stories contain flexible rules where happenings are interpreted in a particular way. No value-judgment regarding "the best" or "the worst" story is made (Hoffman, 1994). Because this study focuses on the traumatic experiences and constructed meanings of a problem-system, it appears that a narrative metaphor, as an additional way to elaborate on meaning, can be used appropriately.

Joint constructed truths and realities

Social constructivism questions any position that strives for an absolute truth, ideal discourse or objective knowledge. Any position that lays claim to a final theory of correct interpretations is rejected (Gergen, 1991a; Hoffman, 1994).

Social constructionists especially emphasise the intersubjective influence of the family, cultural context and language in the forming of these specific realities. Hoffman (1994, p. 82) describes it as follows: "...what we know evolves...in the densely languageed give-and-take between people." Social artifacts of products of historical interaction, as part of a specific community, form part of the reality forming process of a problem-system. Reality exists in the social sphere where language, action and meaning meet. Social constructivism emphasises thus that meanings are developed continuously and change as part of a dynamic, social process. These social meanings form part of a joint decision-making process which can be reached by

means of language and social exchange. This process can be binary. On the one hand, decisions are made jointly regarding moral beliefs and social relationships. On the other hand, existing rules and values are challenged. In both instances there is no objective judge with a final decision as to the correct choice or meaning which can be attributed to a given happening (Gergen, 1985; Hoffman, 1994).

Language

Social constructivism underwrites that meaningful behaviour is created by means of the language that we share. Language is used to construct sense and give meaning to events and is the medium through which our beliefs are formed (Anderson & Goolishian, 1988).

The functional worth of language is twofold. It is used on the one hand to get to know a specific community and on the other hand to construct the nature of the community. Language is thus used to adopt the characteristics of a specific community and simultaneously to influence it. The person with which we communicate at any given moment influences the choice to include certain opinions in the conversations, and to exclude others (Gergen, 1985; Matthews, 1996). Language reflects thus not only our own isolated opinions, but also reflects the opinions of people in the environment. It implies that language can extend or limit our possibilities. Language and culture are some of the essential components in the complex combination of behaviour and action in a social community (Efran, Lukens & Lukens, 1988).

Social constructivists aim to make explicit those processes through which people describe their world (Gergen, 1994). Individuals form part of a specific social group or community. In the process of socialising, acceptable communication patterns which fit into this specific community, are learned. The shared values and ideologies of a communication system are accordingly accepted as part of this process. Words are connected to previous conversations, symbols and metaphors. It reflects the underlying cultural values and norms of a

specific community. It implies that language and communication contain a certain aspect of predictability (Efran, Lukens & Lukens, 1988).

The socialising process is not static. The involvement in diverse contexts implies that certain aspects of language and other cultures and communities are taken in as part of the self. Language is part of a dynamic and developing process. The fluidity and continual changing characteristics of language and communication creates the way in which we experience the world at any given moment (O'Leary, 2001). Language is influenced by the current dominant discourse, but also influence the functioning of individuals and communities as part of a complex and intertwined process.

The Self in context

The technology of the 20th and 21st centuries, amongst others telephones, cell phones, vehicles, radios, air transport, computers, the internet and faxes, were the methods by which distance and space can be bridged easier and where communication occurs with less effort and time. However, this contributes to the fact that the social and cultural world expands and becomes more complex on a daily basis. Television and radio expose us to other cultures that were previously relative inaccessible and unknown. Competitive perception makes us aware that the world exists from more than just our own restricted knowledge (Gemin, 1999). Part of this social experience is to create a living space between the traditional and revolutionary, in order to connect fixed beliefs with freedom of thoughts. The possibility of singular choices is reduced because we are confronted with contradictory, but confusing convincing opinions from outside the self. The result of our involvement with multiple relationships, confrontations with never-ending possibilities and confusion regarding our own beliefs are described by Gergen (1991b) as the saturated self.

Gergen (1991a) claims that a person, as part of multiple relationships and interactions, absorbs numerous parts of others, like values, attitudes, opinions, lifestyles and personality

characteristics, as part of the self experience. "We have gathered so many bits of being to create ourselves that the pieces no longer mix well together, even contradict each other" (p. 28). "Identity" does not involve a singularity, but exists from multiple phases from which different choices of behaviour are made (Mahoney, 1993).

Social constructionists place emphasis on the interconnection between the self and social experiences. Identity is developed in relation to various perceptions that are based on aspects such as culture, ethnicity and sex (Matthews, 1996). The self is thus formed and reformed in dialogue with others, and is subjected to continuous change (Crossley, 2000). The development and adaption of our thoughts are inevitable in the search of shared realities and meanings. Gergen (1991b) describes it as follows..."each truth about ourselves is a construction of the moment, true only for a given time and within certain relationships" (p. 16). There is no absolute truth on which self experience can rest. This implies that the true self is never discovered. It doesn't mean however that the events in the social environment can not be absorbed in a passive way as part of the self. We react in a flexible and creative way on the changes in the environment (Cox & Lyddon, 1997; Crossley, 2000).

From a social constructivistic perspective, identity can also be defined as personal meaning systems that are created and recreated during the individual's experience of the world. A person's ability to self-reflection, as well as the joint reflections during social interaction, enables him/her to re-evaluate systems of meaning and make changes. The identity of self-experience is thus not an entity in its own, but forms part of a developing process (Cox & Lyddon, 1997).

Flaskas (1999) claims that individuals portray a certain image of the self in time and relationships. Although he uses the term "core self", this does not imply a fixed, unchangeable entity. It only means that certain ideas regarding the self are most likely "true" in most of the contexts in which the person moves. The core of human behaviour is experienced by means of a

central self, namely “me”, that feels, thinks and behaves in interaction with other people (Becvar & Becvar, 1996).

Is everything necessarily acceptable?

One of the most common misconceptions regarding social constructionistic thinking and constructed social realism is that it creates a framework wherein everything is interpreted as acceptable. This interpretation ignores one of the core assumptions of social constructivism, namely that we are not living in isolation, but are part of the social-cultural environment with specific prescriptions regarding acceptable behaviour. Our shared language distinctions form an integral part of our social realities. The way in which an event is constructed in the social domain/society, becomes inseparably a part of the way in which we experience it. Joint and shared definitions in a society influence accordingly the way in which an event is interpreted. Behaviour requirements and restrictions are built into the society's social reality (Efran, Lukens & Lukens, 1988). This implies that certain behaviour is regarded as acceptable in a specific community, while in another it is totally rejected. Rules, values and norms are jointly constructed stories which develop from the attempts to make sense of the chaos of the world (O' Hara & Anderson, 1991).

A social constructivist position does not imply that religion and belief systems are interpreted as worthless because of the so-called constructed nature of these systems. O'Hara & Anderson (1991) describe it as follows: "... we are reality-constructing, valuing creatures" (p. 25).

A constructed social reality is experienced as a fixed reality in the specific community. It is thus crucial that the therapist should be familiar with the value criteria which are applied in a specific community, in order to interpret the nature of their involved reality (Efran, Lukens & Lukens, 1988).

Physical problems such as poverty, rape, severe obesity, hijacking, family violence and other traumatic events are, within the framework, not only regarded as constructions. These events remind the social constructionist that he/she is also part of a concrete and physical world. Minuchin (1991) describes it as follows: "... in the face of such social reality, family therapists risk clinical irrelevancy by getting too wrapped up in abstractions about the subjectivity of truths" (p. 50).

Therapists can over-emphasise the relativistic nature of problem resolution, with the risk of reducing behaviour patterns such as physical abuse and molesting to nothing more than constructed and equivalent stories of those involved. In doing this, the ideas of social constructivism are reduced to an adapted form of modernistic practice.

Influences of social constructionist principles on qualitative research

Social constructionism was influenced by, amongst others, disciplines like philosophy, sociology, anthropology and language (Gergen, 1991b). Philosophers like Wittgenstein and Rorty assumed that words and gestures are used to refer to other words to define and explain phenomena (O'Leary, 2001). Only recently these ideas were incorporated into the psychology and psychotherapeutic practices by theoreticians such as Anderson & Goolishian (1988); Gergen (1991b) and Hoffman (1994).

Social constructionist theory emphasised language, the co-construction of meaning and multiple realities (Hoffman, 1994). An important contribution of this theory to psychology is the inclusion and recognition of social, historical and political interpretations as part of the process through which meaning is constructed. The various interpretations as part of the process of constructing meaning will be explored during the interview with the obese patient. Construction takes place through language, in interaction with others and in coordination with specific social, cultural and historical contexts (Drewery & Mackensie, 1999). This implies that the emphasis

placed on studying the individual in isolation is a social description of the individual and the problem-system as part of an extended context.

The social constructivist approach is interested in language and more focussed on the meaning of it. Meanings are filled with contradictions and are open for perceptual re-evaluation (Doherty, 1991). This statement implies that the resolution of problems is not only found in specific answers, but more in the finding of meaning. This study will therefore apply the principles of social constructionism in the understanding of bariatric patients and the emphasis on the meanings of their experiences (voices). The researcher accepts that there is an “inter-subjective understanding” between the patient and the observer. This inter-subjective understanding implies that the patient is not an “object/thing” under observation, but rather the same as the observer/therapist, a subject within the context of the same research entity under discussion.

For the purposes of this study, the interconnection between qualitative research methods and research principles of social constructionism will be highlighted according to the following assumptions:

- As indicated by Keeney & Morris (1985), the researcher forms part of the construction and observations. Social constructivism acknowledges both the expectations of the researcher and other members of the problem system (bariatric patients) as central to the research context. Broad agendas and tentative hypotheses of the researcher about his communications with literature and experiences with bariatric patients shape the qualitative method of the inquiry. As stated by Holstein & Gubrium (1997), an objective, unbiased data analysis from this perspective, seems unattainable.
- As pointed out by Holstein & Gubrium (1997), qualitative research requires a creative, flexible approach to enable the development and construction of new ideas and to be able to facilitate therapeutic conversations, stories and research procedures as an interdependent process.

- Social constructionist research is grounded on a relativistic ontology that implies that there is no objective reality. As indicated by Lincoln & Guba (1985), multiple realities are constructed in an attempt to create sense and meaning from observations and experiences. Therefore, for the purposes of this study, as pointed out by Atkinson & Heath (1985), it is impossible for the researcher to have direct access to the true reality of traumatic experiences as found among the group of bariatric surgery patients he observed.
- The researcher will attempt, as part of qualitative research from a social constructionist view, to expose his own preconceived ideas about the observations made, in order to prevent control over the co-constructed realities of bariatric patients (Gergen, 1999). As stated by Keeney (1987), observations are often influenced more by the observer than the observed, therefore implying that the researcher should approach phenomena under observation from a dialogue paradigm (descriptions about phenomena also expose the observer) as to a monologue paradigm (the observer observe phenomena as an outsider) (Keeney & Morris, 1985).
- As suggested by Jankowski, Clark, & Ivey (2000), a position of “not know” does not imply a lack of knowledge but rather an “interest” in the phenomena under observation as an active role.
- Language and communication form the basis of social constructivism as a means to get direct access to the co-researchers (bariatric patients) within a general communication context (Rizzo, Corsaro, & Bates, 1992). This will serve as a means to verify interpretations of the language used and the meaning thereof (Jankowski, Clark, & Ivey, 2000).
- Self-reflection as a common and reciprocity research process associated with a social constructionist approach (Steier, 1991), implies that the researcher’s own perceptions and behaviour becomes the target of observation and is built on previous conversations in an attempt to emphasise alternative perceptions. The researcher’s epistemological assumptions on the ecology of ideas within the problem system is best described by

Gergen (1994, p.48) as: "...reflexive doubt is not then a slide into infinite regress but a means of recognizing alterior realities, and thus giving voice to still further relationships. In this sense, constructionist scholars may employ self-reflexive deconstructions of their own theses, but simultaneously declaring a position, but removing authority and inviting other voices into the conversation."

- Social constructionism approaches proclaim that no single scientific method of inquiry can provide fixed results and is best described by Moon, Dillon & Sprenkle (1991), who described the research results in terms of "assertions", which imply that the meanings attached to data are negotiable. Therefore, the results of the observations are dependable on the quality of interaction between the researcher and the problem system.
- Social constructivist researchers attempt to link various relationship levels as part of the research process, and as stated by Sarbin & Kitsuse (1994), the researcher does not intend to explain traumatic experiences in terms of these relationship connections, but rather to describe the unique process that evolves.
- Perceptions of the participants in the problem system are considered, and the researcher does not attempt to oversimplify complex phenomena. Therefore, the researcher is focusing on the enmeshed perceptions and experiences as a sensitive and appreciable way through which units fit and adapt to situations (Efran, Lukens & Lukens, 1988).

The methodological process

An exploratory case study design will be applied to identify questions and specific constructs to be used in the analysis of the themes related to the study. This method of research enables the researcher to obtain a clear understanding of the causal factors and experiences of bariatric patients.

In order to narrow down the themes that the researcher will investigate initially, primary questions related to the lived experiences of adults suffering from obesity, will be explored and

strategies for data collection will be specified (Patton, 1990). As a prelude to social research, both Tellis (1997) and Pope, Ziebland & Mays (2000) suggest that in the case of exploratory case studies, fieldwork and data collection may be undertaken prior to the definition of the research problem, to allow questions to be refined and new avenues of inquiry to be developed.

To provide a more holistic view of the research subjects, the multi-design approach, also called "Patchwork case study", uses multiple case studies of the same research entity, and also makes use of snapshot, longitudinal, and/or pre-post designs (Jensen & Rodgers, 2001). This approach is particularly useful for this study because of the diverse nature and amount of information that needs to be incorporated among participants. Multiple methods will include semi-structured interviews, case notes, clinical observations, questionnaires, collateral information (where available) and secondary data analysis and thematic content analysis. As the study progresses, more methods could evolve and will be included as part of a multi-design approach.

Credibility

Patton (1990) states that credibility depends less on sample size than on the richness of the information gathered and the analytic abilities of the researcher. Credibility can be enhanced through what Patton identifies as four types of triangulation: 1) Methods triangulation; 2) Data triangulation; 3) Triangulation through multiple analysts; and 4) Theory triangulation. Lincoln and Guba's (1985) view suggest that credibility can be improved by making segments of the raw data available for others to analyse, in which respondents are asked to corroborate the findings ("member checks"). As part of this research, practical methods of triangulation will be implemented to corroborate the final findings in the form of trends and themes. The researcher decided to use five subjects for this research and chose participants who are representative of the specific research issues and who pose a richness of information related to the aspects under discussion in this study. As stated by Patton (1990), the richness of the subjects' "voices" and willingness to take part in the research guided the researcher in the selection process of the five

subjects. The researcher also selected subjects that are representative of the array of experiences documented in literature and commonly observed during his engagement with bariatric patients.

Sampling

Purposive sampling

The method used to select these cases was done according to “purposive sampling” as described by Hoepfl (1997). Purposive sampling, as an approach to an in-depth study, seeks information rich cases (Patton, 1990).

Among the 16 types of purposeful sampling as identified and described by Patton (1990), the researcher decided to apply the principles of “maximum variation sampling” as a specific form of purposive sampling. According to Patton (1990, p. 172), this strategy “aims at capturing and describing the central themes or principal outcomes that cut across a great deal of participant or program variations. For small samples a great deal of heterogeneity can be a problem because individual cases can be different from each other. The maximum variation sampling strategy turns that apparent weakness into strength by applying the following logic: Any common patterns that emerge from great variation are of particular interest and value in capturing the core experiences and central, shared aspects or impacts of a program”. Although purposive sampling can be very flexible, Patton (1990) alerts qualitative researchers to three types of sampling errors: 1) Distortions caused by insufficient breadth in sampling; 2) Distortions due to changes that may occur over time; and 3) Distortions caused by lack of depth in data collection at each site.

Selection of cases

The researcher has access to at least 400 potential research subjects. Patients with “information-rich voices” were approached individually to discuss their willingness to participate in the research. The researcher identified potential participants out of more than 400 respondents, based on the richness of their “voices”, willingness to participate and the information available from psychometric tests, questionnaires and case notes.

Potential subjects were identified that present with symptoms of Complex Trauma, and were approached individually, to discuss their willingness to take part in the research as proposed. Due to the researcher's long-term involvement and rapport with most of the patients under discussion, it was probable that most of the patients who met the following criteria were included in the study. Patients included in the study had to fit the following basic criteria:

- Adult males and females (not younger than 18 years);
- Bariatric patients who already underwent bariatric surgery and had the ability to provide detailed, rich information about their experiences;
- Only patients with a Body Mass Index of 35 and more, thus meeting the criteria for “obesity class II and III”, according to the WHO (World Health Organization, 2004), were included.
- Patients with a history of subjection to prolonged (months to years) totalitarian control or “bullying”/abuse within a traumatic context (childhood and adolescent) were included;
- All relevant other information, questionnaires and case notes should be available;
- Willingness to participate in the research and signing of the agreement/declaration was needed to participate in the study (a copy of the proforma agreement is attached - Appendix A: Participant Consent Form).

The case study design as a means of inquiry

Apart from the various types of case studies (illustrative, exploratory, critical instance, programme implementation, programme effects, cumulative, business school and medical case studies), the researcher chooses to use the exploratory case study design. Rogers (1978), who distinguishes case studies from case histories and projects, also suggests describing events in a framework within an environment. Problems are therefore not always highlighted or events made clear but rather emerge as the case information is subjected to analysis. He also states that a conclusion is not necessarily stated, nor is the situation reached in a case irreversible.

A hallmark of the exploratory case study design is to condense the case study process, specifically where considerable uncertainty about operations, goals and results exists. The intent is to help identify questions, select measurement constructs and develop measures even before implementing a large-scale investigation as a safeguard in larger studies. Distinguished pitfalls in the exploratory case study involve premature conclusions and the tendency to extend the exploratory phase, therefore creating inadequate representation of diversity. Another drawback is determining the actual subject and whether to study a “typical case, or a maximum variation case, or an extreme case” (Creswell, 1998, p. 112).

The case study design as a particular method of qualitative research provides a systematic way of looking at events, collecting longitudinal data, analysing information, and reporting the results. The complexity of dealing with obese patients enrolled for bariatric surgery often creates uncertainty among patients and the treating professionals about assessments, interventions, treatment goals and outcomes associated with bariatric surgery. The case study design will enable the researcher to capture the wide array of factors, according to a proposed typology of bariatric patients' experience of early trauma and the effects and implications for their involvement in bariatric surgery. This method of research enables the researcher to have a clear understanding of why the instances/events happened as they did, and what might become

important to look at more extensively in future research. The case study design will thus enable the researcher to capture the wide array of factors involved in bariatric surgery. A qualitative case study design lends itself specifically to generating (rather than testing) hypotheses.

Data collection techniques

Hoepfl (1997) refers to interviews and observations as the two prevailing forms of data collection associated with qualitative inquiry. The researcher will focus on primary and secondary sources of information. For the purposes of this study, the primary data sources are identified as the case notes, written documents, reports, questionnaires and information from the follow-up semi-structured interviews. In some cases, information from a partner was used as secondary sources of information. Observations made during therapy, as documented in the case notes, were used during the follow-up semi-structured interviews to correlate and explore themes unique to every patient.

Lincoln & Guba (1985) do not recommend recording of interviews, except for "unusual reasons". According to Hoepfl (1997), recordings have the advantage of capturing data more faithfully than written notes; therefore the researcher chooses to record the final semi-structured interview with the consent of the patient.

Case notes and other information were analysed and "mapped" with the intent to build a repertoire and reference of existing information of the bariatric patient's "living experiences" of early trauma and the effect of this on obesity, ultimately reflecting on the experiences of bariatric surgery. Possible themes and questions for further exploration during the semi-structured interviews will also be noted during this phase.

The interview and observations

Among the three types of qualitative interviewing styles (informal/conversational, semi-structured and standardised open-ended interviews) Patton (1990) describe, the researcher chose to focus on the semi-structured interview. The semi-structured interview evolved around the recalled and lived experiences of bariatric patients, with a history of early traumatic exposure to various forms of childhood abuse. Some of the questions related to the “Structured Interview for Disorders of Extreme Stress (SIDES)” (Pelcovitz et al., 1997), relevant literature, leading professionals’ descriptions, general observations as made during the engagement by the researcher in assessing and supporting bariatric patients who underwent bariatric surgery pre- and post-operatively, were used to conduct a semi-structured interview. Additionally, questions related to other aspects and experiences of the process of bariatric surgery were also explored during the final interview.

As Patton (1990) suggests, “interview guides” keep the interactions focussed and are flexible in nature as are the notions of a social constructivist approach to data gathering. Observations have the potential to lead to a deeper understanding than the interview alone and can provide the researcher with information that the participants themselves are not aware of, or unwilling to discuss (Patton, 1990).

Other available data

Other data, available from the participants, include: a completed questionnaire with open ended questions about the participants’ history; case notes of the evaluation process, therapeutic interventions and observations prior to and post bariatric surgery; and the content of the researcher’s “recommendation report for surgery” addressed to the surgeon. As indicated by Hoepfl (1997), other data have the potential to enrich the amount and quality of data gathered through the interview process.

Data analysis

Inductive data analysis

Tellis (1997) supports the notion that in exploratory case studies, the fieldwork and data collection may be undertaken prior to the definition of the research question, although the basic framework of the study should be created first. For the purposes of this study, no specific pilot study was done. The researcher's long-term involvement with bariatric patients warranted enough observed information (as Tellis, 1997 described as fieldwork) to exclude a formal pilot study before the collection of data could be undertaken. This approach might be in contradiction to the notions of Pope, Ziebland & Mays (2000), who suggest that an interim analysis (pilot study) be done, allowing the refining of questions and pursuing merging avenues of inquiry. According to the researcher, the broad spectrum of available literature and documented observations will be sufficient to collect in-depth information pertaining to the relevant research issues.

Thematic content analysis is a technique for gathering and analysing the content of text. The content can be words, phrases, sentences, paragraphs, pictures, symbols or ideas. It can be done quantitatively as well as qualitatively, and computer programmes can be used to assist the researcher. The mechanics for handling large quantities of qualitative data can range from physically sorting and storing slips of paper to using one of the several computer software programmes (like NUD*IST and AnSWR) that have been designed to aid in this task. The various languages used by the different patients, warrant that physical sorting and analysis of data will be a more appropriate mechanism for handling the qualitative data gathered for this study.

The data analysis will focus on traumatic experiences, obesity and bariatric surgery. "Other data", not specific to the focus of the inquiry, may highlight aspects not initially obvious to

the focus of the research and add to “unexpected/serendipity findings” that may be valuable in future studies.

According to Hoepfl (1997), the analysis process begins with the identification of themes from the raw data. Strauss & Corbin (1990) refer to this process as “open coding” and imply the tentative naming of conceptual categories into which the phenomena under observation will be grouped. The goal is to create multi-dimensional descriptive categories. A coding scheme was inter alia devised in basic terms like frequency, direction, intensity and space. The initial coding is also referred to as “manifest coding” and is considered highly reliable because phrases or words either are or are not present and do not take the connotations of these words and phrases into account (Neuman, 1991/1997).

The next stage, according to Hoepfl (1997), involves the re-examination of categories to determine how they are linked, this stage is called “axial coding” according to Strauss & Corbin (1990). This makes co-axial analysis and interpretations of data possible. This phase is also called “semantic analysis” or “latent coding” and focuses on the underlying implicit meaning in the context of the text. Latent coding is also considered less reliable than manifest coding because it depends on the coder’s knowledge of the language text and it’s meaning (Neuman, 1991/1997). They further noted that during this phase the researcher is responsible for building a conceptual model and for determining whether sufficient data exists to support the interpretations.

Finally, the gathered data/content, once thematically analysed, will be extrapolated and translated into a story line. The story line will then be discussed according to relevant literature and theory applicable to the lived experiences of bariatric patients who had to endure childhood maltreatment. Although the stages of analysis are described in a linear fashion, they occurred simultaneously and repeatedly.

Conclusion

This chapter provided a detailed description of the qualitative research paradigm and its characteristics and the extent of the “trustworthiness” thereof. The researcher’s perceptions of the qualitative paradigm, and the epistemological as an analogy to the social constructivist approach to the process of the research domain, were highlighted in this chapter. Within the context of the qualitative research paradigm, the researcher’s social constructivist epistemology led the way to the practical methods that can be applied by the researcher to report on the results from the thematic content analysis about the lived experiences of bariatric patients who had to endure forms of Complex Trauma as children.

The etiology of obesity, the experience of early traumatic events, the reasons for maintaining obesity and finally the forced behavioural intervention of five different participants who underwent bariatric surgery to “cure” a chronic disease like obesity, will as follow be explored. The following five chapters will therefore be structured around the prominent themes identified by the researcher from the “voices” of the five bariatric patients in order to build a final “voice” that will reflect collectively on their stories in Chapter 9, as supported by relevant literature on the experience of bariatric surgery.

Introduction to the “voices” of bariatric patients

The following five chapters are based on the experiences of bariatric patients during their involvement with the psychological evaluation process and preparation for bariatric surgery, followed by a semi-structured interview after bariatric surgery. The case notes on each participant as well as the final transcribed interview were carefully analysed and will be presented according to themes. The highlighted themes may not necessarily be mutually exclusive or the only true reflection represented as an ultimate truth about the realities of the experiences of bariatric patients. The researcher also acknowledges that another researcher may highlight different themes, due to the specific lens through which this researcher viewed the “voices” of bariatric patients.

The researcher will also structure the observed experiences of bariatric patients according to their **biographical information**, the **nature of the patients’ involvement**, followed by the **emerging themes** from the content analysis and the researcher’s personal reflections. Finally, the themes unique to every patient will be captured as a conclusive summary at the end of each chapter.

The participants were referred to the researcher by their bariatric surgeon for a pre-bariatric assessment and to support them throughout the pre-, peri- and post-operative phases of bariatric surgery. Apart from the results and recommendations after the initial psychological assessment pre-surgery, the referring surgeon also expects all his patients to attend at least three pre-operative psychotherapeutic sessions, followed by three more sessions post-operatively. In total, all the bariatric patients were seen in therapy over a period of six months (three months pre- and three months post-surgery). As part of the initial assessment, to determine their suitability for bariatric surgery, they also had to issue the researcher with a completed questionnaire (as compiled by the researcher) prior to their first appointment. The

questionnaire enables the researcher to identify psychological problem areas and to prepare for the first assessment interview.

The themes were derived from the content analysis method. The researcher immersed himself into the collective data (text) of the participants to make sense of their experiences of bariatric surgery, based on his (the researcher's) case notes and transcribed interview of each participant. Inferences were drawn from the text and grouped under the various themes. To derive deeper meaning, an exploration into the themes was conducted and through constant questioning, the researcher derived at the deeper meanings as described under the various themes. Thematic content analysis, for the purposes of this exploration, means that common themes were identified and excerpts from the participants' "voices" were used to substantiate those themes.

"Life script, a family driven socialisation", implies a linear progress or repetition of past events that modulate the life script of an individual. A person's birth expectancy is considered part of his/her life script and can have an impact on the perceptions of wanted and unwantedness, according to the process of socialisation. Also, the impact of traumatic life events that occurred in the lives of these bariatric patients' parents, shaped their parents' parenting styles, health and eating behaviour, ultimately reflecting on these bariatric patients' perceptions of the reality of their life and the interpretations and perceptions of their world view as a social construct.

The researcher observed that the impact of childhood trauma causes the abused person to stay in an abusive family environment due to the **inability to escape** from the impact thereof, ultimately forcing them to keep the abuse in the family a secret due to exposure and possible legal interventions, should anyone outside the family become aware of the true impact of trauma that was taking place. This implies a form of **double bind and helplessness**, meaning that the abused person will rather stay in the dysfunctional environment because he/she had no other

alternatives as a child. The implications of these inescapable traumatic exposures are that the abused child feels traumatised even more due to the inescapability of the situation and the older the person gets, the more likely he/she is to fulfil the full criteria for a Complex Trauma symptom constellation due to prolonged traumatic exposure.

The helplessness and powerlessness following prolonged exposure to traumatic events is synonymous with the **Complex Trauma constellation of symptoms** and aspects related to the participants' psychological symptoms following prolonged exposure to childhood trauma will be discussed. For purposes of this inquiry into the symptoms that followed these participants' experiences of the various forms of childhood trauma, the researcher relied on the transcribed information after the semi-structured interview to determine the extent to which the participants display the full spectrum of Complex Trauma symptoms. The main themes under discussion will include the following:

- Affect and impulse dysregulation
- Alterations in attention or consciousness
- Disturbances in self-perception
- Disturbances in relationships
- Somatisation
- Meaning systems

The **psychological defence mechanisms and coping strategies** these patients use to mediate their engagement with themselves and others, will then be explored according to their "voices".

For purposes of this study, **negative life stressors** refer to, among others, feelings of uncertainty, frustration, depressed mood, anxiety and anger. In contrast, **positive life stressors** refer to the **paradoxical** emotional impact that prosperity, success and more specific for purposes of this research, a different physique, self-perception and social / work interaction have

on the obese person. **Adaptation** to positive and / or negative life stressors can equally be a major concern for the obese patient, his/her support systems and healthcare professionals and will accordingly be explored and discussed.

Each chapter will be concluded with the bariatric patients' **perceptions of bariatric surgery and the psychological processes** they were exposed to, followed by their own unique interpretations of the causes for their struggle with obesity.

Due to the sensitive nature of the information, pseudonyms are used throughout the following five chapters to protect the core identities of the participants and their family members.

CHAPTER 4

ANN'S "VOICE"

Biographical information

Ann is a middle aged Caucasian, married female with a daughter. She works in a semi-medical environment. She reported issues with her weight since the age of 10 years after she had a horse riding accident leaving her immobilised for a period of time. She also reported weight gain of 30 kg after the birth of her daughter. Ann, her husband and daughter reside in Gauteng, South Africa.

Nature of interaction

The researcher's first interaction with Ann was on 21 February 2007. Ann was approached by the researcher after she underwent bariatric surgery on 9 May 2007, to request her willing participation in this research project. The researcher decided to approach her due to her "rich voice" and array of exposure to childhood trauma that she displayed during the therapeutic engagement prior to surgery. Her initial weight at the start of the therapeutic process was 142 kg (BMI = 56.2 – Obese Class III) and at the time of the final interview on 11 December 2007, she weighed 91 kg (BMI = 36 - Obese Class II). In total, Ann attended seven therapeutic sessions and lost 51 kg up to the date of the final interview.

Emerging Themes

The following themes emerged from Ann's "voice":

Life script: a family driven socialisation

Ann described her maternal grandparents as stable and loving. In contrast to Ann's perceptions of her maternal grandparents, she perceived her paternal grandparents as poor and rejecting her father. Ann's father was one of 14 children.

My Ma se familie was baie stabiel en Ma-hulle het in 'n loving omgewing grootgeword. (father)...baie arm grootgeword. Sy pa het in soveel woorde vir hom gesê hy weet nie hoekom hy hom gehad het nie, hulle het meer as genoeg kinders gehad.

With reference to Ann's parents' emotional stability, she commented that her mother abused diet pills and had an extramarital affair later in her life. She described her father as diagnosed with a bipolar mood disorder, being an alcoholic and also extremely controlling over his family. Ann's interpretation of her father's controlling attitude was that he controlled her mother with, amongst others, finances. She also reported that he had various extramarital affairs.

Birth expectancy

Ann felt rejected by her father and commented that her father wanted a son instead of a daughter. This implies that when she became aware of her father's expectations of her birth, she developed a life script of being unwanted. Although her feelings could be interpreted as having the wrong "gender", she interpreted her father's perceptions of her as rejection in totality and not only because of her gender.

Health and eating patterns according to parental styling

Ann's interpretations of her parents' parenting styles and health habits are considered part of her life script in terms of references to her relationship with food and authority later in her life, and is captured in this section.

Questions about her parents' parenting styles reflect that they were strict and autocratic and that she was not heard by them. One of the characteristics of her parents' relationship with each other was the presence of extreme conflict between them.

Vir 'n begin, my ouers was redelik streng en outokraties en jy het nie eintlik 'n sê gehad nie. Dit is, baie keer, waar ek dink dit begin het. Ek wil gehoor word.

From a young age, Ann perceived her father as having issues with both her and her mother's weight. The result of his perceptions of weight issues were a major form of conflict between them (her parents). Ann felt that she is a mirror image of her mother and interpreted her father's comments not only as attacking her mother but also her own integrity in terms of weight issues.

Hy het 'n vreeslike ding oor gewig gehad. Soveel so dat hy haar altyd verskree het as sy oorgewig is en dat ek as 'n tiener een dag vir hom gesê het as hy haar nie kan aanvaar soos wat sy is nie, hoekom skei hy nie van haar nie want hy maak ons almal se lewens hel. So ja, hy het verseker 'n probleem gehad met voorkoms. Vandag nog, het hy baie te sê oor voorkoms. (Father implied)... maar die implikasie was genoeg, want ek was dan die spieëlbeeld van my Ma.

At the age of six, Ann fell from a horse and injured her back. She considers the inability to be physically active and her early sexual development (developing breasts) at a young age as contributing factors to why she started gaining weight at a young age.

Daar is twee goed wat definitiewe implikasies gehad het. Die een is, ek het begin hormone ontwikkel want ek het begin borste kry in standerd 3 en ek het geval met 'n perd en 'n baie ernstige rugbesering opgedoen. Ek kan daardie twee goed definitief koppel aan daardie tyd. ... ek was minder aktief.

Ann mentioned that her father was of a small built, although he was always overeating. She attributed his light weight as result of a fast metabolism. Her mother had the habit to eat

secretly. The interpretation could be made that Ann's mother ate secretly due to her father's issues with weight.

Inquiry about the eating patterns in her family indicated that during her preschool years her father forced the family to eat all their food and eating occurred according to fixed routines. During her primary school years, there were no fixed routine meals and during her secondary school years she went to a school residence where she was exposed to routine meals. Inconsistencies about routine meals during her developmental phases until she left school were therefore prominent. Ann interpreted her father's demands in terms of eating all the food that was dished up due to the environment he grew up in, where it was considered wrong to waste food and therefore you had to eat all the food on your plate.

Ons moes altyd al ons kos op ons borde klaar eet, of ons nou vir onself ingeskep het en of dit vir ons ingeskep is, was irrelevant. Ons het 'n vaste eet roetine gehad as voorskoolse kinders. In die laerskool het ons ontbyt geëet as ons wou. Dan is ons skool toe en ons het eers in die middag 14:30 by die huis gekom, partykeer later, dan was my ma nie daar nie – sy het 'n winkel gehad – dan het jy brood geëet of glad nie, of jy het alles geëet wat jy kan want jy was so dood van die honger. As ons nie vir onself broodjies gemaak het skool toe nie, dan het ons geen kos by die skool gehad nie. Dit was jou eie keuse. In die hoërskool was ek in die koshuis en daar het ons vaste eetgewoontes gehad – ontbyt, middagete, aandete. (Ann's interpretation of her father's issues with food)...omdat hy nie kos gehad het as kind nie.

According to the researcher's process notes and enquiry into her eating behaviour, Ann developed unhealthy eating behaviour as reflected by her binge eating and night eating.

An inescapable double bind by the caregiver/s

Ann had to endure physical abuse as a child. Even things she did as a child that could be considered child's play had the implications of physical punishment. At about the age of five

years she engaged in experimental child's play (exploring gender differences between males and females) with her cousin and her brother who were in the same age group as her. When they were caught by her parents, they were punished.

... ek kan nie mooi onthou hoe oud ek was nie, ek dink ek was vyf. 'n Nefie van ons het by ons gekuier. Ek kan nie onthou wat het gebeur nie, maar my ma-hulle het gevoel hy het iets seksueel met my probeer. Ons is ingeroep in 'n kantoor in, ons twee. Die ouers het met mekaar gepraat en die kinders het met mekaar gepraat en ons het met 'n liniaal pak gekry. En ek kan nie eers onthou wat gebeur het nie. Hy is seker twee jaar ouer as ek, as ek reg onthou. Dis wat ek onthou. Dit staan vreeslik uit, want ek het al baie gedink oor seksuele molestering, maar ek kan nie iewers 'n konneksie maak nie. Dit is die enigste fisiese seksuele blootstelling wat ek gehad het, waar iemand my probeer tenagekom het.

Ann described severe emotional abuse during childhood and intense emotional abuse during school age and to a lesser extent during adulthood. She considers her father as being very inconsistent and on an emotional level having double standards. Ann's father abused the children in the family emotionally by becoming very aggressive and angry to the extent where he will wake the children up in the middle of the night and start screaming at them. Consequently, Ann reported that they had very little sleep and eventually, as a form of empowering, she and her brother fantasised that they will tie him to a chair and scream at him in the same way that he screamed at them. They only fantasised about the idea but never had the courage to really do that because of their fear of him.

En dan, my pa wat sulke woede, aggressie buie gekry het hier 02:00 in die more, dan het hy ons kinders so wakker geskree. Hy het min geslaap in die aande, so by 18:00, 19:00, dan het hy hier by 02:00 wakker geword en dan breek alle hel los in die huis. Wat vir my besonder traumaties was, is ek het een aand wakker geword en gevoel ek kan hom vasmaak op 'n stoel en sy mond toepak en vir hom sê, "nou gaan ons bietjie vir jou skree en dan voel jy hoe voel dit". Ek en my boetie het daarvoor gepraat. Hy was 'n jaar jonger as ek. Hy het vir my gesê hy wil die haelgeweer uit die kluis haal – so intens. Dit was vir my opvallend dat ons albei se emosies so intens was.

Ann's father was known for the double messages that he projected onto direct family members. Outsiders perceived him as a leader. Ann interpreted this part of his personality as abuse and also indicated that most people outside the family did not know about the verbal abuse the family had to endure.

My pa... almal het altyd opgekyk na hom toe, want hy was hierdie besigheidsman, maar niemand het geweet van die verbal abuse wat ons in die huis ervaar nie. Hy was 'n intelligente man en almal het ... ek kan nie sê hy het goeie menseverhoudings gehad nie, want hy was die tipe ou wat 'n besluit maak, dan loop hy vooruit, of iemand nou saamkom of nie.

Another aspect of the emotional abuse Ann had to endure was after her father and mother divorced, her father insisted that the children had to choose between parents. This form of emotional pressure caused the children to be in a double bind, especially since the children and Ann's mother were dependent on his financial support after the divorce. To make matters more complicated for the children to choose between the two parents, Ann's father decided to start a relationship with a Negroid lady, whose cultural perceptions differed from the cultural value system they were brought up with.

Hy bly saam met 'n swart vrou, heeltemal op sy eie. Ons was as kinders baie verskeur, want hy het bly sê ons moet kante kies en ons kon nie kante kies nie en as jy enigsins by jou ma staan, dan het jy nou kant gekies. En al vier van ons het regtig daarteen gestry. Jy kan nie jou ma net los nie want sy het nie meer 'n inkomste nie. Maar die oomblik wat jy by haar staan het jy haar gekies. Nou nog word daar na ons messe gegooi en gesê "jy het mos kant gekies teen my".

Ann's life script repeated later in her life when she got involved with a man who was very passive and genuine but who had an inferiority complex. He gave Ann everything she wanted but according to her life script he did not fit the profile of a lifelong partner, most probably because he lacked the "excitement" of being abusive like her father; after she broke that relationship she got involved in a verbally abusive relationship. Ann's life script most likely causes her to feel attracted

to a person who has the potential to abuse her, in the same way than her father abused her. A parallel can be drawn between the verbal abuse which she was exposed to during childhood and this relationship in which she experienced verbal abuse; which might explain why she got involved in this relationship that had the potential to repeat the abusive nature to which she was exposed to during childhood.

Al twee die verhoudings wat ek gehad het voor ek met my man getroud is... as ek nou terugdink sal ek sê hulle was 'slapperds'. Die eerste ou was genuine baie goed vir my en vir hoe ek na myself gekyk het. Ek het gevoel hy gee regtig vir my om. Maar hy was 'n minderwaardige tipe mens, baie arm grootgeword en geen vooruitsigte vir homself gehad nie. Wat hy vir my gesê het van myself en die caring was vir my goed. Die ou met wie ek daarna uitgegaan het, het my verbally abuse. Ek dink nie ek het dit besef in die verhouding, tot ek eendag vir my ma gesê het ek kan nie meer lag nie. En ek is nie eintlik 'n persoon wat nie kan lag nie. Toe het ons gepraat daaroor en ek het besef ek ervaar eintlik verbal abuse. Toe het ek weggestap uit die verhouding uit.

Ann had to witness various forms of violence between her father and mother. Ann's observations of an important emotional caregiver (mother) being physically abused caused major traumatic and disturbing feelings within her.

The amount of conflict between her parents caused her to feel powerless and eventually she ran away from home due to the intolerable amounts of conflict that she experienced during childhood. In essence she tried to escape the impact of witnessing the abuse that her father imposed on her mother.

Baie konflik. Extremely baie konflik. O ja. Hulle het nie geweet nie, maar ek het magteloos gevoel. Jy wil weghardloop. Dat hulle nie soos normale mense ooit 'n gesprek kon voer met mekaar nie, dit was altyd 'n geskree, jy voel so magteloos, jy kan nie keer en vir hulle sê "kan julle nie net met mekaar praat nie?" Dit was nooit 'n geval van, kom ons sit en praat 'n ding deur nie. Dit was altyd 'n geskree en 'n heen en weer toutrekkery.

The experiences of being rejected, neglected and being excluded were considered a major form of trauma for Ann, specifically her father's rejections, due to his expectations that she was supposed to be born a son. Ann's brother, who was favoured by her father, caused her to have intense feelings of being "not good enough" and excluded.

Ek en my boetie verskil veertien maande en ek het altyd gevoel of ek in sy skaduwee staan, of hy die beter een is. Hy was die meer sosiale een, ek was eintlik 'n skaam kind gewees. Ek kon die goed doen wat hy kon doen maar hy was altyd beter. Hy het altyd die limelight gekry en ek het altyd gevoel maar, ek kan dit ook doen, wat van my? Hoekom kan ek nie ook die aandag kry wat hy kry nie? Ek kan nie sê ek het onwelkom gevoel nie, maar ek het gevoel of ek nie deel is van die groep nie, ek was op my eie en ek moes maar cope so. Ek dink ek het myself ook op 'n stadium ge-exclude.

Ann also indicated that as a child she had a near-death experience when she fell of a horse's back and after that incident, as observed by the researcher, her feelings of being unsafe in her family were exacerbated.

...toe ek 6 jaar oud was, het ek op 'n perd gery wat op hol geraak het en ek het afgespring. My voet het vasgehaak aan die stiebeuel en hy het my saamgesleep. Ek het regtig daai dag gedink ek gaan doodgaan. Dit was baie traumaties.

Ann considers herself as less emotional cautious, therefore allowing her to engage with people who have the potential to abuse her emotionally. She describes herself as having a "pleasing" personality and an inability to be more self-assertive. For Ann to be pleasing and self-assertive creates yet another feeling of being trapped in a double bind. The implications of this interactive pattern may lead to feelings that she has to be kind to others to be accepted and included. Ann's need for inclusion and recognition means that she will take emotional risks that can have far-reaching emotional discomfort. She also exposes herself to the emotional abuse by others.

Ek is fisies 'n baie versigtige mens. Over cautious. Maar emosioneel, snaaks genoeg, nie....Wat ek wel baie voel is dat mense my wil misbruik vir my goedheid. Maar ek ervaar dit baie uit die aard van ons werk. Ek sukkel soms om die lyn te trek en te sê 'nee, ek gaan dit nie doen nie'.

The implications of Ann's need for inclusion and fear of rejection created opportunities for her to become a victim and even to be revictimised.

A Complex Trauma symptom constellation following childhood trauma

The following section will highlight some of the themes associated with Complex Trauma as reported by Ann.

Affect and impulse dysregulation

The tendency to be more emotional sensitive and to react impulsively to threats is a prominent characteristic of Ann. She developed a coping style to manage her emotional outbursts by allowing herself time to think about the problem situation. Before Ann had the bariatric surgery, she used to overeat as a compensator for her inability to control her emotional sensitive reactions to situations.

Dis nogal vreemd as iemand my teëgaan. Dis 'n stupid ding, eintlik, maar dit trigger partykeer iets in my. Dan vra ek myself af, hoekom het ek nou so ge-oorreageer? Hoekom het dit my so ontstel. Ek het nie altyd 'n antwoord vir dit nie, maar ek doen baie nabetraging en dan kan ek sien ek het nie soos ander mense gereageer nie en ek weet nie hoekom nie... het as kind, maar nie meer nie. Ek kan onthou dat ek as kind oor baie klein, stupid goedjies gehuil het. Voor die operasie sou ek altyd, as ek ontsteld geraak het, iets geëet het. Dit gebeur nou nog van tyd tot tyd maar dis asof ek nie meer daai selfde pleasing of comfort daaruit kry nie.

The researcher's clinical notes reflect that Ann has a tendency to become emotionally impulsive and she experiences difficulty to control her emotional impulses. The strict preparation programme she had to attend before the operation might have been compromised in terms of the risks of over or under usage of her medication due to her impulsive nature.

The presence of passive aggressive behaviour is reflected by her frustrations and lack of impulse control, and limited to ideations of aggressive behaviour. Instead of acting on difficult situations, Ann becomes verbally aggressive. An observation made by the researcher also indicates avoidance behaviour if she is confronted, and she will use her non-verbal skills to suppress her true feelings of aggression and anger.

...ek is nie eintlik 'n aggressiewe soort mens nie. Ek het so 'n rukkie terug skielik woede uitbarstings gekry waar ek gevoel het ek kan die muur slaan, maar ek het nog nooit fisies gevoel.... alhoewel ek moet sê as my dogtertjie nou baie stout is en sy maak my baie kwaad, voel ek ek kan haar baie hard pak gee (lag). Maar dis die naaste wat ek kom daaraan. Ek kan nie dink dat ek al ervaar het dat ek iemand genuine wil seermaak nie. Ja, ek sal nie fisies aggressief raak nie, maar ek kom agter dat ek harder en harder praat en dan skielik besef jy's nou heeltemal onrealisties. Kyk na die mense om jou, niemand reageer soos jy nie.

Observations made by the researcher indicate that she is meticulous in her planning, therefore she overcompensates mostly in her work environment. Further inquiry into the possibility that Ann has obsessive compulsive traits was confirmed by the researcher's process notes as part of his clinical observations throughout the process of engagement with the patient.

One of the symptoms, as described by the symptom constellation of a person who suffers from Complex Trauma, is the need to either commit suicide or to have strong suicidal ideations. Ann refers to an incident when she was still at school when she contemplated the idea of suicide. The incident that she refers to seems more like a quasi attempt, probably to focus the attention of

her caregivers on her deeply routed emotional pain and inability to escape the impact of the dysfunctional behaviour in her family.

Ek wou op skool selfmoord pleeg, sê my ma, maar toe sy vir my die broodmes gee, het ek besluit om dit te los.

Another symptom of Complex Trauma is the inability to modulate sexual urges and behaviour and these are often associated with either the need to be touched or not to be touched, and in many instances are synonymous with elements of childhood sexual abuse. For some, it is an attempt to re-enact the traumatic experience by taking unsafe risks, while others avoid touch in a sexual context. Ann's exposure to experimental play as a child did not seem to have an impact on her ability to modulate sexual needs. Ann interpreted her sensitivity and avoidance of sexual touch and sexual talk after bariatric surgery due to the intent by others to compliment her on her physique instead of the true unchanged person she really is. This also implies that she does not trust the motives of other people.

Ja, ek was altyd versigtig dat mense nie onnodig aan my vat nie, ek bedoel nou soos in nié hallo of goodbye nie. Maar ek was altyd baie sensitief dat mense nie onnodig aan my moet vat nie. Ek skram redelik weg van dit, alhoewel ek maklik met mense kontak maak, dié wie ek naby my wil hê, laat ek toe om naby my te kom. Net meer suggestief half, van, "jy's spesiaal vir my" of "oe dis nou so lekker dat jy nou maer is". Ek voel dis fake. Hoekom was jy nie so toe ek vet was nie? Hoekom is jy nou nice? Hoekom kon jy my nie toe waardeer het nie, want ek het nie verander nie?

Within the boundaries of her marriage, Ann feels that since she had bariatric surgery, she has to be sexually pleasing towards her husband. Prior to bariatric surgery she had to initiate intimacy with her husband and vowed to herself that she will take part in sexual interaction even after surgery although she does not always feel the need. Ann interpreted her sexual interaction with her husband prior to surgery as rejection by him and feels that although she does not have the same sexual needs as her husband after surgery, she will engage in his sexual demands to

prevent him from feeling that she punishes him. The implication of Ann's opinion about sexual engagement means that she will force herself to be intimate with her husband even though she does not have the need, in order to prevent him from feeling rejected and punished in the same way than she was.

Hy het my baie reject in ons fisiese verhouding in die begin van ons huwelik en ek het myself belowe ek sal dit nooit doen nie. Die verwerping wat ek ervaar het was vir my so intens, dat ek nooit ooit vir hom sal sê "nee" nie. Ja ek is bang hy voel dat ek hom straf. Alhoewel hy dit obviously nie dieselfde kan ervaar as ek nie. ...hy sal dalk net meer onttrek.

Elements of risk taking behaviour within certain situations, like security at her home, is a characteristic of Ann's perceptions of risk taking behaviour. She avoids taking risks on a sexual level, although she forces herself to engage in sexual activities with her husband since she had bariatric surgery.

...jy raak untouchable? Ja. Nie met die kar nie maar wel by die huis. Ek weier om veiligheidstralies om al die vensters te sit en ek sluit nie die deur deur die dag nie. Ek het net 'n muur om my en ek sit nie elektriese heinings en sulke goed op nie, wat vir ander mense careless is.

Alterations in attention or consciousness

Ann shows amnesia for periods during her childhood and on further inquiry she suggests that the medication she used as a child might be responsible for the memory loss during those periods. It is the researcher's opinion that the inability to remember periods from her childhood serves as a form of defence (medication as a form of rationalisation) against the impact of the traumatic experiences she had to endure.

Van nul tot seker ses jaar. Ek kan klein goedjies onthou maar meeste van dit is asof dit uitgevee is. Ek wonder partykeer of dit so moet wees. Daar is mense wat sê hulle kan onthou van goed wat gebeur het toe hulle drie jaar oud was, maar dan dink ek hoe kan jy dit onthou? (Ann's

explanation for memory loss) *Ek het bed natgemaak as kind en het Tofranil gebruik en ek het nie 100 jaar terug besef jy mag nie Tofranil gebruik vir langer as twee maande nie, want dit veroorsaak korttermyngeheueverlies, as ek reg onthou.*

Ann acknowledges that at times she finds it difficult to keep track of time in her daily life, but she developed a defence strategy to assist her in creating order in her environment and claims that making lists every day helps her to structure her thoughts. Ann also reported that after the operation she experienced episodes where she felt “out of control” and disorientated. Under pressure, Ann reported that she tends to become overly involved in tasks, almost as if she wants to deny the fact that she feels confused and disoriented.

Elements of transient dissociative episodes and depersonalisation were observed and confirmed by Ann’s reply to questions about her ability to keep track of time in her daily life. She feels “spaced out” or frightened under stress and the experience of having more than one driving force inside her becomes more apparent. Ann’s reply to a question about the ability to take control of her life was answered positively, although she immediately defended her situation, implying that she manages with the help of structures and routine she has created. She also reports a recent transient dissociative episode and depersonalisation shortly after she had bariatric surgery.

...maar ek het al ‘n mooi manier gekry om dit te orden. Ek het so ‘n rukkie terug nogal erg so gevoel. Maar ek maak ‘n lys elke dag van wat ek moet doen, en ek probeer om net by dit te hou, dan orden dit my gedagtes ... (Ann’s answer to a question about disorientation). Ja, snaaks genoeg na die operasie het ek dit meer gereeld ervaar, maar dit was net ‘n week of twee. Nie direk na die operasie nie, seker ‘n maand of twee terug. Maar ek het dit nogal intens ervaar en gevoel of ek verward is, of my kop besig is om my te los. Toe het dit beter geword (Ann’s experience of a recent transient dissociative episode and depersonalisation)... Dit voel eintlik vir my of ek iemand anders is en op ‘n trappie staan en ek kyk so af op die situasie.

Disturbances in self-perception

For most people suffering from Complex Trauma, their self-perception is negative, as is the case with Ann. Ann perceives her inability to control all aspects of her life; being permanently damaged; the inability to control her food intake; the fact that she is different to most other people and not understood by others; as a disturbance in her self-perception. The following expressions used by Ann to describe her self-perception, also confirm her negative and sometimes different self-view:

(Ann's reply to a question about aspects of losing control) *Die grootste deel daarvan... voor die operasie het ek geloof in myself verloor, dat ek dit nie meer sal kan doen nie...* (The inability to believe that she can control her food intake due to a negative self-perception) *Ek het nog altyd gevoel ek kan nie...* (The inability to feel in control of situations is considered a character weakness by Ann) *...hierdie ding dat ek so opgecharge raak oor goed. Dat ek so hard begin praat as ek my punt wil stel. Dit irriteer ander mense grensloos en myself ook, maar voor ek myself kan kry is ek weer daar. As ek sterk voel oor iets dan doen ek dit. Dis nie vir my lekker om so te wees nie, hoekom kan ek maar nie soos normale mense net sê 'ek stem nie saam nie'...* (Feeling different to others) *Ek besef daar moet ander mense ook wees wat voel soos ek, maar vir die oomblik voel dit vir my ek is deel van iets maar ook nie deel daarvan nie... Ek dink nie jy kan die hele kompleksiteit van enige persoon ooit verstaan nie, so as ek dit nie van ander mense verstaan nie, kan ek nie dink dat hulle dit van my moet verstaan nie...* (Not understood by others) *Ek voel partykeer "kan hulle nie net verstaan nie"... Dit voel die meeste van die tyd vir my of hulle verkeerd is en ek is reg, alhoewel ek baie keer besef dis nie noodwendig so nie.*

Ann's need for acceptance and inclusion by others is projected by her over developed sense of responsibility due to guilt feelings she has. Feelings of guilt and self-punishment are reflective of her self-perception, even to the extent that she would blame herself if her surgery was unsuccessful (Clinical observation prior to surgery). As a child, Ann occasionally took the responsibility of feeding her younger brother during the night. The researcher interpreted her

over developed sense of responsibility as an inappropriate burden, considering that she was a child herself. The extent to which Ann will accept responsibility and blame is displayed by the notion that she feels responsible for her parents' conflict. The need to be included and be heard is a prominent emotional need that Ann expresses through self-blame, guilt and responsibility. The following statements made by Ann substantiate the above-mentioned interpretations of her over developed sense of responsibility as a defence mechanism to feelings of guilt as a reflection of her self-perception:

Ek het nie nodig gehad om 'n ouer se rol fisies te vervul nie, ek het maar net verantwoordelik gevoel. En ja, die normale ding van, ek gaan gou bad, kyk na jou boetie... dit moes ek doen. Ek was sewe toe my jongste boetie gebore is. Ons het al vier in een kamer geslaap en ek het in die nag opgestaan vir sy bottels en sy doeke en ek het hom partykeer gebad, maar dit was nooit my werk, dat ek dit moes doen nie...ek het hom gebaba. Hy was vir my soos my baba...As daar konflik was, hoe ek altyd gevoel het ek was die bydraende faktor tot hul konflik...so jy voel maar baie keer verantwoordelik vir alles en almal...Ek wil gehoor word...(uniqueness warrents acceptance) ...dat ek anders is, dat ek uniek is, dan kry ek erkenning.

Disturbances in relationships

Ann's inability to trust the motives of others is considered a prominent theme related to her relationship history. Even in a committed relationship with her husband, Ann questions his true intent to love her and also projects indifference about other close relationships.

...dan vertrou ek nie weer nie. Oor die algemeen dink ek vertrou ek eintlik niemand nie. Ek dink eerder so. Ek wil graag vertrou, maar ek verwag altyd maar ... (Husband) Ek wonder partykeer of hy lief is vir my. Hy sê hy is, maar ek dink hy wys dit op 'n ander manier as ek... (Relationship with mother) Maar ons verhouding is ook so dat ons naby-ver-naby-ver is, so dit voel vir my soos ruimte, eintlik. Met my man, het ek maar voor die tyd ook so gevoel – ver en naby, ver en naby, maar dit voel vir my nou meer ver as naby. Dit voel vir my hy reik meer uit na my toe, maar ek... ek beweeg nie weg nie, maar ek staan stil. Ons kom nie bymekaar uit nie.

Somatisation

Ann reported a history of digestive system complaints. For an unknown period of time she suffered from "Irritable Bowl Syndrome" and continuous stomach pains. After Ann had a colonoscopy she read up on Irritable Bowl Syndrome and concluded that stress was a major contributing factor. She also indicated that she purposefully took caution to limit stressors in her life.

Ek weet ek het dit baie intens gehad op 'n stadium (Irritable Bowl Syndrome). Toe het ek 'n kolonoskopie gehad om te kyk. Ek het aanmekaar maagpyn gehad. Toe met die kolonoskopie het hulle klein Bilharzia-larwetjies gekry en dit verwyder. Toe het ek bietjie gaan lees oor Irritable Bowel Syndrome en stres en sulke goed was 'n faktor. Ek het baie maatreëls gevat om sulke goed uit my lewe te kry wat stres veroorsaak.

Ann also has a history of non-specific chest pains, joint pains, menstrual problems that could last for up to six weeks, Polycystic Ovarian Syndrome and reflux problems. She reported that since she had the bariatric surgery, her menstrual cycle normalised and for the first time in ten years she has a normal menstrual cycle. Since Ann had problems with her back (chronic pain), she felt that she was limited in terms of movability and indicated that she felt very frustrated because of her back condition. The neurosurgeon and orthopaedic surgeon whom she consulted gave conflicting advice as to the best treatment, and therefore she decided to initially follow the more conservative (non-surgical) approach to the problem.

Ek kry borskaspy, ek het dit voor die operasie al gekry, maar ek kan nie sê dis my hart nie. Dit kan net sowel ook die spier hieroor wees, dit kan enigiets wees, ek kan nie sê nie. Ag hel ek sê vir jou dit maak my gefrustreerd (back pain). Nou wil ek aktief wees, dan sê een dokter ek mag nie lank sit nie, die ander sê ek mag nie lank staan nie, ek mag nie dit of dat doen nie. Dan dink ek ag hel, wat mag ek doen? Kan ek darem nog lewe?

When Ann was asked during the interview if she suffers from any non-specific or unclear diagnoses, she commented that since she had bariatric surgery, she suffered from stomach and chest pains. Ann's own interpretation of these pains is that of referred pains due to her back problems, although not confirmed by her surgeon.

Meaning systems

On a question posed by the researcher during the final interview about hopelessness and pessimism prior to surgery, Ann replied that she had those feelings prior to surgery and apart from the back pains she feels less hopeless and pessimistic after the surgery.

Voor die operasie het ek so gevoel. Oor baie faktore. Na die tyd kan ek nie sê het ek so gevoel nie. Ek het eintlik baie goed gevoel tot hierdie rug nou so seer was, ek moet vir jou sê daar moet 'n fisiese konnotasie aan pyn...voor die operasie het ek geloof in myself verloor.

A general lack of motivation to create specific long-term goals, seems to indicate a disturbance in her meaning systems and worth. Ann sees herself as a role model for her daughter and wants to "fix" those things that went wrong in her own life, even though she indicated that she feels senseless at the moment.

My dogtertjie is my groot rede. Ek wil daar wees vir haar as 'n rolmodel. Ek voel eintlik in haar wil ek fix wat in my lewe verkeerd gegaan het en as ek nie daar is nie, sal dit mos nie so kan wees nie. So, dis my groot rede. Ek kan nie sê dat ek nie 'n rede het om aan te gaan nie, dat ek nie wil lewe nie, dis net, partykeer as jy vorentoe kyk dink jy 'waar gaan dit als opeindig, waarheen beweeg ek?' Dis asof mens nie 'n goal het waarheen jy werk nie. Dit voel vir my die feit dat ek nie 'n goal gestel het en nie in daai rigting werk nie, of ek bietjie doelloos aangaan op die oomblik.

Ann indicates that due to the chronic pain she endures at work, she feels that she has lost her passion for work and this is best described by the following statement she made during the final interview:

Gatvol daarvoor! lewers het ek my passie vir hierdie werk verloor, maar ek dink dis omdat ek pyn het.

Psychological defence mechanisms: a coping strategy

Religion, independence, clear structure (routine) and self-discipline are characteristic of the coping styles and stress modulators that Ann uses to maintain emotional stability in her life. The extent to which Ann plans and tries to control her life with structure is evident of obsessive compulsive traits and although these compulsions are not the ideal, they seem to help her cope with uncertain situations and create feelings of emotional safety.

Obviously sal ek moet volhou met struktuur daaraan, as dit al is hoe ek beheer gaan kan toepas...Die oomblik wat ek uit daai situasie van struktuur en beplanning kom, is ek heeltemal uneasy...ek was in die koshuis en daar was 'n struktuur... ek maak 'n lys elke dag van wat ek moet doen, en ek probeer om net by dit te hou, dan orden dit my gedagtes. Miskien is dit waar die struktuur vandaan kom. Toe ek beseef het dat dit my laat veilig voel en in beheer voel, versus my omstandighede in die laerskool en by die huis.

Clinical observations made by the researcher indicate that Ann uses avoidance, obsessive dedication to her work, spiteful behaviour and rebellious reactions to potentially threatening situations, as psychological defence mechanisms. She also portrays elements of overcompensation, need for acceptance and minimising the impact of situations as defences against the fear of being rejected. The implication of her dedication and meticulous behaviour causes her to become emotionally very tired. Her reaction to emotional tiredness then, drives her to work harder and eventually lose control over, amongst others, her eating routine, ultimately making her feel out of control and unsafe.

Ann tends to dissociate from her obese body by metaphorically referring to a “body suit” that she has to unzip to expose her true (thinner) body weight. Another psychological defence mechanism she uses is to deny the extent to which she was obese before surgery. In retrospect, Ann also minimises the true effort, commitment and challenges she had to endure throughout the bariatric programme. The following statements she made substantiate her views:

Ek het altyd gevoel dat ek nie so groot is nie. Dat ek hier binne-in my lyf eintlik 'n suit aanhet wat ek moet oopruk. Amper asof ek ontken het dat ek so groot is (Pre-surgery phase). Ek weet toe ek in dit was het dit baie commitment geverg en ek kon dit doen. Maar nou voel dit vir my of dit niks was nie.

Process of bariatric surgery: a positive and/or negative life stressor

Based on the English psychological questionnaire which Ann had to complete prior to her first assessment by the researcher, she indicated that her expectations following bariatric surgery are as follows:

Constant hunger will disappear; my blood sugar/insulin/hormonal problems will stabilise; I won't have any complications; I will really lose the weight that is possible and; I will be able to buy normal sizes of clothes again.

Ann's reply to practical lifestyle changes she expects to make after surgery included:

To be more active; to eat more controlled and smaller portions; to be able to perform better/without pain at my job and to be and act more attractive to my husband.

Collectively, it appears that Ann expects bariatric surgery to alleviate some of the medical problems she experience: to have less pain in order to perform better in her work environment, to have a more healthy and stable long-lasting relationship with food and to improve her sexual appearance towards her husband.

Ann's feedback to a question asked in the psychological questionnaire about her fears was as follows:

That I will be able to stick to the diet; that I will become too active after I lost weight; that I will lose some friends and that I will have complications.

Based on the written responses to the questionnaire, aspects that Ann were concerned about and experience discomfort with prior to surgery, include:

That I won't finish all my responsibilities before the operation; that I won't be able to cope with hunger pre-op; that I might have some complications post-operative; that it will put more strain on my marriage post-op; and that all my health symptoms won't clear, e.g. Cholesterol, high blood pressure, osteoarthritis, etc.

Observations made by the researcher during the course of the engagement with Ann, pointed towards fears prior to surgery about the medical procedure (bariatric surgery) and the fear of not being able to control the need for food, therefore gaining weight after surgery. She also experiences uncertainty about the possibility that the co-morbid medical issues would not be resolved.

Perceptions of bariatric surgery and psychological processes

Ann's feedback to negative experiences she had after surgery includes more back pain due to less bodily support to her back since she lost weight. The interpretation Ann made post-operatively about the pain in her back is almost a paradoxical reaction, implying a double bind. The double bind refers to the notion that her overweight supports her back, having less pain prior to surgery versus having a lower body weight, improving other co-morbid medical conditions but having more back pain post-operatively.

Ek het 'n maand terug gevoel ek wonder of ek ooit die operasie moes doen. Hierdie rugbesering wat ek het, het ek al die jare ge-manage. Skielik, na ek omtrent 30kg verloor het, het my pyn

ondraaglik begin word. Ek het X-strale geneem en my postuur het so verander toe ek oorgewig was, dat ek half die beserings gesupport het daarmee. En dit het nou so verander, ek loop anders en nou het ek drasties skielik ander probleme wat ek moet face. Dit voel vir my of my kop nie hierdie pyn kan hanteer nie. Nou sit ek in hierdie weegskaal van, as ek gebly het waar ek was, sou ek doodgegaan het van obesiteit, dit sou eventually gebeur het. Ek het pyn gehad, maar ek kon dit manage. Nou het ek pyn en ek hoop ek gaan dit weer kan manage op 'n punt, miskien gaan ek 'n operasie moet kry om dit te fix en ek wil dit nie hê nie.

Other negative experiences Ann had after surgery include a lower libido, difficulty to be self-disciplined, a greater need for structure and an annoyance with her husband's lack of responsibility. Ann describes a binge eating episode after surgery and although this behaviour could be interpreted as a negative reaction, she used the incident to do introspection. The results of the introspection was that she accepts logically that she can control her eating habits but needs to exercise more self-discipline.

Ek kon tot nou toe amper glad nie sjokolade eet nie, ek het nie 'n behoefte gehad nie. Ewe skielik het ek agtergekom ek kan dit eet. Voor ek myself kon kry het ek saam met haar 'n slab 'n dag geëet. Die feit dat dit my nie siek gemaak het nie, het veroorsaak dat dit my nie meer keer nie. Ek moes ernstig introspeksie doen om te besef ek kon sonder dit klaarkom, ek moet 'n besluit neem om nie weer daai pad te loop nie. Ek was half bang dat ek dit nie kan doen nie. Tot so 'n mate dat ek gevoel het ek het die hele operasie klaar ongedaan gemaak...Wel, ek probeer om weer meer gestruktureerd te eet. Maar ek kom regtig agter dat dit weer vir my moeite is om kos te maak. Dis vir my makliker om nie te eet nie, as wat dit is om gedissiplineerd kos te maak en slaai te maak. Maar wanneer ek dit doen, voel ek baie goed as ek dit regkry.

Ann's advice to prospective bariatric candidates is to be serious about it and to comply with the programme prescriptions prior to surgery to enable the patients to make important perception shifts in their minds and to prepare them for the post-operative phase.

Wat baie belangrik is, is hoe jy eet voor die tyd, dit is 'n voorbereidingsprogram. Jy hoef dit nie tot op die letter korrek te doen nie, want almal crook voor die tyd. Maar weet net, die rede hoekom jy dit doen, is om jou kop voor te berei vir na die tyd. Dit help jou, dan is al jou goed klaar reg. Moenie skop daarteen nie, dis nie omdat hulle jou wil straf nie, dis om jou kop te leer. Dis eintlik voorbereiding vir na die tyd. En... dat niks jou kan voorberei op hoe goed jy gaan voel na die tyd nie! Dat jy nie siek is na die operasie nie, dat jy jousef eintlik al moet keer om nie na die eerste week al terug te gaan werk toe nie...Enige persoon wat dit oorweeg moet weet dat hy baie committed moet wees. Dit verg intense voorbereiding. Die na die tyd is nie so intens nie want jy is eintlik geforseer om so te leef. Maar voor die tyd.... dit vat baie van jou. Mens moet dit nie ligtelik opneem nie.

Ann's interpretations of the causes of obesity for her as an adult is that she chose to "let go", because when she lost weight previously, this was a "barrier" to protect her from the feelings of intimate physical exposure to others. The "weight barrier" Ann refers to within this context is the extent to which she felt that others controlled her and invaded her intimate space. To be overweight for Ann was therefore a protective mechanism against intimacy.

Ek dink tog dit kan waar wees dat ek gekies het om te let go omdat dit vir my 'n barrier geword het. Dit het my beskerm. Ek het vir 'n lang ruk baie ontbloot gevoel toe ek gewig begin verloor het.

Conclusion

Prominent themes that emerged from Ann's voice include a life script of "unstable parents" who could not contain and resolve their own conflict. Ann endured rejection mainly from her father, felt emotionally abused and had to keep painful family secrets from the rest of the world. A common theme in Ann's life is the inconsistent parenting style, reflective of the eating habits and patterns she was exposed to. The feeling of being trapped in a "double bind" also seems to be a prominent theme in Ann's life. The double bind implies that what the outside world

knew and what she was exposed to did not correlate. Apart from periods of amnesia she experienced, Ann's interpretation of the role food played in her life was that food serves as a compensator for lack of control over other aspects of her life. She overcompensates for this lack of control by being overcommitted in her work environment, possibly because it is an aspect of her life that she can control. Not only did the injuries she had during childhood (felling off a horse) forced her to be less active, therefore causing weight gain, but she also perceived her parents' management of the "experimental sexual play" she had as a child as a negative association with intimacy. Ann relates this incident to a possible reason why she has become overweight, subconsciously preventing others to challenge her intimate space due to the negative associations. This could imply that overweight serves as a barrier between herself and others' intentions due to the perceptions that if she cannot accept herself, she does not accept that others can.

Ultimately, Ann's perception of bariatric surgery was that it is a paradox due to the pain she endured after surgery because of "less support" to her back, compared to the benefits and long-term advantages of bariatric surgery.

CHAPTER 5

ELLA'S "VOICE"

Biographical information

Ella is a 37 year old Caucasian, single female. She works for a Corporate Company. She reported issues with her weight since the age of about 10 years. Ella resides in Gauteng, South Africa.

Nature of interaction

The first interaction the researcher had with Ella was on the 27th of March 2007. After her surgery on the 14th of June 2007, Ella was approached by the researcher to participate in his research project – the reason she was approached was because she had various experiences of childhood trauma which would provide a rich text for analysis. At the start of the therapeutic process, Ella weighed 107 kg (BMI = 34.5 – Obese Class I), and by the time the final interview was conducted, she weighed 89.8 kg (BMI = 29 – Pre-obese). Ella attended seven therapeutic session and lost 17,2 kg up to the last session.

Emerging Themes

The following themes emerged from Ella's "voice":

Life script: a family driven socialisation

Ella describes her paternal grandfather as a "hard" man who did not tolerate any "softness". As an adult Ella's uncle (father's brother) told her about her father's family history and

indicated that he was abused (emotionally and physically) by his father. Her uncle was at times more caring towards Ella than her own father. She described a situation where she broke her arm and her father prevented her mother to take her to hospital; only after her mother made contact with her uncle, he came from Pretoria to take her to hospital. Ella's uncle also fulfilled the role of a substitute parent before and after her father's death.

(Paternal grandfather) *Buiten die feit dat hulle op die plaas gebly het, hulle was nie welaf nie maar hulle was ook nie vrek arm nie. My oupa was 'n harde man... Hy het nie geduld dat jy sagtheid toon of so iets nie. As jy 'n "mistake" maak is jy gelooi daaroor. Dis die milieu waarin my pa grootgeword het.* (Father's brother) *ja, ek weet dit is so want ek het eendag na my Oom op Carolina gery en met hom 'n gesprek gehad oor hoe my pa grootgeword het. Hoekom my pa so is met ons en my oom was in daardie opsig vir my 'n beter pa as my pa. Ek het my arm gebreek een Sondag en my ma het my pa gesê dat hy my Hospitaal toe vat dat my arem gegips kan word en my pa het geweier en my ma het my pa se broer gebel en hy het van Pretoria af gery na Maraisburg toe en my hospitaal toe gevat en my arm gelaat set. Dis hoekom ek die vrymoedigheid gehad het om na hom toe te gaan toe ek nou groot is, om met hom te gaan praat daaroor en ons het 'n hele Saterdag gesit en praat oor my pa se dinge en dis hoe ek nou weet van my oupa en hoe hy grootgeword het en so aan want ek wou hierdie dinge weet maar my oom is so drie jaar terug oorlede en, toe het hy vir my gesê soos wat my pa my as kind vreeslik vasgedruk en gekielie totdat ek gehuil het en hy het net aangehou en aangehou, presies dit het my oupa met my pa gedoen. En, hy het dit nie met hom gedoen nie, my oom nie.*

Ella's perception of her maternal grandfather, in contrast to her paternal grandfather, is as strict, protective, fair and loveable towards his family.

(Maternal grandfather) *Aan Ma se kant was my oupa, hy was 'n baie beskermende man gewees maar hy was baie streng gewees, maar hy was regverdig gewees. Ouma was strenger as hy gewees maar sy was 'n baie liefdevolle vrou. Sy het haar kinders ook grootgemaak om liefdevol en regverdig te wees en sy was die versorger gewees en Oupa was die broodwinner gewees.*

With reference to Ella's parents' emotional stability, she commented that her father was very controlling, "self-centred", unfaithful to her mother with a history of infidelity and abusiveness towards the family. Ella's father's self-centred behaviour could be interpreted as a form of narcissism as evident in the following statement she made:

Ek het net altyd gedink dat my pa is verskriklik selfsugtig, want daar was altyd vir hom geld, hy het altyd die nuutste klere, die nuutste karre, die beste kos gehad en ons moes oorleef op brood. Daar was nie eens geld vir groente nie. Hy het vir my ma 'n bedrag geld gegee in haar hand en daarmee moes sy vir ons sorg en die ander geld wat in 'n ander "pool" was moes sy vir hom sorg vir die beste van alles. Daar was nie eens geld vir my vir skoolklere nie, ek moes "hand me downs" dra.

She describes her mother as submissive to her father, a person with a "balanced view" and "humane". Ella's perception of her mother, apart from the good qualities she describes, was that she had "no back bone", with reference to her ability to stand up to her father.

Sy was bang gewees vir hom, maar sy was lief vir hom... dan sê sy vir my, "daar is vir my een man". My ma was vir my pa lief totdat sy die dag dood is.

Birth expectancy

According to Ella, her father wanted a son instead of her. She also indicated that her father's physical abuse towards her mother during her pregnancy with Ella, resulted in her premature birth as well as a birth defect (under developed heart) from which she suffers as a consequence of the physical abuse.

My Father kicked my Mother during a fight. That induced a birth. I was born on 28 weeks with a lot of complications and a defective under-developed heart.

Health and eating patterns according to parental styling

Ella's father used to overeat and was very insistent and persistent about his preferences for food. Her mother had a small physique. Ella described mealtimes as a very unpleasant experience when her father was present. Conflict seemed to evolve around mealtimes. Ella's father also insisted that they had to eat all the food that was dished up for them and if they did not; the children would be physically punished, followed by detention and a "treat". Ella's interpretation of the "treats" following punishment and detention was for him to relief his guilt feelings due to the inappropriateness of the punishment. Ella's father also physically punished her mother if she did not eat all her food.

My pa het geëet asof "there is no tomorrow". My ma was fyn en skraal en mooi maar my pa moes elke aandete vleis gekry het al het niemand in die gesin vleis gekry nie. Ma moes gesorg het dat hy 'n ordentlike ete met vleis kry al kry ons net brood... Pa het ons altyd gedwing om aan tafel te eet en dit was altyd vir ons aaklig gewees want hy het altyd met hierdie bomme gekom... Pa was anders gewees, hy kon nou by die huis gekom het en hy het 'n bord kos geëet en sewe uur vanaand sou hy in die kar geklim het en kafee toe gery het en vir hom vis en "chips" gaan koop het en by die tafel kom sit en eet het... My pa het ons geslaan as ons nie ons bord leeg eet nie en as hy ons klaar geslaan het, het hy ons in die toilet toegesluit en as hy die toilet kom oopsluit het hy vir ons Imperial, hierdie harde Imperial Mints in ons monde kom inforseer en tot vandag toe moet jy my nie 'n Imperial Mint gee nie.

An inescapable double bind by the caregiver/s

The researcher observed that Ella interpreted the various forms of abuse that she had to endure during childhood as a double bind. She knew she did not deserve the unfair abuse and punishment her father imposed on her, but she could not escape the family situation, mainly due to fear of her father and threats by her mother, if the true situation at home would be exposed. The intense feelings of unfairness, rejection by her father and abuse (verbal, emotional, physical

and sexual) could be interpreted as an inescapable double bind, not only by her father but also her mother's inability to stand up to her father. As a child she had no other choice but to stay in the abusive family situation and therefore developed psychological defence and coping mechanisms, which will be discussed later in this chapter.

(Unfairness) *Omdat dit ons kamer was, raai wie altyd die slae gekry? En dit was nie vir my regverdig nie en ook die feit as daar iets in die huis verkeerd gegaan het maak nie saak wat dit was nie dan was die drie kinders bymekaar geroep - wie het dit gedoen? En dan hoef my sussie net so vir my te gekyk het en dan het ek slae gekry of ek dit gedoen het of nie en hoe meer ek ge-insist het dat dit nie ek was nie dan kry ek ekstra slae want ek is 'n liegbek.*

(Rejection by father) *Ek het op sy skoot geklouter as hy voor die TV gesit het. Dan het ek my arms om sy nek gesit en vir hom gesê ek is lief vir hom. Dan het hy vir my gesê 'jy is in my pad, ek kyk TV' of so iets. Dan sal hy my afstoot.*

Ella had to endure physical abuse and victimisation by her father and also by her sister during her primary school years. Ella witnessed numerous incidents where her mother was emotionally and physically abused by her father to the extent that she refers to physical evidence of the abuse to be present in her family home until today. Her mother tried to rescue her from the physical abuse, but would be punished severely by her father whenever she attempted to do so. Ella had an intense fear of separation from her family due to her mother's interpretation of the implications if others had to find out about the family abuse. This caused Ella to keep the family secret of her father's abuse, a secret in fear of separation from her mother and siblings. The inability to "escape" the childhood trauma is interpreted by the researcher as yet another form of an emotional double bind that Ella had to endure as a child.

Maar hy het haar al geslaan as ons gaan slaap het in die aand sommer net om van sy frustrasies ontslae te raak. Ek het vele nagte, want ek was nog altyd 'n baie ligte slaper gewees, vele nagte, dan het ek wakker geword en dan het ek opgestaan en dan het ek gesien hoe vlieg sy daar deur die lug...in die sitkamer, daar is nou nog merke en ek meen dis al 7 jaar na haar dood. Nou nog

merke in die sitkamermuur soos wat sy teen die meubels geland het en dan het die meubels tot teen die mure, sulke groewe in die mure gemaak waar die meubels dit getref het.

My pa het wild en wakker te kere gegaan. My ma het 'n bottel wit jodium gehad in die huis. En as hy my geslaan het of my sussie geslaan het... alhoewel hy my baie meer geslaan het... het my ma daai hale met wit jodium gedokter sodat dit nie so sleg lyk nie, sodat die skool nie die welsyn op ons moet sit nie. My ma het altyd gesê as ons ooit met 'n welsynwerkster praat, gaan hulle haar kinders van haar af wegvat en haar kinders is vir haar alles. En dit het my gekeer om met enigiemand te praat... want my ma was my alles. Sy (mother) het een keer probeer (to protect her children) en Pa het haar geslaan dat sy oor die vertrek trek en toe besef ek sy moet dit liewers nie doen nie en ek het vir haar gesê, nee.

Ella was sexually abused by two people outside her family, witnessed sexual abuse between her father and sister and had to endure physical abuse by her father when he got sexually excited while he physically punished her.

(First sexual abuse) En dit was 'n tweedehandse fiets gewees, so, ja, daar was weer 'n probleem gewees. En die ou het mos gesê ek moet terugkom, ek het geen rede gehad om hom te distrust nie. En omtrent die derde keer wat ek teruggegaan het na hom toe, toe druk hy my vas en doen met my dinge wat geen standerd ses-meisie met haar gedoen wil hê nie. Dit was regtig traumaties gewees. Ek het met niemand daaroor gepraat nie. (Second sexual abuse by a neighbour)...het gaan grenadellas pluk en hy't ons almal binnetoe genooi vir koel drank. En hy het die ander klomp kinders op die stoep laat koel drank drink en vir my gesê hy wil my gou-gou iets wys. Toe ek weer sien, toe vat hy my in sy slaapkamer in en...ja.... en toe hy klaar was, toe maak hy asof dit niks gewees het nie.

Ons was een oggend laat vir skool. Ek en my sussie was nie lus gewees vir skool nie en toe speel ons bietjie daar in die kamer rond en wil nie aantrek vir skool nie. My pa het daar ingestap en my sussie uitgejaag. Vir haar gesê sy beter gaan aantrek. Hy het sy belt losgemaak

en my geslaan. Hy het aangehou slaan en slaan en slaan en toe besef ek, maar my pa is totally sexually erect. Hy het plesier daaruit gekry. Hy het ook my broek heeltemal uitgetrek om my te slaan, hy het my nie sommer net geslaan nie. Dit was vir my 'n groot skok en 'n groot "revelation" gewees...Ek het verskriklik vuil gevoel. Daar was niemand na wie toe ek kon gaan en sê 'dis hoe ek voel' nie.

(Witnessed incest)...ek weet daar was 'n hofspraak gewees later jare oor bloedsbande en sulke goeters. Ek weet nie wat die "outcome" daarvan is nie, ek het my sussie daarvoor gevra, sy weier om dit enigsins met my te bespreek. My tannie het ook daarvan "mention" gemaak, maar sy sê sy weet ook nie wat die "outcome" daarvan was nie. Dit was nogal vir my 'n "issue" gewees, want kort daarna het my sussie verskriklik promisku geraak.

The inescapable double bind of the abusive situations made Ella feel that she could turn to no-one and had to internalise her feelings. She internalised her feelings by becoming very isolated to the extent where she would lock herself in her room to escape the impact of the family reactions to the abuse enforced by her father. This psychological internalisation caused her to feel neglected and rejected by both her caregivers. Ella perceived the array of abuses she had to endure because of her father's inability to control his temper, as unfair.

Omtrent 13 en jare daarna het my ma vir my gesê dis omtrent die ouderdom toe ek absoluut verander het van haar sonskynkind, na hierdie donker, mislike kind wat net moeilikheid gegee het. Hulle kon nie meer met my praat nie, hulle kon nie meer iets uit my uitkry nie. Ek het myself in my kamer toegesluit en ek wou nie meer aan enige aktiwiteite deelneem nie. Daar was niemand na wie toe ek kon gaan en sê 'dis hoe ek voel' nie. Want omdat my pa sy goed gevat en getrek het, het my ma haarself onttrek aan die lewe en met haar pakkie sigarette op die bed gaan sit. Ek het probeer om met haar te praat, maar daar was geen "interest" van haar kant af gewees nie.

Ella also felt trapped in a double bind even when she performed well because of her father's reaction to her successes. In spite of her father's promise to assist with her studies later in life, he recanted his promises. Ella saw this as further evidence of her father's untrustworthiness. The following words substantiate Ella's interpretations of her father's reactions to her ideals and successes:

Ek het gehoop om eendag universiteit toe te kan gaan. Alhoewel ek nie die slimste kind op skool was nie. Ek was hardwerkend. Ek het goeie punte gekry, ek het matriek toelating gekry. Hy het my beloof hy sal betaal dat ek gaan swot. Toe dit tyd kom dat ons moet gaan inskryf, toe sê hy, hy't nie geld vir sulke dinge nie, dis sy geld. Toe sê ek vir hom, maar hy't belowe. Toe sê hy vir my 'en, jou punt is..?'. So, ek het nooit gaan swot op sy geld nie. Ek het na skool gaan werk, ek het geld opge-“stock”, ek het 'n kursus gaan loop by 'n “computer institute” en ek het myself opgewerk.

Ek was goed gewees. Maar ek dink nie ek was ge-encourage om iets daaromtrent te doen nie... My sussie was gekies vir die jeugkoor op hoërskool en sy het koor gesing. Die koorafrigter se naam was Werner gewees – skeef soos 'n drie rand noot, maar dierbaar. Sy het papiere huis toe gebring want dit sou haar wegvat van die huis af, na die kunstefees op Graaff-Reinet en so aan, maar Pa moes geteken het daarvoor. My sussie is skool toe die volgende oggend met 'n af neus en 'n blou oog en nie-getekende papiere. Toe ek natuurlik later jare ook in die koor sing en ook gekies word vir die jeugkoor, toe roep Werner my in en toe sê hy, hy gaan nie eers die papiere vir my huis toe gee nie, want hy onthou wat met my sussie gebeur het. Nou daar is twee pragtige stemme daarmee heen, want nie ek of my sussie sing koor nie!

A Complex Trauma symptom constellation following childhood trauma

This section will highlight some of the themes associated with Complex Trauma as reported by Ella.

Alteration in regulation of affect and impulses

Ella describes herself as emotionally sensitive, tend to overreact and will overeat (as an element of self-destruction and empowerment) in an attempt to modulate emotions. She also personalises “food” as her friend and that could be interpreted as a fictitious support system.

... ek is baie beskuldig dat ek heeltemal te liggeraak is... Deesdae is dit makliker om kwaad te raak en dan te dink, maar dis nou 'n totale oorreaksie vir die situasie waarin jy jou bevind. Maar voorheen het ek nie gevoel dis 'n oorreaksie nie. Ek het gedink dis heeltemal geregverdig, intendeel, ek moes nog erger gereageer het. Maar deesdae weet ek dis nie nodig nie... My maatjie, kos. My wonderlike, vriendelike, altyd daar maatjie.

The period before her bariatric surgery she had intense compulsive feelings that caused frustration.

...my huis moes presies perfek, netjies wees. As my bediende daar was en my bank is twee sentimeter uit plek uit, sou ek daai bank stormgeloop het en hom so hard geskuif het dat hy oor die breedte van die sitkamer geskuif het... Dit was nie vir my lekker as mense by my kom kuier het nie. Want as hulle goeters vat, of breek 'n glas of so iets, het ek gefreak!... Dis moontlik dat ek total control wou gehad het oor ten minste iets. As ek nie total control oor ten minste iets gehad het nie, was my wêreld heeltemal van sy as af.

Ella also used to control her emotions by isolating herself when she feels extremely angry or frustrated.

Ek sou myself in die kamer toemaak, of so...En ek het myself in een van die konferensiekamers gaan toesluit by die werk sodat hulle nie moet hoor hoe ek op hierdie mense se case klim nie.

After the operation she felt more in control and less frustrated with others.

En ek het gedink “this is the reward for change”. En dit was net great!

Before the operation, Ella had to force herself to control her feelings of anger, but since the operation, she had a lesser need.

Ek moet sê ek raak nie meer so maklik kwaad nie. Maar ek dink... soos ek sê my ma het gesê ek het daai donker periode ingegaan en ek het 'n humeur aan my gehad wat geskrik het vir niks... Dit was nie lekker om so te voel nie, ek het gevoel mense kritiseer my... Dis makliker om nie kwaad te word deesdae nie, om vinniger daarvoor te kom... Die change is nou al baie langer as die vorige keer... Dis amper asof dit nou baie natuurliker kom as voorheen. Voorheen het dit gevoel of ek myself forseer om beter te voel, waar nou is dit baie meer natuurlik.

Although not an aggressive type of person, she describes aggressive ideations and need to protect herself that manifested in her dreams, specifically towards her brother.

My boetie het my fisies aangerand in die tyd dat my ma dood is. Ek word wakker met daai beelde, dat ek hom probeer slaan om hom te probeer weghou van my af. Dan word ek wakker met die besef dat ek nie sterk genoeg is om hom weg te hou nie... Ek haat dit dat iemand sy wil op my kan afdwing en dat ek geen beheer het daarvoor nie... Ek is nie die violent tipe wat mense seermaak nie... Ek word net wakker in die nag van hierdie nagmerrie waar ek probeer om myself te verdedig en ek kan nie.

After she was raped during her secondary school years, she attempted to commit suicide by cutting her wrists and drinking pills with the intent to die.

Op hoërskool, net nadat ek verkrag is. Ek het my polse probeer sny en ek het al 'n klomp pille probeer drink... ek wou dood wees. Ek wou nie meer daar wees nie. Dis ook hoekom ek pille gedrink het... Enige metode sou goed gewees het... Ek het nie toegang gehad tot 'n vuurwapen nie. As ek toegang tot 'n vuurwapen gehad het, was ek waarskynlik suksesvol.

Ella attempts to avoid sexual contact but will force herself to engage in sexual activities with her boyfriend due to fear of being rejected by her partner. This could imply a need to modulate her sexual involvement with her partner.

Ja, ek het al...Partykeer voel ek net ek doen dit omdat hy 'n behoefte het daaraan en as ek nie daai behoefte fulfil nie dan...

Alteration in attention or consciousness

Ella refers to periods of her history that her sister recalls but that she cannot recall. This could refer to episodes of amnesia about some of the traumatic periods Ella had to endure during childhood.

Dis moeilik om te sê watter gedeeltes ek nie kan onthou nie. Maar ek weet daar is tye waarna my sussie byvoorbeeld verwys het, wat traumatiese tye in ons lewe was, wat ek niks van weet nie.

When Ella was questioned about “weird” perceptions or sensations, she reported episodes where she felt “spaced out”, having unexplainable bodily sensations while driving home on the highway after work. Ella described feelings of “unreality” of things and events, almost as if she is an outside “observer” and refers to a perceptual split in her mind about herself as a “happy pink one” and the “dark one”. This could be interpreted as transient dissociative episodes or “splitting” from her core personality identity (“split-off”).

Somtyds, ja...as ek sien mense lag en lyk gelukkig, dan dink ek 'just for show'...The happy pink one. And the mean, dark one...Die happy pink one dink ek, is die een wat ek inherent is en wat veg om uit te kom. Maar die dark een is die een wat sorg dat ek staande bly...Die happy pink one is tans besig om baie nuwe dinge te leer.

Alteration in self-perception

When questioned about feelings of lack of control in her life and feelings of ineffectiveness, Ella replied that after the surgery she felt less out of control, more relaxed, approachable and more self-confident than before the surgery.

...dis asof dinge net out of control gespiral het...Selfs by die werk approach mense my wat my nooit voorheen direk approach het nie. En ek kan net relax. Ek hoef nie maer te wees nie. Dis nice. Dis asof mense my in ag neem wat my nooit voorheen in ag geneem het nie.

Ella also commented that the operation created more structure and a more concrete feeling of future confidence within herself.

...en ek het in 'n gestruktureerde omgewing begin kom en ek het gesien hoe dinge in plek begin val. Toe het ek besef, maar dinge is aan die verander.

Ella also reported feelings of being “not good enough” prior to the surgery.

Dit het voorheen baie so gevoel. Maar dit voel nog soms so. Dit voel soms vir my ek is nie goed genoeg nie.

Ella considers herself as a person who still feels guilty about most things in her life as evident in the following statement:

Die geringste goed laat my skuldig voel. As ek 'n blokkie sjokolade eet, wat ek weet ek nie mag doen nie, sal ek vir drie dae loop en tjank daaroor. Ek het 'n naam daarvoor: ek is 'n professionele worrier (worrying). Ek dink dis nogsteeds 'n bietjie te veel.

Ella expresses feelings of being ashamed, although these feelings are considerably less than what she used to experience before she had surgery.

Ek laat nogsteeds nie regtig vreeslik baie mense in my lewe toe nie. Ek kan al amper sê die sirkel raak al bietjie groter, ek het darem al begin oopmaak teenoor familie en daai klas van goeters waar ek voorheen die familie uitgesluit het. So ek maak al oop, maar nog nie regtig teenoor vreemdelinge nie.

When asked about how she feels in relation to others, she indicated that she still feels different and not understood by others, although these feelings are considerably less after the surgery.

Meer vantevore as op hierdie stadium. Maar ek kry nogsteeds die gevoel ek is anders.

With reference to the researcher's case notes, Ella reacted with relief when the aspect of guilt in terms of her own "wrongdoings" related to sexual abuse were explained and interpreted as minimising the true effects of the abuse. Until the abuse was explained to her therapeutically, she considered herself as the person "at fault". Ella was born with a heart defect. When asked if she is concerned about the condition, she replied that she does not "worry" about it but that she feels more tired than most other people. Ella's reaction to the question asked by the researcher could also be indicative of a form of minimising the effect and the functional incapacity of this condition. Her heart defect resulted in her having to undergo a hysterectomy and therefore being unable to have her own children in spite of her need to have children of her own.

Ek sou nie sê ek is bekommerd daaroor nie. Ek weet hoekom dit so is en daar is niks wat ek regtig kan doen daaraan nie. Dis net nie lekker nie. Want dit maak dat mens nie soos ander mense is nie. Ek het nie die uithou vermoë wat ander mense het nie...Ek het 'n histerektomie gehad toe ek 33 was, want hulle het gesê weens my hart kan ek nie kinders hê na 30 nie en my hartspesialis wou verseker dat ek nie per ongeluk swanger raak nie, want ek sal nie 'n kind in die lewe kan bring na 30 nie...Ek is jammer daaroor, want ek dink ek sou 'n fantastiese ma gewees het.

Alteration in relationships with others

When Ella was asked about her ability to trust others, she replied that in general, even after the surgery, she still feels that she cannot trust the motives of others, as evident of the following incident she describes:

Daar het 'n vrou by ons begin werk...Maar ek kry regtig die gevoel dat sy probeer om my gat toe te steek...Nog nooit, vandat sy daar begin werk het, het sy net iets aanvaar en gedoen as ek vir haar sê sy moet dit doen nie. Sy moet altyd na my baas toe gaan en 'hoekom moet ek dit doen?'. En as my baas vir haar sê 'Ella het gesê doen dit', dan sal sy dit doen.

In an attempt to escape the feelings of rejection and distrust towards others, Ella spent most of her time by herself, but since the operation she has more confidence in herself and spends more time with familiar others.

Voorheen sou ek gesê het, ek sal 80% van my tyd alleen spandeer. Deesdae is dit the other way around. Ek spandeer omtrent 80% van my vrye tyd met ander mense...Ek sou voorheen gefight het. Deesdae sal ek net omdraai en wegloop.

In her relationship with her boyfriend she still feels uncertain and distrustful, which implies that although she spends more time with familiar others, she still feels uncertain about intimate relationships.

Ella reported incidents of revictimisation by her brother: *"My boetie het my fisies aangerand in die tyd dat my ma dood is"* and sister: *"My sussie het ook baie soos my pa opgetree ten opsigte van my. Om my af te knou en so aan...My sussie was vreeslik afknouerig gewees, sy het my gegooi met die mayonnaise-bottel en ek het geduck...sy het die vurk gevat en my gegooi en hom so in my inge-peg. Dan moet my ma nou eers die vurk uit my kom haal, ek kon hom nie self uitkry nie, hy't te vas gesit. Dit het sy baie gedoen. Sy't my een keer met 'n mes gegooi"*.

She felt that her sister victimised her in a similar way than her father did. Eventually, during her late adolescence, Ella reacted to her sister's physical abuse with intense aggression.

Toe vat sy my pa se bierbeker en slaan my oor die kop daarmee. Sy het geslaan en geslaan tot daai ding gebreek het. Ek het toe besluit vandag is die dag dat ek terugbakei. Maar my sussie is so sterk soos 'n os. Sy het my só gevat met haar linkerhand en sy het my opgetel en my geslaan

en geslaan. Ek het omgedraai gekry en haar begin byt. Die bloed het later geloop, toe los sy eers...En dit was die eerste keer ooit wat ek my teëgesit het teen my suster. Dis ook die laaste keer ooit wat sy my fisies aangerand het. Maar ek meen toe was ek al in standerd nege gewees.

Prior to her surgery Ella refers to herself as “*I was destined to be a victim*”, but considers herself after surgery to be less of a victim.

Somatisation

When questioned about unexplainable pains she experiences, Ella refers to what she thinks might be “Fibromyalgia”. The doctors she consulted could not confirm the diagnosis. As mentioned previously, Ella was born with a heart defect that caused her to easily become physically tired. In order to prevent a catastrophic cardiovascular dysfunction if she would fall pregnant, she had a hysterectomy at the age of 33 years. Not only could this stance be interpreted as a huge disappointment, but it also implied yet another form of control by circumstances she had to endure. She also suffers from endometriosis while her ovaries also “dried up” (“*Ek het endometriose. En albei my eierstokke is heeltemal verskrompel. Dit het sommer net opgedroog*”). Apart from the hysterectomy, the question could be asked if there might be a link between her gynaecological symptoms and the sexual abuse she had to endure during childhood.

Alterations in systems of meaning

Ella describes feelings of being hopeless as a general pattern in her life, although she acknowledges that she now has more meaning than before surgery; this is best captured by the following she said:

Ek het altyd so gevoel. My thoughts was altyd ‘you won’t amount to much ‘cause you’re not worth much’. Ek voel nou anders. Ek kan vir mense baie beteken.

Prior to surgery, Ella expressed feelings of “emptiness” and that she found it difficult to carry on with life; unlike the feelings she expressed after she had bariatric surgery.

Dis nie nou meer so moeilik nie. Ek het nou iets om na uit te sien. My lewe is nie meer so leeg nie. My siening oor myself het verander.

Psychological defence mechanisms: a coping strategy

It is the researcher’s interpretation that Ella uses her religious beliefs, attached to her overly developed sense of responsibility and value system, to cope with life stressors as a defence mechanism. This defence style could be indicative of an altruistic defence mechanism. There are also strong indications that she uses sublimation as a defence mechanism to avoid the impact of childhood trauma. Her strong need for isolation as a child was justified by her keen interest in reading. The specific interest she showed in books related to violence and crime as well as medical related books could be an indication of her need to express her helplessness and subconscious escape from the violence and abuse she had to endure during childhood, as well as her need to nurture and care as evident by the medical related books she prefers to read.

(Overly responsible for others) *En alles het op my skouers geval. Ek was te jonk en te stupid om te weet, maar dit was nie my verantwoordelikheid nie, dit was nie myne om te vat nie, ek hoef dit nie te vat nie. En ek het dit gevat...(Sublimation through reading) Ja. Kos en boeke. Ek het my ma se boekrak – omtrent so groot as wat jy hier het – het ek in ‘n kwessie van ‘n jaar klaar gelees...Goed met meer gewelddadige inhoud of intriges...en mediese boeke...Ek het baie wyd gelees oor allerhande siektes wat mens kan kry, daai klas van goeters. As iemand in die huis ‘n rash het, het ek presies geweet hoe om dit te gaan opsoek. Ek het dit dadelik ge-diagnose. Dan het ek vir my ma gesê ‘jy kan hom maar dokter toe vat, of jy kan hom self dokter’.*

Ella’s need to act out her frustrations and aggression as well as her passive-aggressive behaviour could be considered a coping mechanism to deal with the enormous impact her

traumatic childhood experienced. Ultimately, food and overeating served as a coping mechanism. *Ek het 'n bebliksemde, beneukte klein dogtertjie geword. Ek het 'n humeur ontwikkel wat min mense gehad het. 'n Ou moes my net skeef aangekyk het, en ek het ontplof.*

For Ella, food serves as a constant element in her life, the only “thing” she feels she can control. Although a paradoxical form of control, food therefore served as an emotional support system for Ella.

Process of bariatric surgery: a positive and/or negative life stressor

The following themes emerged from the therapeutic interactions with Ella in relation to her expectations and fears about bariatric surgery.

Ella indicated that her expectations prior to bariatric surgery are as follows:

I will keep off the weight I lost; I will have lowered cholesterol; I will not develop diabetes; I will be healthier in general; I will relieve the current issues I have with my knee; I will have to change my diet; will have to start walking more; will be socially more interactive; and look at food differently.

Most of Ella’s expectations about bariatric surgery are therefore based on the need to have a healthier lifestyle.

Ella’s written feedback about her fear of the bariatric surgical procedure was documented as follows:

Dumping; weight gain after a while; jealousy/non-acceptance from friends and family; the way I see myself will not change; and I will have deficiencies due to surgery.

Ella also indicated that her “health, relationship and work” is considered a major form of stress prior to bariatric surgery. It is the researcher’s perception that Ella has realistic fears about

the reality and impact of bariatric surgery which evolves around fears of the self and others' acceptance of her after surgery. Based on Ella's feedback after surgery, she also fears that her obsessive dependency on food might be replaced by other dysfunctional addictions as evident in the following statement she made:

...want kos is 'n verslawing, as jy nie kos as verslawing het nie, gaan jy aan iets anders verslaaf raak. Drank, seks, whatever.

Perceptions of bariatric surgery and psychological processes

Ella's perceptions of bariatric surgery were that "one trauma replaces another". The researcher chooses to interpret Ella's perceptions as a negative stressor that is replaced with a positive stressor like the outcome after bariatric surgery. Ella reports that after the surgery she feels more outgoing, is happy and has a better sense of humour; she also experiences more acceptance by others. The interpretation Ella made of others' acceptance of her is with a passive aggressive undertone due to the fact that others judge on grounds of physical appearance and not the true person.

Bariatriese chirurgie is trauma in itself...Dis 'n baie traumatiese ondervinding gewees. Veral omdat ek nog na die tyd die ander drama gehad het toe ek moes teruggaan; die goed was in my longe in en ek kon nie asemhaal nie. Die hele ondervinding was vir my verskriklik traumaties. En dis verskriklik as jy dink jy moet die een trauma stop met die ander trauma...Ek is definitief meer outgoing as wat ek was. Dis eintlik baie moeilik om te beskryf, maar ek lag makliker. Dis asof ek weer my sin vir humor ontdek het, wat ek gevoel het iewers verlore geraak het. En ek voel ek het meer waarde. Maar dis jammer dat die mense jou waarde meet aan jou gewig. Ek het dit by my matriekreünie weer besef, want almal het gesê 'aaah, jy lyk stunning', hulle het my nie herken nie. Toe dink ek, maar dis deur julle wat ek was wat ek was, dat ek is wat ek is! En hulle is nie bereid om eienaarskap daarvan te vat nie en dis typical.

Ella holds the opinion that due to bariatric surgery she will most probably not find another “moral acceptable addiction” to replace her addiction with food since she had bariatric surgery. She also indicates that psychological preparation is needed and should even be more intense prior to surgery. She also believes that the psycho education she received from the researcher prior to surgery made her feel more confident and safe. Her interpretation of the team approach also created more trust in the process of surgery, which she considers as paradoxical for trauma. She also indicated that the realistic effect of surgery as only a means to an end should be emphasised more by the surgeon.

Ek sal tien teen een nie weer aan iets verslaaf raak nie, want kos was vir my die enigste moreel aanvaarbare ding waaraan mens kan verslaaf raak. Maar as hier iemand instap wat nie die morele waardes het as ek nie, gaan hulle meer hulp voor die tyd nodig hê...(Psychological support) Ek sou dit definitief beskou as nodig. Ek sou net dink daar moet bietjie meer voor die tyd gedoen word. Want jou kop moet eers reg wees voor jy die operasie deurgaen. Jou kop moenie na die tyd reggemaak word nie...(Psycho education) Dit het, ja. Baie. Ek het redelik geweet wat om te verwag, ek het net nie gedink daar gaan komplikasies wees nie. Maar ek moes dit verwag het want sulke goed gebeur met my... Ek moet sê dit was vir my lekker om te weet die chirurg werk saam met 'n sielkundige, dat daar ondersteuning is. Dat jy bewus gemaak word dat jou kop moet verander, alhoewel ek geweet het my kop moet verander. En ek weet die verandering moet eers in jou kop plaasvind voor dit in jou lyf plaasvind. Want jy dieet nie met jou lyf nie, jy dieet met jou kop. Maar ek voel die chirurg moet dalk meer eerlik wees met die ouens wat hy opereer – die operasie maak jou nie maer nie. Jy moet nog steeds eet om maer te word. En hy sê dit nie vir mense nie. En mense voel half ingedoen.

Ella also indicated that she felt safe in the therapeutic relationship with the researcher due to the immediate trust that he created from the start of therapy. The researcher's interpretation of Ella's reflection of the therapeutic environment could be explained by the researcher's direct, honest and realistic approach to patients and his sincere respect for others and the patient's decision to undergo a life threatening and changing surgical procedure.

Vandat ek jou ontmoet het, het ek so gemaklik met jou gevoel, ek het dinge met jou gedeel wat ek nog nooit eers met Henry (boyfriend) gedeel het nie. Jy het onmiddellik 'n vertrouwe ingeboesem wat ek met bitter min mense...Ek weet nie, ek het net hierdie kalmte met jou ervaar. Nogsteeds. Miskien die feit dat jy, vandat jy my ontmoet het, my in my oë gekyk het... jy het met my gepraat, nie verby my gekyk nie. Ek weet nie, ek kan regtig nie my vinger daarop lê nie maar ek het net veilig gevoel by jou.

Ella's advice to other prospective bariatric patients is that it is needed to invest "time" with the diet, that surgery is not a "miracle cure" and "cheating" on the prescribed programme prior and after surgery could cause problems.

Ella's perceptions of the causes of obesity are related to her own interpretation that the rejection she felt as a child forced her to use food as an emotional comfort.

Oh yes. Ek is verwerp en ek het nie maats gehad nie want ek is nooit toegelaat om maats te hê nie. En die enigste manier hoe ek my tyd kon omkry en myself kon troos, was met kos.

Conclusion

Ella considers her father to have been self-centered and controlling over the family. She also believes that her father rejected her even before her birth, and due to a violent attack on her mother, Ella was born with a heart defect. During Ella's lifetime, she had to endure verbal-, physical-, emotional-, and sexual abuse by two outsiders. Due to the family secrets (abuse and incest), she could never tell anyone outside her family due to fear of being separated from her mother. This could be interpreted as a "double bind", the same as the double bind that she experienced with good performances (chosen for Youth Choir) at school and her father's intense rejection of her successes.

Ella considers food a “moral acceptable addiction” and interprets her obsession with food as an emotional comforter. Apart from the intense anger, frustrations and passive-aggressiveness she felt more intensely before she had bariatric surgery, she uses various psychological defence mechanisms and coping strategies, like being overly caring and responsible, to cope with the inner turmoil of unfinished emotional business she experiences.

A unique expression Ella uses to describe the process of bariatric surgery was that “one trauma replaces another”. Therefore, it is concluded that the amount of abuse Ella endured during childhood caused her to find comfort in food, resulting in severe obesity; and as part of the “rectification” of being unacceptable to herself and others, she had to undergo bariatric surgery. This statement by Ella reiterates the double binds she had to endure most of her life. After surgery she expressed positive feelings of self-worth and confidence, uncommon to her emotional experiences prior to surgery.

CHAPTER 6

SUE'S "VOICE"

Biographical information

Sue is a 34 year old Caucasian, divorced female, presently involved in a lesbian relationship. She works in a paramedical environment. She reported issues with her weight as a child before she went to school and major weight issues since her adolescence. Sue resides in Gauteng, South Africa.

Nature of interaction

The researcher's first interaction with Sue was on 21 June 2007. After she underwent bariatric surgery on 13 September 2007, Sue was approached by the researcher to ask her to be a participant in his study. The decision to approach her was based on her "rich voice" as well as her involvement in the medical profession. Sue had to endure prolonged traumatic experiences since childhood that she mentioned during the therapeutic involvement prior to surgery. Sue's weight at the start of the therapeutic process was 113.5 kg (BMI = 42.7 – Obese Class III) and at the time of the final interview on 10 December 2007, her weight was 84.3 kg (BMI = 31.8 – Obese Class I). Overall, Sue attended six therapeutic sessions and lost 29.2 kg up to the date of the final interview.

Emerging Themes

Themes that emerged from Sue's "voice" will be described and discussed:

Life script: a family driven socialisation

Sue describes her paternal grandparents as stable. Sue's interpretation of her maternal grandparents was that they were very poor. Her mother was one of ten children and was raised by her aunt. From what Sue knew, her mother was rejected by her biological mother and had to endure rejection not only from her, but also from her siblings who stayed with her mother.

My ma het in baie arm omstandighede grootgeword. Sy was in 'n huis gewees met tien kinders en sy is weggee. Dit was either die weeshuis of haar sussie-hulle. Toe het haar niggies haar gesteel toe sy drie maande oud was, hulle haar gevat. Hulle het in dieselfde straat gebly en my ma kon nooit verstaan hoekom haar ma 'n gedeelte van haar kinders gehou het en 'n ander gedeelte van haar kinders nie gehou nie. So sy is eintlik deur haar tannie grootgemaak. Die twee sussies was met die twee broers getroud gewees. Sommige dae, as sy hulle kwaad gemaak het – sy was blykbaar baie stout gewees toe sy klein was – dan het hulle vir haar gesê sy is nie hul sussie nie sy moet teruggaan na haar eie ma toe. So sy het nogal 'n baie rowwe lewe gehad toe sy klein was.

Sue refers to her mother as strict and what she can remember of her father before his death, when she was seven years old, was that he was a quiet man and did not physically punish them (children).

My pa ... hy was 'n baie eenkant-mens. Wat ek baie goed van hom onthou is, as hy af was, het hy in sy kar gesit en radio luister en pyp rook en boek lees. Hy was baie lief vir kosmaak.

Sue describes her mother as not a “child-mother”, implying that she did not like children. It could be surmised that because of Sue's mother's stance towards children, she experienced feelings of rejection. This notion is strengthened by an incident where Sue's mother hit her so hard that blood splatter was evident against the bathroom wall.

Kyk my ma is nie 'n baie kinder-mens nie...het 'n lelike woord gesê en my ma het net in die badkamer ingekom en die eerste beste een 'n klap gegee en die bloed het so 'n mooi pragtige strepie teen die muur gesit.

Sue's mother remarried twice after her father's death and Sue's interpretation of her family situation at that stage was abusive and very traumatic. Sue described her first stepfather as a person who bullied them. He would tease them and tickle them until she wet herself. Sue questioned his behaviour as being sadistic. Sue's first stepfather also had an affair with a lady across the street, which caused major conflict between her mother and first stepfather. This conflict resulted in a divorce after Sue's mother begged him not to divorce her. The family at that stage was dependent on his financial support. Her second stepfather had a sex change and was abusive towards her. According to Sue, her mother did not know about his (second stepfather) sex change until much later in their married relationship.

(First stepfather) Hy het ons baie geboelie, maar nie soos in geslaan nie... hy het daarvan gehou om jou te knyp en "dare". Hy sou jou vyf uur die oggend kom wakker skud en sê hy "dare" jou vir vyf rand om in die swembad te gaan spring, in die winter. Hy (stepfather) het 'n handsak binne-in my ma se handsak ingesit. Net voor sy by die deur (shop) uitloop... voor hulle haar gevang het.... hy het gedink dis 'n groot grap. Sulke goeters. Hy sou jou gekielie het tot jy jouself nat gepiepie het. Ek het myself 'n paar keer nat gepiepie soos wat ek lag. Ek weet nie of is dit sadisties nie?

Sue felt that her mother and her second stepfather had psychological issues. Sue's mother started having panic attacks when she was married to her second stepfather. Her second stepfather insisted that the family had to see a therapist and everyone in the family had to take a mood stabiliser called Lithium. Sue suspected that she had to take the mood stabiliser due to her aggressive moods as a child. Her second stepfather was, according to Sue, very manipulating and used to project his own unresolved feelings onto the family members. He insisted that Sue's brother was gay, threatened Sue's mother that if she divorces him, he will have the children taken away from her and were very controlling towards the family members. He also showed very inappropriate behaviour like frequent crying in church. Sue's mother could not handle these

emotional outbursts and manipulation of her second stepfather and ever since that time she (mother) had an increase in the frequency and intensity of the panic attacks she suffered from. Sue's mother was threatened by her second stepfather not to disclose the issue that he had a sex change. The issue with his sex change became unbearable for Sue's mother to the extent that she wanted to divorce him but was caught in a double bind (emotional manipulation) by him. Her second stepfather and mother physically attacked each other and Sue described an incident where she tried to intervene. Sue's interpretation of the situation was that she lost control over her anger when her second stepfather physically attacked her mother.

(Second stepfather)...hy het altyd die laaste sê gehad... Hy het byvoorbeeld gesê my oudste broer is gay, want hy't 'n vriend gehad – sy naam was Eben – hulle was baie goed bevriend, my broer was soos 'n kind in hulle huis... (Second stepfather) was eintlik 'n weird mens, as ons byvoorbeeld kerk toe gaan, het hy in die kerk gehuil as jy nie by hom in die kerk sit nie... My ma wou naderhand nie kerk toe gaan nie. Toe ons in matriek was, met sy (Sue's older brother) aanneming, het my ma 'n senuwee ineerstorting gekry. As sy in die kerk instap of tussen mense kom het sy angs aanvalle gekry. 'n Paar keer moes oom Charles haar huis toe vat, soos byvoorbeeld die dag toe Garry (Sue's younger brother) aangeneem is, sy kon nie met die situasie "cope" nie. Sy was 'n paar keer in die hospitaal gewees. Dit het alles gegaan oor oom Charles, omdat hy vir haar begin sê het as sy vir iemand sê van sy situasie (sex change)... Sy kon nie meer "cope" nie, sy wou hom skei. Maar hy wou dit nie toelaat nie... Hy het vir haar gesê hy sal haar kinders van haar wegvat. Hy het op die ou end. Hy het my jongste broer so gemanipuleer dat hy (Sue's younger brother) 'n geweer teen my ma se kop gedruk het en vir haar gesê het hy sal haar doodskiet as sy haar goed vat, want sy is die probleem in die huis. Oom Charles het ons almal na sielkundiges gevat. Ek was in standerd vyf gewees, Peter was in standerd vier, Garry was begin matriek. Ons moes sielkundiges toe gaan omdat my ma die angsaanvalle gekry het en nie met situasies kon "cope" nie. Sy was by 'n psigiater in Johannesburg, 'n ouerige man. Ons almal was op "Lithium" gewees want ons vlakke was in die grond in gewees. Toe het ons almal "Lithium" gedrink. Ek het dit gedrink want hulle het gesê ek was 'n baie aggressiewe mens gewees.... Ek het een aand toe oom Charles en my ma mekaar aangerand het - hulle het mekaar

van die bed af geduik - toe het ek met die sambok ingestap en met die sambok op die bed geslaan om hulle uitmekaar te kry. Daai aand het ek so gebewe van woede. My ma moes kom en my vingers losmaak om die sambok uit my hand te kry nie. Ek het altyd tussenbeide getree en geskree hy moet my ma uitlos en sulke dinge.

Birth expectancy

According to Sue, she was a planned, expected and wanted child. According to her mother, no birth complications were reported.

Health and eating patterns according to parental styling

On a question about her parents' eating habits, Sue answered that her father enjoyed food. Before her father's death, the family maintained routine mealtimes, but after her father's death the idea of having meals at dinner table faded and became more chaotic in that there were no set mealtimes; neither were there family time together with having meals. Sue's mother insisted that the children had to finish their plates of food and this could be interpreted as a form of control that became a habit, as evident of the following Sue said after she was asked about where her overeating habits came from:

Van kleintyd af. My ma sê nou die dag vir my – want al drie ons kinders is groot gebou – my jongste broer is bietjie kleiner, hy het 'n groot magie maar kierietjie-bene. Hy sal byvoorbeeld fiets ry en sulke goed. My oudste broer is baie, baie oorgewig. Maar my ma het vir ons geleer, as jy 'n bord kos kry, moet jy alles eet wat daarop is. En ek sê vir haar sy het vir ons baie groot borde kos opgeskep. Toe ek begin werk het, het ek gesê met my eerste salaris gaan ek nie vir my 'n rok of dit of dit koop nie, ek gaan vir my pasta maak en 'n pak "chips" koop. Altyd kos.

Sue's father suffered from high cholesterol and cardio vascular disease. He eventually died of a heart attack after a formal barbeque with colleagues when Sue was seven years old. After Sue's mother married her second husband, the children started picking up weight. Sue's

first stepfather enjoyed food. Sue also reported that her mother married, divorced and remarried her first stepfather before she finally divorced him and married her second stepfather.

Since her father's death, Sue started collecting money to buy food when she felt sick or upset. She used to hide the money on the pelmet in her room. This could be interpreted by the researcher as comfort eating; almost as an exclusive ritual which Sue used to distinguish her from the others at home, and therefore she started a pattern to reward herself with food whenever she felt upset.

Die rede vir dit weet ek nie maar ek het permanent maagpyn gehad. As ek siek was het ek die geld op die pelmet afgehaal en biltong gaan koop by die winkel.

An inescapable control by her circumstances

Sue felt controlled by her circumstances and in specific the uncertainty of her mother's relationship patterns after her father's death. Sue also had to endure the emotional burden of keeping and defending secrets (second stepfather's sex change) in the family, was sexually abused by her brother and others, witnessed physical abuse in her family, felt rejected by her mother at times, had to deal with the loss of her father, felt separated from her family, being bullied by her peers, and also felt unsafe and neglected as a child. Her interpretation of her relationship with her first stepfather was that he had double standards and she felt that this caused her to feel unsure of him. As a child she projected her anger onto others as evident of her disclosure that she bullied others the same way as she was bullied at school. This could be interpreted as a desperate attempt by Sue to control her environment in the same way that others controlled her and as a way to ventilate her suppressed frustration and anger with her circumstances (re-enactment of the prolonged traumatic exposures she had to endure).

The following expressions were used by Sue to substantiate and express her interpretations of the various traumatic experiences she had to endure:

(Secret in the family) *Eendag het ek saam met hom (second stepfather) op die bed gelê toe het hy sonder 'n hemp gelê. Toe sien ek nou die merkies. Hy het vir ons gesê hy was in 'n baie groot motorongeluk en hy het vir die Here gevra Hy moet sy lewe red dan sal hy sy lewe vir die Here gee...Die aand het hy vir haar gesê dat hy 'n "sex change" gehad het. Sy sê sy het buite haarself geraak oor dit...Ons het nooit presies geweet wat het gebeur nie. Sy familie het net altyd my ma gebel en gesê as sy daaraan dink om vir enigiemand te vertel, sal hulle 'n hofspraak teen haar maak en hulle sal bewys dat sy verkeerd is en sulke goeters...toe sien ek haai maar hy is net soos 'n vrou gebou...hy wou vir almal wys hy is 'n man.*

(Sexual abuse) *Die bure se seun het met my gelol toe ek, ek dink vyf of ses was, my pa het nog gelewe. In die buitekamer hand in die broek gesteek en al sulke goeters en "whatever". My ma het dit op 'n manier uitgevind ek weet nie hoe nie. Sy en die tannie langsaan was op 'n stadium kwaad vir mekaar gewees. My oudste broer het met my gesukkel, ek dink ek was in standerd 5 want ons was toe al by oom Charles gewees. Maar een of twee keer. As hy iets met my wou doen het ek vir hom gesê hy maak my baie baie seer. Dit het heeltemal opgehou. Toe gebeur dit weer, ek dink dit was maar dít waardeur hy gegaan het.*

(Loss of her father) *Dit was sy tweede hartaanval. Hy was 26 toe hy sy eerste major hartaanval gehad het en toe op 34 was dit 'n gonner. Ja, in die huis. (When she was asked about a huge disappointment she commented) My pa is dood toe ek nog baie jonk was. (A question about a disturbing incident that she can recall) My pa is in die huis oorlede. (Rejected) ...ek het altyd verwerp gevoel.*

(Separated) *Ek was standerd drie...Elke kwartaal was ek in 'n ander skool...my ma-hulle was besig om te skei...My tannie-hulle was baie kwaad vir my gewees want hulle het gesê dit is ek wat veroorsaak het dat hulle geskei het. Toe het ons by my tannie-hulle gaan bly.*

(Being bullied) *My niggies het my verskriklik verniel, want as ek met my ma op die foon gepraat het, het hulle die foon kom dooddruk. As ons op 'n Vrydag kinderkrans toe gegaan het,*

het my niggie my geslaan en gesê ek het nie my oë toegehou toe die dominee gebid het nie maar hoe het sy geweet?..Hulle het my klere gevat, ek kon nooit my eie klere dra nie.

(Questions about feelings of being unsafe according to the case notes). *Patient reported feelings of being unsafe during young childhood and school age.*

(Case notes reflect that Sue felt neglected). *Patient felt neglected during school age, adolescence and adulthood.*

(Double messages from first stepfather). *En as hy klaar geskree het en by die huis gekom het, wou hy weet of jy nou by die “tjommie” was, dan sê jy nee, want Pa het gesê jy kan nie gaan nie. Dan het hy gesê maar dis nie wat hy gesê het nie. So, hy was baie dubbelsinnig gewees. Voor mense byvoorbeeld het almal gedink Charles was die wonderlikste mens wat op twee bene is. Hy was vriendelik en het vir almal alles gedoen en as hy by die huis kom ... ek sou nie sê hy was 'n tiran nie, maar hý het die besluite geneem.*

(Sue's reply to a written question from the questionnaire whether she bullied others) *Yes, I bullied others at school.*

When asked about her interpretations of the experiences she had to endure during childhood, Sue used words like: lonely; powerless; unsafe; dominated by her stepfathers; sad; and being controlled by her circumstances.

A Complex Trauma symptom constellation following childhood trauma

In this section, the symptoms that resulted from Sue's experiences as a child, will be described according to the transcribed information from the interview. This will be done in order to assess the extent to which Sue shows the full range of Complex Trauma symptoms.

Affect and impulse dysregulation

Sue tends to overreact and worry excessively about things and by implication finds it difficult to regulate her affect. She also finds it very difficult to calm herself down once she has made a mistake, even if it was a human error or minor mistake, as evident in the following she said:

Ja, ver naam voor die operasie. Enige klein goedjies kan vir my in 'n flat in wheelie en ek kan worry oor dit vir dae lank. Ek tob die heeltyd daaroor...Die dokter wou weet wie het die pasiënt opgeneem en ek het gesê ek het. Sy wou weet hoekom het ek nie vir haar gesê die pasiënt is allergies vir penicillin nie. Ek het gesê ek is verskriklik jammer. Ek was die hele dag in 'n toestand oor dit. Toe sê ek vir Samantha (present partner) die dokter gaan my nie weer vertrou nie...Ek het daai aand niks geslaap nie.

Sue uses food to help her calm down and comfort her when she feels upset, guilty or angry.

Sodra daar iets is wat my trouble, dan is kos vir my 'n comfort.

When Sue was asked about her feelings of anger, she replies that since childhood she had a short temper and although she considers herself to be a “pleaser” she will become very destructive when she feels frustrated, angry and sad:

Ja, baie. Na die operasie voel ek baie goed oor myself. Ek kry nog steeds die kwaad-gevoelens oor dinge wat met my gebeur het, wat ek voel baie aanleiding gegee het, soos my huwelik. Met my huwelik het ek baie gewig opgetel en net nooit weer verloor nie...So ek kan nogals baie aggressief raak. As kind was ek ook baie bakleierig gewees, moody, my altyd in my kamer toegemaak en wou niks met niemand te doen gehad het nie. Een keer het ek so erg aggressief geraak dat ek my duvet opgesny het van woede...ek het baie erge aggressiewe aanvalle gehad...Ek is 'n pleaser.

When questioned about her ability to control her emotions, she indicated that she sometimes “totally, totally” loses control, even at work. This causes her to feel extremely guilty after such an incident, implying a very volatile emotional inability to modulate her emotions and impulses.

Apart from overeating as a self-destructive act, Sue also tends to take anger towards others out on herself by physically hurting herself. Her inability to hurt others in the same way that she feels emotionally hurt, is therefore projected onto herself instead of the person who caused the emotional discomfort.

Ek het al 'n paar keer my vuig teen die muur geslaan. Ek hou aan slaan tot ek die pyn voel. Ek het nou, die tweede Saterdag na die operasie, myself seergemaak...Dan voel ek niemand het my lief nie en sulke dinge, ek het my borste geslaan dat ek potblou was vir twee weke lank...Ek wil iemand seermaak, maar dan doen ek dit liewers aan myself.

In her intimate relationship, she tends to use physical force when she feels upset or frustrated.

Ons het mekaar gegryp aan die hemde en mekaar se hangertjies gebreek. Samantha het gesê sy gaan my slaan en ek het gesê ek gaan haar slaan, maar ons het mekaar nie regtig geslaan nie, net gegryp en woedend aangestaar en gesê ons is nou klaar met mekaar.

Sue indicates that she has suicidal ideations and due to the inescapable struggle with her sexual identity, while married, she attempted suicide.

Gedagtes gehad, ja...Toe ek met Brink getroud was, het ek een aand besluit ek wil nie meer lewe nie. Ek het drie maande van my tydperk in 'n apteek gewerk ook en ek het begin pilletjies drink. Ek het in die apteek gewerk en daar was vrye toegang tot medikasie gewees. Wellconal is pynmedikasie wat hulle vir kankerpatiënte gee. Ek het baie Wellconal gedrink. Ek het Wellconal en Stilnox gedrink. Ek het enige ding wat ek in die hande kon kry, het ek gedrink.

Sue indicated that she consciously has to make an effort to avoid thinking about sex, even to avoid thinking about having sex with her partner. In her heterosexual relationship she also avoided sexual interaction. Sue's sexual relationship with her lesbian partner causes her to feel guilty for not being able to perform optimally, resulting in a negative image of herself in a sexual context.

...hier in die helfte sê ek vir haar "Samantha ek dink niks gaan gebeur nie" en dan het ek so sleg gevoel en healtyd gesê ek is jammer, ek is jammer, ek is jammer.

In her marriage, Sue had to force herself to engage in sexual activities with her husband "Ja, maar dit was in my huwelik gewees. Net in die huwelik". This also points towards an inability to modulate her true intent not to engage in sexual contact with her husband.

Prior to when Sue lost weight due to the bariatric surgery programme, she avoided being intimate with her lesbian partner, but since she had bariatric surgery, she reported to be more sexually active. It could be interpreted that for functional and aesthetic reasons, her improved self-confidence added to a more comfortable engagement on a physical level in her present relationship.

Ja, Samantha het veral die laaste jaar voor die operasie baie, baie gewig opgetel. Toe het ons dit liewer vermy. Maar nie meer nie.

Sue indicates that she will rather "worry" about other people's safety than her own, which could be an indication of risk-taking behaviour that she rationalises as a possible psychological defence mechanism.

Ja. Ek sal liewer oor iemand anders s'n worry as wat ek oor my eie worry. Ek is glad nie 'n deursluit-mens nie...Ek kry gereeld raas omdat ek nie die veiligheidshek sluit nie. Dit het al 'n paar keer gebeur dat ek glad nie die kar sluit nie. En ek haal nie eers my handsak uit die kar nie, dis te veel moeite om hom weer terug te dra...Ek sal nalatig wees om deure te sluit en sulke

goed, maar ek sal nie in onveilige omgewings ingaan nie. Ek is nie iemand wat onnodig laat sal uitgaan nie maar ek sal alleen in my kar klim en mense huis toe vat in ander woonbuurte, alhoewel ek weet dit nie heeltemal veilig is nie.

Sue's need to take risks was mainly based on the challenges others imposed on her, and in return she claims that she felt good about the attention and focus on her if she did engage in risk-taking activities. The need to be recognised seems to be a strong driving force behind some of the risk-taking behaviours Sue exposed herself to.

Vinnig ry – baie beslis. As iemand my dare...Maar dit was om aandag te kry. Om aanvaarding te kry.

When asked about flirtations Sue had while married to her husband, she mentioned that she started courting her lesbian partner and at the same time she “did flirt with another man”, knowing that it could be a dangerous and far-reaching liaison that could affect her marriage and the new lesbian relationship she pursued.

Alterations in attention or consciousness

With reference to periods of Sue's life that she cannot recall, she primarily refers to her marriage. She also indicates that she has a good long-term memory but sometimes a poor short-term memory. The inability to be in “touch” with the here and now (short-term memory) could be compromised in Sue's case, due to elements of transient dissociation.

Baie van my huwelik-dinge... is daar gate...Sommige goed onthou ek net baie goed. Dan ewe skielik is daar goed wat ek net uitsny, korttermyn geheue-goeters. Langtermyn is ek baie goed mee. Maar dis al asof die korttermyn goeters net uitsnap iewers.

When questioned about aspects that may relate to dissociation, Sue indicated that she is “absent-minded” at times and when under high levels of stress, it appears that she feels “spaced

out” and tends to retreat within herself. The researcher also observed transient dissociative (perceptual and sensory) episodes as evident of her feeling that she represents two different personality styles:

Baie. Vernaam as ek kar bestuur, byvoorbeeld. Ek sal skielik op 'n gedeelte van die pad kom en nie eers onthou dat ek die afdraai gevat het nie...Ek dink so. Ek kry altyd 'n snaakse gevoel hier binne wat sê iets skort, of iets is verkeerd, of sulke goed...Ek is twee tipes mense... by my werk is ek baie uitgelate en spontaan en by my huis is ek hierdie teruggetrokke persoon...Dan raak ek doodstil – dis al wanneer ek nie praat nie, is as ek daai gevoel begin kry...Dit is 'n bang, naar gevoel. Dit voel heelyd of jy opgestres is, hierdie hol kol wat jy hier binnekant het die heelyd.

Disturbances in self-perception

Sue describes feelings of not being in control of her own life which can be indicative of feelings of being ineffective. She however indicates that since she had bariatric surgery, she feels less “unable” to do her work.

(Lack of control) Dit gebeur baie...Voor die operasie het ek so bietjie laks begin raak met my werk. Ek sou nog alles gee, maar ek sou nie 101% gegee het nie. Maar ek moet sê dit begin nou weer beter word.

When Sue was asked if she has feelings of being permanently damaged, she replied that her bad self-image caused her to feel damaged since childhood. She also indicated that she does not trust beneficial things that happen in her life and constantly questions the realness of positive things that happen to her.

Die feit dat ek 'n swak selfbeeld het. Ek het nou gedink ek sal al beter word maar dis nogsteeds daar. Nou die dag het my ma vir my gesê ek moenie so neersien op myself nie, ek moet begin glo in myself...dit begin met 'n goeie aanloop, dan begin ek ewe skielik twyfel. Was dit die regte ding? Sulke goed. Dit is bietjie beter as wat dit altyd was, maar dit kom nog terug.

Sue expresses feelings of permanent guilt and the need to be responsible. It could be interpreted that Sue's choice of career can be indicative of her need to be responsible and to take care of others as a projective emotional need (justification).

Ja, as ek met iemand baklei het, voel ek so skuldig oor dit, omdat ek my mond oopgemaak het en vir hom gesê het hoe ek voel, dat ek op die ou end na daai persoon toe gaan en sê ek is jammer...Dan sal ek heelyd skuldig voel omdat ek haar nie liewers gaan help het nie, dan sit ek Samantha in 'n moeilike posisie tot sy later vir my sê ag hemel, bel net daai persoon en sê vir haar jy sal haar kom help. Dan weet ek nie wie om tevrede te stel nie. Dan sal ek dink sy is spiteful, sy laat my 'n ekstra dag werk omdat ek haar nie wou help nie – maar dit is glad nie wat gebeur nie. Ek probeer almal altyd tevrede stel en as ek hulle nie tevrede gestel het nie, voel ek permanent skuldig...ek sal ekstra gaan doen om iemand tevrede te stel, om aanvaar te word. Maar dis nie net in my werk nie, dis sommer orals.

When Sue was asked about feelings of being ashamed of herself, she indicated that she agrees that she does feel ashamed of herself most of the time.

It sometimes happens that Sue reacts to emotional conflict by driving away from home in spite of others being worried about her. The researcher interprets this behaviour as a form of minimising the potential dangers that she might encounter when in rage.

Ek is geneig om weg te hardloop. Ek spring in my kar en ry weg. Dan sal my ma en Samantha worry – is ek veilig, waar is ek? En ek sal net nie worry nie. Ek sal op die highway klim en net ry.

Disturbances in relationships

When asked a question about her ability to trust others, Sue replied that she does not trust the motives of others and related the distrust to her intimate relationship with her partner.

Dit gaan nou snaaks klink. Ek weet nie. Ek en Samantha... sy sê sy is lief vir my, maar ek weet nie of sy regtig is nie. Sommige kere voel dit net glad nie vir my of sy is nie. Dan gaan ek in

hierdie toestande in waar ek... byvoorbeeld laasweek het ek toenadering gesoek en sy het net gesê ek kan maar kamer toe gaan as ek wil, maar sy wil nie gaan nie. Op die manier wat sy sommige dinge hanteer, sê vir my "jy's gerieflik".

Evident of her inability to trust is her need for isolation from others and her conflict avoidant style.

Ek verkies om by my huis te wees...Ek loop weg van konflik af met mense met wie ek nie vertrou is nie. As ek by die werk byvoorbeeld beheer verloor het, sal ek na die persoon toe gaan en al weet ek daai persoon was verkeerd, sal ek sê ek is verskriklik jammer al het ek dalk rede gehad om te reageer soos ek het. Maar ek is altyd jammer.

Sue was asked about the tendency to get involved in situations where she would be victimised and she replied that she felt rejected most of her life and recalled an incident where one of her stepfathers (stepfather who had a sex change) accused her of being sexually active and would send her to the doctor for a sonar. According to Sue he was very suspicious about her activities. Sue interpreted his suspiciousness as a form of victimisation.

Ek moes gegaan het vir sonars en wat ookal want hy het elke naweek gedink ek is swanger as ek gaan fliëk het...Definitief het ek my hele lewe deur gevoel of ek verwerp word. My ma het baie meer aandag aan my broers gegee. Ek het altyd gesê die middelkind is die afskeepkind.

Attempts by Sue to victimise her intimate partner were followed by intense feelings of guilt.

Ek het probeer maar dan voel ek te skuldig, soos met Samantha. In die begin van ons verhouding het ek haar baie seergemaak. Ek het haar weggejaag. Maar nog voordat ek haar heeltemal weggejaag het, gaan haal ek haar weer. Of ek sê vir haar sy kan nie meer by my bly nie, sy moet uittrek. Maar as sy uittrek, gaan koop ek vir haar 'n bed en TV en sy bly net een aand in haar eie huis dan kom sy weer terug na my toe. Ek het haar baie seergemaak maar niemand anders wat naby my is nie. Ek sal nie uit my pad gaan om ander seer te maak nie.

Somatisation

Sue complains of different bodily aches and pains and a general feeling of being very fatigued at times. The reasons for most of these vague medical complications could not be confirmed by a medical doctor and are therefore considered more psychosomatic in nature. Prior to Sue's bariatric surgery, she complained about chronic stomach pains, especially when she enters a less stressful period.

Tot voor die operasie het ek permanent Colofax gedrink en op 'n stadium het ek Librax gedrink, wat ek permanent erge maagpyn gekry het. Selfs toe ek by die apteek gewerk het, het ek baie stres gehad...Ja, sodra ek in 'n rusfase ingegaan het – sodra daai stres eintlik moes weggaan, het ek hierdie erge maagpyne en diarree gekry.

Meaning systems

Sue's reply on a question related to her general view of life and her future, indicated that others perceive her as negative and that she feels lonely and very distant from others. This could be an indication of her perceptions of the meaning of life and being foreshortened about the future.

Met tye voel ek baie vêr, ek kry soms die gevoel dat ek heeltemal alleen is. Samantha is by my en my ma-hulle is daar maar ek voel steeds alleen...Ja ek was 'n baie negatiewe mens. Ek het altyd net ge-moan, Samantha sê mos my tweede naam is Mona...ek weet nie, ek kry net hierdie hartseer gevoel hier binne in my.

Sue interpreted that her belief system related to the way she was brought up, however, it changed when she got married, but since she met her present partner she became more like the way she was when she grew up. She describes herself as being a "perfectionist" and that she

finds comfort in being a “perfectionist” in order to get positive feedback from her environment. It is the researcher’s interpretation that Sue has an intense need to be recognised and validated.

Dit het definitief bietjie verander. As kind was ek 'n verskriklike, erge perfeksionis gewees. Met my huwelik het dit omtrent heeltemal weggeval...Maar in my werksituasie is ek 'n perfeksionis. Ek wil hê iemand moet vir my se “jissie, jy het goed gedoen”. Ek hou daarvan om te hoor dat ek goed gedoen het.

Psychological defence mechanisms: a coping strategy

Clinical observations made by the researcher about Sue indicates that she uses aggression, isolation from others and an intense need to please others and to be in control of her situation as psychological defence mechanisms and coping strategies to deal with emotional discomfort. Sue also uses food to help her cope with uncomfortable emotional distress. (Aggression) *Hulle het gesê ek was 'n baie aggressiewe mens gewees...(Isolation). So ek was 'n baie stil persoon, ek het nie maats gehad nie... Ek het pouses in die badkamer gaan wegkruip...Ek verkies om by my huis te wees...(Food a comforter). Sodra daar iets is wat my trouble, dan is kos vir my 'n comfort.*

The need to be acknowledged and protected was clearly displayed by an incident after her father’s death where she “enjoyed” the care of others who sympathised with her due to the death of her father. This could be interpreted as a form of intense emotional neediness for emotional support and recognition of other aspects of her deeply rooted emotional pain that she had to endure.

Ja, dit was vir my lekker gewees as iemand vir my kom sê het (sjoe dit klink verskriklik om te sê lekker) Ek was 'n smartvraat gewees. Ek het lekker gevoel as iemand my jammer kry, ek het dit twee keer erger gemaak. Daar was een spesifieke kind wat my verskriklik jammer gekry het en gesê het die kinders mag nie lelik wees met my nie want my pa is nou net dood.

Process of bariatric surgery: a positive and/or negative life stressor

Excerpts from the psychological questionnaire Sue had to complete prior to her first assessment by the researcher, she indicates that her expectations following bariatric surgery were as follows:

Om my ideale gewig weer te bereik; gesonder te lewe; om enigiets te kan doen wat ek wil, soos oefeninge; om sosiaal aanvaarbaar te wees; weer lus te wees vir die lewe; gesond en aktief te wees; lus te wees om in die openbaar te verskyn; en om sonder kroniese medikasie klaar te kom.

Conclusively, Sue has existential expectations to be acceptable to herself, be socially comfortable amongst others and to have a healthier lifestyle.

Sue's feedback to the psychological questionnaire about her fears was as follows:

Bang dat ekself iets verkeerd sal doen wat my gesondheid in gevaar sal stel byvoorbeeld te min eet of te veel probeer eet.

Sue also gave an indication of stressors she endured prior to surgery and refers to her "work, finances, safety in this country, crime and her parents' situation".

Perceptions of bariatric surgery and psychological processes

Sue sees bariatric surgery as a means to "correct" her inability to control her relationship with food. She also indicates that after the operation she felt better about herself and less ashamed to appear in public.

Voel baie beter oor myself en is nie meer skaam om in die openbaar te wees nie.

Sue considers the psychological preparation as necessary and the most important part of the operation.

Alles is net beter...Ja, dit is nodig, want dit is deel van die grootste ondersteuning met die operasie.

Lessons Sue learnt from the process were that she has always been a “good person” and that she can say “no” to others and that it is her “right”.

Dat ek 'n klaar goeie mens is en nie net altyd ja moet sê nie, ek mag nee sê, dit is my reg.

The advice Sue wanted to give prospective bariatric patients is that the psychological support is a very important aspect of support and that patients should give their full cooperation with the preparation.

Die sielkundige gedeelte is belangrik vir ondersteuning. Gee jou volle samewerking vir die voorbereiding, dit is die moeite werd.

When Sue was asked if she can identify the causes for her obesity, she indicated that food created an opportunity to escape from the criticism from others.

Ek het my gaan vergryp aan kos...Niemand het my gekritiseer as ek op my eie in die hoekie gesit en eet het nie.

Conclusion

The life script Sue describes is evident of a repeat of the rejection and abuse pattern her mother had to endure as a child. Sue identifies with the abuse and rejection her mother endured and to an extent Sue also felt unwanted by her mother. Her father's death caused a string of events that caused great emotional turmoil in Sue's life. For Sue, both her stepfathers were considered manipulating and abusive.

Sue's life story tells of control by various others, rejection, physical abuse, sexual abuse, neglect, secrets, inconsistencies and double bind messages.

Based on the researcher's observations, Sue displays elements of borderline personality traits as evident of self-inflicted pain, volatile mood changes, constant feelings of emptiness and sexual identity crises. The emptiness, frustration and fear of rejection were "soothed" with food and isolation. The result was self-rejection and severe obesity, almost like a self-fulfilling prophecy.

For Sue, bariatric surgery was a means to become integrated with others, to accept herself and to escape from the criticism from others.

CHAPTER 7

JAMES'S "VOICE"

Biographical information

James is a 28 year old Caucasian, single male with no dependants. He works as a data analyst. He reported issues with his weight since the age of about six years. James resides in Gauteng, South Africa.

Nature of interaction

The researcher's first interaction with James was on the 26th of June 2007. After his surgery on the 27th of August 2007, James was approached by the researcher to request his willing participation in this research project. The researcher decided to approach him because of his "rich voice" and exposure to childhood trauma that he displayed during the therapeutic engagement prior to surgery. His initial weight at the start of the therapeutic process was 240 kg (BMI = 68.6 – Obese Class III) and by the time the final interview was conducted on the 11th of December 2007, his weight was 198 kg (BMI = 56.6 – Obese Class III). In total, James attended six therapeutic sessions and lost 42 kg up to the date of the final interview.

Emerging Themes

The following themes emerged from James's "voice":

Life script: a family driven socialisation

James was adopted at birth; he does not know his biological parents and only found out about his adoption two years after his foster father committed suicide. To find out about his adoption was a huge emotional shock for him. James was the person who found his foster father

and who had to take control of the trauma scene due to his foster mother's inability to manage trauma matters. James described his foster maternal grandparents as a happy family and his foster paternal grandparents as rigid with a history of alcohol abuse. James's foster father was the parent who took charge of the family matters and his foster mother was a "housewife". In the rest of this chapter, reference to James's foster father and mother will be made not referring to their foster status but as his "father" and "mother", unless otherwise stated.

My ma-hulle het uit 'n redelik gelukkige huis gekom. My pa-hulle het bietjie meer rigied grootgeword, daar was dinge soos alkoholisbruik in hulle huis gewees. My pa was redelik sterk gewees, hy was maar die man in die huis, het alles gerun, die geldsake en daai goed. Hy het gewerk en alles gedoen. My ma was 'n tipiese huisvrou. Sy het maar 'n sagte geaardheid gehad en altyd die sagter sy van die lewe gewys. Met haar kon mens kanse vat, maar net tot my pa by die huis gekom het.

With references to James's parents' emotional stability, he commented that his father had an alcohol problem and had a history of infidelity. James described his father as aggressive when he had too much to drink. His mother was described as soft-hearted, kind and not a leader.

Op 'n stadium het ons hom gesoek en toe kry ons hom in 'n kroeg saam met 'n ander vrou. Interaksie maar nie vriend-vriendin interaksie nie, jy weet? Meer as dit. Sy broer het ook dit gedoen. Sy broer het ook baie gedrink en ek het my oom ook saam met 'n ander vrou gevang. Met tye het hy (father) maar redelik aggressief geraak, daar was sekere goed wat hy nie moes gedrink het nie... wit drankie en daai tipe goed.

After James's father committed suicide, his mother remarried his stepfather after about four years. His stepfather had a son who stayed with them.

Birth expectancy

James had no information about his biological parents apart from his biological mother who was English speaking. Uncertainty about what they looked like and where they came from caused him to question his own identity and who he “should be”.

My biologiese ma was Engels gewees. Ek was altyd goed met Engels, ek het nog nooit gesukkel of 'n Afrikaanse aksent gehad as ek Engels praat nie. Dit maak sin, eweskielik, maar eweskielik weet jy ook nie meer wie jy is nie. As jy vir jousef kyk in die spieël wonder jy 'is ek nogsteeds wie ek veronderstel is om te wees?'.

Eating patterns and parental styling

James recalls that as a child they had structured eating routines and ate as a family at the dinner table for supper.

Toe ek klein was, was daar baie roetine. In die oggende ontbyt, in die aande saam eet. My kinderlewe was redelik gestruktureerd gewees. Naweke partykeer miskien take-aways en so aan, maar ons het 'n roetine gehad.

James was never limited to the portion size and quantities he was allowed to eat. Food was always readily available and he was not limited in terms of “sweets” and other treats. He also recalls the awareness that he had more access to “nice” food than his peers.

Daar was nie eintlik reëls nie; die porsies was maar redelik groot gewees. As 'n ou nie wou eet nie, kon jy maar regtig opgehou het...As jy maar net gevra het vir 'n sweetie dan het jy hom gekry.

(If compared to his peers, the question was asked if he had more food readily available to eat?)

Ja, ek kon meer geëet het as wat hulle kon.

From the researcher's case notes, James indicated that he would eat because of boredom. He also describes eating patterns typical to binge eating and grazing.

James indicated that his parents were overprotective and involved in his life, specifically his father. James shared an incident where he was molested by one of his cousins at the age of about five and after he told his father about the molestation incident; his father took immediate action to address the matter. James's interpretation of his father's immediate action created a feeling of trust and safety for James.

...my pa was baie betrokke, my ma ook. My pa sou byvoorbeeld as ek TV-programme en goed opgeneem het, dit saam met my gekyk het. Daar is baie dinge wat ons saam gedoen het. Ek het nie regtig sport gedoen toe hy nog geleef het nie, want hy wou nie gehad het ek moet rugby en so speel nie, hy was bang ek kry seer.

Dit was 'n baie, baie beskermende omgewing. Baie. Verskriklik. Op 'n stadium het ons dit en dat en sulke goed gehad, dan sou hy eerder iets anders probeer reël of iets koop dat ek eerder nie moet gaan nie. Dat ek eerder by die huis moes weet. My ma was baie erg oor my gewees. Ek het nooit regtig uitgeslaap nie, as ek op laerskool een keer uitgeslaap het by vriende, is dit baie. Hoërskool ook, tot my pa dood is. Ek was amper nooit uit die huis uit alleen nie. ...ek was gemolesteer deur my nefie toe ek omtrent vyf was...Ek het nog my pa vertel daarvan, ek het hom alles vertel...Hy het net daar omgedraai en ek kan nie onthou wat toe gebeur het nie, maar ek onthou ek mag nooit weer soontoe gegaan het nie. Hy het met hulle gepraat en vandag nog kom ons nie goed met hulle oor die weg nie. Tot na hy dood is. Daai kant van die familie sien ek nie.

James's mother remarried about four years after his father's death when he was in his final year at school. James describes his stepfather as a good man and indicated that his mother and stepfather's relationship was good. James also describes a period where he and his stepfather experienced conflict, mainly due to a power struggle about who should be the "man in

the house". The conflict was resolved and James projected a positive attitude towards his stepfather and his stepbrother.

...kyk dis 'n goeie iemand om in die huis te hê. Dis lekker om iemand te hê wat... skielik het jy 'n pa en 'n boetie en 'n oupa, goed wat jy vir jare lank nie gehad het nie, wat jou eintlik heelmaak...Die konflik was basies gewees oor dat hy nie gevoel het hy is die man in die huis nie. En ek kan vir jou eerlikwaar sê, ek het hom ook nie daai gevoel gegee nie. Ek is nie iemand wat terugstaan nie...Hy het bedreig gevoel...vandat hulle op hulle eie is, in hul eie huis en hul eie ding doen, gaan dit regtig baie beter met baie goed.

An inescapable traumatic loss of a caregiver

As reflected by questions asked about negative or traumatic life events related to abuse and trauma, James reacted that he was sexually molested (as already discussed); endured emotional abuse; witnessed his father attacking his mother and abused alcohol; witnessed his father's suicidal death with shock and helplessness; was shocked at the revelation two years after his father's suicidal death that he was adopted; felt separated; at times feeling neglected; being bullied at school and victimised by others; interpreted his father's death as a form of emotional rejection; being rejected by his father's family after his death; and endured emotional feelings of loss, most of his adolescent years. James's reaction to questions related to the array of traumatic events he experienced during his life is reflected by the following interpretations and statements he made during the final interview:

(Emotional abuse based on the case notes compiled during James's engagement during the process of bariatric surgery). *He experienced emotional abuse during adolescence.* (James interpreted his father's attempt to hypnotise him when he was drunk as a form of psychological intimidation)...*baie betrokke met hipnose en sulke tipe goed, geestelike dinge en so, verstaan? So, hy het my 'n paar keer probeer hipnotiseer, wat hy nie kon regkry nie. Wat hy ook gewoonlik net gedoen het as daar drank by betrokke was.*

(Witness physical abuse by father)...toe ek met hom baklei het omdat hy aan my ma geslaan het, ja... maar hy't gestop, sy't hom gestop. (Witness father's alcohol abuse) My pa het baie gedrink. Dit was nog altyd vir my 'n "issue"... hy het vir 'n ruk probeer ophou en weer begin. Hy het baie goed met sy hande gewerk, houtwerk en daai tipe goed. Hy het op 'n stadium dit gedoen terwyl hy gedrink was, toe het daar 'n deel op sy gesig gekom wat sy hele neus ... dat hulle sy hele neus moes herbou het, opbou het. Toe het hy ook vir 'n ruk opgehou en weer begin. Dit was altyd daar, dit was altyd betrokke. (James's mother started drinking with his father in an attempt to be part of his life and to better understand him) Sy het saam met hom gedrink in 'n sekere mate. Ek dink nie ek het haar al twee keer gesien dat sy te veel gedrink het nie. Regtig, my ma is nie iemand wat baie drink nie. Maar sy het ook maar saam met hom gedrink om te probeer om deel te wees van sy lewe. Wat ook net tot op 'n punt gewerk het, dan het hy gesê maar 'jy kan my nie verstaan nie'. Maar as jy nie verstaan wil word nie, sal jy nie verstaan word nie. (Witness: James's father committed suicide at their home, James found him and took control of the situation by informing others of the suicide) My ma het begin huil en begin skree, kop verloor. Ek het haar maar net uit die kamer uit gehou. Sy het hom nie gesien nie... Ek het kamer toe gegaan en die deur oopgemaak, toe sien ek hy lê op die bed met 'n geweer in sy hand. Daar was bloed orals gewees. Dis maar wat gebeur het. Ek het omgedraai en telefoon toe geloop. Ek het my ma uit die kamer uit gehou. My oom-hulle gebel en ek kan nie onthou nie... my twee ooms gebel, my ma se broer en my pa se broer. Toe my vriendin gebel – 'n skoolvriendin...Ja, ons het net oorkant die dominee gebly. Ek het na hom toe gehardloop en gesê iets is nie lekker nie. Hy het toe later oorgekom en daai soort van dinge. Paramedics, almal het gekom. Die polisie het gekom en kom soek vir 'n nota...Ek het nie gedink hy lewe meer nie. Toe die paramedics daar kom het hulle my ook uit die kamer gehou, maar ek meen.... dit het nie eintlik enige doel gedien nie, want ek het mos als gesien...Hulpeloos. 'n Ou weet nie wat jy kan doen nie...Ek het die geweer uit sy hand uit gevat. Umm, verder as dit, nee. Ek kon nie regtig hoor dat hy asemhaal of so iets nie, ek het nie so naby aan hom gegaan nie. Jy kon gesien het dis mos maar wat gebeur het. Hulle is toe weg, die paramedics het toe gebel op pad soontoe... ek kan onthou die EKG, daai ding... op pad

hospitaal toe is hy toe dood. Ek en my oom het op 'n stadium die matras gaan weggooi. Toe moes ons sy werksmense sê. My oom kon dit nie doen nie, toe moet ek dit doen.

(At the age of 14 years when James's father committed suicide, his mother expected him to take over the role as the "husband" and responsible person in the family – a role that James feels was not appropriate for a 14 year old adolescent, but he had no choice). *Ek was nooit regtig kind gewees na dit nie. Ek het nog altyd aan myself gedink as 'n redelike volwasse persoon, iemand wat dinge kan laat gebeur of kan sorg dat dinge nie handuit ruk nie. En dan kom daai ding waar almal vir jou sê 'okay, nou is jy die man in die huis'. Daai tipe van goed. Dis nie iets wat jy leer nie, dis iets wat dadelik posvat, dis die rol wat jy moet speel...Kyk, op 'n punt moet mens sekere verantwoordelikhede hê. Jy kyk maar dat die huis gesluit is en goed in die aande. As jy jou boundaries overstap laat sy jou vinnig weer weet jy is 'n kind, wat bietjie verwarring veroorsaak. Jy weet nie regtig waar jy inpas nie.*

Based on the case notes, James indicated that his father's death left him with feelings of being rejected, "dropped" and left behind. He expresses intense feelings of anger towards him (father) for dying, although he also mourns his death and the loss of him. These opposing emotions caused James to have intense internal conflict surrounding the emotional experiences of his father's suicidal death. These feelings were exacerbated by his father's family who rejected him and his mother after his death.

A Complex Trauma symptom constellation following childhood trauma

For the purposes of this section, the inquiry into the symptoms that followed James's experience of the various forms of childhood trauma that he was exposed to, will be described while using the transcribed information after the semi-structured interview in order to determine the extent to which he displayed the full spectrum of Complex Trauma symptoms.

Affect and impulse dysregulation

According to observations made by the researcher during his engagement with James, he presents with a chronic depression, high levels of anxiety, feels overwhelmed by situations and his emotions tend to rise to the surface very quickly.

James indicated that he has a volatile temperament and it takes him a long time to “cool down”, even more so before he started on the bariatric programme.

Ek is 'n ou wat half, baie gou kwaad geword. Ek kan gou die wetter in raak. Maar dis nie 'n probleem nie, maar as ek regtig kwaad geword het vat dit lank om my weer af te koel. Baie meer so voor ek op die program gekom het.

Prior to the bariatric surgery, James indicated that he used food to modulate his volatile feelings. Within this context, food serves the purpose to comfort and calm him down.

Voor die operasie, moet ek eerlikwaar sê, kos het 'n rol gespeel. Na die operasie... ek is baie lief vir musiek, ek sal musiek luister of computer games speel of so.

When James was questioned about feelings of anger he might experience, he replied by indicating that prior to the operation he endured more intense feelings of anger. The way to cope with the frustration and anger is, according to James, remedied with excessive food intake.

Ek verwerk dit of bêre dit binne myself. Dis ook so as iets my regtig ontstel. Dit maak dit makliker dat 'n ou nou vriende het wat baie meer ondersteunend is. Daar is iemand met wie mens kan praat...Voor die operasie was dit baie so. Ek was baie ongelukkig met myself gewees. Jy begin agterkom jy kan nie meer doen wat jy altyd gedoen het nie. Jy kan nie meer 'n aktiewe rol speel in baie dinge wat jy graag sou wou nie. Ek doen nou al ses jaar dienswerk by die kerk. Ons gaan elke jaar Ballito toe met die kinders. Ek kon nog nooit ver loop op die strand nie...dis amper half of hulle vir my gelag het...Dan begin 'n ou kwaad raak...Mense sien dit ook raak...Jy hou nie van jouself nie, jy hou nie van wat jy sien nie...En dit kos jou R400 of R500 om 'n jean te gaan koop.

En ek het nie die geld daarvoor nie...Dit maak 'n ou baie kwaad. Jy kan nie gaan go-karts ry nie, want jy gaan nie inpas nie. Jy kan nie gaan paintball speel nie, want jy kan nie in die flippen oorpak pas wat jy moet aantrek nie...As jy wil gaan sit, moet jy eers kyk of die stoel jou gaan hou. Dit maak dat jy sê, 'dan eet ek'...Amper asof mens op 'n punt kom waar jy sê, ag ek kan dit nie verander nie, so laat ek net sowel dit wat vir my lekker is geniet – kos.

James tends to suppress his true feelings of anger by relegating his emotions to become a person with a fake demeanor in order to feel accepted in spite of his intense feelings of anger. *Ja, oor jy oorgewig is dink jy bitter min mense wil regtig by jou wees. Kyk, na Karien (ex fiancé) is al my pelle weg, behalwe een. Ek het hulle almal verloor. 'n Ou wil maar die persepsie skep dat jy eintlik 'n nice guy is.*

James reports previous suicidal ideations and the need for self-inflicting pain but never attempted or reacted on those impulses. When questioned about the frequency of those thoughts, he indicated that during the break-up with his fiancé he had frequent suicidal thoughts and/or ideations.

Daar was gedagtes van selfmoord of selfbesering. Maar dit het nooit uitgekom nie...Dit het op 'n stadium redelik gereeld voorgekom. Toe my pa weg is en veral toe ek en Karien uitmekaar is, dit het 'n groot rol gespeel op daai stadium van my lewe.

James describes preoccupation with thoughts about sexual involvement but due to his abstinence from sexual interactions he fulfils the need for sexual exposure by getting overly involved in computer pornography as a substitute for a healthy normal sexual relationship.

Ek dink partykeer en dink bietjie meer daaraan as ander ouens...Ja nee, daar is baie pornografie by betrokke, ja.

James describes a period in his life where he would drive excessively fast and overindulged in alcohol as a way to create a feeling of excitement in his life. Since he has lost a lot of weight after bariatric surgery, he claims to be less interested in taking unnecessary risks.

Vinnig ry, onverskillig wees saam met die vriende, daai tipe goed...Drink, ja, het ek op 'n stadium, so paar jaar terug.

Alterations in attention or consciousness

James describes amnesia for periods during his primary school years as “hazy”.

Die kindertyd, ja. Baie. Dis asof 'n ou sekere goed uitlig en rondom dit kan jy party goed onthou. Ek kan nie vreeslik baie van die laerskool onthou nie. Dis of dit half hazy is, daai tyd.

Feelings of “losing track of daily activities” were described by James, mainly referring to the experiences he had pre-operatively. James rationalised his perceptions by indicating that he thinks that the use of alcohol caused the experiences. When he experienced high levels of stress, he described feelings of disorientation. When asked about these experiences, he indicated feelings of being an observer of his situation, rather than a participant. James also described transient dissociative episodes almost as if a part of him is “lazy” and another part is “reliable and responsible”. When asked if he feels that there might be two personalities inside himself, he answered that he does feel that way.

Ja, dit het op 'n stadium so geraak. Kyk, ek dink saam met drank gebeur dit, want 'n ou is maar geneig om half aan die slaap te wees, jy weet nie lekker of jy kom of gaan nie. Maar dis nou baie makliker, baie skoner kop en helderder verstand...Voor die tyd het ek. Asof jy nie regtig daar is nie...Wel, dit kan voel of jy nie regtig betrokke is by goed nie, of jy nie kan deel wees daarvan of jou punt kan oordra nie...Kyk, 'n ou is baie keer 'n persoon waarop mense staatmaak, wat goed gedoen kry. Aan die ander kant is daar 'n deel van my wat partykeer net wil lyf wegsteek, net aan jouself wil dink. Party mense sien dit so.

Disturbances in self-perception

James describes feelings of “not worthy of” being in this world and that he does not fit into society. This implies a strong feeling of being ineffective as a person.

'n Ou voel partykeer of jy nêrens inpas nie, of jy nie 'n verskil maak nie, dan dink 'n ou maar daaraan. Mens voel amper wat is die punt, wat doen jy nou eintlik hier? Die wêreld kan normaal sonder jou aangaan.

When James was asked about his experiences of feeling in control of his life, he indicated that he feels like a “bystander”, implying that he does not feel in control and referring to the pre-operative period where he neglected his “self-care” and did not bother to take pride in who he is, as evident of the following remarks he made when questioned:

Ja, dit het op 'n stadium so vir my gevoel. As 'n ou met jou gesondheid begin sukkel en jy begin met mense sukkel en jy begin agterkom hoe oud jy raak en daai tipe ding, dan begin dit vir jou voel of jy net 'n bystaander is...Die feit dat jy nie regtig meer worry oor hoe jy lyk nie. Ek het myself verwaarloos. Of ek nou my hemp stryk voor ek hom aantrek of nie. Daai tipe van goed.

James made the remark that he feels that people only “accepts” him for a “short period of time”, when asked if he feels “permanently damaged”. This could imply that, due to people’s short and conditional acceptance of him, he feels permanently damaged.

Ja, want al kry jy iemand wat jou aanvaar soos jy is en alles, is dit kortstondig. Al kry jy iemand wat jou onvoorwaardelik aanvaar soos jy is, soos dit veronderstel is om te wees in 'n verhouding, gaan jy net x-aantal jare lewe en jy gaan in elk geval net soveel goed kan doen.

In answer to a question about guilt feelings he has, James replied that it is easy to make him feel guilty and therefore he feels that he tends to overcompensate by feeling overly responsible for others. This could be interpreted as a defence mechanism implying a form of “projective identification”.

Ja, partykeer. Ek dink dis makliker om my te laat skuldig voel as iemand anders.

Pre-operatively, James describes feelings of being ashamed of himself, and feeling rejected and inhibited in terms of exposure to specifically the opposite sex.

Kyk, dit is in 'n mindere mate nou nog so. Ek het nie nou al die vrymoedigheid om sommer met 'n meisie te begin praat nie. Ek het 'n redelike outgoing persoonlikheid, ek kan mense byvoorbeeld regtig redelik vinnig opsom en daai goed. Maar dit is partykeer so, maar in 'n meerdere mate voor die program, dat 'n ou nie wil deel wees van iets nie, dat jy jousef eerder nie daaraan wil blootstel nie. Dat jy eerder die persepsie het dat mense jou sien as 'X,Y,Z'.

During the final interview, when James was asked to what extent he feels that nobody can understand him, he replied that he considers himself different in the sense that he is more serious about things. It could be interpreted that certain aspects of his life are different to most others; this notion is based on his perceptions of teenage boys whom he deals with in a religious context.

Ek dink ek is baie meer ernstig as ander mense, in baie opsigte. Ek werk baie met kinders wat sestien jaar oud is wat al rondgeslaap het, of whatever. Dit wat 'n ou nie regtig weet nie... Alhoewel jy goeie redes het daarvoor, is dit partykeer moeilik om jousef heeltyd daarvan oortuig te hou. Veral as die wêreld 'n ander persepsie het op daai vlak.

James used to minimise his weight issue and in retrospect he has insight into this emotional reaction to an issue that could have cost him his life.

Ek dink die gewig was nie vir my 'n issue nie, op 'n stadium. Of dit was 'n issue, maar ek het nie regtig iets gedoen om dit reg te kry nie. En ander mense het baie bekommerd geraak. My dominee het gesê 'kyk, ek wil jou nie begrawe nie, ek sien jou as 'n seun en ek wil nie langs jou graf staan nie'. Hy het gesê iewers sal ek 'n plan moet maak, want dit kan nie so aangaan nie.

Disturbances in relationships

James indicates that he has a problem in trusting people more than what he should, and accepts that as an adult it could be to his disadvantage. His need for acceptance and naïve approach to the motives of others could be interpreted as a projective need for inclusion. For periods in James's life, specifically pre-operatively, he has withdrawn from having quality social time with others. He describes having more qualitative engagements post-operatively.

Kyk, ek het nog altyd sosiaal verkeer. Daar was 'n tyd waarin ek nie regtig sosiaal wou verkeer nie, maar mens kom weer daaroor. Ek het nog altyd redelik sosiaal verkeer...Voorheen seker maar bietjie minder. Of jy kan maar sê dieselfde, maar dit was nie altyd kwaliteit tyd nie. 'n Ou kon nie regtig betrokke geraak het nie. Nou kan mens eintlik eers regtig daaraan waarde heg...Ek kon byvoorbeeld in die aand nie meer gedans het nie, wat ek nou agt, tien keer kan doen. Verstaan jy, dit maak jou baie deel van baie dinge. Jy kan dinge geniet.

The researcher made the interpretation that due to James's "gullible" and "naïve" coping styles, he opens himself to the direct and subtle abuse and needy projections of others as evident in the following comment when asked about this aspect:

...op 'n stadium het ek baie af-vlerkies na my toe aangetrek. Dat 'n wildvreemde ou na my toe gekom het en gesê het 'ek hoor jy's die man om mee te praat'. Wat nie noodwendig sleg is nie, maar iemand soos ek kan dit vir myself aantrek en daarby betrokke raak. Want ek is nie iemand wat dit net kan los nie, ek sal nogal wonder wat gebeur met die ou, hoe gaan dit, watter situasie is hy in.

Somatisation

James describes an array of physical symptoms that include constant headaches, swollen feet, feeling out of breath most of the times and skeletal pains. These symptoms could

be interpreted as caused by his overweight, but James interprets these symptoms as separate from his weight issues, therefore implying a form of somatisation.

James describes an incident where he had pains in his heart but according to medical examinations he does not have any heart condition. This could be interpreted as a form of internalised anxiety about his health and a need to have a clear explanation for his internal emotional feelings.

Ja. Op 'n stadium het ek 'n pyn op my hart gekry. Hulle het 'n EKG gedoen en niks gekry nie...Dit laat jou worry. Jy weet nie regtig wat om te verwag nie. Jy wil weet wat met jou aangaan.

No specific problems with his genitalia were reported although he indicates that the size of his penis seems to be a concern he cannot change. His perceptions in this regard could be interpreted as relegated to his weak self-image, resulting in self-doubt and confidence in intimate relationships.

'n Ou worry maar altyd oor die grootte, maar dis nie 'n mediese toestand nie...Want dit is mos maar waarmee jy uitgedeel is.

Meaning systems

James was asked about possible feelings of hopelessness and pessimism about the meaning of life and indicated that pre-operatively his emotional and physical condition impacted his work performance. He describes feelings of more control and enjoyment in terms of his present job since he had the bariatric surgery. James also justifies his sense of existence in a religious context by referring to himself as "his own worst enemy".

Ek was baie so gewees voor ek op die program gekom het. 'n Ou het nie regtig 'n uitkyk gehad op daardie stadium nie...Ja, want mense sien jou ook dadelik anders. Jy lyk so goed, jy dink so goed, jy weet? Nie net lyk nie, jy klink anders as wat jy geklink het. Dit skep by 'n ou 'n nuwe verwagting vir wat dalk kan voorlê...Ek voel goed oor my werk. Nou eers. Voorheen... het gewerk

op kommissie-basis. Ek het nog altyd goeie kwaliteit gelewer maar ek kon nie kwantiteit lewer nie. Ek kon nie. Partykeer het ek by die werk aan die slaap geraak. Dit is nie nou meer so nie. Waar ek voorheen basies net-net klaargekom het... my output is nou baie beter...Op 'n stadium, ja. Die Here speel 'n groot rol in baie dinge. Die duiwel en al daai dinge ...jy is partykeer jou eie worst enemy. Jy maak jousef dinge wys: hoekom is jy in hierdie lewe? Wat doen jy in hierdie lewe? Die ouens kan net sowel sonder my aangaan, hulle het jou nie regtig nodig nie. Al daai tipe van goed. Tot 'n mindere mate nou, maar ek dink dit sal eers regtig regkom as 'n ou die plekkie kry waar jy regtig veronderstel is om te wees.

Psychological defence mechanisms: a coping strategy

Observations made about James's psychological defences and coping styles, indicate that he uses a variety of strategies to harness himself against external and internal emotional discomfort he experiences. James uses high adaptive defences like sublimation, suppression and altruism to maximise gratification, to handle stressors and to allow conscious awareness of feelings, ideas and their consequences. These defences promote an optimum balance among the conflicting emotional motives he experiences. James's reaction to the intense trauma he had to face when his father committed suicide could be interpreted as sublimation in order to cope with the intense impact of the exposed trauma. His almost paradoxical inappropriate and calm management of the trauma could be reflective of this form of defence mechanism. Observations made by the researcher during his involvement with James also highlight the use of sublimation to cope with various other emotional distressing situations he encountered.

(Sublimation) Kyk sy dood was vir my baie traumaties...Ek het kamer toe gegaan en die deur oopgemaak, toe sien ek hy lê op die bed met 'n geweer in sy hand. Daar was bloed orals gewees. Dis maar wat gebeur het. Ek het omgedraai en telefoon toe geloop. Ek het my ma uit die kamer uit gehou. My oom-hulle gebel en ek kan nie onthou nie... my twee ooms gebel, my ma se broer en my pa se broer. Toe my vriendin gebel – 'n skoolvriendin. Ek het na hom toe gehardloop en gesê iets is nie lekker nie. Hy het toe later oorgekom en daai soort van dinge...Toe die

paramedics daar kom het hulle my ook uit die kamer gehou, maar ek meen.... dit het nie eintlik enige doel gedien nie, want ek het mos als gesien...Ek het die geweer uit sy hand uit gevat...Ek kon nie regtig hoor dat hy asemhaal of so iets nie, ek het nie so naby aan hom gegaan nie...En dan kom daai ding waar almal vir jou sê 'okay, nou is jy die man in die huis'. Daai tipe van goed. Dis nie iets wat jy leer nie, dis iets wat dadelik posvat, dis die rol wat jy moet speel...Kyk, op 'n punt moet mens sekere verantwoordelikhede hê. Jy kyk maar dat die huis gesluit is en goed in die aande...(Suppression) Ja. Kyk ek is die tipe ou wat, as iets my pla, as ek iets het om oor te praat en ek praat nie binne 'n halfuur of 'n uur daaroor nie, dan praat ek nie daaroor nie. Dan verwerk ek dit en dan gaan ek aan. Dit was nog altyd so, dis nogsteeds so.

A tendency to be overly responsible might be an indication of an altruism defence mechanism. A defence mechanism like altruism is known to deal with emotional conflict or stressors by dedication to the needs of others.

(Altruism) My ma het begin huil en kop verloor...Ek het haar uit die kamer uit gehou. Ek en my oom het op 'n stadium die matras gaan weggooi. Toe moes ons sy werksmense sê. My oom kon dit nie doen nie, toe moet ek dit doen...Ek was nooit regtig kind gewees na dit nie. Ek het nog altyd aan myself gedink as 'n redelike volwasse persoon, iemand wat dinge kan laat gebeur of kan sorg dat dinge nie handuit ruk nie.

A minor image-distorting level of defence and omnipotence is also characteristic of James's defence style. The distortion of the self, body, or others is applied to regulate his self-esteem. (Omnipotence) *Op daai stadium was dit eintlik nog 'n voordeel as jy kontak sport doen om groot te wees. Om mense af te skrik om nie regtig met jou te sukkel nie. Hulle sukkel nie met 'n groot ou nie, hulle bly uit jou pad uit...Dit was een van die redes hoekom 'n ou dit gedoen het, want jy het geweet die ouens gaan redelik uit jou pad uit bly as jy kan sorg dat jy intimiderend lyk. Terwyl jy nie regtig is nie. Dit speel definitief 'n rol daarin.*

For James, food serves as a constant and reliable factor to comfort and calm the emotional moody dysphoria and anxiety he experiences.

(Food a comforter)...ek het op 'n stadium as jy depressief raak dan eet jy maar...as jy depressief is, kry jy half comfort daarin...Kos, dis iets wat altyd daar was.

Process of bariatric surgery: a positive and/or negative life stressor

The psychological questionnaire James had to complete prior to his first assessment by the researcher, indicated that his expectations following bariatric surgery are as follows:

To lose weight; be more healthy; be able to live; easier to move around; be able to meet someone; wear normal clothes; to be seen as normal with others; and better job opportunities to arise.

James has a clear need to be healthier and to engage in meaningful relationships based on his expectations from bariatric surgery.

Feedback to a question asked in the psychological questionnaire about James's fears was as follows:

Getting to know the new me; adapting to being normal; other's perceptions; more attention from the opposite sex; and not being able to do my Private Pilot Licence.

Present life stressors James worry about include his "work situation", being "alone at his present age", his "finances", "health" and "friendships".

Perceptions of bariatric surgery and psychological processes

James's perception of the effect of surgery is that it is "phenomenal" and that the surgery changes your view of life and the quality thereof. He further commented that bariatric surgery changed his personal view of "the self" as a major benefit.

Ek dink dis 'n fenomenale ding. Ek het nog nie regtig besef wat dit kan beteken nie. Die fisiese aspekte is nogal goed, ja. 'n Ou weet waarvoor jy jouself inlaat. Jy weet dit, jy sien dit en jy beleef dit. Maar jy besef nie dat dit... al verloor jy nie eers gewig nie, as dit net jou lewensuitkyk en lewenskwaliteit kan verander, al is dit logies dat jou lewenskwaliteit nie gaan verander voor jy gewig verloor nie, maar... Die gewig verloor is amper nie vir my die grootste ding nie. Dis amper vir my asof die kwaliteit of tipe persoon of die uitdrukking wat jy vir jou persoonlikheid kan kry, die grootste is...(Changes outlook on life)...jou lewe of jou uitkyk verander 180°.

James also indicated that the choice of the surgeon creates a feeling of safety and trust that is according to him needed to have a positive outcome after surgery.

Daar is 'n risiko. As net doen wat jy behoort te doen. Daai ouens waarvan die chirurg gepraat het wat daai ding op die dikderm het... daar is 'n groot wanpersepsie daar rondom, oor wat dit regtig is. As jy met baie mense daaroor praat dan sal hulle vir jou sê 'maar hierdie ou is dood daaraan en daardie ou is dood daaraan'. Maar bariatriese chirurgie dink ek, is soos 'n nuwe kar, daar is verskillende modelle. Daar's 'n BMW en daar's 'n Uno. As jy na die ou gaan wat die Uno verkoop, gaan jy nie regkom as jy in 'n ongeluk was nie. Maar as jy na die ou toe gaan – waar ek glo ek was – en die BMW ry, staan jy 'n 90% kans om daaruit te kom.

James also acknowledges that the surgery could, to an extent, be considered traumatic. *Tog, as mens na die verband kyk – as dit nie vir 'n klomp traumatiese goed was nie, sou jy nooit daar uitgekome het nie. So, trauma het tot gevolg gehad dat jy... jou eie lewe gered het...Dit is trauma. Ek sien dit in 'n sekere sin so.*

The benefits James mentioned were that he felt less tired and that his more energetic approach to his work improved his performance.

My hele persepsie van dinge, van myself. My hele gevoel rondom myself. My werksituasie, baie dinge het verander. Belangrike goed. Jy word nie meer so moeg nie. Ek sou nie sê jy word glad nie moeg nie, maar jy kan langer werk en meer doen. Kyk ek het altyd langer gewerk, maar nooit vreeslike goeie resultate gekry nie. Waar jy nou baie beter resultate kry.

Initially James thought that the psychological part of the process was unnecessary but he soon realised that it is crucial to prevent long-term complications after surgery.

In die begin het ek nie gedink dis regtig nodig nie. Ek dink mens dink dis 'n geval van ... dis 'n mediese operasie, dis nie nodig om 'n sielkundige te sien om jou derms te laat uithaal of so iets nie. Maar as 'n ou eers besef wat jou uitkyk nou, na die tyd is, is dit belangrik dat mens voorberei word daarop. Ek dink ouens wat dit nie doen nie, loop 'n baie groot risiko om hulself meer te beseer na die tyd.

The lessons James learnt from the psychological process were that “things that happened to you” is not your “fault” and that most of the unspoken emotions he experienced were normal.

Ek dink dat 'n ou dinge wat met jou gebeur het, nie noodwendig jou skuld is nie, want jy dink dit is. Dat dit okay is dat dinge met jou gebeur het. Soos, die feit dat jy aan seks dink, baie keer, nie vuil is nie, nie verkeerd is nie. Die feit dat jy deur al hierdie dinge is, dat die gevoelens wat mens het, normaal is. Dit maak jou wie jy is. Jy is nie 'n psigopaat wat mense wil vermoor in die aand as 'n stokperdjie nie. Dat die negatieweit wat in jou is... dat dit orraait is om dit te hê, maar dat mens tog op 'n manier daarvan ontslae moet raak. Op 'n manier wat nie skadelik is vir jouself nie...Die grootste ding vir my, is dat 'n ou normaal is. Dat jy nogsteeds ... dat al hierdie gevoelens en dinge normaal is, dat jy nie hoef skuldig te voel oor wie of wat jy is nie. Dat jy 'n ingryping moet maak baie keer is waar. Maar om te kan aanvaar dat jy 'n probleem het en om te weet dit is okay, dan is jy klaar 50% daar.

The unconditional acceptance by the researcher during the process created an emotional feeling of safety. He further commented that if it was not for the psycho education, he would not have been in a position to realise that after the surgery a mistake was made by the ward sister which could have cost him his life, and therefore this education forms a critical part of the bariatric process.

Maar dit is lekker om op jou eie terme oor goed te praat. Ek moet ook besef, as 'n ou 'n sukses wil maak moet jy 100% insit, heeltemal eerlik wees. Dit help nie mens steek goed vir iemand weg, wat vir jouself gevaarlik kan wees nie. Goed wat ouens nie dadelik optel nie. Byvoorbeeld. as ek nie met jou eerlik was nie, sou jy nie opgetel het dat ek nie presies geweet het wat aangaan nie; sou daai vrou nie onthou het om (.....inaudible word) te gee nie, dan sou ek dalk nie meer daar gewees het nie. Net daai klein goedjies, die feit dat jy jouself blootstel, kon dalk jou lewe gered het. Who knows?

James also mentioned that he felt comfortable with the researcher during the preparation process and reflected that people have a misperception of the role of the psychologist before and after bariatric surgery.

...ek praat moeilik oor persoonlike dinge, maar dis vir my lekker om met jou te gesels...Ek dink sielkundige behandeling is iets waaroor baie mense 'n wanpersepsie het.

James considers honesty and a good support network as a prerequisite for a successful outcome after bariatric surgery.

Ek dink om eerlik te wees met jouself...Om te weet dat dit jou hele lewe gaan verander. En dan om 'n goeie ondersteuningsnetwerk te hê; jy kan dit nie doen as jy nie mense het wat agter jou kyk, saam met jou bly raak as jy gewig verloor en so aan nie.

James considers “inconsistencies” and the amount of trauma he had to endure as the main reason why he found comfort in eating excessively and the reason why he became morbidly obese.

Daar was baie trauma gewees, daar was baie dinge wat seker maar daartoe kon gelei het. Daar was baie inconsistensies gewees. Daar was nie stabiliteit gewees nie. Ek dink dit speel 'n rol. Die goed wat 'n ou gesien het speel 'n rol. Kos speel seker ook 'n rol. 'n Koek bly 'n koek, kos bly kos...Ek weet nie of dit 'n plaasvervanger is nie, maar dit was definitief 'n beloning gewees. Iets wat jy jouself kon beloon mee.

Conclusion

James describes a life story of being adopted, a secret his parents kept till after his father committed suicide, followed by strong rejection from his paternal family after his father's death. The disclosure that he was adopted had a major impact on his perceptions of the self and his existential role in society. James's father was an alcoholic, very protective, involved and caring over him. James's interpretation of his father's attempt to hypnotise him when he was under the influence of alcohol was a traumatic experience he recalls. He also interprets his father's abuse of alcohol, lack of control versus his protectiveness and involvement in his life as a double bind message from him. After James's father's suicidal death he had to take the role of an adult and the events that followed after his death caused him to “lose out on healthy childhood activities”.

Although James was exposed to healthy eating patterns in the form of routine meals as a child, he was allowed to eat between meals whenever he felt like it. This behavioural pattern became a fixed behaviour and is considered a contributing factor to James's obesity. The inability to express painful emotions and inconsistencies from his father was comforted by food, ultimately resulting in severe obesity and lack of self-confidence and further feelings of rejection, specifically within intimate relationships. At one stage James used his overweight to intimidate

others to regain a feeling of power and control. Unfortunately he became too obese to maintain his dominance within that context and diverted to a stance where he felt inferior to others.

Indirectly, James perceived bariatric surgery as a form of trauma resulting in the paradoxical interpretation that the trauma of bariatric surgery due to inconsistencies resulting in obesity in his life, enables him to be healthier and to engage in meaningful intimate relationships in the future.

CHAPTER 8

MANNY'S "VOICE"

Biographical information

Manny is a 39 year old Asian, married male with three sons. He runs his own fast food business. He reported issues with his weight since the death of his mother during his early primary school years. Manny resides in Gauteng, South Africa.

Nature of interaction

The researcher's first interaction with Manny was on 9 September 2007. The researcher approached Manny after he underwent surgery on the 8th of November 2007, in order to ask him to be a willing participant in the study. Manny was approached because of his "rich voice" and exposure to childhood trauma which he described during the first session. Manny's initial weight was 206 kg (BMI = 66.5 – Obese Class III) and at the time of the concluding interview on the 12th of December 2007 he weighed 168 kg (BMI = 54.2 – Obese Class III). In total, Manny attended six sessions and lost 38 kg up to date of the final interview.

Emerging themes

The following themes emerged from Manny's "voice":

Life script: a family driven socialisation

Manny's father came from a poor family and he was the third of four children (two brothers and a sister). From what Manny knew, his paternal grandfather was a kind person. Manny's mother was one of two sisters. Manny's maternal grandfather passed away when his grandmother was 21 years old. His grandmother did not remarry after her husband passed away

and raised her two daughters all by herself. The interpretation Manny made after his maternal grandfather passed away was that his grandmother had to endure difficult socio-economic circumstances to raise her two daughters all by herself. Manny's grandmother was also his primary caregiver who took care of him and his younger brother when his mother passed away. Manny also describes his maternal grandmother as a loving and caring person. After Manny's mother died, his father remarried and had three daughters from that marriage. While being married to his first stepmother, his father also engaged in a relationship with his "other" wife and had two daughters and a son from that relationship. Manny always felt that his position as the oldest son was never respected by his father, stepmothers and half-siblings as evident from the following statement.

They disrespected me as the eldest brother.

The childhood experiences Manny recalled were that they also moved house very often and for a period of six months the whole family (Manny, his brother, maternal grandmother, first stepmother with her three kids and his father) stayed with Manny's father's brother. Manny considers this period of time and most of his recollections of his childhood as disruptive and reinforced the feelings of rejection he had to endure as a child.

...we even stayed with my Dad's brother, the youngest brother, the whole year in and the new year, all six of us...the whole six months. His wife also had a problem with me.

His interpretation of his father's attitude towards the family was that until his mother's death he used to "spoil" them and gave them "everything" they wanted. His involvement changed after Manny's mother died after which he became "absent" from the family. Manny's father's absence caused him to feel very angry and upset in spite of him (father) knowing how it made him (Manny) feel at the time. This could be interpreted as "not being heard" and is reflected in the intense feelings of neglect Manny had to endure after his mother's death and the inescapable "new" reconstructed family situation he was exposed to.

Not having him around when you need him...A lot of anger growing inside. He knew how upset we were getting, he was not with us. I know my Dad wasn't much at home. He was more out than he was with us... It wasn't too pleasant, but my Granny always said we should give him some time, he will come right. But in the meantime, he already carried on with his life, with someone else.

Birth expectancy

Manny does not have any recall or information pertaining to his birth expectancy.

Health, eating patterns and parental styling

Manny describes his father as "small build" and his biological mother as overweight. For a period after his mother's death, while in the nurturing care of his maternal grandmother, and while his father was absent, he was exposed to routine meals. After Manny's mother died, his maternal grandmother took the role of being the "mother" to Manny and his younger brother. Manny indicated that when his grandmother left and they stayed with his first stepmother, there was less routine in terms of meals. Reference to his grandmother was that she was a substitute parent and the person who protected him and his younger brother until his first stepmother moved into the same house.

She was the one who actually protected us in that period as well. She was basically like a mother.

His description of his grandmother's physique was that she was "quite big". She was a very "kind person" and always made sure that they had ample of everything, almost as if she spoiled them with whatever she could lay her hands on as evident from Manny's reply to a question in this regard:

We used to have our meals at the table, together... she always gave us whatever we wanted. And whenever we wanted it. There was never something she kept us away from.

Due to Manny's father's marriage with his first stepmother and concurrently the relationship with his alternative "stepmother" who did not share the same household, Manny's maternal grandmother and first stepmother was responsible for preparing the food in the house. Manny perceived the relationship between his grandmother and first stepmother as conflicting. They were both responsible for preparing meals and that caused uneasiness between them.

Observations made by the researcher during the pre-operative assessment were that Manny had problems with nocturnal eating and "grazing" due to emotional upset. Due to Manny's weight issues (overweight) since childhood, he lacked the confidence to participate in physical activities that evidently resulted in becoming more overweight.

An inescapable rejection and/or loss of a caregiver

The dominant themes that came from the analysis of Manny's voice were that of loss (death and/or neglect by a caregiver) and intense feelings of rejection by his father and in specific his stepmothers and family members related to his father. To witness his father's rejection of his nurturing substitute parent (maternal grandmother) was interpreted by Manny as an intense traumatic experience. He had to endure the trauma of separation from meaningful others in his life; he also felt unsafe, were bullied by peers; endured emotional abuse; and had to keep family secrets. Manny also shared his intense feelings as an adolescent to bully others, a known reaction to prolonged exposure to childhood abuse, which is considered a form of re-enactment following trauma with the intent to control others the same way he was controlled by his circumstances. The researcher considers this reaction to bully others also as a way to try and create meaning from the meaningless abuse he had to endure as a child. Evident from the observations made by the researcher during his engagement with Manny was that food became a substitute comforter (caregiver), implicating that this could be a driving force behind his eventual chronic illness (morbid obesity) Manny suffered from most of his life. Observation case notes

made by the researcher during the pre-operative preparation phase were that *“after mother’s death the patient started gaining weight – used food to comfort the feelings of loss, anger towards his father and to soothe the feelings of rejection from his stepmothers and aggressive father”*.

The following descriptive extracts from Manny’s voice support the enormous array of childhood abuse he had to endure:

(Loss due to the death of his mother)...*she dropped us...It felt that way...a disturbing incident...Until the age of maybe eight or nine, it felt that way. We started learning that things are what God wants, it is out of our control. We started learning that and accepting it.*

(Loss and guilt due to the death of his grandmother/substitute nurturing parent) *She was the one that brought us up (crying). Well, I couldn’t do much for her...She was very sickly, she was very, she was a diabetic...Whether she was wrong or right...Whether she can forgive us (crying)...I think the way we behaved... we couldn’t give her what she wanted...She didn’t really ask so much.*

(Loss due to emotional neglect and abuse)...*eventually things started taking a turn for the worse. And every time he would get cross, he would walk out of the house and you wouldn’t see him for two or three days. Sometimes even a week, you don’t see him. He’s on the other stand. On the other side. (Case notes) Experience neglect by his family during school age, adolescence and adulthood...he (Father) was never with us much. And as the family started growing, there was less time for us, and more time for the others...He was absent a lot. (Case notes on emotional abuse) Emotional abuse was present from the ages of seven to 18 years and even as a young adult. My mother passed away when I was only six years old. The only person to care enough was my granny, but she lived very far away. No one could/would give us the love and attention we needed at such a small and impressionable age.*

(Rejection)...*it was really depressing at times, getting pushed around from one home to another home. Annoyed with you, and they say they don’t want you. Nobody wanted to keep me. Maybe they felt we were too much in the way, we were just kind of, like the odd people. We were always the wrong ones. In most cases it was myself. I was always wrong. If something was wrong, I was*

to be blamed, because I kept quiet, I never said anything. It was always that I had something to do with it. They made me feel so (crying)...I don't belong, I feel rejected, I'm not okay...That's exactly what I felt... feel like rejection. It felt like it. Not having him around when you need him.

(Witness of his substitute caregiver being rejected by his father)...after my dad got married, he thought that my Granny was a problem. For my stepmom...I think because she was following us around. Protecting us, you know? And she had to move out and stay by my aunt. (Separation)

(Extracts from the case notes) After mother's death we were forced to stay in school residence...(During his adolescent years he felt separated from his family and also during young adulthood)...my Dad wasn't much at home. He was more out than he was with us. He was absent a lot.

(Feel unsafe) (From the case notes) - Experienced lack of security from early age until adulthood.

(Being bullied) In high school – children use to tease me all the time. They called me all sorts of fat names.

(Responsibility to keep the family secrets – Father's gambling problem and subsequent socio-economic situation) My dad had a gambling problem. He was in the clubs. Normally used to get together with friends and come Friday night you don't see him 'til Monday morning...There were shortages at home. Because, end of the month comes, the salary's gone. I can hear my mom screaming 'where is my money now, there is no food in the house'.

A complex trauma symptom constellation following childhood trauma

In this section, the inquiry into the symptoms that followed Manny's experience of the various forms of childhood trauma that he was exposed to, will be described according to the transcribed information after the semi-structured interview. This is done in order to determine the extent to which he displayed the full spectrum of complex trauma symptoms.

Affect and impulse dysregulation

When Manny was asked if small things that go wrong upsets him, he answered that “it does” and after he gave an example he started crying and indicated that when he feels upset he would eat and isolate himself as remedial behaviour.

Just a few years back, I could look after everybody. I used to feed everybody. I looked after every home I could. Now that my business has taken a bit of a turn...Nobody comes to rescue you (crying) ...preferably just being on my own.

Although Manny indicates that his vulnerable mood has improved since he started on the bariatric programme, he also indicates that he previously would “shock” people to try and relieve the emotions he experienced. A possible interpretation could be that the “shock”-effect might be an unexpected dominant reaction by Manny to create a feeling of being “in control” when others upset him.

The one thing I used to do, was to actually shock the people.

Manny considers people who “don’t appreciate him” as the reason for most of his anger. He also pointed towards his father as provoking very strong emotions of anger and felt that in his father’s eyes he was “not good enough”. Manny also describes an incident where he threw a piece of wood at his brother due to the intense feelings of anger he experienced at that time. He also indicated that at times he has ideations of hurting others, although he trusts his own ability to not hurt another person physically with intent. To be able to imagine hurting another person could be interpreted as an artificial feeling of being able to control others with a form of physical dominance. This could imply suppressed anger and a strong need for recognition and acceptance.

When people don't appreciate you. (Manny's interpretation of his father's perception of him) You try your best and it's not good enough...(physical reaction to provocation) It actually happened when we were young. My brother did something to me, which upset me. I actually threw him with a piece of wood. There was a nail on the piece of wood...(ideations of physical aggression towards others) I feel that way sometimes, that I can harm somebody.

Manny expresses feelings of being unable to control his impulses of suppressed anger when he was asked how often he experiences feelings of anger.

I try my best not to let it take a hold of me, but sometimes it does happen where you do lose it, you know? And you can't control it sometimes.

During the ages of 14 and 16 years, Manny cut himself and interpreted the pain as a relief of the emotional "hurt and frustration" due to lack of emotional support he experienced during that time. The self-inflicting pain caused by the cutting had the emotional effect on Manny which caused him to feel that he had to do something worse than cutting afterwards. This could be interpreted as an escalation of the intense need to have relief from the emotional pain by physically injuring himself (cutting increased the need to do something worse).

There were a few times where I took a knife and I tried to cut myself...The pain that I was causing for myself, it wasn't very pleasant. It was, you harm yourself, you feel it afterwards...It was the hurt or frustration. You know, growing up and not having anybody to talk to (cutting increased the need to do something worse). It felt as if I should have done something even worse.

When asked about a possible explanation for the cutting as suggested as an interpretation by the researcher of "I did something wrong, therefore I have to be punished", Manny reacted by saying "I never thought of it that way. It does make sense to me".

Until the age of 21 years when Manny got married, he felt a constant “emptiness” in his life. The relief of being loved and included by his partner created new meaning in his life as evident of the following expression by Manny:

Then it felt there was something worth going forward for. I used to feel a lot of emptiness until the age of 21, when I got married. Then things changed.

Manny never attempted suicide but had suicidal ideations most of his life until he got married. Marriage changed his meaning system to the extent that he lost the ideations from that time period.

I never tried anything. The thoughts were in my mind, but...I would have looked for the easiest way. Where death was instant. Not something where you would suffer and go through a whole lot of pain.

Many feel that he might be preoccupied with sexual thoughts and expresses concern and guilt about his thoughts. Manny also indicated that he does not like to be touched in general and that should someone touch him it makes him feel “uncomfortable”. He strongly had to avoid sexual thoughts during his teenage years due to religious beliefs (Islam), but expressed satisfaction with his sexual relationship with his wife.

(Sexual thoughts) I think thinking about it is more prominent..(Avoidance during teenage years)...I avoided it through my teenage years, until I got married. It was waiting for something you wanted to do...Islam... you should abstain from it, and wait for right partner...(Sexual interaction with his wife) Good. It is pleasant.

When Manny was asked about the risks he would take which others would consider dangerous, he indicated that sometimes he would drive too fast and his wife would mention that she feels scared by his driving. He also told the researcher that he used to have his take away shop open until 3 a.m. in the mornings but since he was armed robbed about a year ago he decided to close at 1 a.m. The researcher interpreted his decision to close his take away

business earlier as a “risk preventative” measure Manny took, although his need to drive too fast could be an indication of excessive risk-taking.

Driving fast. And closing the business, we stayed open ‘til three in the morning before. There were a lot of risks we had to take... (wife’s reaction to driving too fast) I think so, yes. My wife does sometimes (feel scared).

Alterations in attention or consciousness

Manny’s initial reaction when asked about any memory loss was that paradoxically he cannot remember the “good” times during childhood, but when the researcher probed his response he indicated that he had amnesia for periods during the ages eight and 12 years. A possible interpretation of Manny’s reaction to the question posed by the researcher could be that the impact of traumatic experiences during childhood seem to be very overwhelming and therefore the subconscious mind does not have clear recall of the “good” things and only when probed, releases the suppressed traumatic memories that he does not want to consciously recall. For Manny the recall of traumatic events seems more prominent than the recall from “good” periods he was exposed to during childhood.

Maybe the good times we had when we were very young. But there isn’t very much to remember about it... (After Manny was probed) more bad things come to mind...between the age of eight and 12. I don’t remember clearly the things that happened.

When Manny was asked about his ability to keep track of daily activities; he indicated that prior to bariatric surgery he found it difficult to keep track of daily activities. He also told the researcher that prior to bariatric surgery he would be confused and sometimes disoriented about “places and time”. When Manny experiences high levels of emotional stress, he describes feelings of being “spaced out”, almost as if he looks at himself from a distance, through an imaginary “glass wall”. He would recall situations where people would not notice him in a social

context, almost as if he is “invisible”. Collectively, Manny’s reaction to questions related to possible dissociation indicates that he might have transient dissociative episodes.

It used to happen a lot when we used to go to functions. You’re sitting with people, but nobody sees you. People will have a conversation as if you don’t exist...some days. It happens. It feels like people don’t notice you.

According to Manny, his wife would point out that he is perceived differently by different people and situations, almost like they “don’t know him”.

My family sometimes tell me they don’t know who am I...Especially my wife...You sometimes feel rejected. When somebody wants you to be something you can’t be...It is difficult sometimes to be the person that everybody wants. You can’t be that always.

Disturbances in self-perception

When Manny was asked about his ability to control things that happen in his life, he reacted by referring to a spiritual control (God) that allows things to happen the way it should. Even after bariatric surgery, Manny feels that sometimes “things are out of his control”. *Sometimes I feel like I can do something about it, but when I sit and think about it... it’s what God wants. No matter what you try and do, if He says it’s going to happen this way, it’s going to happen...(Unable to control) I did. I still do have them sometimes. Even after the operation.*

Prior to bariatric surgery, Manny describes feelings of being permanently damaged and not being able to do things for himself.

I used to feel that way, before I started losing weight. I felt I will never be able to do something for myself.

Manny indicated, when asked about guilt feelings, that he feels guilty about most things, “most of the time”.

Manny's response to a question asked about feelings of being ashamed reflected that, prior to surgery, he would have avoided social gatherings to steer clear of feelings of rejection and shame. After surgery he reports that although still feeling ashamed, it feels as if the situation is "changing".

I used to. I never used to attend functions, or go to any family gatherings. I felt on my own...Nobody used to really be bothered much with me.

Based on a question about feelings of being different to others and not understood by others, Manny replied that "because of overweight" he felt that he was different and not understood.

Manny minimises his worth as a person; this is an indication of his inability to accept that others appreciate him. Manny indicated that his wife makes him aware of his worth, therefore balancing the way he minimises himself.

My wife preaches to me. About the way things are going. She is more worried than I am...I don't think other people really worry about me. Nobody really, you know, asks 'how are you'. My wife does, she used to see what I would go through.

Disturbances in relationships

Manny's reaction to his ability to trust others indicated that he does not trust people and situations. Manny feels that his family criticises him and due to the inability to trust his family he will try to avoid them.

It used to happen quite a bit, especially among family. That's when I started avoiding them, that's what put me off going to them. They would think there is something wrong with you, something wrong with your wife, something wrong with your kids. They were always looking for a finger to point. That's also what used to keep me from going to anybody.

The ability to end up in situations where a person can be victimised could be an indication of the emotional discomfort and abuse people can endure. Manny is of the opinion that due to his “kindness” people tend to often “misuse” him.

Although Manny does not consider himself as a “bully” he indirectly decided to “avoid” his stepbrothers, the same way he felt they “avoided” him. This could also be interpreted as a subtle form of victimisation of others and could be interpreted as a form of projective identification due to the inescapable feelings of rejection and being “avoided” he endured during childhood.

To my stepbrothers. Maybe the past year and a half. They avoided me, so I started avoiding them also. When I was waiting for the op, I even sent a message that I don't want to see them. Even if anything happens to me, if I die or anything. I don't want them to come bury me... I did everything in my power for them. I got them married. I spent every cent there...I made up my mind. I told my Granny and my Stepmom, I don't want to see them...I was hospitalised about three times already, before the op. Not on one occasion did they come see me in hospital or even out of hospital, or even make contact to ask whether you are okay, do you need any help. Nothing.

Somatisation

Manny endured chronic pain in his right leg and due to his weight the x-ray machine could not compensate for his weight; therefore the cause of this pain could not be clarified. Even after surgery, although the pain is less, he still suffers the pain in his right leg.

My knees hurt for the past two years now. I have a pain in my right leg. It burns sometimes. But because of my weight they couldn't do an MRI scan and all that. The machines could not compensate me. They said it is probably a pressed nerve...(other pains) mainly in my knees. My back. My joints... I still do, it tends to burn sometimes, it gets numb. There has been a relief. Before that, I could not even walk. It used to irritate me.

About 18 months ago, Manny started having problems with discomfort in his chest. He complained of being out of breath and from his interpretation of the doctor's diagnosis, the pains in his chest could be related to his overweight.

...about a year and a half back. When I started getting admitted to hospital for water in the lungs or water near the heart. Chest pains. Being out of breath.

Meaning systems

On a question about feelings of hopelessness and pessimism about the future, Manny replied that he used to feel very negative about the future until he started losing weight. The mere indication that there was a solution to his weight problems created hope for Manny, and also changed his life completely.

Mainly when I was overweight. Not being able to do something – to walk, to bend. Just to fetch something from the fridge. Even when you wanted a glass of water. It was always an effort in the past. Since I started losing weight, I can walk from the room to the toilet. It used to be very tiring...Almost like life was a drag.. (His future outlook changed when he realised that he could change the course of his life) Before, I had that attitude that I don't care anymore. Whatever happens, happens. I think then, in hospital those three times, when the doctor told me that this is what is going to happen... Suffering wasn't an option I wanted to go through. That's when I started thinking 'what are my last options?'...My family. My wife, my kids. Knowing that I have somebody there that I need to be there for. They need me more than I really need myself...I thought whatever happens, happens. I'm not going to fight it...I think, you know, I want to see my kids become something, or somebody. I want to see them standing on their own feet before I close my eyes. In the world we live in, there's very little chances for survival today.

Psychological defence mechanisms: a coping strategy

The coping styles and stress modulators that Manny uses to maintain emotional stability in his life include suppression, projective identification and the need for isolation due to shyness, hesitation and sadness. These observations were made and substantiated by the researcher during his engagement with Manny. Manny also relies heavily on his spiritual beliefs as a justification for the consequences of the array of traumatic exposures he had to endure during childhood, adolescence and early adulthood. The following selected examples seem appropriate to substantiate the perceptions of the researcher:

(Suppression through religious justification) *We started learning that things are what God wants; it is out of our control. We started learning that and accepting it...*(Projective identification) *They avoided me, so I started avoiding them also...*(Isolation) *If something was wrong...I never said anything.*

For Manny, food became a substitute and comforter since his mother passed away. The frustration, anger towards and rejection he experienced from his father were “soothed and comforted” by food and overeating. This could imply a defence mechanism and a constant he could rely on if compared to the unreliable circumstances he grew up with. Manny also reported that when his grandmother (substitute parent after his mother died) left the family, he had a greater need to be comforted by food and indicated that he then also picked up more weight.

Process of bariatric surgery: a positive and/or negative life stressor

Based on the initial written assessment by the researcher, Manny indicated that his expectations following bariatric surgery are as follows:

To lose weight; to be healthy and helpful; to be able to exercise to maintain a healthy lifestyle; to be admired by others; to live a happier life; to look slimmer and neater; to be fit and productive; and to be able to take long walks with my wife.

Stressors that Manny experienced prior to bariatric surgery included his “business finances”, “family conflict” and “weight preventing me from doing work”.

Based on Manny’s expectation from bariatric surgery, he wishes to be healthier and able to participate in healthy activities with his wife and family, be more productive and be acknowledged by others. These emotional needs he expressed during his engagement with the researcher seem apparent throughout most of his life.

Manny’s written reply to a question asked about his fears prior to surgery was answered as follows:

The pain after surgery; overly hopeful about the success of the surgery and possible disappointment; and the new adjustments I will have to make.

It is the researcher’s opinion that Manny’s fears are realistic. The fear of making new adjustments and being too hopeful are fears associated with Manny’s life script due to the uncertainty he experienced about even the most attainable goals he has previously set for himself. Fear of failure is therefore considered a reality for Manny.

Perceptions of bariatric surgery and psychological processes

For Manny bariatric surgery was unplanned, a desperate attempt to be healthier and to ensure longevity.

Going for surgery was not something I was planning on. After looking at things with a different view, it made me feel this was one of my last options. If this doesn’t help me, I may have only a

couple of years to spare. It all depends on what God wants, as well. It is a gift, but that gift also comes from Him. Whatever happens, it is in His control.

After bariatric surgery, Manny reports feelings of being calmer, more physically active and more aware of stressors in his life. His awareness of the impact of stressors might be related to the link he makes with stressors and the need to eat excessively.

I am still the same person I was, mostly. Still sensitive at times. I'm actually more calm than what I was before. I try to avoid stress, although it is something that comes with business today. I try not to let it bring me down.

Manny makes use of humour to describe him walking home from work while his son drives his car home as "now I'm scared that he is going to get a big head". Manny's use of humour could be interpreted as a strong indication that his feelings of depression have been relieved and that he has a less serious approach to life as compared to when he started with the bariatric programme.

I feel much more healthy. I can walk a bit. To know if I have to walk slowly towards you, I know I can do it. It is something I used to be reluctant to do. When I close up in the evening at seven, I'd tell my son to take the car home and I would take a walk.

Manny considers the therapeutic process as needed and necessary. He also felt that he had the opportunity to speak freely and to be heard. The therapeutic environment forced him to think about himself, created calmness and helped him to find the reasons why he became overweight.

It has helped a lot. Because certain things that you never thought of, that make you see you can also be a better person. You have given me the strength towards a view, what I never wanted to do before...The first session we had, before I started going on the diet, you said certain things that made me think if I don't do something for myself, I might not get where I want to be...I felt I had the willpower in me, but I never used to make use of it...Maybe it made me feel a bit more

calm about things I had in me, which I couldn't speak to anybody about. It has helped me, it took a burden off my chest...To my knowledge, there is nothing that I can think that wasn't done to my advantage. Everything was done to give me a new insight, to look at life differently.

Manny's advice to prospective bariatric patients is to "do everything exactly as suggested by the bariatric team" and to "change negative perceptions about psychologists" in general, implying that the psychological process is as needed as the surgery itself.

The lack of support and care that Manny needed as a child and the work environment he operates in (take away food business) is according to Manny the reasons why he gained excessive weight.

It was not really having somebody that was behind me, or gave me the moral support I wanted...In the business I am in, whenever you want you just help yourself.

Conclusion

Manny comes from an unstable family environment where his father was absent most of the time due to commitments to his other wife and gambling problems. As a child, Manny felt that he was not heard by his father, not respected or acknowledged by others, and projected a strong need for acceptance and recognition from others.

As a child after his mother died, his maternal grandmother took the role of his mother as a substitute parent and would overfeed him and his younger brother. It could be interpreted that she used food to compensate for the perceived perceptions she had of the painful loss of their mother. The extended family Manny was exposed to after his mother's death, exacerbated the feelings of rejection and disregard.

During this time, Manny discovered that food can fulfil the painful emotional feelings of emptiness and not being included as a comforter that replaces emotional trauma. For Manny to witness his main caregiver (maternal grandmother) being rejected by his father, emphasised the feelings of helplessness and rejection of a meaningful other “parent”. In response to his grandmother being rejected by his father, Manny developed intense feelings of guilt and self blame when she died. Manny’s grandmother’s absence from the extended family caused Manny to also feel unsafe, separated, emotionally neglected and at times abused by his circumstances.

For Manny, the lack of support as a child and the exposure to his present work environment is considered a contributing factor to the morbid obesity he suffers from. Bariatric surgery, for Manny, ensures longevity and he expresses a desperate attempt to be able to care for his family.

CHAPTER 9

RECONSTRUCTION OF BARIATRIC PATIENTS' "VOICES": A COMPARATIVE ANALYSIS ACCORDING TO THE LITERATURE

Life script: a family driven socialisation in terms of historicity, birth expectancy, health, eating patterns, and parenting styles

Gottesman and Gould (2003) holds the notion that extrinsic and intrinsic **genetic vulnerabilities, environmental and developmental factors associated with obesity** as well as specific eating pathology could be implicated in various forms of eating pathology that can **produce biological changes** as commonly observed among the obese. No information pertaining to genetic factors was associated with any of the participants but the impact of **environmental factors** as part of **historicity**, could be **related to grandparents, parents and caregivers, and could therefore (according to “a family driven socialisation” as a linear progress or repetition of past events that modulate the “life scripts” of an individual) explain the development of dysfunctional associations and attitudes by caregivers towards their children**, for example the participants in this research. For a child to be **exposed to dysfunctional behavioural and eating styles**, either by force or complete neglect by a caregiver therefore builds **negative interactions with, among others, the concept of food and what appropriate eating styles and a mealtime environment should look like** (Lilliamson et al. 2002; Van Hanswijck de Jonge et al. 2003; Stefaniak et al. 2007; Selway, 2006; Oppong, Nickels, & Sax, 2006; Noll et al. 2007; Mitchell & Mazzeo, 2005; Mazzeo & Espelage, 2002; Laitinen, Ek, & Sovio, 2002; Goodwin & Stein, 2004; Gunstad et al., 2006; Grilo et al., 2005; Gustafson & Sarwer, 2004; Grilo & Masheb, 2001; Zhang & Wang, 2004). All the participants, except Sue, reported that their **paternal grandparents** were perceived as generally more **dysfunctional** compared to their **maternal grandparents** who were perceived as more **functional**. A dominant theme amongst all the participants, except Sue, was that the **perceptions** of their **mothers** in general were more likely to be **positive** and that of their **fathers**

more **negative**. The lack of concrete information about the experiences of participants' parents of their parents/caregivers, imply that according to historicity, the impact on the patients' parents can only be speculated about. It could therefore be argued that according to the linear progression or repetition of past events, that life script according to a family driven socialisation seems to be apparent and confirmed based on the limited information available from the participants about historicity.

If **adoption** (in James's situation) is seen as **rejection** by the biological parents, a dominant theme among the participants, excluding Sue and Manny who do not have any recall of their birth expectancy, could be an indication of a **negative expectation in terms of birth and being unwanted, specifically by their fathers**.

A dominant theme from the participants' voices about their general perceptions of their fathers' interaction with food and health habits, except for James, was that they perceived their **fathers** to have a **negative attitude** towards weight, mealtimes and other people. The participants' perceptions of their **mothers'** interaction with food and health habits seem to be more likely to be **positive**, except for Sue who does not have a specific viewpoint of her mother's relationship with food, and Manny who perceived his biological mother and substitute mother (grandmother) to have been overweight. Except for James, all the other participants indicated that **inconsistencies** and **negative associations** in terms of routine meals, "being forced to eat all their food" and/or mealtime structure were prominent during important **personality development** periods in their lives.

All participants indicated that they perceived their **parents and/or step-parents** to have had **conflict** between them. This indicates that all five participants observed conflict between their caregivers at a given point in their development during childhood and adolescence. Feedback by the participants indicated the perceptions of a parent, mealtimes and food to be negative associations. Exposure to **dysfunctional eating patterns** and the "fear" associated

with food, mealtimes, the family environment, and conflict between caregivers as dysfunctional, are supported by Treasure and Collier's (2005) notion that the **regulation of emotions** and eating is considered intimately connected. For a child, during crucial psychological developmental periods, the examples of the caregivers are considered a point of reference and therefore will have an impact on the **child's perceptions** of a healthy interaction with, amongst others, food, mealtimes, control and the relationship with others. This has been confirmed by Stillwell, Galvin, & Kopta's (1991) opinion that the moral development of the traumatised child in various ages is challenged, and therefore has an **impact** on the child's **moral developmental perceptions**.

Exposure to childhood trauma: an inescapable double bind by the caregiver/s

Herman (1992, p. 101) refers to what the researcher describes as a "**double bind**" as "the power of holding **two contradictory beliefs** in one's mind **simultaneously**, and accepting both of them" as "**doublethink**". For the purposes of this study, the reference to "double bind" and "doublethink" is synonymous, and implies an **inescapable attachment to the patients'** "**caretaker** who is either dangerous or from her perspective, negligent" (Herman, 1992). The inability to escape the **double bind** and in most cases **double standards** from a caregiver/s, was a dominant theme observed among all the participants of this study. For all the participants, excluding James, the **inescapable** double bind and trauma during childhood was considered "**prolonged**". Schwarz and Perry (1994) as well as the National Institute of Mental Health (NIMH) (2001) hold the notion that the **more severe the abuse** and the longer (**duration**) the child had to endure the exposure to the maltreatment, the greater the **impact** will be on the child. For the abused child, to be exposed to **inconsistencies** and **double standards** by a caregiver, could have an effect on the child's developmental and information processing, ultimately causing **developmental distortions** that have the tendency to make **abuse more injurious** (Schwartz & Cohn, 1996).

Emotional abuse, feelings of being **rejected**, having to keep family **secrets** and the use of **food as a comforter** and defence mechanism against emotional painful feelings, and the need to be responsible for the wellbeing and care for others, were reported by all the participants. When compared to the rest of the group, a unique theme that emerged from the voices of Ann and Ella was the presence of **physical** and **verbal abuse** in their homes. Schwartz and Cohn (1996) stated that when internal **schemas for safety** are **disrupted** and parents and others are **too scary to trust**, **food** serves as a **transitional object**. **Overeating** therefore, for the abused child, helps to alter his/her mood by “numbing” or “altering” the terrified child when the **child is too “numb” to react** to associations related to exposed trauma.

With the exception of two (Ann and Manny) of the participants, all endured a form of **sexual abuse** and according to Herman, Perry and Van der Kolk (1989), sexual abuse is more destructive than most other forms of abuse. The majority of participants **witnessed physical and emotional abuse** as well as **rejection of a caregiver** by another caregiver, feelings of being **neglected, separated** or having lost a caregiver, feeling **unsafe** within the family, **being bullied** by others and either attempted or **fantasised about bullying others**. For Caporino, Murray and Jensen (2003), the process of abuse is complicated by the frequent coexistence of many types of trauma and the potential **secondary traumatisation** than the different types of trauma the child was exposed to. They also indicated that the secondary effects of trauma usually occur in the **aftermath** of the traumatic exposure, as commonly observed among this group of adult bariatric patients.

Collectively, this group of bariatric patients was exposed to a wide range of maltreatment and various types of abuse. Luxenberg, Spinazzola and Van der Kolk (2001) indicated that exposure to **multiple forms of trauma** and the **lack of safety** and **competence** as an adaptive function and protection during early childhood, pose as a key indicator of **poor prognosis** as an adult survivor of childhood traumatisation. For the child to be **“trapped”** in an **inescapable environment**, and being exposed to the impact of trauma that takes place **in the family**, could

be too **overwhelming** and therefore the child rather **paradoxically “accepts”** the abuse instead of exposing some of the family members/caregivers. This form of **“capture”** could imply a **double bind** by a caregiver/s, ultimately **“confusing”** the child’s **adaptive functioning and feelings of safety**.

Symptoms after prolonged traumatic exposure during childhood: a complete symptom constellation of Complex Trauma

A dominant theme that emerged from all the participants were that they either feel easily upset, overwhelmed, emotionally sensitive, worry excessively or overreact to situations with either impulsiveness or anger. According to Ford (1999) and Van der Kolk, Pelcovitz, Roth, Mandel, McFarlane, and Herman (1996), **alteration in regulation of affect and impulses** as diagnostic criteria for those suffering from Complex Trauma seems typical of the participants in this bariatric group. Food as a compensator to “calm” the emotional distress was a common theme among all the participants and for the majority of the participants, when they feel **emotionally out of control**, they tend to become more **compulsive** in their behaviour. By implication or direct expression, all the participants experience a form of **depression or anxiety**. For two of the participants (Ella and Manny), feelings of being more in control of their emotions after surgery, were reported.

Difficulty in expressing or modulating their emotions like **anger, taking excessive risks** about their own safety, having **suicidal preoccupations, sexual preoccupations** or difficulty in **modulating sexual impulses** according to Felitti, Anda and Norderberg (1998), seem evident of the dominant themes coming from this group of bariatric patients’ voices. For all the participants, the feelings of **anger** and the expression thereof either with **physical** and/or **verbal aggression, passive aggressiveness** or **destruction**, were observed as a common theme. Sue reports feelings of **guilt after** she had an **emotional outburst** and both Ella and James

reported that after surgery they felt more in control of their feelings and were able to control anger more effectively.

The element of **overeating** that results in obesity could, by implication or omission, be interpreted as a form of **self-destructive behaviour**. However, only two of the participants reported either previously or at present to have the intent or **attempt to injure themselves** when they feel **emotionally frustrated**. This is a known element of Complex Trauma, according to Luxenberg, Spinazzola, and Van der Kolk (2001). All the participants reported that at some or other time during their lives, they had **suicidal ideations** and both Ella and Sue had unsuccessful previous **suicidal attempts**. All the participants indicated that they either avoided, or as in the case of the two male participants, went through periods in their lives where they felt **guilty** for being **preoccupied** with **sexual thoughts** or stimulation through pornography. For the female participants, at some or other time in their lives, they had to “**force**” themselves to **participate in sexual activities** with their partners. Except for Ella, all the other participants engaged to a certain extent in **risk-taking behaviour**, like personal safety precautions and engaging with people who have the potential to abuse them, during periods of their lives (Ford, 1999; Ford & Kidd, 1998; Spinazzola et al. 2001; Van der Kolk, 1996; Van der Kolk, 2001; Van der Kolk et al. 1993). Both males reported that after bariatric surgery they became more risk averse.

All the participants indicated that there are periods of their lives which they could not remember; this could be an indication of selective **amnesia** due to **traumatic exposure**. The periods referred to could be interpreted as the most traumatic periods during their lives. For Luxenberg, Spinazzola and Van der Kolk, (2001), the chronically traumatised person's ability to “**forget**” certain parts of his/her experiences can be **intermittent** if confronted with painful emotional reminders of traumatic experiences. For the traumatised individual to have amnesia of **single experiences, whole months** or even **years**, seems common. Amnesia not only could be a source of **distress**, but can also **complicate** history gathering and **recall** during therapy, as evident from the experiences of this group of bariatric patients.

A unique comment made by Manny was that there were “**good**” periods in his life that he **cannot remember**. The researcher could only speculate about the interpretation of this almost paradoxical statement by Manny: that for him to recall the more pleasant periods in his life is a **paradoxical “reminder”** of the overwhelming **traumatic episodes** that seemed to dominate his life experiences.

A dominant description that represents the feelings of disorientation as “**spaced out**” was reported by the majority of the respondents. Variations of descriptions used by the respondents to explain their feelings of **transient dissociation** included “**absent-minded**”, “**lost track of daily activities**”, **disorientation** about “**places and time**” and “**felt out of control**”. According to Draijer and Langeland (1999), experiences that are **too overwhelming** or traumatic resulted in the **inability to reconcile** traumatic experiences and become relegated to **separate aspects of consciousness** that do not impinge on the day-to-day consciousness, as evident from these bariatric patients’ voices. For Ann to **create structure** and **routine** as well as **denial** as a **defence mechanism**, serves as a **coping strategy against** the feelings of being “**out of control**”.

Ann also reported that after surgery she had feelings of being “**out of control**”, unlike the dominant voices of the other participants who indicated that **after surgery** they felt “**more in control**”.

Dissociation as a **psychological defence mechanism** serves as a **mediator** when the traumatised person **looses the ability to integrate information** into a coherent whole (Luxenberg, Spinazzola and Van der Kolk, 2001). All the respondents indicated directly or by implication that they had or still have feelings of having **more than one “personality”**. This “**split**” of the core personality could be an indication of elements of **depersonalisation** and **transient dissociation**. **Visual, emotional** and **somatic** elements of an **experience** which are

too overwhelming, may be **“split off”** from the traumatised person’s own personal **narrative** and typically be **perceptual or sensory**, rather than linguistic in nature (Van der Kolk, Van der Hart, and Marmar, 1996). A **unique description** used by Manny was that it felt as if he looked at others through a **“glass wall”** and even among others and in spite of his body weight, he felt **“invisible”** at times. This could be interpreted as an almost **paradoxical experience** of his life world.

With reference to **disturbances in self-perception**, for all the participants except for Manny (to a lesser extent), the feelings of being **ineffective prior to bariatric surgery** were more prominent and **dysfunctional** if compared to their post-surgery experiences. A dominant theme amongst the participants therefore implies that **after they had bariatric surgery**, they feel more **in control** and **effective**.

According to Herman (1992b), descriptions of a **negative view of the self** due to **childhood abuse**, lead to the negative views of being **helpless, not understood, damaged, undesirable** to others and **ineffectual**. The presence of these negative views of the self and the world seems evident from the descriptions this group of bariatric patients use to describe and report their self-perception. To feel **permanently damaged** due to traumatic exposure as a child, or due to the **criticism of others** because of their **body weight**, was a dominant theme observed among most of the participants. The element of **guilt** and an overdeveloped sense of **responsibility** was a dominant theme among all of the participants. The complicated **deformation of identity** therefore presents with a malignant and **fragmented sense of the self** as **contaminated** and **guilty** (Herman, 1992b). The need to take **responsibility** for certain activities that their caregivers should be responsible for during childhood, could be interpreted as an emotional need **to be “heard”** and to be **accepted** by others.

For most of the participants the feeling of being **ashamed** of themselves seems to be an **overwhelming** feeling. For James the feelings of being ashamed seem more related to the

opposite sex. Both males indicated that the feelings of **shame are associated** with feelings of **rejection**, and for James it is a form of **inhibition** as a **protective mechanism** against the **criticism** of others. The feelings of **being different to others** and **not understood** by others were confirmed by most of the participants, therefore this is a dominant theme amongst this group of bariatric patients.

An attempt to **minimise** the effect of earlier trauma on the participants' lives, seem to be a dominant theme. Minimising the true impact of their **weight**, being overly **worried** about **uncontrollable** aspects of life, the inability to be aware of personal **safety** and in Ella's case the feelings that she was at "**fault**" and therefore "**deserved**" the trauma she had to endure as a child, seem evident. The child's perception of being "**bad**", regardless of the fact that he/she was abused by adults, emphatically causes the child to believe that he/she is **at "fault"**. These perceptions spring directly from the way the child interprets his/her world. The child's pre-operational thinking places him/her in the centre of the universe, causing him/her to believe that **he/she has "caused" the abuse** (Luxenberg, Spinazzola, and Van der Kolk, 2001). For Ella, the reality of "**not being at fault**" as a child, brought a **relief** once discussed and explained in a therapeutic environment.

The need to **avoid others**, to be more **isolated**, and the **inability to trust** the motives of others seem to be dominant themes amongst all the participants and are indicative of some of the **disturbances in relationships** often observed among people suffering from **Complex Trauma**. For the three women who took part in the research, the ability to **trust** even their **intimate partners**, seems **problematic**. The **chronically traumatised** or **abused** children, present with dysfunctional relationships and are likely to **distrust others**, to be **revictimised** and even **victimise others** (Herman, 1992b). A statement by Herman (1992b, p. 52) that "when **trust is lost**, traumatized people feel that they **belong more to the dead than to the living**" seems to describe the feelings of distrust these patients endure. As stated by Green (1993), people who endured sexual abuse during childhood have a **greater risk** for **subsequent victimisation**

during **adulthood** as evident from the more dominant “voices” of some **female participants** in this study. The **lack of a “healthy reference”** to healthy interactions, often presents in the form of **inappropriate behaviour** towards others or allowing others to interact with the “self” in an inappropriate manner. **Prolonged exposure** to trauma can cause the victim to **lose “touch”** with physiological **bodily signals** and therefore the victim only feels **“alive” when agitated, revictimised** or involved in **conflict** in a relationship. Luxenberg, Spinazzola, and Van der Kolk (2001) further noted that distrust in others and the **inability** to use appropriate **defence mechanisms** create a feeling of **helplessness** and **powerlessness** as often observed among chronically traumatised people and evident from the voices of these bariatric patients.

Another dominant theme observed amongst all the participants was that due to the **emotional need to be accepted** and the intense **fear of being rejected**, they felt that others tend to victimise them to a certain extent. It could also be argued that the **need for inclusion** and **fear of rejection** from others is the driving force for the participants to frequently end up in potentially abusive or **victimised roles**.

A less dominant occurrence of **trying to victimise others** either directly or in a more subtle manner, was reported by Sue and Manny, therefore considered a more unique theme amongst this group of bariatric patients. The need for **re-enactment** by these traumatised patients explains why some of them sometimes get involved with people who have the potential to, for example, dominate them, the same way they were dominated as a child; or even why they choose people to engage with, whom they can **victimise in the same way they were victimised** or abused (replicate their own traumas) (Roth et al. 1997; Chu, 1998).

It is not unusual for **chronically traumatised patients** to present with **physical symptoms** that often **defy medical explanations** (Luxenberg, Spinazzola, and Van der Kolk, 2001). All the participants in this study endured some form of **chronic pains** for which the treating doctors could **not give a clear explanation**, therefore the interpretation could be made

that a form of **somatisation** could be present as a dominant theme amongst this group of bariatric patients. Van der Kolk (1996) pointed out that **emotional pain** among traumatised individuals who lost the ability to put words to their traumatic experiences, may **display physical symptoms** as a symbolic way of **communicating** their inner **emotional distress**. **Obesity** is seen as a **symbolic** way of trying **to express and protect** the core person as commonly observed among those suffering from severe forms of obesity.

Chronically traumatised individuals not only exhibit **multiple somatic difficulties** but, as the number of **traumatic experiences increase**, physical health decrease precipitously and evidently traumatised individuals, who reported three or more adverse childhood events, were twice as likely to develop **heart disease, stroke, diabetes, skeletal fractures** and **cancer** if compared to their peers without any adverse traumatic exposures (Felitti, Anda, and Norderberg, 1998). Berkowitz (1998) also noticed that traumatised individuals have documented increasing difficulties in their **digestive systems, cardiopulmonary** and **urogenital areas**. Unconfirmed issues pertaining to problems due to the **digestive system** were only reported by Ann and Sue, therefore this is considered as a more unique theme among the participants. For the researcher, although not directly reported by the participants, **morbid obesity** is considered a problem associated with the **digestive system**. Sue reports an almost **paradoxical** effect of having **stomach pains** mostly **after stressful** periods in her life.

For most of the participants in this study, **somatic complains** related to **cardiopulmonary symptoms** were reported. In Ella's case a clear diagnosis was made due to a heart defect with which she was born. Issues pertaining to their **genitalia** and/or within a sexual context were reported by all the participants, except Manny. Therefore, issues related to **sexual functioning** could be considered a **dominant theme** amongst this group of **bariatric patients**. For Ann, her **intense pains** due to **menstruation** were **relieved after** she had bariatric **surgery**.

Evidence conclusively links the **physiological stress response** and the release of endogenous stress responsive hormones as proof of repeated traumatic experiences that has an impact on the **biological levels of the body** (Van der Kolk, 1996; Yehuda, 1999). According to Yehuda (2000), the release of **stress hormones** acts as a trigger to **prepare** and **mobilise the body** to respond to threatening situations and **chronic exposure to stress** (typical of prolonged exposure to threatening situations like child maltreatment), significantly **compromising this physiological system**.

Expressions used by the participants that include “**hopeless**”, “**pessimistic**”, “**emptiness**”, “**lonely**”, “**distant from others**” and “**negative about the future**” could be indicative of feelings of **despair** and **hopelessness** as a common theme amongst this group of patients. Herman’s (1992a, 1992b) notion of **chronically traumatised individuals** that see the world through a very “**dark lens**”, **no longer have a purpose**, and **do not make sense to themselves**, is confirmed by the expressions used by this group of bariatric patients. For Herman, this belief system poses a **profound, persistent** and **physical sense of helplessness** that can **affect** the **ability** to make **choices**, **act on one’s own behalf** and implement **new changes**. For most of the participants, the ability to make changes and choices are supported by **feeling less foreshortened and hopeless after surgery**. The conclusion derived from their perceptions is that **bariatric surgery changes their outlook on life as a whole**.

The **loss of sustained beliefs** does not seem to be a common theme among this group of bariatric patients. In spite of the researcher’s expectations that some participants would probably have reported **loss in sustained beliefs**, this could **not be confirmed**.

Psychological defence mechanisms and coping styles: a mediator between childhood traumatic exposure and the impact of obesity

The most common, **dominant themes** that emerged from these bariatric patients' voices were the role of **religion** and **spiritual** aspects, the **need for independence** and **isolation** from others, and the **role of food** and eating as a paradoxical form of **comfort and control** in their lives. With reference to the dominant theme of the role of **religion** amongst this group of bariatric patients, Herman's (1992b, p. 52) position that "wounded soldiers and raped woman cry for their **mothers**, or for **God**" seems to confirm the perceptions behind these patients' strong dependence on **religion** as a **coping mechanism**. Furthermore, according to Herman, the need for the traumatised person to be **isolated**, **independent** or **autonomous** from others and to protect the **secrets** from the past, seems **typical**. A lesser form of defence observed from this group of bariatric patients was "**aggressiveness**", "**altruism**", "**sublimation**", and "**suppression**" as defensive coping styles against the emotional impact of others. For Herman (1992b, p. 87,153) coping mechanisms like "altruism", "sublimation" and "suppression" are considered "**mature coping abilities**" to **survive** and **integrate** the wide array of traumatic exposure that people who endured **traumatic childhood** use.

Collective themes that emerged from the researcher's interaction with this group of bariatric patients also indicate the **need** for "**structure and routine**", the use of "**compulsive behaviour**", "**avoidance**", "**spiteful and rebellious reactions**", "**minimising** the impact of trauma on their daily functioning", "**dissociation** from the overweight body", "**omnipotence**" as a defence mechanism, "**passive aggressiveness** towards others" and forms of "**projective identification**" onto others. The above-mentioned collective themes from this group of bariatric patients' "voices" are echoed to some extent by research in the field of trauma, and for the purposes of this study these themes are synonymous with the experiences of some of the bariatric patients in this study (Caporino, Murray, & Jensen, 2003; Chu, 1998; Draijer & Langeland, 1999; Drossman et al.,1990; Folsom et al., 1993; Ford & Kidd, 1998; Grilo & Masheb,

2001; Herman, 1992a; Herman, 1992b; Herman, Perry & Van der Kolk, 1989; Luxenberg, Spinazzola, & Van der Kolk, 2001; Pelcovitz et al., 1997; Perry et al., 1995; Roth et al., 1997; Spinazzola et al., 2001; Wolfe, Gentile, & Wolfe, 1989; Van der Kolk, 1996; Van der Kolk, 2001; Van der Kolk et al., 1993; Van der Kolk, van der Hart, & Marmar, 1996).

The process of bariatric surgery: a positive and/or negative life stressor

Collectively, all the participants indicated that they **expect** to relieve some medical **problems** and have a **healthier lifestyle** with **less medication** after surgery. A dominant theme was that weight loss will improve their capacity to function more efficiently and optimally in their **work environments**. Themes common to the majority of the participants and which related to the expectations of the outcome of surgery were: the anticipation to be **social** either with close family or others, **more interactive** and the expectation to be perceived as different (physique) and “**normal**” by others. To be seen as “normal” for some, implies the ability to buy clothes at accessible general clothing stores. Expectations shared by at least two of the participants include the expectations to have a **normal relationship with food** and to be more comfortable with aspects of **sexual** appearance and intimacy. A unique theme which emerged from Sue’s voice was the expectation to be more **acceptable to the self**. This unique theme could indicate an expectation that might be related to a more existential need for acceptance and acknowledgement by others.

Dominant themes shared by all the participants, except James, were the fear of being **compliant** to the full pre- and post-programme instructions, having **complications** and/or **pain** after surgery, and that the **health** issues prior to surgery would **not be relieved by weight loss surgery**.

A dominant theme shared by most of the participants was the fear of losing friends and **not being accepted by others** once they have lost weight. This fear could be interpreted as a

fear of dealing with positive stressors and imply a **paradoxical fear to be accepted by others**. A unique fear mentioned by Ella was that she will substitute **food** with **another “addiction”**.

Both expectations and fears of patients prior to surgery could be an indication of either **realistic** or **unrealistic** views on the true **outcomes** after surgery. Expectations and fears before and after bariatric surgery about **medical issues** or complications, **work and psychosocial** functioning, **sexual** or intimacy issues, medical and psychological **complications**, **dysfunctional eating patterns**, ability to be **physically active**, **self-acceptance** (self-image), **amount of weight loss** before and after surgery, and **quality of life** are well documented and supported by literature about the predictors and outcomes after bariatric surgery. The expectations and fears this group of bariatric patients expressed are therefore considered synonymous with the described predictors and outcomes associated with bariatric surgery, as described in the literature (Oria & Moorehead, 1998; Powers, 1992; Powers, 1999; Puhl & Brownell, 2001; Rand & Macgregor, 1991; Sansone et al., 2007; Sarwer & Thompson, 2002; Sarwer, 2004; Sarwer, Fabricatore, & Wadden, 2006; Sogg & Mori, 2004; Vallis & Ross, 1993).

Dominant themes that emerged from the participants' voices after bariatric surgery include: the perception that bariatric **surgery** is considered a form of trauma, therefore implying that **“one trauma replaces another”** as a **paradoxical interpretation**; feeling **less tired** and more active; feeling more **outgoing and accepted by others**; **improvement** in the **quality of life**; and a better **self-image** after surgery. A unique expression used by Ella and implied by the other participants in this study, is the concept of “one trauma replaces another” and is therefore considered descriptive of this group of bariatric patients who endured prolonged exposure to various forms of trauma during childhood. No research could be found to support this unique notion about the impact that bariatric surgery has on those who have to endure a paradoxical “repair” by means of bariatric surgery.

Although a **unique theme**, the element of **paradoxical back pain** as reported by Ann, could be noteworthy. For Ann, the loss of weight caused more back pain due to lesser bodily support to her back once she started losing weight. The paradox of having less “other” medical complaints compared to the increase in her back pain must be an important aspect to discuss with future bariatric patients. Ann’s perception of the **paradoxical experience of more pain** after surgery could not be substantiated by any of the available literature the researcher consulted, and is therefore considered a unique contribution to the experiences of one of the participants of this study.

Less dominant themes reported by at most two of the participants include a better sense of **humour** after surgery (probably due to an improvement in general mood), the importance of the **choice of surgeon**, feeling more **calm**, elements of **passive aggressiveness** towards others for accepting the “new body” and not the person prior to surgery, **difficulty** with **self-discipline** after surgery, **lower libido** and a reported **binge eating** episode by one of the participants after surgery. Larsen’s (1990) notion that patients experienced **less anxiety after surgery** is therefore evident of the more “calm” effect described by at least two of the participants. **Contradictory** to Chandarana et al.’s (1990) findings that post-surgery patients experience less **passive aggressive** traits, Ella experienced feelings of passive aggressiveness towards others due to the “sudden” acceptance of her as a person due to her new body weight; this is therefore considered a unique phenomenon in this study. The element of **binge eating post-surgery** is **supported** by Kalarchian et al. (2002) and Green et al. (2004) where they stated that patients reported continued difficulties with binge eating. The occurrence of binge eating among patients who have a history of binge eating prior to surgery and then to show post-operative eating disturbances that interfere with **optimal weight**, is also supported by Saunders (2001) and (Niego et al. (2007).

Perceptions of psychological assessment and support after bariatric surgery

The following collective and dominant themes emerged from all the participants' voices when asked about their perceptions of the psychological process before and after surgery: psychological **assessment** and **support** is **needed, necessary, crucial** and **important**; the therapist's **realistic, direct, comfortable approach** created **trust** and **safety** for the participants; and the ability to **understand the causes of overweight** created a sense of being "**normal**" as reported by all the participants. The importance of being informed of the causes of obesity is therefore considered a very important aspect of **making sense of the impact of childhood trauma** and the paradoxical traumatic exposure to an invasive forced behavioural intervention like bariatric surgery. Although there is **little consensus** about the psychological **screening procedures** and **criteria** for **selection** into bariatric surgery, evidence suggest that the inclusion of mental health professionals in the assessment of bariatric patients is rather **the norm** than the exception (Bauchowitz et al., 2005). The **need** for a **safe environment** to help the bariatric patient to get "unstuck" from the claws of the severe impact of childhood trauma and obesity is echoed by Perlman, Reinold, & Nadzam (2004), who suggest that the **theoretical context** of the bariatric patient serves as a "**map**", and by Kinzie (2001) who advises clinicians working with traumatised individuals to place **less emphasis** on the **therapeutic techniques** and more on the **importance of the relationship** with the patient. Patients who received **behavioural interventions** prior to surgery, according to Tucker et al. (1991), reported **greater compliance** to **physical activities** and ate **less dietary fat** and reported **greater satisfaction** than those who only had bariatric surgery without any psychological support. This is supported by Mitchell, Swan-Kremeier, & Myers (2007) who suggest that **support** to the bariatric patient should be **solution-focused** as beneficial to those patients who pose more psychological risk factors prior to surgery. A **non-judgmental approach** is suggested as evident of motivational types of interviews designed for substance abuse patients (Miller & Rollnick, 1991). For Mitchell, Swan-Kremeier, & Myers (2007), the importance of the **psychological assessment** is paramount and as proposed by Ritz (2006), should include the assessment of **factors associated with the onset of obesity**,

maintenance factors, unusual **life stressors** (as evident of this group of bariatric patients), **copng skills** and **psychological resources**.

Patients' perceptions of the causes of obesity and the advice to prospective bariatric patients: a lesson learnt

Collectively from the voices of this group of bariatric patients, their own interpretations for the reasons why they became obese include: **“due to rejection”**; **“lack of support”**; **“inconsistencies”** and the **“criticism of others”**; and the intent to **protect the self from “intimacy”** as evident in a **“weight barrier”** attributed to the **“comfort and safety”** found in **overeating**, eventually resulting in the **inability to accept the self**, and ultimately the **acceptance of others**.

Collectively, the advice from the participants indicate that the psychological process is **“needed”** and that prospective patients should invest **“time and effort”** with the full prescribed bariatric programme, do everything **“exactly as suggested”** and accept that the role of the **“psychologist in the process is very much needed”**. For some, **“honesty”** and **“a good support network”** also help in coping with the emotional demands pre- and post-bariatric surgery. **“Cheating”** while on the programme can, according to some participants, be **“life threatening”**. Prospective bariatric patients' approach to the programme should be **“realistic”** and **not be considered “a miracle cure”**, but the focus should instead be on a true shift in perceptions about the self and the causes of their weight issues on themselves and others.

The advice or interpretations of the psychological process prior to bariatric surgery and the advice to prospective bariatric patients seem to be of great importance to those who support, treat and undergo bariatric surgery. This group of bariatric patients therefore add a very rich description of their own interpretations and suggestions to prospective patients and these **voices** and issues could be **encapsulated** in the more **comprehensive psychological assessment**

and design for a **support programme** for **prospective bariatric patients, healthcare professionals, bariatric surgeons** and the **support systems of the patients** with the intent to **build** a well-defined and **complete pre-surgical assessment and support programme** for bariatric surgery.

Conclusion

Through a process of **social constructionism** and **dialogue** between the **researcher** and the **participants**, the **meanings** attached to this group of five participants were made possible and **co-constructed** according to **themes**. The aim was **not to generalise** their experiences but to reflect on **their own unique meanings (voices)** attached to the experience of **childhood trauma, obesity** and the **healing process** as suggested through **bariatric surgery**. The use of **verbal** and **written language** enabled the researcher to **co-construct** the **experiences** of these patients.

The summarised findings of the experiences of bariatric patients who endured childhood trauma and the struggle with obesity will be reflected in the final chapter of this thesis.

CHAPTER 10

CONCLUSIVE REFLECTIONS AND FINDINGS OF THE STUDY

This study intended to punctuate the experiences of bariatric patients who endured childhood trauma resulting in obesity, ultimately having to endure the process of bariatric surgery as a remedial form of intervention. The aim of the present study was to give “voice” to these bariatric patients, by taking each participant’s unique social context and history into account in building a social constructed view of their realities, perceptions and life worlds. Through a process of thematic content analysis and the use of language, experiences, interpretations and reflections of this group of bariatric patients’ “voices”, the researcher derived at a deeper understanding of the nature of childhood trauma, obesity and bariatric surgery these patients had to endure as a new social construction of their “voices”.

General discussion of the study

The motivation, aim and rationale of this study were proposed in Chapter 1, and also served as an introduction to the effects of childhood trauma on the development of obesity that resulted in bariatric surgery for this group of participants. Chapter 2 provided a broad literature overview of the underlying mechanisms promoting and ameliorating obesity, the context of childhood trauma, the connection between, and the role of bariatric surgery as a remedial intervention. This chapter also served as a “map” to guide the reader through the “minefields” and array of various perspectives current literature have to offer, to assist in the understanding of the complexity of childhood trauma, obesity and the process of bariatric surgery. The researcher’s qualitative research paradigm and social constructionist epistemological stance is exposed in Chapter 3, followed by the methodological process that forms the basis of this study to derive at the deeper meanings of this group of bariatric patients. Chapters 4, 5, 6, 7 and 8 include the “voices” of these participants during their engagement with the researcher. In

Chapter 9, the participants' "voices"/themes were collectively and conclusively co-constructed and discussed according to current literature. Although the researcher accepts that the construction of these patients' realities could be subjective, it is anticipated that the reader will infer his/her own meanings and distinctions regarding the nature of childhood trauma, obesity and the process of bariatric surgery.

This concluding chapter will reflect on the objectives and main findings of this study, followed by the recommendations for further research, and the limitations of this study.

Objectives of the study

- The main objective of this study was to **give a "voice"** to those suffering from childhood trauma and morbid obesity that justifies bariatric surgery as a remedial intervention. To give "voice" implies to **be heard** and **acknowledged** for their suffering, to guide bariatric **patients**, their **support** system and **professionals** treating them with more insight into the lived experiences this specific group of bariatric patients had to endure. The experiences of this group of patients could therefore be instrumental in the development of a **"typology" of typical experiences** traumatised individuals with morbid obesity that underwent bariatric surgery, had to endure.
- A second objective of this research was to expose the researcher's notion that within a therapeutic context, some bariatric patients who endured childhood trauma, presents with a **Complex Trauma constellation of symptomatology** and therefore should be dealt with **differently** compared to more uncomplicated forms of trauma. Complex Trauma as a diagnostic description implies unusual and different psychological defence mechanisms and coping styles than for patients suffering from more simple forms of trauma (Van der Kolk, et al., 2005).
- Ultimately, a third objective of this study is based on the notion that the experiences of this group of bariatric patients could lead the way to the development of a unique

“**psychological support programme**” within a **South African** context for morbid obese patients who wish to undergo bariatric surgery. This could enable professionals treating bariatric patients to do better and more accountable pre-surgical **assessments**, be more **understanding**, have more **insight**, could suggest **alternatives** to bariatric surgery, and be more supportive to the bariatric patient and his/her support systems.

Collectively, the aim of this study was **not to quantify** the experiences of bariatric patients in terms of measurable data, but to assist the researcher as an **active participant in co-constructing** their experiences.

Main findings of the study

For the purposes of this study, the following findings are not finite, but remain a co-construction of the personal experiences and epistemologies as shared by the five participants and the researcher in this study:

- The **presence of dysfunctional differences** as reported by this group of bariatric patients referring to their parents and grandparents (either positive or negative of either genders and maternal or paternal families separately) in terms of **parenting styles**, **conflict**, **consistency**, negative impact of their **environment** on their psychological development and **eating styles** during childhood, and **wantedness** as reflective of birth expectancy, could be indicative of a **dysfunctional family driven socialisation**, implying a form of **historicity** and “**life script**” that could **negatively** affect the **psychological development** of these bariatric patients, since childhood.
- **Prolonged exposure to multiple forms of childhood trauma/abuse, inconsistencies, and double standards** by caregivers imply a “**double bind**”/being “**trapped**” by a **caregiver/s**, causing a **paradoxical acceptance** by the abused person **of the “capturer”/caregiver/s**. This, in turn, creates **confusion** to the person’s **adaptive**

functioning and feelings of **safety** as reported among this group of bariatric patients. Collectively, **multiple traumatic exposures** among this group of bariatric patients include: **emotional; physical; verbal abuse; witnessing of emotional and physical abuse and rejection; having to keep family secrets; being rejected by a caregiver/s; being neglected; feeling unsafe; being bullied/victimised** by others and lack of **competence** by a caregiver/s. For all five of the abused participants, **food** served as a **comforter**, eventually resulting in **morbid obesity** as an **adult**, to assist in the **psychological defence** against **emotional discomfort** due to the impact of **childhood trauma**.

- All five participants met the full diagnostic criteria for **Complex Trauma** (DESNOS / CPTSD) (Luxenberg, Spinazzola, & Van der Kolk, 2001) that include: **alteration in regulation of affect and impulses; alteration in attention and consciousness; alteration in self-perception; alteration in relations with others; somatisation and alterations in systems of meaning**.
- Collectively, the presence of **psychological defence mechanisms** and **coping styles** used by this group of patients include: **aggression; passive aggressiveness; altruism; sublimation; suppression, avoidance; rebellious reactions; minimising** the effect of traumatic impact; **projective identification**; reliance on **religion**; need for **structure/routine**; need for **independence/isolation** from others and ultimately **food as a comforter**.
- The notion that the process of **bariatric surgery** could be considered a **paradoxical positive and/or negative life stressor** is supported by a unique description by one of the participants' "voices" that bariatric surgery is considered a form of "**trauma**" that **replaces other traumas from the past**.
- For this group of bariatric patients, the role of the **psychologist** in the process of assessing their **suitability**, **supporting** them through the **process of bariatric surgery**, being **realistic** in his approach, **direct** and **non-judgmental**, seems necessary for

positive outcomes after bariatric surgery. This notion is also supported by Mitchell, Swan-Kremeier, and Myers, (2007).

- The participants' own **interpretations** of the **psychological causes** of obesity include the impact of **rejection** as a child; **lack of support**; **inconsistencies** during childhood; **criticism** from others; **weight as a “barrier”** and **fear of intimacy**, and ultimately the role of **food** and overeating due to the **need for comfort and safety**.
- Reflective of the participants' perceptions of **lessons learnt**, and to be conveyed to prospective bariatric patients, the following concepts are of importance as a **“non-miracle”** stance for successful outcomes post bariatric surgery: that **successful outcomes** rely on the **“time and effort”** spent to comply **“exactly”** to the much **“needed”** interventions by the **psychologist** and the **“realistic approach”**, being **“honest”** with themselves and the bariatric treatment team, building a proper **“support network”** and not to **“cheat”** on the dietary instructions. To know that they (traumatised patients who underwent bariatric surgery) are **not responsible and did not cause the psychological damages** during **childhood**, is a **valuable lesson learnt** from the “voices” of these participants.
- **Serendipity** findings among this group of bariatric patients' “voices” were the array of **paradoxical** descriptions of, amongst others, **amnesia** for **“good periods”**; being **morbid obese** but feeling **“invisible”**; more back **pain after surgery** due to **“less bodily support”** as well as more **“stomach pains”** after **“stressful periods”**. These findings seem unique and unexpected. For this group of bariatric patients, **“loss of sustained beliefs”** as either one of the two diagnostic criteria for **“alteration in systems of meaning”** on enquiry, were **not confirmed** by any of the participants and therefore considered unique to this group of bariatric patients.

Future recommendations

Based on the discussions of the research project, the following recommendations for further research in the field of trauma and bariatric surgery could be made:

- Future research could possibly use a wider range and cultural diverse group of bariatric patients as evident from a more quantitative research methodology;
- Attempts to involve meaningful others associated with bariatric patients could be of value in the future;
- An exploration into some psychological factors (e.g. defence mechanisms and coping styles) associated with childhood trauma and obesity as well as appropriate therapeutic interventions as an alternative to bariatric surgery could add value to future research;
- A social constructionist framework as a basis for this study seems appropriate within the South African context and is recommended as a research paradigm for future research;
- Further exploration of the causes of obesity, a more appropriate, standardised and rigid assessment for bariatric patients as well as a well-defined and sustainable psychological support programme for bariatric patients could add future value to the growing number of bariatric surgery interventions in South Africa;
- On a macro level, future studies can also focus on more preventative methods to curb the ever growing obese population in South Africa and internationally as an alternative to an invasive intervention like bariatric surgery.

Strengths and limitations of the study

Social constructionist ideas as reflected in this study, prevented the dualistic division and evaluation of occurrences in terms of “good” and “bad”, implying that aspects like “strengths” and

“limitations” are context bound. The discussion of specific strengths associated with specific ideas cannot be accepted without questioning and reflecting the exact original ideas from different perspectives.

The flexibility of qualitative methods within the context of social constructionism created an opportunity within which applicable and new ideas can be developed. The researcher attempted to use perceptions from existing resources from his engagement with the participants to create new perceptions, ideas and interpretations as a co-construction of the participants' experiences. A flexible research framework could be confusing to the reader who might have fixed and clearly defined methods of enquiry in mind.

A possible limitation of this study might include the lack of quantifiable methods of inquiry for some, and for others the qualitative nature of this research could prevent the reduction of occurrences to an oversimplified numeric number.

For the researcher, no final and/or ideal interpretation of what is “correct” or “incorrect” could be assumed, therefore it was decided to make the research results tentative, negotiable and open to alternative interpretations (Moon et al., 1991). A possible strength of this notion is the possibility for new and hopeful alternative ideas about the research entities, but this could also be limiting in terms of “successful” or “unsuccessful” outcomes.

The number of participants in this study could be a limiting factor in making generalised assumptions about the research data. A possible strength of the small population used for this study could, according to Bromley (1986), refer to an in-depth description of unique occurrences, and be reflective of similar occurrences in some other contexts that might be related or appropriate to the research results from a small population, as is the case in this study (Becvar & Becvar, 1996). This notion is supported by the social constructionists' assumptions that previous

experiences could affect future behaviour and evidently our choice in techniques used to gain information from the research entities.

The notion that behaviour could not be identified according to linear and simple cause, could be interpreted as a limitation of this study. The occurrences of phenomena are not at random allocated to specific causes, but rather attributed to various causes and could therefore be assumed to be a strength of this study.

The period of engagement with the participants warrants that more information about their experiences could be documented as a strength of the case study design (Bromley, 1986), but could also be considered limiting in terms of long-term outcomes after bariatric surgery due to the demarcated time frames imposed on the participants and researcher during the research process.

The researcher's logical interpretation of occurrences based on his training, experience and long-term engagements with bariatric patients as a psychologist, can provide alternative interpretations of their experiences, but could also be limiting in terms of his absolute knowledge and experiences of bariatric patients.

A contribution of this study could also be the contextualisation of occurrences as part of a bigger social cultural environment, but limiting in terms of exposure to the opinions and perceptions of others.

The researcher also acknowledges that another researcher might focus on different aspects of the experiences of bariatric patients and that his perceptions and focus areas of this group of bariatric patients were coloured (epistemological views) by his observations (lens) that bariatric patients in general present with aspects of childhood trauma, therefore presenting with symptoms associated with Complex Trauma. No research could be found linking prolonged

childhood trauma, morbid obesity and the process of bariatric surgery to the symptom constellation of Complex Trauma, and therefore it is hoped that the descriptions of this selected group (limited in terms of selective participants) of bariatric patients, could lead the way to further investigations into the field of Complex Trauma and bariatric surgery.

Conclusions

This research project focused on the ecology of ideas following childhood trauma, obesity and the invasive process of bariatric surgery. The researcher trusts that the reader, as a co-researcher, has also benefited from the knowledge and experiences of the participants (co-researchers) of this research venture. The construction of new ideas and interpretations from this research is open to further negotiation as a co-construction of future exploration into the field of psychology. Words are not enough to describe the researcher's experiences during the research process; these experiences are best captured by Okri's (1997, p.88) notion that "we began before words, and we will end beyond them".

References

- Adami, G. F., Gandolfo, P., Meneghelli, A., & Scopinaro, N. (1996). Binge eating in obesity: A longitudinal study following biliopancreatic diversion. *International Journal of Eating Disorders, 20*(4), 405-413.
- Adams, C. H., Smith, N. J., Wilbur, D. C., & Grady, K. E. (1993). The relationship of obesity to the frequency of pelvic examinations: Do physicians and patients attitude make a difference? *Women Health, 20*(2), 45-57.
- Adolfsson, B. (2004). Are sexual dissatisfaction and sexual abuse associated with obesity? *Obesity Research, 12*(10), 1702-1709.
- Ahima, R. S., Bjorbaek, C., Osei, S., & Flier, J. S. (1999). Regulation of neuronal and glial proteins by leptin: Implications for brain development. *Endocrinology, 140*(6), 2755-2762.
- Alciati, A., D'Ambrosio, A. D., Foschi, D., Corsi, F., Mellado, C., & Angst, J. (2007). Bipolar spectrum disorders in severely obese patients seeking surgical treatment. *Journal of Affective Disorders, 101*, 131-138.
- Allen, J. R., & Allen, B. A. (1997). A new type of transactional analysis and one version of script work with a constructionist sensibility. *Transactional Analysis Journal, 27*(2), 89-98.
- Allied Health Science Section Ad Hoc Behavioral Health Committee. (October 2004). Suggestions for the pre-surgical psychological assessment of bariatric surgery candidates. In D. LeMont, M. K. Moorhead, M. S. Parish, C. S. Reto, & S. J. Ritz (Eds.), *Allied Health Science Section Ad Hoc Behavioral Health Committee*. Washington, USA: American Society for Bariatric Surgery.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- Anderson, D. A., & Wadden, T. A. (2004). Bariatric surgery patients' view of their physicians' weight-related attitudes and practices. *Obesity Research, 12*(10), 1587-1595.
- Anderson, H., & Goolishian, H. A. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process, 27*(4), 371-393.

- Artz, L., & Themba Lesizwe. (2005). *Ethics Relating to Social Science Research with Victims of Violence and Other Vulnerable Groups* [Brochure]. Hatfield, South Africa: Author.
- Atkinson, B. J., & Heath, A. W. (1985). Beyond objectivism and relativism: Implications for family therapy research. *Journal of Strategic and Systematic Therapies*, 6(1), 8-17.
- Atkinson, R. C., Lindzey, G., & Thompson, R. F. (1991). *The Psychology of Eating and Drinking* (R. C. Atkinson, G. Lindzey, & R. F. Thompson, Eds.). New York: W.H. Freeman and Company. (Original work published 1986)
- Bauchowitz, A. U., Gonder-Frederick, L. A., Olbrisch, M. E., Azarbad, L., Ryee, M. Y., Woodson, M., et al. (2005). Psychosocial evaluation of bariatric surgery candidates: A survey of present practices. *Psychosomatic Medicine*, 67, 825-832.
- Becvar, R. J., & Becvar, D. C. (1996). *Family Therapy*. Boston: Allyn & Bacon.
- Beebe, D. W., Lewin, D., Zeller, M., McCabe, M., MacLeod, K., Daniels, S. R., et al. (2007). Sleep in overweight adolescents: Shorter sleep, poorer sleep quality, sleepiness, and sleep-disordered breathing. *Journal of Pediatric Psychology*, 32(1), 69-79.
- Belke, T. W., & Wagner, J. P. (2005). The reinforcing property and the rewarding aftereffect of wheel running in rats: A combination of two paradigms. *Behavioural Processes*, 68(2), 165-172.
- Berkowitz, C. D. (1998). Medical consequences of child sexual abuse. *Child Abuse and Neglect*, 22, 541-550.
- Berthoud, H. R. (2002). Multiple neural systems controlling food intake and body weight. *Neuroscience and Biobehavioural Reviews*, 26(4), 393-428.
- Bi, S., Scott, K. A., Hyun, J., Ladenheim, E. E., & Moran, T. H. (2005). Running wheel activity prevents hyperphagia and obesity in Otsuka Long-Evans Tokushima Fatty Rats: Role of Hypothalamic Signaling. *Endocrinology*, 146(4), 1676-1685.
- Birmingham, C. L., & Beumont, P. J. V. (2005). *Medical management of eating disorders*. Cambridge, UK: Cambridge University Press. (Original work published 2004)

- Bjorvatn, B., Sagen, I. M., Oyane, N., Waage, S., Fetveit, A., Pallesen, S., et al. (2007). The association between sleep duration, body mass index and metabolic measures in the Hordaland Health Study. *J. Sleep Res*, 16, 66-76.
- Blaustein, M. E., Spinazzola, J., Simpsom, W., & van der Kolk, B. A. (2000, November). *Psychological sequelae of early trauma: Comorbid diagnoses or diagnostic entity?* Paper presented at the 16th Annual Meeting of the International Society for Traumatic Stress Studies, San Antonio, TX.
- Bogdan, R. C., & Biklen, S. K. (1982). *Qualitative research for education: An introduction to theory and methods*. Boston: Allyn and Bacon, Inc.
- Bond, D. S., Evans, R. K., DeMaria, E., Wolfe, L., Meador, J., Kellum, J., et al. (2006). Physical Activity and Quality of Life Improvements Before Obesity Surgery. *American Journal of Health Behavior*, 30(4), 422-434.
- Bonne, O. B., Bashi, R., & Berry, E. M. (1996). Anorexia Nervosa following gastroplasty in the male: Two cases. *International Journal of Eating Disorders*, 19(1), 105-108.
- Bouchard, C., & Perusse, L. (1993). Genetics of obesity. *Ann Rev Nutr*, 13, 337-354.
- Bremner, J. (1995). MRI-based measurement of hippocampal volume in patients with combat-related posttraumatic stress disorder. *American Journal of Psychiatry*, 152, 973-981.
- Briere, J. (2004). *Psychological assessment of adult posttraumatic states: Phenomenology, diagnosis, and measurement* (2nd ed.). Washington DC, USA: American Psychological Association.
- Briere, J., & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. Thousand Oaks, CA: Sage Publications.
- Briere, J., & Spinazzola, J. (2005). Phenomenology and psychological assessment of complex posttraumatic states. *Journal of Traumatic Stress*, 18, 401-412.
- Brodzinsky, D. M., Gormly, A. V., & Ambron, S. R. (1986). *Lifespan human development* (3rd ed.). New York: Holt, Rinehart & Winston.
- Brolin, R. E. (1996). Gastrointestinal Surgery for Severe Obesity. *Nutrition*, 12(6), 403-404.

- Bromley, D. B. (1986). *The case-study method in psychology and related disciplines*. Chichester, UK: Wiley.
- Bryer, J., Nelson, B., Miller, J., & Krol, P. (1987). Childhood Sexual and Physical Abuse as Factors in Adult Psychiatric Illness. *American Journal of Psychiatry*, *144*(11), 1426-1430.
- Buchwald, H. (2005). Consensus conference statement of bariatric surgery for morbid obesity: Health implications for patients, health professionals, and third-party payers. *Surgery for Obesity and Related Diseases*, *1*(Suppl 4), 371-381.
- Bulik, C. M., Sullivan, P. F., & Kendler, K. S. (2002). Medical and Psychiatric Morbidity in Obese Woman with and without Binge Eating. *International Journal of Eating Disorders*, *32*, 72-78.
- Bungum, T., Satterwhite, M., Jackson, A. W., & Morrow, J. R. (2003). The relationship of Body Mass Index, medical costs, and Job absenteeism. *American Journal of Health Behaviour*, *27*(4), 456-462.
- Buser, A. (2004). Outcome following gastric bypass surgery: Impact of past sexual abuse. *Obesity Surgery*, *14*, 170-174.
- Canning, H., & Mayer, J. (1966). Obesity - its possible effects on college acceptance. *New England Journal of Medicine*, *275*, 1172-1174.
- Caporino, N., Murray, L., & Jensen, P. (2003). The impact of different traumatic experiences in childhood and adolescence. *Report on Emotional and Behavioral Disorder in Youth*, *3*(3), 63-64, 73-78.
- Ceru'-Bjork, C., Andersson, I., & Rossner, S. (2001). Night eating and nocturnal eating - two different or similar syndromes among obese patients? *International Journal of Obesity and Related Metabolic Disorders*, *25*, 365-372.
- Chandarana, P. C. (1990). A prospective study of psychosocial aspects of gastric stapling surgery. *Psychiatr J Univ Ott*, *15*, 32-35.
- Chu, J. A. (1998). *Rebuilding shattered lives: The responsible treatment of Complex Post-traumatic and Dissociative Disorders*. New York: Wiley.

- Coccaro, E. F., Siever, L. J., Klar, H. M., & Maurer, G. (1989). Serotonergic studies in patients with affective and personality disorders. *Archives of General Psychiatry*, *46*, 587-598.
- Combrinck-Graham, L. (1991). Development of school-age children. In M. Lewis (Ed.), *Child and adolescent psychiatry: A comprehensive textbook* (pp. 157-265). Baltimore: Williams & Wilkins.
- Cox, L. M., & Lyddon, W. J. (1997). Constructivist conception of self: A discussion of emerging identity constructs. *Journal of Constructivist Psychology*, *10*(3), 201-219.
- Crandall, C. S. (1995). Do parents discriminate against their heavy-weight daughters? *Pers Soc Psych Bull*, *21*, 724-735.
- Creswell, J. W. (1998). *Qualitative inquiry and Research Design: Choosing among five traditions*. London: Sage Publications.
- Cronbach, L. J. (1975). Beyond the two disciplines of scientific psychology. *American Psychologist*, *30*(2), 116-127.
- Crossley, M. L. (2000). *Narrative Psychology: Self, trauma and the construction of meaning*. Philadelphia: Open University Press.
- Darves-Bornoz, J. M., Lemperiere, T., Degio Vanni, A., & Gaillard, P. (1995). Sexual victimization in women with schizophrenia and bipolar disorder. *Social Psychiatry and Psychiatric Epidemiology*, *30*, 78-84.
- De Zwaan, M. (2005). Ninge eating, EDNOS and obesity. In C. Norring & B. Palmer (Eds.), *Eating Disorders Not Otherwise Specified* (pp. 83-113). New York: Routledge Taylor & Francis Group.
- Decker, W. H. (1987). Attributions based on managers' self-presentation, sex, and weight. *Psychol Reports*, *61*, 175-181.
- Denzin, N. K., & Lincoln, Y. S. (1994). *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage Publications.
- Devlin, M. J., Allison, K. C., Goldfein, J. A., & Spanos, A. (2007). Management of Eating Disorders Not Otherwise Specified. In J. Yager & P. S. Powers (Eds.), *Clinical Manual of*

- Eating Disorders* (pp. 195-224). Washington DC, USA: American Psychiatric Publishing, Inc.
- Doherty, W. J. (1991). Family therapy goes postmodern. *The Family Therapy Networker*, 15(5), 36-42.
- Dong, C., Sanchez, L. E., & Price, R. A. (2004). Relationship of obesity to depression: A family-based study. *International Journal of Obesity*, 28, 790-795.
- Draijer, N., & Langeland, W. (1999). Childhood trauma and perceived parental dysfunction in the etiology of dissociative symptoms in psychiatric inpatients. *American Journal of Psychiatry*, 156, 379-385.
- Drewery, W., & Mackenzie, W. (1999). Therapy and faith. In I. Parker (Ed.), *Deconstructing psychotherapy* (pp. 132-149). London: Sage.
- Drossman, D. A., Leserman, J., Nachman, G., Li, Z. M., Gluck, H., Toomey, T. C., et al. (1990). Sexual and physical abuse in women with functional or organic gastrointestinal disorders. *Annals of Internal Medicine*, 113(11), 828-833.
- Ebert, A., & Dyck, M. J. (2004). The experience of mental death: The core features of Complex Posttraumatic Stress Disorder. *Clinical Psychology Review*, 24(6), 617-635.
- Efran, J. S., Lukens, R. J., & Lukens, M. D. (1988). Constructivism: What's in it for you? *The Family Networker*, 27-35.
- Eisner, E. W. (1991). *The enlightened eye: Qualitative inquiry and the enhancement of educational practice*. New York: Macmillan Publishing Company.
- Fassino, S., Leombruni, P., Piero, A., Abbate Daga, G., Amianto, F., Rovera, G., et al. (2002). Temperament and character in obese woman with and without Binge Eating Disorder. *Comprehensive Psychiatry*, 43(6), 431-437.
- Faust, I. M., Johnson, P. R., & Hirsch, J. (1980). Long-term effects of early nutritional experience on the development of obesity in the rat. *J Nutr*, 110, 2027-2034.
- Felitti, V. J. (1991). Long-term medical consequences of incest, rape, and molestation. *South Med J*, 84(3), 328-331.

- Felitti, V. J. (1993). Childhood sexual abuse, depression, and family dysfunction in adult obese patients: a case control study. *South Med J*, 86(7), 732-736.
- Felitti, V. J. (2002). The relation between adverse childhood experiences and adult health: Turning gold into lead. *Permanente Journal*, 6(1), 44-47.
- Felitti, V. J., & Williams, S. A. (1998). Long term follow-up and analysis of over one hundred patients who have lost over 100 pounds. *Permanente*, 2, 12-21.
- Felitti, V. J., Anda, R. F., & Norderberg, D. (1998). Relationship of childhood abuse to many of the leading causes of death in adults: the adverse childhood experiences (ACE) study. *American Journal of Preventative Medicine*, 14(4), 245-258.
- Flaskas, C. (1999). Limits and possibilities of the postmodern narrative self. *Australian and New Zealand Journal of Family Therapy*, 20(1), 20-27.
- Folsom, V., Krahn, D., Nairn, K., Gold, L., Demitrack, M. A., & Silk, K. R. (1993). The impact of sexual and physical abuse on eating disordered and psychiatric symptoms: A comparison of eating disordered and psychiatric inpatients. *International Journal of Eating Disorders*, 13(3), 249-257.
- Fontaine, K. R., Faith, M. S., Allison, D. B., & Cheskin, L. J. (1998). Body weight and health care among women in the general population. *Arch Fam Med*, 7, 381-384.
- Ford, J. D., Courtois, C. A., Steele, K., Van der Hart, O., & Nijenhuis, E. R. S. (2005). Treatment of complex posttraumatic self-dysregulation. *Journal of Traumatic Stress*, 18, 437-447.
- Ford, J., & Kidd, T. (1998). Early childhood trauma and Disorders of Extreme Stress as predictors of treatment outcome with chronic Posttraumatic Stress Disorder. *Journal of Traumatic Stress*, 11(4), 743-761.
- Ford. (1999). Disorders of Extreme Stress following war-zone military trauma: Associated features of Posttraumatic Stress Disorder or comorbid but distinct syndromes. *Journal of Consulting Clinical Psychology*, 67(3), 3-12.
- Garbarino, J., Kostelny, K., & Dubrow, N. (1991). What children can tell us about living in danger. *American Psychologist*, 46(4), 376-383.

- Garbers, J. G. (1996). *Effective Research in the Human Sciences*. Pretoria, South Africa: Van Schaik.
- Gemin, K. J. (1999). The dissolution of the self in unsettled times: Postmodernism and the creative process. *The Journal of Creative Behaviour*, 33(1), 45-61.
- Gentry, K., Halverson, J. D., & Heisler, S. (1984). Psychologic assessment of morbidly obese patients undergoing gastric bypass: a comparison of preoperative and postoperative adjustment. *Surgery*, 95, 215-220.
- Gergen, K. J. (1985). Social constructionist movement in modern psychology. *American Psychologist*, 40, 266-275.
- Gergen, K. J. (1989). Social psychology and the wrong revolution. *European Journal of Social Psychology*, 19, 463-484.
- Gergen, K. J. (1991a). *The saturated self*. New York: Basic Books.
- Gergen, K. J. (1991b). The saturated family. *The Family Therapy Networker*, 27-35.
- Gergen, K. J. (1994). *Realities and relationships: Soundings in social construction*. London: Harvard University Press.
- Gergen, K. J. (1999). *An investigation to social construction*. London: Sage.
- Gertler, R., & Ramsey-Stewart, G. (1986). Pre-operative psychiatric assessment of patients presenting for gastric bariatric surgery (surgical control of morbid obesity). *Aust N Z J Surg*, 56, 157-161.
- Glinski, J., Wetzler, S., & Goodman, E. (2001). The psychology of gastric bypass surgery. *Obesity Surgery*, 11, 581-588.
- Goodwin, R. D., & Stein, M. B. (2004). Association between childhood trauma and physical disorders among adults in the United States. *Psychological Medicine*, 34, 509-520.
- Gottesman, I. I., & Gould, T. D. (2003). "The endophenotype concept in psychiatry: etymology and strategic intentions". *American Journal of Psychiatry*, 160, 636-645.
- Grave, R., Molinari, E., Petroni, L., Bondi, M., Compare, A., Marchesini, G., et al. (2005). Weight loss expectations in obese patients and treatment attrition: An observational multicenter study. *Obesity Research*, 13(11), 1961-1968.

- Green A.H. (1993). Child sexual abuse. Immediate and long-term effects and intervention. *J Am Acad Child Adolesc Psychiatry*, 32(5), 890-902.
- Green, A. E. C., Dymek-Valentine, M., Pytluk, S., Le Grange, D., & Alverdy, J. (2004). Psychosocial outcome of gastric bypass surgery for patients with and without binge eating. *Obesity Surgery*, 14, 975-985.
- Greenberg, I., Perna, F., Kaplan, M., & Sullivan, M. A. (2005). Behavioral and psychological factors in the assessment and treatment of obesity surgery patients. *Obesity Research*, 13(2), 244-249.
- Grilo, C. M., & Masheb, R. M. (2001). Childhood psychological, physical, and sexual maltreatment in outpatients with binge eating disorder: Frequency and associations with gender, obesity, and eating-related psychopathology. *Obesity Research*, 9(5), 320-325.
- Grilo, C. M., Masheb, R. M., Brody, M., Toth, C., Burke-Martindale, C. H., & Rothschild, B. S. (2005). Childhood maltreatment in extremely obese male and female bariatric surgery candidates. *Obesity Research*, 13(1), 123-130.
- Grilo, C. M., White, M. A., Masheb, R. M., Rothschild, B. S., & Burke-Martindale, C. H. (2006). Relation of childhood sexual abuse and other forms of maltreatment to 12-month postoperative outcomes in extremely obese gastric bypass patients. *Obesity Surgery*, 16, 454-460.
- Grilo, C. M., Wilfley, D. E., Brownell, K. D., & Rodin, J. (1994). Teasing, body image, and self esteem in a clinical sample of obese woman. *Addict Behav*, 19(4), 443-450.
- Guisado, J. A., & Vaz, F. J. (2003a). Psychopathological differences between morbidly obese binge eaters and non-binge eaters after bariatric surgery. *Eating Weight Disord*, 8, 315-318.
- Guisado, J. A., & Vaz, F. J. (2003b). Personality profiles of the morbidly obese after vertical banded gastroplasty. *Obesity Surgery*, 13, 394-398.
- Gunstad, J., Paul, R. H., Spitznagel, M. B., Cohen, R. A., Williams, L. M., Kohn, M., et al. (2006). Exposure to early life trauma is associated with adult obesity. *Psychiatry Research*, 142, 31-37.

- Gustafson, T. B., & Sarwer, D. B. (2004). Childhood sexual abuse and obesity. *Obesity Review*, 5, 129-135.
- Hennessey, M., Ford, J.D., Mahoney, K., Ko, S.J., & Siegfried, C.B. (2004). Trauma among girls in the juvenile justice system. Retrieved 2008, from National Child Traumatic Stress Network Web site: http://www.nctsn.org/nctsn-asset/pdfs/edu_materials/trauma_among_girls_in_jjsys.pdf.
- Herman, J. L. (1992a). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, 5(3), 377-391.
- Herman, J. L. (1992b). *Trauma and Recovery: From Domestic abuse to political terror*. London: Pandora.
- Herman, J. L., Perry, C., & Van der Kolk, B. A. (1989). Childhood trauma in Borderline Personality Disorder. *American Journal of Psychiatry*, 146(4), 490-495.
- Herzog, D. B., & Eddy, K. T. (2007). Diagnosis, epidemiology, and clinical course of eating disorders. In J. Yager & P. S. Powers (Eds.), *Clinical Manual of Eating Disorders* (pp. 1-29). Washington, DC, USA: American Psychiatric Publishing, Inc.
- Hetherington, A. W., & Ranson, S. W. (1940). "Hypothalamic Lesions and Adisposity in the Rat". *Anatomical Record*, 78, 149-172.
- Hoepfl, M. C. (1997). Choosing qualitative research: A primer for Technology Education researchers. *Journal of Technology Education*, 9(1), 1-17.
- Hoffman, L. (1994). *Exchanging Voices*. London: Karnac Books.
- Holstein, J. A., & Gubrium, J. F. (1997). Active interviewing. In D. Silverman (Ed.), *Qualitative research: Theory, method and practice* (pp. 113-129). London: Sage.
- Hsu, L. K. G., Benotti, P. N., Dwyer, J., Roberts, S. B., Saltzman, E., Shikora, S., et al. (1998). Nonsurgical factors that influence the outcome of bariatric surgery: A review. *Psychosomatic Medicine*, 60(3), 338-346.
- Hsu, L. K. G., Betancourt, S., & Sullivan, S. P. (1996). Eating disturbances before and after vertical banded gastroplasty: A pilot study. *International Journal of Eating Disorders*, 19(1), 23-34.

- Hsu, L. K. G., Mulliken, B., McDonag, B., Krupa Das, S., Rand, W., Rairburn, C. G., et al. (2002). Binge eating disorder in extreme obesity. *International Journal of Obesity*, 26, 1398-1403.
- Hsu, L. K. G., Sullivan, S. P., & Benotti, P. N. (1997). Eating disturbances and outcome of gastric bypass surgery: A pilot study. *International Journal of Eating Disorders*, 21, 385-390.
- Irving, L. (2000). Promoting size acceptance in elementary school children: The EDAP puppet program. *International Journal of Eating Disorders*, 8, 221-232.
- James, B. (1994). *Handbook for treatment of attachment-trauma problems in children*. Lexington, MA: Lexington Books.
- James, P. T., Leach R., & Shayeghi M. (2001). The worldwide obesity epidemic. *Obesity Research*, 9(Suppl 4), 228-233.
- Jankowski, P. J., Clark, W. M., & Ivey, D. C. (2000). Fusing horizons: Exploring qualitative research and psychotherapeutic applications of social constructionism. *Contemporary Family Therapy: an International Journal*, 22(2), 241-250.
- Jensen, J. L., & Rodgers, R. (2001). Cumulating the intellectual gold of case study research. *Public Administration Review*, 61(2), 236-246.
- Jones, A. P., Pothos, E. N., Rada, P., Olster, D. H., & Hoebel, B. G. (1995). Maternal hormonal manipulations in rats cause obesity and increase medial hypothalamic norepinephrine release in male offspring. *Brain Res Dev Brain Res*, 88(2), 127-131.
- Jongedijk, R. A., Carlier, I. V. E., Schreuder, B. J. N., & Gersons, B. P. R. (1996). An exploratory investigation of PTSD and DESNOS among Dutch War Veterans. *Journal of Traumatic Stress*, 9(3), 577-586.
- Kalarchian M.A., Marcus., M.D., Wilson., G.T., Labouvie., E., Brolin., R., & LaMarca, L. (2002). Binge eating among gastric bypass patients at long-term follow-up. *Obesity Surgery*, 12, 270-275.
- Kalarchian, M. A., & Marcus, M. D. (2003). Management of the bariatric surgery patient: Is there a role for the cognitive behavior therapist? *Cognitive Behavioral Practice*, 10, 112-119.
- Kalarchian, M. A., Wilson, G. T., Brolin, R. E., & Bradley, L. (1998). Binge eating in bariatric patients. *International Journal of Eating Disorders*, 23, 89-92.

- Kalarchian, M. A., Wilson, G. T., Brolin, R. E., & Bradley, L. (2000). Assessment of eating disorders in bariatric surgery candidates: Self-report questionnaire versus interview. *International Journal of Eating Disorders, 28*, 465-469.
- Keeney, B. P. (1987). *Aesthetics of change*. New York: The Guilford Press. (Original work published 1983)
- Keeney, B. P., & Morris, J. (1985). Implications of cybernetic epistemology for clinical research: A reply to Howard. *Journal of Counselling and Development, 63*, 548-550.
- King, T. K., Clark, M. M., & Pera, V. (1996). History of sexual abuse and obesity treatment outcome. *Addict Behav, 21*(3), 283-290.
- Kinzie, J. D. (2001). Psychotherapy for massively traumatized refugees. *American Journal of Psychotherapy, 55*(4), 475-491.
- Klassen, M. L., Jasper, C. R., & Harris, R. J. (1993). The role of physical appearance in managerial decisions. *J Bus Psychol, 8*(2), 181-198.
- Klein, D., Najman, J., Kohrman, A. F., & Munro, C. (1982). Patient characteristics that elicit negative responses from family physicians. *Journal of Family Practice, 14*, 881-888.
- Klem, M. L., Wing, R. R., McGuire, M. T., & Hill, J. O. (1997). A descriptive study of individuals successful at long-term maintenance of substantial weight loss. *American Journal of Clinical Nutrition, 66*, 239-246.
- Laitinen, J., Ek, E., & Sovio, U. (2002). Stress-related eating and drinking behavior and Body Mass Index and predictors of this behavior. *Preventative Medicine, 34*, 29-39.
- Larsen, F. (1990). Psychosocial function before and after gastric banding surgery for morbid obesity: A prospective study. *Acta Psychiatr Scand Suppl, 359*, 1-57.
- Larsen, F., & Torgersen, S. (1989). Personality changes after gastric banding surgery for morbid obesity. A prospective study. *J Psychosom Res, 33*(3), 323-334.
- Lax, W. D. (1992). Postmodern thinking in a clinical practice. In S. McNamee & K. J. Gergen (Eds.), *Therapy and social construction* (pp. 69-85). London: Sage.
- LeGarde, C. (2006). Overcoming the complexities of establishing an adolescent bariatric surgery program. *Bariatric Nursing and Surgical Patient Care, 1*(4), 263-271.

- Levin, B. E. (1999). Arcuate NPY neurons and energy homeostasis in diet-induced obese and resistant rats. *American Journal of Physiology*, 276, 382-387.
- Levin, B. E. (2000). Metabolic imprinting on genetically predisposed neural circuits perpetuates obesity. *Nutrition*, 16, 909-915.
- Levin, B. E. (2005). Factors promoting and ameliorating the development of obesity. *Physiology & Behavior*, 86, 633-639.
- Levin, B. E., Magnan, C., Migrenne, S., Chua Jr, S. C., & Dunn-Meynell, A. A. (2005). The F-DIO obesity-prone rat is insulin resistant prior to obesity onset. *American Journal of Physiology*, 289, 704-711.
- Levin, B. E., Triscari, J., & Sullivan, A. C. (1986). Metabolic features of diet-induced obesity without hyperphagia in young rats. *American Journal of Physiology*, 251, 433-440.
- Lewis, M. (1991). Normal growth and development: An overview. In J. M. Wiener (Ed.), *Textbook of child and adolescent psychiatry* (pp. 25-39). Washington, DC, USA: American Psychiatric Press.
- Lewis, M. (1995). Memory and psychoanalysis: A new look at infantile amnesia and transference. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34(4), 405-417.
- Lilliamson, D. F., Thompson, T. J., Anda, R. F., Dietz, W. H., & Felitti, V. (2002). Body weight and obesity in adults and self-reported abuse in children. *International Journal of Obesity*, 26, 1075-1082.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage Publications, Inc.
- Lissau, I., & Sorensen, T. L. A. (1994). Parental neglect during childhood and increased risk of obesity in young adulthood. *Lancet*, 343, 8893.
- Logue, A. W. (1991). *The psychology of eating and drinking* (2nd ed.). New York: W.H. Freeman and Company. (Original work published 1986)
- Luxenberg, T., Spinazzola, J., & Van der Kolk, B. A. (2001). Complex Trauma and Disorder of Extreme Stress (DESNOS) Diagnosis, Part One: Assessment. *Directions in Psychiatry*, 21, 373-392.

- Macksound, M. S., Dyregrov, A., & Raundalen, M. (1993). Traumatic war experiences and their effects on children. In J. P. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 625-632). New York: Plenum Press.
- Mahoney, M. J. (1993). The postmodern self in psychotherapy. *Journal of Cognitive Psychotherapy, 7*(4), 241-250.
- Malone, M., & Alger-Mayer, S. (2004). Binge status and quality of life after gastric bypass surgery: A one-year study. *Obesity Research, 12*(3), 473-481.
- Maroney, D., & Golub, S. (1992). Nurses' attitudes toward obese persons and certain ethnic groups. *Percept Mot Skills, 75*, 387-391.
- Matthews, W. J. (1996). Ericksonian approaches to psychotherapy: From objective to constructive reality. *Journal of Cognitive Psychotherapy, 10*(3), 205-218.
- Mazzeo, S. E., & Espelage, D. L. (2002). Association between childhood physical and emotional abuse and disordered eating behaviors in female undergraduates: An investigation of the mediating role of alexithymia and depression. *Journal of Counseling Psychology, 49*(1), 86-100.
- Miles, M., & Huberman, M. A. (1994). *Qualitative data analysis* (2nd ed.). London: SAGE.
- Miller, W. R., & Rollnick, S. (1991). *Motivational Interviewing: Preparing People to Change Addictive Behavior*. New York: Guilford Press.
- Minuchin, S. (1991). The seduction of constructivism. *The Family Therapy Networker, 47-50*.
- Mitchell, J. E., Swan-Kremeier, L., & Myers, T. (2007). Psychiatric aspects of bariatric surgery. In J. Yager & P. S. Powers (Eds.), *Clinical Manual of Eating Disorders* (pp. 225-253). Washington DC, USA: American Psychiatric Publishing, Inc.
- Mitchell, K. S., & Mazzeo, S. E. (2005). Mediators of the association between abuse and disordered eating in undergraduate men. *Eating Behaviors, 6*, 318-327.
- Moeller, T., Bachman, G., & Moeller, J. (1991). The combined effects of physical, sexual and emotional abuse during childhood: Long-term health consequences for woman. *Child Abuse and Neglect, 17*, 623-640.

- Moon, S. M., Dillon, D. R., & Sprenkle, D. H. (1991). On balance and synergy: Family therapy and qualitative research revisited. *Journal of Marital and Family Therapy*, 17(2), 187-192.
- Mouton, J. (2001). *How to succeed in your master's and doctoral studies: A South-African guide and resource book*. Pretoria, South Africa: Van Schaik.
- Mueser, K. T., Goodman, L. B., Trumbetta, S. L., Rosenber, S. D., Osher, F. C., Vidaver, R., et al. (1998). Trauma and posttraumatic stress disorder in severe mental illness. *Consult Clinical Psychology*, 66(3), 493-499.
- Murray, C. C., & Son, L. (1998). The effect of multiple victimization on children's cognition: Variations in response. *Journal of Aggression, Maltreatment and Trauma*, 2(1), 131-146.
- Myers, A., & Rosen, J. C. (1999). Obesity stigmatization and coping: Relation to mental health symptoms, body image, and self-esteem. *International Journal of Obesity and Related Metabolic Disorders*, 23, 221-230.
- Myers, M. (2000). Qualitative research and the generalizability question: Standing firm with Proteus. *The Qualitative Report*, 4(3/4), 1-9.
- Nader, K. (2004). *Treating psychological trauma & PTSD* (J. P. Wilson, M. J. Friedman, & J. D. Lindy, Eds.). New York: The Guilford Press. (Original work published 2001)
- Nader, K., & Pynoos, R. (1993). School disaster: Planning and initial interventions. *Journal of Social Behavior and Personality*, 8(5), 299-320.
- National Institute of mental Health (NIMH). (2001). *Helping children and adolescents cope with violence and disaster*. Washington, DC, USA: Departement of Health and Human Services, Public Health Services, National Institute of Health.
- Neuman, W. L. (1997). *Social Research Methods: Qualitative and Quantitative Approaches* (3rd ed.). Needham Heights, USA: Allyn & Bacon. (Original work published 1991)
- New IPEG Guideline. (2003). IPEG guidelines for surgical treatment of clinically severely obese adolescents. *Pediatric Endosurgery & Innovative Techniques*, 7(4), 461-463.
- Niego, S. H., Kofman, M. D., Weiss, J. J., & Geliebter, A. (2007). Binge eating in the bariatric surgery population: A review of the literature. *International Journal of Eating Disorders*, 40(4), 349-359.

- Noll, J. G., Zeller, M. H., Trickett, P. K., & Putnam, F. W. (2007). Obesity risk for female victims of childhood sexual abuse: A prospective study. *Pediatrics, 120*(1), 61-67.
- O'Hara, M., & Anderson, W. T. (1991). Welcome to the postmodern world. *Family Therapy Networker, 19*-25.
- Okri, B. (1997). *A way of being free*. London: Phoenix House.
- O'Leary, J. V. (2001). The postmodern turn in group therapy. *International Journal of Group Psychotherapy, 51*(4), 473-487.
- Olson, C. L., Schumaker, H. D., & Yawn, B. P. (1994). Overweight women delay medical care. *Arch Fam Med, 3*, 888-892.
- Oppenheimer, R., Howells, K., Palmer, L., & Chaloner, D. (1985). Adverse sexual experiences in childhood and clinical eating disorders: A preliminary description. *Journal of Psychiatric Research, 19*, 157-161.
- Opong, B. A., Nickels, M. W., & Sax, H. C. (2006). The impact of a history of sexual abuse on weight loss in gastric bypass patients. *Psychosomatics, 47*(2), 108-111.
- Oria, H. E., & Moorehead, M. K. (1998). Bariatric Analysis and Reporting Outcome System (BAROS). *Obesity Surgery, 8*, 487-499.
- Patterson, C., & Levin, B. E. (2004). Post-weaning exercise prevents obesity in obesity-prone rats even after exercise termination. *Obesity Research, 12*, A22 [Suppl].
- Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods* (2nd ed.). Newbury Park, CA: Sage Publications, Inc.
- Paul, R. J., & Townsend, J. B. (1995). Shape up or ship out? Employment discrimination against the overweight. *Employee Responsibilities Rights Journal, 8*(2), 133-145.
- Pelcovitz, D., Van der Kolk, B. A., Roth, S., Mandel, F., Kaplan, S., & Resick, P. (1997). Development of a criteria set and a Structured Interview for Disorder of Extreme Stress (SIDES). *Journal of Traumatic Stress, 10*(1), 3-16.
- Perlman, S. E., Reinhold, R. B., & Nadzam, G. S. (2007). How do family practitioners perceive surgery for the morbidly obese? *Surgery for Obesity and Related Diseases, 3*, 428-433.

- Perry, B., Pollard, R., Blakeley, T., Baker, W., & Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation and use-dependent development of the brain: How 'states' becomes 'traits'. *Infant Mental Health Journal, 16*(4), 271-291.
- Peterson, C. B., Mitchell, J. E., Engbloom, S., Nugent, S., Mussel, M. P., Crow, S. J., et al. (1998). Binge eating disorder with and without a history of purging symptoms. *International Journal of Eating Disorders, 24*, 251-257.
- Picot, A. K., & Lilenfeld, L. R. R. (2003). The relationship among binge severity, personality psychopathology, and Body Mass Index. *International Journal of Eating Disorder, 34*, 98-107.
- Pitman, R. K., Orr, S. P., Fogue, D. F., De Jong, J., & Claiborn, J. M. (1987). Psychophysiological assessment of posttraumatic stress disorder imagery in Vietnam combat veterans. *Archives of General Psychiatry, 44*, 970-975.
- Pitman, R. K., Van der Kolk, B. A., Orr, S. P., & Greenberg, M. S. (1990). Naloxone reversible stress-induced analgesia in post-traumatic stress disorder. *Archives of General Psychiatry, 47*, 541-547.
- Plagemann, A., Rittel, F., Waas, T., Harder, T., & Rohde, W. (1999). Cholecystokinin-8S levels in discrete hypothalamic nuclei of weanling rats exposed to maternal protein malnutrition. *Regul Pept, 85*(2-3), 109-113.
- Pope, C., Ziebland, S., & Mays, N. (2000). Qualitative research in health care: Analysing qualitative data. *British Medical Journal, 320*, 114-116.
- Powers, P. S. (1992). Psychiatric issues in bariatric surgery. *Obesity Surgery, 2*, 315-325.
- Powers, P. S. (1999). Eating pathology before and after bariatric surgery: a prospective study. *International Journal of Eating Disorders, 25*, 293-300.
- Price, J. H., Desmond, S. M., Krol, R. A., Snyder, F. F., & O'Connell, J. K. (1987). Family practice physicians' beliefs, attitudes, and practices regarding obesity. *American Journal of Preventative Medicine, 3*(6), 339-345.
- Puhl, R., & Brownell, K. D. (2001). Bias, Discrimination, and Obesity. *Obesity Research, 9*(12), 788-805.

- Rand, C. S., & Macgregor, A. M. (1990). Morbidly obese patients' perceptions of social discrimination before and after surgery for obesity. *South Med J*, *83*(12), 1390-1395.
- Rand, C. S., & Macgregor, A. M. (1991). Successful weight loss following obesity surgery and the perceived liability of morbid obesity. *International Journal of Obesity*, *15*, 577-579.
- Ravelli, G. P., Stein, Z. A., & Susser, M. W. (1976). Obesity in young men after famine exposure in utero and early infancy. *N Eng J Med*, *295*(7), 349-353.
- Reifsnnyder, P. C., Churchill, G., & Leiter, E. H. (2000). Maternal environment and genotype interact to establish diabetes in mice. *Genome Res*, *10*(10), 1568-1578.
- Ritz, S. J. (2006). The bariatric psychological evaluation: A heuristic for determining the suitability of the morbidly obese patient for weight loss surgery. *Bariatric Nursing and Surgical Patient Care*, *1*(2), 97-105.
- Rizzo, T. A., Corsaro, W. A., & Bates, J. E. (1992). Ethnographic methods and interpretive analysis: Expanding the methodological options of psychologists. *Developmental Review*, *12*, 101-123.
- Robert, H. B., & Gabriela L. (1991). Outcome of Gastric Surgery for Morbid Obesity: Weight Changes and Personality Traits. *Psychother Psychosom*, *56*, 146-156.
- Roberts, R. E., Kaplan, G. A., Shema, S. J., & Strawbridge, W. J. (2000). Are the Obese at Greater Risk for Depression? *American Journal of Epidemiology*, *152*(2), 163-170.
- Rodgers, C. S., Lang, A. J., Laffaye, C., Satz, L. E., Dresselhaus, T. R., & Stein, M. B. (2004). The impact of individual forms of childhood maltreatment on health behavior. *Child Abuse and Neglect*, *28*, 575-586.
- Roehling, M. V. (1999). Weight-based discrimination in employment: psychological and legal aspects. *Personnel Psychology*, *52*(4), 969-1017.
- Rogers, L. A. (1978). *Business Analysis for Marketing Managers*. London: Heinemann.
- Rorty, M., & Yager, J. (1996). *Speculations on the role of childhood abuse in the development of eating disorders among women* (M. F. Schwartz & L. Cohn, Eds.). New York: Brunner / Mazel, Inc.

- Ross, C. A. (1991). Epidemiology of multiple personality disorder and dissociation. *Psychiatry Clinics of North America*, 3, 503-517.
- Roth, S., Newman, E., Pelcovitz, D., Van der Kolk, B. A., & Mandel, F. (1997). Complex PTSD in victims exposed to sexual and physical abuse: Results from the DSM-IV field trial for posttraumatic stress disorder. *Journal of Traumatic Stress*, 10(4), 539-555.
- Rothblum, E. D., Miller, C. T., & Garbutt, B. (1988). Stereotypes of obese female job applicants. *International Journal of Eating Disorders*, 7(2), 277-283.
- Sansone, R. A., MacDonald, S., Wiederman, M. W., & Ferreira, K. (2007). Gastric bypass surgery: A survey of primary care physicians. *Eating Disorders*, 15, 145-152.
- Sarbin, T. R., & Kitsuse, J. I. (Eds.). (1994). *Constructing the social*. London: Sage.
- Sarwer, D. B. (2004). Psychiatric diagnoses and psychiatric treatment among bariatric candidates. *Obesity Surgery*, 14, 1148-1156.
- Sarwer, D. B., & Durlak, J. A. (1996). Childhood sexual abuse as a predictor of adult female sexual dysfunction: A study of couples seeking sex therapy. *Child Abuse Neglect*, 20(10), 963-972.
- Sarwer, D. B., & Thompson, J. K. (2002). Obesity and body image disturbance. In T. A. Wadden & A. J. Stunkard (Eds.), *Handbook of Obesity Treatment* (pp. 447-464). New York: Guilford Press.
- Sarwer, D. B., Fabricatore, A. N., & Wadden, T. A. (2006). The behavioral evaluation of bariatric surgery candidates. *Obesity Management*, June, 103-109.
- Saunders, R. (2001). Compulsive eating and gastric bypass surgery: What does hunger have to do with it? *Obesity Surgery*, 11, 757-761.
- Saunders, R., Johnson, L., & Teschner, J. (1998). Prevalence of eating disorders among bariatric surgery patients. *International Journal of Eating Disorders*, 6, 309-317.
- Scheeringa, M. S., & Zeanah, C. H. (1995). Symptom expression and trauma variables in children under 48 months of age. *Infant Mental Health Journal*, 16(4), 259-270.

- Schurink, E. M. (2000). Deciding to use a qualitative research approach. In A. S. de Vos (Ed.), *Research at grass roots: A primer for the caring professions* (pp. 239-251). Pretoria, South Africa: Van Schaik Publishers. (Original work published 1998)
- Schwartz, M. F., & Cohn, L. (1996). *Sexual abuse and eating disorders* (M. F. Schwartz & L. Cohn, Eds.). New York: Brunner/ Mazel, Inc.
- Schwarz, E., & Perry, B. (1994). The post-traumatic response in children and adolescents. *Psychiatric Clinics of North America*, 12(2), 311-326.
- Selway, J. S. (2006). Childhood maltreatment and adult obesity. *Bariatric Nursing and Surgical Patient Care*, 1(4), 273-282.
- Siegel, D. J. (1996). Cognition, memory and dissociation. *Child and Adolescent Psychiatric Clinics of North America*, 5(2), 509-536.
- Sogg, S., & Mori, D. L. (2004). The Boston Interview for Gastric Bypass: Determining the psychological suitability of surgical candidates. *Obesity Surgery*, 14, 370-380.
- Solovay, S. (2000). *Tipping the Scale of Injustice: Fighting Weight-Based Discrimination*. New York: Prometheus Books.
- Sorensen, T. I. A., & Stunkard, A. J. (1993). Does obesity run in families because of genes? *Acta Psychiatr Scand*, 370, 67-72.
- Spinazolla, J., Blaustein, M., Kisiel, C., & Van der Kolk B.A. (2001, May). *Further evidence for a complex adaptational response to traumatic life events*. Paper presented at the American Psychiatric Association Annual Meeting, New Orleans, USA.
- Stefaniak, T., Babinska, D., Trus, M., & Vingerhoets, A. (2007). The impact of history of sexual abuse on weight loss in gastric bypass patients. *Psychosomatics*, 48(3), 270-271.
- Steier, F. (Ed.). (1991). *Research and reflexivity*. London: Sage.
- Stillwell, B. M., Galvin, M., & Kopta, S. M. (1991). Conceptualization of conscience in normal children and adolescents, ages 5 to 17. *Journal of the American Academy of Child and Adolescent Psychiatry*, 30(1), 16-21.
- Strader, A. D., Vahl, T. P., Jandacek, R. J., Woods, S. C., D'Alessio, D. A., & Seeley, R. J. (2005). Weight loss through ileal transportation is accompanied by increased ileal

- hormone secretion and synthesis in rats. *Am J Physiol Endocrinol Metab*, 288(2), 447-453.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage Publications, Inc.
- Stunkard, A. J., & Costello, A. K. (2003). Two forms of disordered eating in obesity: Binge eating and night eating. *Journal of Obesity*, 27, 1-12.
- Tellis, W. (1997). Introduction to Case Study. *The Qualitative Report*, 3(2), 1-12.
- Terre Blanche, M., & Durrheim, K. (1999). Histories of the present: Social science research in context. In M. Terre Blanche & K. Durrheim (Eds.), *Research in practice: Applied methods for the social sciences* (pp. 1-16). Cape Town, South Africa: University of Cape Town Press.
- Thuan, J. F., & Avignon, A. (2005). Obesity management: Attitudes and practices of French general practitioners in a region of France. *International Journal of Obesity*, 29, 1100-1106.
- Treasure, J., & Collier, D. (2005). The biology of EDNOS. In C. Norring & B. Palmer (Eds.), *Eating Disorders Not Otherwise Specified* (pp. 161-185). New York: Routledge.
- Tremblay, A., Despres, J. P., & Bouchard, C. (1984). Adipose tissue characteristics of ex-obese long-distance runners. *International Journal of Obesity*, 8(6), 641-648.
- Tucker, J. A., Samo, J. A., Rand, C. S. W., & Woodard, E. R. (1991). Behavioral interventions to promote adaptive eating behavior and lifestyle changes following surgery for obesity: Results of a two-year outcome evaluation. *International Journal of Eating Disorders*, 10(6), 689-698.
- Vadlamudi, S., Kalhan, S. C., & Patel, M. S. (1995). Persistence of metabolic consequences in the progeny of rats fed a HC formula in their early postnatal life. *American Journal of Physiology*, 269, 731-738.
- Vallis, M. T., & Ross, M. A. (1993). The role of psychological factors in bariatric surgery for morbid obesity: Identification of psychological predictors of success. *Obesity Surgery*, 3, 346-359.

- Van der Kolk, B. A. (1996). The complexity of adaptation to trauma: Self-regulation, stimulus discrimination, and characterological development. In B. A. van der Kolk, A. McFarlane, & L. Weisaeth (Eds.), *Traumatic Stress: The Effects of Overwhelming Experiences on Mind, Body, and Society* (pp. 182-213). New York: Guilford Press.
- Van der Kolk, B. A. (2001). The assessment and treatment of Complex PTSD. In R. Yehuda (Ed.), *Traumatic Stress* New York: American Psychiatric Press.
- Van der Kolk, B. A., Pelcovitz, D., Roth, S. H., Mandel, F. S., McFarlane, A., & Herman, J. L. (1996). Dissociation, somatization, and affect dysregulation: The complexity of adaptation to trauma. *American Journal of Psychiatry*, *153*(7), 83-93.
- Van der Kolk, B. A., Roth, S., Pelcovitz, D., & Mandel, F. (1993). *Complex PTSD: Results of the PTSD Field Trial for DSM-IV* (4th ed., text rev.). Washington DC, USA: American Psychiatric Association.
- Van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorder of Extreme Stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress*, *18*(5), 389-399.
- Van der Kolk, B. A., Van der Hart, O., & Marmar, C. R. (1996). Dissociation and information processing in posttraumatic stress disorder. In B. A. van der Kolk, A. MacFarlane, & L. Weisaeth (Eds.), *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society* (pp. 303-327). New York: Guilford Press.
- Van Hanswijck de Jonge, P., Waller, G., Fiennes, A., Rashid, Z., & Lacey, J. H. (2003). Reported sexual abuse and cognitive content in the morbidly obese. *Eating Behaviors*, *4*, 315-322.
- Van Hout, G. C. M., Van Oudheusden, I., & Van Heck, G. L. (2004). Psychological Profile of the Morbidly Obese. *Obesity Surgery*, *14*, 579-588.
- Vanderlinden, J., & Vandereycken, W. (1996). Is sexual abuse a risk factor for developing an eating disorder? In M. F. Schwartz & L. Cohn (Eds.), *Sexual abuse and eating disorders* (pp. 17-22). New York, USA: Brunner / Mazel, Inc.

- Wadden, T. A., Anderson, D. A., Foster, G. D., Bennett, A., Steinberg, C., & Sarwer, D. B. (2000). Obese women's perceptions of their physicians' weight management attitudes and practices. *Arch Fam Med, 9*, 854-860.
- Walfish, S., & Brown, T. A. (2006). Patient expectations of weight loss from bariatric surgery. *Bariatric Nursing and Surgical Patient Care, 1*(3), 205-210.
- Waller, N. G., & Ross, C. A. (1997). The prevalence and biometric structure of pathological dissociation in the general population: Taxometric and behavior genetic findings. *Journal of Abnormal Psychology, 106*, 499-510.
- Weiner, E. J., & Stephens, L. (1996). Sexual barrier weight: A new approach. In M. F. Schwartz & L. Cohn (Eds.), *Sexual Abuse and Eating Disorders* (pp. 68-77). New York: Brunner / Mazel, Inc.
- West, D. B., Diaz, J., & Woods, S. C. (1982). Infant gastrostomy and chronic formula infusion as a technique to overfeed and accelerate weight gain of neonatal rats. *J Nutr, 112*(7), 1339-1343.
- White, M. A., Masheb, R. M., Rothschild, B. S., Burke-Martindale, C. H., & Grilo, C. M. (2006). The prognostic significance of regular binge eating in extreme obese gastric bypass patients: 12-Month postoperative outcomes. *Journal of Clinical Psychiatry, 67*(12), 1928-1935.
- Wiederman, M. W., Sansone, R. A., & Sansone, L. A. (1999). Obesity among sexually abused woman: An adaptive function for some? *Women Health, 29*(1), 89-100.
- Wilfley, D. E., Friedman, M. A., Douchis, J. Z., Stein, R. I., Welch, R. R., & Ball, S. A. (2000). Comorbid psychopathology in Binge Eating Disorder: Relation to eating disorder severity at baseline and following treatment. *Journal of Consulting and Clinical Psychology, 68*(4), 641-649.
- Williamson, D. F., Thompson, T. J., Anda, R. F., Dietz, W. H., & Felitti, V. (2002). Body weight and obesity in adults and self-reported abuse in childhood. *Int J Obes Relat Metab Disord, 26*, 1075-1082.

- Wilson, S., Van der Kolk, B. A., Burbridge, J., Fisler, R., & Kradin, R. (1999). Phenotype of blood lymphocytes in PTSD suggests chronic immune activation. *Psychosomatics*, *40*(3), 222-225.
- Wolfe, V. V., Gentile, C., & Wolfe, D. A. (1989). The impact of sexual abuse on children: A PTSD formulation. *Behavior Therapy*, *20*, 215-228.
- Wonderlich, S. A., Crosby, R. D., Mitchell, J. E., Roberts, J. A., Haseltine, B., DeMuth, G., et al. (2000). Relationship of childhood sexual abuse and eating disturbances in children. *J Am Acad Child Adolesc Psychiatry*, *39*, 1277-1283.
- World Health Organization. (1992). *the ICD-10 Classification of Mental and Behavioral Disorders: Clinical Descriptions and Guidelines*. Geneva, Switzerland: WHO.
- World Health Organization. (2004). Appropriate body-mass index for Asian populations and its implications for policy and intervention strategies. *Lancet*, *10*(363 (9403)), 157-163.
- Yehuda, R. (1995). Low urinary cortisol excretion in Holocaust survivors with posttraumatic stress disorder. *American Journal of Psychiatry*, *152*, 982-986.
- Yehuda, R. (1999). Linking the neuroendocrinology of post-traumatic stress disorder with recent neuroanatomic findings. *Seminars in Clinical Neuropsychiatry*, *4*(4), 256-265.
- Yehuda, R. (2001). Biology of posttraumatic stress disorder. *Journal of Clinical Psychiatry*, *62*, 41-46.
- Yehuda, R., Southwick, S. M., Mason, J. W., & Giller, E. L. (1990). Interactions of the hypothalamic- pituitary-adrenal axis and the catecholaminergic system of the stress disorder. In E. D. Giller (Ed.), *Biological Assessment and Treatment of PTSD* Washington DC, USA: American Psychiatric Press.
- Zhang, Q., & Wang, Y. (2004). Socioeconomic inequality of obesity in the United States: Do gender, age, and ethnicity matter? *Social Science & Medicine*, *58*, 1171-1180.

Appendix A

Participant consent form

Participant Consent Form

Dear Participant: _____

Thank you for agreeing to participate in this research. Your willingness is greatly appreciated.

As this research involves a personal contribution from you as an individual, the Consent Form's function is to give you an awareness of the likely content of the evaluation (interview and psychometric testing) as well as delineating your rights. Should there be something you do not fully understand, please do not hesitate to ask questions.

Purposes and Functions of Research:

We request that you participate in a semi-structured interview and complete some psychometric tests. This is to identify themes and insights into the lived experiences after bariatric surgery. This information will form the research portion of a Doctorate Thesis in Psychology at the University of South Africa (UNISA). However, this information may be used in further academic papers within the field of Psychology.

Risks Involved

The interview is expected to deal with disturbing or painful emotional issues. As a result, the researcher will leave his contact number with you, so that further counselling can be arranged, if you so desire. One week after the evaluation has been completed, the researcher will also contact you to enquire as to whether you need debriefing or counselling. These measures have been designed to protect you from possible painful consequences of the research itself.

Right to Participate

You as an individual have the right not to participate. No ramifications of this possible decision of yours will ensue. You have the right to request that the evaluation be terminated and that the content be erased both during and after the evaluation.

Anonymity

You, as a participant, will remain anonymous in the published paper(s). A pseudonym will be used instead of your name, and all identifying details will be erased or hidden.

Dissemination

The information gained during the course of this evaluation may be transcribed and utilised in a doctoral thesis at UNISA. It will be available at the UNISA library and available on request at other academic libraries. No monetary or other award (aside from academic award) will be gained by either this researcher or yourself as participant, as a result of this research.

Once again, your cooperation is greatly valued. It is hoped that the insights gained from your experiences of bariatric surgery will benefit others.

Yours sincerely

Hermann Liebenberg (Contact number: 0824161324)
(Researcher)

I, _____ understand what is required of me and hereby give consent to conduct and publish this evaluation as stipulated in the above form.
