Bachelor Thesis

A Qualitative Research regarding the Integration of Self-Compassion Interventions in Traditional Treatment -

The Needs and Preferences of Anorexia Nervosa Patients

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Abstract

Objective. Anorexia Nervosa (AN) displays the highest mortality rate compared with other mental disorders. Especially in the long-term, the treatment of AN lacks in patient satisfaction and effectivity. One possible extension to the traditional treatment is the positive psychology. Self-compassion is a concept underlying this approach and is defined as being kind, understanding, and nonjudgmental toward oneself. Due to the fact that AN-patients suffer from high self-criticism and negative self-images, self-compassion exercises might be suitable supplementations to the traditional treatment. The purpose of this bachelor thesis is to investigate in the needs and preferences of AN-patients regarding the integration of a self-compassion intervention in traditional treatment. Key focuses included the experiences with self-compassion, appealing to the concept of self-compassion, and participants' perspectives concerning a future integration of self-compassion interventions in treatment.

Methods. An explorative, qualitative research design was used to answer the research question. With the means of a self-compassion exercise, the concept was presented to the participants. An anonymous online questionnaire, consisting of qualitative and quantitative questions, was used to investigate in participants' perspectives and attitudes towards the concept of self-compassion. The questionnaire contains four topics: (1) background of participants, (2) experiences with self-compassion, (3) appealing to the concept of self-compassion, and (4) perspectives regarding the integration of self-compassion in traditional treatment. In total 16 participants completed the questionnaire. The analysis was done by two independent coders, using a deductive and inductive approach.

Results. The concept of self-compassion is already familiar to the majority of the participants. Whereby some participants had no experiences other faced the concept during treatment or outside clinical settings. The concept of self-compassion is mainly evaluated as positive and expected positive effects, like an increase of self-acceptance and self-kindness, are mentioned. Negative aspects are a very theoretical and difficult upset, a need for guidance and a too long explanation of the concept. Openness for future usage is present by the participants. To a great extent, the integration is supported. In addition, anorexics are part of the target group of practicing self-compassion. No consensus regarding the appropriate date and kind of usage as a part of treatment is found.

Conclusion. This study is novel in establishing the needs regarding the integration of self-compassion in traditional treatment by those affected. The far majority of the participants appreciated the concept of self-compassion. Findings indicate that self-compassion is suitable for AN-treatment. Important information about the needs and preferences regarding a future integration were discussed. Nevertheless, additional experimental research is required to make statements about the effectivity of self-compassion in AN-treatment. Limitations, based upon a revised research method, were mentioned and recommendations for future research were discovered.

Keywords: Self-Compassion, Positive Psychology, Anorexia-Nervosa, Needs, Preferences, Integration, Traditional Treatment

Table of Contents

1. Introduction

In previous years an increase in eating disorders, especially in Western societies, is mentioned (Davey, 2014). According to research by Albertson, Neff, and Dill-Shackleford (2014) women, living in western cultures, are taught that physical beauty is one of the most important characteristics of societal status. Particularly thin physical appearance is valued, whereby thinness is linked to desirable personality characteristics, power, and happiness (Ferreira, Pinto-Gouveia, & Duarte, 2013). In addition, a person's self-image highly depends on fulfilling ideals. Therefore, the self-evaluation of the body gets a central role in everyday life and controlling it, for instance by dieting, is a common strategy to get valued and accepted by others (Morrison, Kalin, & Morrison, 2004).

Although, societal standards are no new phenomena - "today's culture is unique in that the media (including television, internet, movies, and print) is a far more powerful presence than ever before." (Derenne & Beresin, 2006, p. 257). The media, including social network sites, support the broadening of unnatural appearances. Additionally, the increased availability of plastic surgery covered in fashion magazines confronts girls and boys regularly with unrealistic expectations. In the last 10 years, children have been grown up with models which are 23% thinner than the average woman (Derenne & Beresin, 2006). In Germany, one-third of the female population develop Anorexia Nervosa (AN), Bulimia Nervosa (BN) or Binge Eating Disorder (BED) (Konrad, 2017). According to this societal issue and the accompanying raising prevalence, the ongoing development of eating disorder treatment is essential (Zipfel, Giel, Bulik, Hay, & Schmidt, 2015). In the following, existing treatment of eating disorders are assessed and possible supplementations to the traditional treatment are examined.

1.1. Anorexia Nervosa

AN is an eating disorder with a significantly elevated mortality rate compared to other eating disorders. A meta-analysis of 35 published studies shows a crude AN mortality rate of 5.1 deaths per 1000 person per year. In other words, approximately 0.51% of people with AN worldwide die each year. Whereas one in five individuals who died committed suicide (Smink, Van Hoeken, & Hoek, 2012). The lifetime prevalence rate of AN is 0.9%. Moreover, AN is relatively common among females as they are ten times more afflicted than males (Davey, 2014). Especially within the high-risk group of 15-19-year-old girls, the prevalence rate can jump up to 1.7% (Smink et al., 2012).

In general, "AN is suggested to function as a way of regaining control of psychobiological maturing or as a self-punishing defense when fearing lack of control" (Nordbø et al., 2006, p. 554). According to the criteria of The Diagnostic and Statistical Manual for Mental Disorders, fifth edition (DSM-5) AN is characterized by a refusal to maintain a minimal body weight, a pathological fear of gaining weight, and a disturbed body image (Davey, 2014). Anorexics could be described as being obsessive and rigid, perfectionists, preferring the familiar, having a high need for approval, showing emotional restraint and poor adaptability to change (Slyter, 2012).

Those affected suffer from psychological and physical symptoms. One psychological symptom is a destroyed body image and means a disturbance in the way in which someone experiences his own body shape or weight. The result is a negative self-evaluation, which is called body dissatisfaction, denoted by low self-esteem and body shame (Hartmann, Thomas, Greenberg, Rosenfield, & Wilhelm, 2012). Besides, anorexics show a high degree of self-criticism attended by self-punishment and self-destructive rumination (Davey, 2014). The self-critical thinking appears in persistent behavior that interferes with weight gain, for example, dieting and excessively exercising. Harsh actions of self-starvation are chosen to deal with the destroyed body image and the unreachable value of thinness (Kezelman et al., 2018).

Physical symptoms are often life-threatening and caused by an undernutrition. Common physical symptoms are the absence of menstruation, hypotension, chronic tiredness, and/or hypothermic (Davey, 2014). Emotional symptoms express in psychological distress, including mood disturbance or anxiety symptoms (Kristeller, Baer, & Quillian-Wolever, 2006). AN is not only associated with serious medical morbidity, but also with psychiatric comorbidity. Mainly anxiety disorders, as obsessive-compulsive disorder (OCD) or social phobia are highly common in AN. In a study from 2004, Kaye and colleagues show that OCD occurred in 40% and social phobia in 20% of 672 individuals (with AN, BN, or AN and BN). Another common mental disorder found in anorexics is depression. Studies indicated comorbidity prevalence of major depression in AN which ranged from 36% to 81% (Herzog, Keller, Sacks, Yeh, & Lavori, 1992). Considering AN is a dangerous and complex eating disorder, tailored and sustainable treatment of those affected is essential.

1.2. Traditional Treatment of Anorexia Nervosa

Eating disorders, like AN, are eclectic and difficult to treat. Likewise, individuals with AN frequently deny their pathologically underweight and the view of controlled eating as a way

of coping with psychopathology. Owing to this fact, approximately 50% of people with AN do not undergo treatment (Zipfel et al., 2015).

Primary pharmacological treatment for AN does not exist but is rather used as a treatment for coexisting disorders (Davey, 2014.) Medical treatment is only used in life-threating situations based on starvation, like nutritional rehabilitation by the means of gavage feeding (Kezelman et al., 2018). Psychological treatment is applied more often whereby the most widely researched treatments of AN and other eating disorders are the Family-Based Treatment (FBT) as well as Cognitive Behavioral Therapy (CBT) (Fairburn, 2005).

FBT is a departure from traditional therapy which focuses on an expanding treatment into individuals' home. FBT is mainly used for adolescents and empowers the parents to help their child (Fairburn, Cooper, & Sharfran, 2003). By providing family members with skills and resources, they are actively involved in the recovery process outside the clinical setting. FBT addresses three different aspects (1) involving family members in refeeding the adolescent, (2) focusing on new patterns of family relationships, and (3) supporting the patients during adolescent development (Sim, Sadowski, Whiteside, & Wells, 2004). Research indicated that adolescents who received FBT recover at higher rates, compared to patients who received individual therapy. Nevertheless, FBT is not suitable for every family and long-term patients benefit less from this approach (Loeb, Le Grange, & Lock, 2015).

As another approach, CBT is the most used psychological treatment of adults and refers to challenging and neutralizing dysfunctional thoughts (Fairburn et al., 2003). CBT for eating disorders addresses three main aspects: (1) the distinct eating behavior itself (2) the dysfunctional beliefs regarding body and food (3) the dysfunctional self-concept (Davey, 2014). CBT focuses on the overvaluation of eating as well as the abnormal self-perception. Body shaming and the extreme weight-control behavior is of primary importance in maintaining the disorder. By giving strategies to change cognitive and behavioral patterns, CBT helps the patients to recover. Normally one therapy involves about 15–20 sessions over approximately five months (Fairburn et al., 2003). To some extent, patients responded well to CBT. Fairburn and colleagues (2009) found a reduction of eating disorder symptoms after 20 weeks of CBT treatment. However, only 30% of AN-patients who receive CBT treatment achieve full recovery anyway, whereby the highest risk of relapse is during the first year after treatment (Carter, Blackmore, Sutandar-Pinnock, & Woodside, 2004; Zipfel et., 2015). Moreover, one-half of AN-patients abandon their treatment (Nordbø et al., 2005). It appears that current treatment is deficient in effectivity and appealing. This gives rise to adjust existing treatment approaches.

1.2. Positive psychological interventions

One supplementation to the traditional treatment might be the positive psychological approach. Compared with the traditional psychopathology, positive psychology focuses on individual strengths and talents rather than complaints and symptoms. This approach predicts a decline of psychopathology through improving a patient's well-being and self-confidence (Seligman & Csikszentmihalyi, 2000; Duckworth, Steen, & Seligman, 2005). This means a discovery, development, and expansion of personal strengths result in positive emotions, behavior, and experiences (Sin & Lyubomirsky, 2009). The balance between positive and negative emotions determine a person's subjective well-being (Fredrickson, 2004). Only a high level of subjective well-being can cause personal flourishing as well as self-actualization and life satisfaction. The goal of positive psychology is not the replacement of conventional treating methods but rather an adjustment and improvement of those. Current research indicated four possible reasons why the positive psychology should complement the traditional treatment of eating disorders: (1) Patients might find the positive approach more appealing, which improve adherence to treatment of those who have started (Cohn & Fredrickson, 2010) (2) Negative complaints could be reduced (Seligman & Csikszentmihalyi, 2000), (3) Relapse in old behavior patterns could be avoided (Steck, Abrams, & Phelps, 2004), and (4) Patient's quality of life could be enhanced (Steck et al., 2004).

A broad range of positive psychological interventions (PPIs) are already implemented in clinical settings. Almost every PPI is based on the Broaden-and-Built Theory of Positive Emotions (Fredrickson, 2004). According to this theory, positive emotions have a broadening effect on a person's thoughts and actions. If someone feels positive emotions, such as love, joy, gratitude and pride, the field of attention increases. On the basis of this broadening, more perspectives and possible actions come to mind. Subsequently, these perspectives and actions build important and continuous physical, intellectual, psychological and social resources. These resources get trained and become habits. Summarizing, positive emotions cause new strategies of action which improve a person's resilience (Fredrickson, 2004).

PPIs affect two different dimensions to improve people's state of health. On the one hand, positive emotions increase a persons' subjective well-being which results in life satisfaction and flourishing. On the other hand, psychological distress decreases which means that pathology and negative symptoms decline in frequency. This is in line with the two-continua model of mental health which states that health is not only the absence of symptoms but rather a high degree of well-being and low degree of distress (Westerhof & Keyes, 2010).

On account of these positive effects, PPIs are nowadays increasingly used in treating mental disorders.

1.4. Self-compassion

Self-compassion is one domain of positive psychology and means treating oneself like a close friend with kindness, gentleness, and understanding. Neff (2003a) defined self-compassion through three interconnected components: self-kindness, common humanity, and mindfulness. First, self-kindness is the tendency to be understanding and caring toward the self, instead of being critical and judgmental, as many people tend to be harsh and critical towards themselves when they suffer, fail, or feel inadequate (Neff & Germer, 2013). Moreover, self-kindness expresses itself in unconditional acceptance regarding the own body, rather than attacking personal shortcomings. The second component is common humanity, which refers to the recognition that the human condition is imperfect and that all people suffer at a certain point in life. That is to say, being aware of the fact that human beings are making mistakes instead of feeling isolated by the experiences of imperfections. Moreover, people with low self-compassion tend to have a tunnel vision of the own imperfection. When considering failures and thinking about the personal struggle, they often feel isolated and cut off (Neff & Germer, 2013). Finally, the third component of self-compassion is mindfulness and means being aware of one's painful experiences in an accepting and nonjudgmental way (Albertson et al., 2014; Neff, 2003a). Mindfulness is a way of paying attention to what is happening right now, by observing of what is going on inside (feelings, thoughts) and outside (environment) with an open, curious mind and without judgment. Mindfulness is a component of human consciousness and a mental capacity (Grossman, Niemann, Schmidt, & Wallach, 2004).

A compassionate interaction with oneself implicates benefits. Previous research has focused on these positive effects. First of all, Barnard and Curry (2011) reported that greater self-compassion is linked to less psychopathology. Among other, they found evidence that self-compassion is negatively correlated with anxiety and depression. This means that self-compassion is helpful in reducing and preventing psychopathology and psychological distress. For instance, Mill, Gilbert, Bellew, McEwan, and Gale (2009) gave 131 students a series of scales measuring, including a self-compassion scale, developed by Neff and a depression scale, developed by Radloff. Negative factors of the self-compassion scale were highly correlated with depression, while the positive factors of the self-compassion scale were negatively correlated with depression (Mill et al., 2009, Barnard & Curry, 2011). To sum up,

self-compassion is stated as beneficial in decreasing depression and anxiety. Nevertheless, the benefits and suitability of self-compassion interventions for AN had not been studied, yet.

Besides a diminishing pathology, self-compassion is also linked to an increase of positive emotions and being consequently beneficial for subjective well-being. According to Neff (2011), self-compassion leads to positive emotions towards the self. This means a positive image which results in greater emotional stability. Self-compassionate people are less afraid of imperfections and tend to have a higher level of self-forgiveness. Current research states that individuals with higher self-compassion demonstrate fewer extreme emotional reactions, less negative emotions, and more acceptance, in short, higher (emotional) resilience when dealing with negative life events (Albertson et al., 2014). Taken all, self-compassion does not only protect against psychological distress but promotes health and well-being which makes a high amount of self-compassion valuable for treated and non-treated persons (Gilbert, 2005; Neff, 2003a).

Self-compassion is trainable, and training increases not only self-kindness, common humanity, and mindfulness but simultaneously declines self-judgment, isolation, and over-identification (Neff & Germer, 2013). Due to the benefits of self-compassion, it seems to be a tempting mechanism in different forms of psychological treatment. Certain self-compassion interventions as the "self-compassion break exercise" developed by Neff are already implemented in therapy. Furthermore, Gilbert (2005) developed the Compassion Focused Therapy (CFT) which helps self-critical, shame-prone individuals enhancing their self-compassion. CFT is built upon the fact that individuals high in shame and-self-criticism struggle to generate affiliative, warm feelings towards the self. Therefore, it is important to acquire self-compassion strategies (Gilbert, 2010).

1.5. Self-Compassion and Anorexia Nervosa

Anorexics suffer from low self-compassion. They are highly self-critical against their own body (Davey, 2014). Self-compassion can have a positive effect on the patient's well-being and psychological distress to improve mental health. Although sufficient research regarding self-compassion interventions for AN-patients does not exist, research has given some evidence for positive effects of self-compassion in other eating disorders as BED. For example, a pilot study by Kelly and Carter (2015) indicated that exercises that focus on self-compassion may be an effective treatment approach for BED. In this study, a brief CFT-based self-help intervention and a CBT behaviorally based self-help intervention were compared. Individuals with BED practiced one of the two interventions over 2-3 weeks. Kelly and Carter

(2015) showed that improvement in self-compassion reduced the global eating disorder pathology, weight concerns, and eating concerns more than the behavioral strategies and control condition. Although Kelly and Carter showed the effectivity of a self-compassion intervention for BED, patients personal experiences with the intervention was not examined. The involvement of patients' needs and preferences is rather essential to ensure a tailored supplement to the traditional treatment.

Another study by Ferreira and colleges (2013) indicated a beneficial effect of self-compassion for people with eating disorders. This cross-sectional study comprised two samples: 102 female eating disorders' patients and 123 women from the general population. They note that a higher level of self-compassion is linked to a lower level of body dissatisfaction and lower engagement in disordered eating patterns. Regression analyses reveal that self-compassion partially mediated the effect of external shame on a drive for thinness. While this study has indicated that self-compassion could help to break the negative cycle of shame and body dissatisfaction, the patient's perspective of the concept itself has not yet been examined.

This explorative research focuses on perspectives regarding a possible long-lasting supplement to the traditional treatment of AN and therefore addresses the deficiencies in research. By transferring these results, it is expected that self-compassion training will also reduce AN-patients' negative emotions and body dissatisfaction. Due to the fact that existing research mainly focuses on BED, it will be interesting to assess the utility of self-compassion training in AN-treatment. As aforementioned, the treatment of AN should be expanded to improve patient satisfaction and the recovery process. Studies show that self-compassion interventions can be a valuable contribution to the traditional treatment. To examine whether a self-compassion intervention might also be a valuable contribution to the treatment of AN, it is important to look into the needs and preferences of those affected. Before implementing self-compassion exercises in existing treatment, it is essential to consider the openness to this intervention by affected people. This study examined whether self-compassion exercises connect well to the needs of AN-patients. Subsequently, the research question is: *What are the needs and preferences of AN-patients regarding a self-compassion intervention?* To answer the research question three sub-questions were formulated:

1. *What are the participants' experiences and associations with self-compassion?*
2. *To what extent does the concept of self-compassion appeal to the needs and preferences of the participants?*

3. *What do the participants think of an integration of self-compassion in the treatment of AN?*

2. Method

To gain insights into the needs and preferences of AN-patients regarding self-compassion interventions a qualitative, explorative research-design was used. Originally, an in-depth, face-to-face interview with (ex) AN-patients was planned. A newsletter was posted on the online platform from Human Concern. Thereby, (ex) AN-patients were invited to take part in this study. In addition, the researchers inquired about acquittances as possible interview partners. Alternatively, the interview would have been held via telephone. However, the recruitment faced difficulties. Despite an intensive advertising for the study, no participant reacted to the newsletter. As an alternative method, an online questionnaire which guaranteed full anonymity was developed. Moreover, the target group was extended to people with deviant eating behavior. In this study, a deviant eating behavior is defined as an excessive sportive activity, continuous dieting, lack of appetite, imbalanced nutrition, and/or overeating. The research was approved by the Ethics Committee Faculty of Behavioral Science of the University of Twente.

2.1. Participants

The inclusion criteria of participation were that (1) participants have/had personal experiences with a deviant eating behavior and that (2) participants were 18 years or older. Both participants who received a diagnosis and treatment, as well as participants who were not treated, could participate in this study.

The recruitment of the participants took place in three different ways. First, participants were recruited by purposive convenience sampling and snowball sampling. The sampling procedure implies that the participants were recruited by virtue of the researcher's network. Partaken participants were asked to recruit further participants from among their acquaintances. Second, the recruitment took place by the means of clinical specialists. Information about the study, a newsletter (Appendix A), and the link to the online questionnaire were sent to clinical specialists who were asked to distribute the study. The newsletter was published on two well-known Dutch online platforms: proud2beme and human concern. In the third place, the newsletter and the online-link were published on the test-subject pool system (SONA systems) of the University of Twente. All people who met

the inclusion criteria and who showed interest in the study received the link to the questionnaire as well as a self-compassion exercise.

In total, 99 people opened the link to the online questionnaire. Nevertheless, only 16 participants (M_{age}= 25.75 years; *SD* = 10.36; 15 females; 1 male) completed the questionnaire fully. Demographic characteristics are presented in Table 1. The relationship between the researcher and the participants were mostly not personal. In the cases of personal relationship, it was guaranteed that no dependent or subordinate position between the parties existed.

Table 1

Participant Characteristics

Participant Number	Gender	Age	Education	Kind of Deviant Eating Behavior	Undergoing Treatment (Duration)
1	Male	22	Middle	AN	Yes (6 months)
2	Female	22	High	AN	Yes (3 years)
3	Female	25	Middle	BEG	No
4	Female	22	Middle	AN	No
5	Female	23	Low	BN	Yes (around 5 years)
6	Female	42	High	EDNOS	No
7	Female	19	Middle	EDNOS	No
8	Female	23	Middle	BN	No
9	Female	55	High	BEG	No
10	Female	23	Middle	BEG	No
11	Female	39	High	BN	Yes (1 year)
12	Female	19	Middle	EDNOS	No
13	Female	20	Middle	BEG	No
14	Female	20	Middle	BEG	No
15	Female	19	Middle	AN	No
16	Female	19	Middle	BEG	No

Note. AN = Anorexia Nervosa; BN =Bulimia Nervosa, BEG= Binge Eating Disorder, EDNOS= Eating Disorder Not Otherwise Specified; Low = Middle School; Middle = High School, Vocational Training; High = University of applied science degree, Bachelor's degree, Master's degree

2.2. Materials

Two different domains of positive psychology, namely self-compassion and strength enhancement were presented to the participants in the form of respectively one exercise. The exercises developed by Bohlmeijer and Hulsbergen (2013) were illustrations of each positive psychological concept. Participants were asked to read the example exercises. With the means of the anonymous online questionnaire, participants evaluated their needs and preferences regarding the concepts.

This study focused only on the concept of self-compassion and therefore solely the self-compassion exercise (Appendix C) is relevant. The self-compassion exercise was

originally written in Dutch but was translated into German as well. The exercise contains the following content: In the beginning, the model of the emotional regulation system from Paul Gilbert, which is also used in CFT, (Gilbert, 2014) was described. The model claims that human beings can be in states of 'threat' (focused on dangers), 'drive' (with a mindset attuned towards achievement or competition), or 'soothing' (which promotes safeness and feelings of interpersonal connectedness). Each of these systems is associated with distinct emotions and an unbalanced use of one or more systems lead to dysfunctions. Following, the three components of self-compassion (self-kindness, common humanity, and mindfulness) by Neff were explained. In the end, the exercise gives some tips to stop self-criticism. Some example tips are: "*Notice what you say to yourself. Would you also say these things to a good friend?"* and *"It is impossible to suppress thoughts. This applies also to self-critical thoughts. You can give yourself a playful advice when a critical thought arises, for example by saying very loudly and with a smile to yourself: "Stop it!" See also the video on YouTube from stand-up comedian Bob Newhart - stop it."*

The online questionnaire contained both qualitative (open-ended) and quantitative (closed-ended) questions. Answers to open-ended questions are preferable because they contain usually more "richer" data by inviting the participants to express their own opinion (Lang & van der Molen, 2012). Several closed questions, mainly in the form of Likert-scale questions, were chosen to minimize the workload of the participants. Moreover, this kind of questions gave the study a more quantitate value. The online questionnaire was drawn up with Qualtrics Survey Software. After establishing the survey, the setup and content of the questionnaire were evaluated and revised by the means of two experts. The questionnaire was formulated in Dutch and German language to maximize the dissemination of the questionnaire. All of the selected questions are directed to personal perspectives and experiences, which can be best described by a narrative approach. The online questionnaire (Appendix B) contained four topics: (1) Background, (2) Experiences and associations with self-compassion, (3) Appealing to the concept of self-compassion, and (4) Integration of self-compassion intervention in traditional treatment (see Table 2).

Table 2.

The Content of the Questionnaire Divided into four Topics

Topic	Content
Background	Gender (2)
	Age (2)
	Education (2)

	Kind of deviant eating behavior (2)
	Experiences with treatment (2)
	Duration of treatment (2)
Experiences with self-compassion	Prior knowledge of self-compassion (1)
	Definition of self-compassion (1)
	Associations with self-compassion (1) Experiences with self-compassion in treatment (1)
Appealing to the concept of self-compassion	First impression, (2)
	Positive judgments (1)
	Negative judgments (1)
	Attitude towards the future usage of self-compassion (2)
	Improvements for exercise (1)
	Appropriate for Eating Disorders (1), (2)
	Appropriate for Anorexia Nervosa (1), (2)
Integration of self-compassion intervention in the traditional treatment	Integration useful or not (1), (2)
	For who recommended (target group) (1), (2)
	When to use (moment, duration) (1)
	How to use (manner) (1)

Note. (1) = qualitative question (open-ended), (2) = quantitative question (closed)

The first topic contained questions about the background of the participants. Demographical questions concerning gender, age, and education were asked. Moreover, the participants received questions about their deviant eating behavior, possible treatment experiences and if applicable the duration of the treatment. Within this topic, only quantitative questions were used.

Topic two contained questions about the experiences and associations with self-compassion. These questions focused on participants' past experiences and prior knowledge about the concept. The personal definition of self-compassion was asked. Moreover, the participants should give associations of the concept. Participants were asked about past experiences with self-compassion in treatment. Questions like "*Did you encounter the concept of self-compassion in your treatment? So, yes, where?"* and *"What does the term self-compassion mean to you?"* were used to get insight in participants prior knowledge.

Part three included the appealing to the concept of self-compassion. Participants were asked about first impressions, positive and negative aspects of the concept, possible improvements and their openness towards the future usage of self-compassion. Questions like "*What did you find positive, important or meaningful to this exercise?*" or "*What did you find negative, unpleasant, or bad to this exercise*?" were displayed. In addition, participants were asked about the appropriability of self-compassion interventions in the light of AN. A quantitative question where participants answered on a five-point Likert scale (1=totally

inappropriate, […] 5=totally appropriate) was displayed within this topic: "*How appropriate do you judge this kind of exercise for Anorexia Nervosa patients?"*.

The fourth topic was related to the integration of self-compassion intervention in the treatment of AN. This topic referred to the future usage of the exercise. Participants were asked about the usefulness of an integration. These questions focused on a possible future adjustment of current treatment. Also, participants were asked whether the self-compassion exercise is recommended to people with eating disorders and for whom the exercise is less recommended. They were asked about the manner and duration of usage. Finally, participants were asked to describe an ideal therapy. Some example questions of this topic are: *"Could you imagine using this exercise in your everyday life (in the future)? (why / why not)",* "*Which people would you recommend this exercise less?", "What do you think about the integration of self-compassion exercises in the traditional treatment of eating disorders?"* and *"How does the ideal therapy look like for you?"*

2.3. Procedure

The duration of completing the questionnaire was at shortest 11 minutes and at longest 130 minutes ($M_{Duration}$ = 44.44 minutes, SD = 29). In this study, the following procedure was passed through. At first, participants received an invitation letter, a self-compassion exercise, and the link to the online questionnaire via e-mail. When the participants opened the online questionnaire, a written introduction was shown. This introduction contained the goal and background of the study as well as the procedure and duration of the questionnaire. In addition, the participants received the email addresses of the researchers to ask questions if necessary. Second, the informed consent was displayed. Information about participants' anonymity and that personal data will not be given to third parties were mentioned. The participants were told that they are able to stop the study at any time without stating any reason. After confirming the informed consent, the actual questionnaire was started. In the beginning, participants were asked general questions about their eating behavior. Then the participants were asked to read the self-compassion exercises. Next, the participants were asked to answer questions regarding (1) their experiences and associations with self-compassion, (2) the appealing to the concept of self-compassion, and (3) the integration of self-compassion in traditional treatment. The participants were allowed to use keywords instead of full sentences to answer the questions. Afterwards, the demographical questions were displayed. Finally, a closing text, where the participants were thanked, was shown. In addition, the participants were asked to recruit acquaintances. The email addresses of the

researcher were mentioned again to allow participants to ask questions or to give any comments.

2.4. Analysis

The answers to the online questionnaire were analyzed by the means of two coders. First, the researchers read and reread the answers to get familiar with the content. To ensure confidentiality, personal details as names, dates, and locations from the answers were anonymized. The coding procedure was done by means of the coding software ATLAS.ti.8.2.3. Based upon the suitability to answer the three sub-questions three relevant categories were selected to build a preliminary framework. Relevant categories were: (1) Experiences and associations with self-compassion, (2) Appealing to the concept of self-compassion, and (3) Integration of self-compassion in traditional treatment. Relevant text fragments were allocated to one of the three categories, using a deductive approach. Subsequently, the divided text fragments got analysis and classified in subcategories. Each subcategory contains one specific theme. This classification was done by an iterative process whereby an inductive analysis and constant comparison were applied. Initially, the researchers made up a common concept code scheme based on the questionnaires of four participants. The units of analysis were phrases which give information about the content. Codes were created by formulating labels which best covers the meaning of the quotes. Afterward, every researcher coded six questionnaires individually. The coded questionnaires were exchanged and verified for consistency between the coders. When consensus between the coders regarding the established subcategories was met, the concept scheme got revised and negotiated. Then, the final code scheme (Appendix D) was applied to the data. During the coding process, it became clear that no saturation point could be reached. New codes emerged regularly and a broad range within the answers was detected. The amount of the codes was evaluated and summarized.

3. Results

To answer the research question what the needs and preferences of AN-patients regarding a self-compassion intervention are, three sub-questions were formulated. In the following, participants' answers on the online questionnaire will be discussed. Overall, the quality of participants' responses varied. Whereas several participants gave very detailed and concrete answers, others answered with short phrases or a single word.

3.1. Experiences and Associations with Self-Compassion

To answer the first sub-question, "*What are the participants' experiences and associations with self-compassion?"* the definition of the term and the kind of experiences with self-compassion were analyzed. Table 3 gives an overview of the themes identified by the researchers. In the paragraph below the main findings will be discussed.

Table 3

Participants Experiences and Associations with Self Compassion

Code	Theme	Amount Theme	Example quotes
Definition of self-compassion			
	Self-acceptance	11	**P4**:" To *have respect for myself - also for my body."*
	Self-kindness	11	**P2***:" Trying to be nice to yourself."*
	Acceptance of own imperfection	4	**P10:** *"Be aware that it is ok if you are not perfect."*
	Mindfulness	3	**P15:** *"Recognize if I don't feel well and allow the feeling."*
	Self-confidence	2	**P17***: "Being self-confident."*
Existing Experiences with self-compassion			
	No experiences	3	**P12**: *"Most do not practice that."*
	Experiences within therapy	4	**P1**: "*In therapy sessions, it was an important topic (especially when asked: why am I eating disturbed?)*
	Experiences outside therapy	1	**P11**: "*Kinesiology. Only when things are going well, the rest are doing well too."*

Note. Amount Theme = Number of participants who mentioned the theme

Definition of Self-Compassion. To get an insight into participants' prior knowledge about self-compassion it is important to estimate how the participants define the concept. The code definition of self-compassion contains the explanations of and associations with the concept itself. In total five different themes were established. First, it seems that the majority (N= 11) of the participants associated self-acceptance and self-kindness with self-compassion. Respect and treating oneself like a good friend were especially important. *"That I take care of myself like a good friend. So that I accept and respect myself as I am and that I can make mistakes too*." (P5, 23, female, BN, treated). Acceptance and love towards the body were frequently mentioned by the participants. *"That I accept and like myself and especially my body the way he is."* (P1, 22, male, AN, treated). Besides, the acceptance of the own imperfection was mentioned by four participants. *"Be aware that it is ok if you are not*

perfect." (P10, 23, female, BEG, not treated). In addition, being mindful and aware of own emotions were associated with self-compassion. Multiple participants (N=3) described self-compassion as a mindful state and associated it "*with meditation."* (P2, 22, female, AN, treated). "*Being aware of who I am"* (P16, 19, female, BEG, not treated). Furthermore, two participants linked self-compassion to a high amount of self-confidence, this means a belief in own abilities. "*Self-compassion means to me that I have a lot of self-confidence."* (P13, 20, female, BEG, not treated). It seems that the majority were familiar with the concept of self-compassion. Although participants gave different definitions and associations, the majority mentioned one or more of the three components of self-compassion by Neff (2003a) (self-kindness, common humanity, mindfulness).

Existing Experiences with Self-Compassion. Besides the definition of the concept, it is important to analyze participants' existing experiences with self-compassion. The code is divided into three different themes. First of all, the theme no experiences with self-compassion was defined. Three participants reported that they were not confronted with any self-compassion in the past. They indicated that professionals do not use this concept and never had to do any exercises. *"But most do not practice that."* (P11, 39, female, BN, treated).

In contrast, self-compassion appeared to be applied in the treatment of four participants. The manner of using self-compassion during treatment was rather different. On the one hand, two participants describe experiences within the therapy session by talking about self-compassion with their therapist. *"In therapy sessions, it was an important topic."* (P1, 22, male, AN, treated). On the other hand, two participants are familiar with doing self-compassion exercises alongside therapy. *"Yes. My therapist gave me such a book with exercises that I should do every day for 10 minutes."* (P2, 22, female, AN, treated). *"Yes, something similar was done."* (P5, 23, female, BN, treated).

Merely one participant had personal interests in practicing self-compassion and was confronted with self-compassion in newspapers or books. *"I have been practicing this for several weeks [...] I also like to read appropriate newspapers."* (P11, 39, female, BN, treated). Experiences within kinesiology courses were also mentioned by this participant. *"Kinesiology. Only when things are going well, the rest are doing well too."* (P11, 39, female, BN, treated).

3.2. Appealing to the Concept of Self-Compassion

To answer the second sub-question, "*To what extent does the concept of self-compassion appeal to the needs and preferences of the participants?"* the positive and negative assessments of the concept were analyzed in the following paragraph. Table 4 gives an overview of the established themes.

Table 4

Participants Appealing to the Concept of Self-Compassion

Code	Theme	Amount Theme	Example quotes
Positive Assessment			
	Improving self-kindness	11	**P2***: "Somehow the exercise makes it easier to have got things straightened out with oneself."*
	Improving self-acceptance	10	**P10:** *"Yes, because I can learn to accept myself as I am, with all my strengths and weaknesses."*
	Effect on person's character	2	**P10:** *"I think this kind of exercise can also strengthen a person's character. This exercise gives people more self-confidence and strengthens the personality. You become less vulnerable."*
	Improving self-image	1	**P14:** *"With the exercise, you can later get a better self-image."*
	Interesting content	7	**P1**: "*The explanation of the three systems was very interesting."*
	Usage is important	2	**P1:** *"Very important and I find it very useful to practice that."*
	Well-structured	2	**P13**: *"Useful: first the information in the text then the open questions."*
	New information	1	**P13**: *"New information."*
	Nothing negative	4	**P5:** *"Nothing."*
Negative Assessment			
	Too long	10	**P8**: "*The text is too long. "*
	Too theoretical	2	**P5**: *"Too theoretical."*
	Requires perseverance	2	**P7***: "It is an exercise that you have to apply very consistently, while in my opinion otherwise, it does not work. That costs some perseverance and the real will to get it done."*
	Too difficult	2	**P12**: *"Many cannot do that and understand it."*
	Needs guidance	1	**P7**: *"Requires quite [...] guidance to make this good."*
Potential Improvements			
	Needs more examples	3	**P5:** *"More examples."*
	Needs more visual information	4	**P10**: "*I would define more concrete tasks. Maybe something written*."
	Needs less text	1	**P11:** *"For visual people, it's just too much text."*
	Extension with relaxation	1	**P1**: "*Maybe only a few relaxation exercises."*
	Discuss body positivity	1	**P9:** *"Also discuss body positivity. In the form of lyrics or videos from people who talk about their experiences of not feeling well in their body."*
	Practicing personal appreciation	1	**P10:** *"Show yourself compliments and empathy should be practiced more."*

Openness to the use of self-compassion			
	Positive attitude	11	**P1**: "*I have always been open to new things.*"
	Negative circumstances	4	**P16:** *"I would like to try it out because I notice that I am often too critical against myself."*

Note. Amount Theme = Number of participants who mentioned the theme

The Positive Assessment of the Concept of Self-Compassion. A global assessment of self-compassion was done with the question of how suitable participants evaluate a self-compassion exercise in general. Analyzes showed an evaluation of *M*= 3.68 (*SD*=0.79; Min =1; Max =4) on a five-point Likert scale (1=totally inappropriate, […] 5=totally appropriate). This means that the majority (N=13) of participants assess the exercise as appropriate.

The far majority was positive about the concept of self-compassion. Positive aspects were: improving self-kindness, improving self-acceptance, effects on person's character, interesting content, usage is important, well-structured new information, and nothing negative. Although the participants only read one exercise, some positive effects were expected. First, eleven participants judged the concept as helpful for improving self-friendliness and self-love. "*That it [the concept] shows ways to accept oneself and possibly love them. Because self-love is in my eyes an important step to get away from an eating disorder* (P5, 23, female, BN, treated). Self-kindness is described as an important step towards recovery. Second, several participants (N=10) reported that self-compassion helps to treat oneself with respect. *"Yes, because you can re-learn how to treat yourself respectfully."* (P2, 22, female, AN, treated). Self-compassion was described as helpful in learning and improving self-acceptance. *"If you reduce yourself to your appearance and you are not satisfied with it, it is important to learn to accept and love yourself as you are. I think this exercise will be very helpful."* (P10, 23, female, BEG, not treated). Moreover, participants also described a possible effect on a person's character. One participant stated that self-compassion can improve a person's self-image. *"With the exercise, you can later get a better self-image."* (P14, 20, female, BEG, not treated). It was mentioned that the exercise can also strengthen self-confidence which might lead to emotional resilience. *"I think this kind of exercise can also strengthen a person's character. This exercise gives people more self-confidence and strengthens the personality. You become less vulnerable."* (P10, 23, female, BEG, not treated). The content of the concept was evaluated as interesting. *"Very interesting."* (P13, 20, female, BEG, not treated). Especially the biological explanation of the emotional regulation system by Gilbert was described as new and positive. *"I think it is very positive that self-criticism is something quite natural, [...] It is good to know that this can be*

established with our evolutionary (biological) history as human beings." (P10, 23, female, BEG, not treated*).* The usage of self-compassion was assessed as useful. Moreover, the content was described as clear and comprehensible and practicing was seen as important. The structure of the example exercise was evaluated as useful and logical. "*Useful: first the information in the text, then the open questions."* (P13, 20, female, BEG, not treated). Some participants indicated that they evaluate nothing as negative (N=4). *"So far, nothing."* (P5, 23, female, BN, treated).

The Negative Assessment of the Concept of Self-Compassion. On the contrary, participants also evaluated some aspects of self-compassion as negative. Negative aspects were: too long, too theoretical, require perseverance, too difficult, and needs guidance. Ten participants indicated the lengths of a self-compassion exercise as negative. The explanation of self-compassion and its components was assessed as too long. *"The text is too long."* (P7, 19, female, EDNOS, not treated). *"Long explanation for the concepts."* (P15, 19, female, AN, not treated). First, the concepts were evaluated as too theoretical. *"Too theoretical*." (P4, 22, female, AN, not treated). The next theme refers to the require perseverance to do a self-compassion exercise. Two participants mentioned that the time consuming of the exercise is high. Without applying the exercise regularly, the effect is not sufficient. Therefore, time and endurance are required. *"It is an exercise that you have to apply very consistently, while in my opinion, it does not work at all. That costs some perseverance and the real will to get it done."* (P6, 42, female, EDNOS, not treated). Moreover, the exercise was evaluated as too difficult by two participants. It was indicated that several people cannot understand the explanation of the concept of self-compassion. *"Many cannot do that and understand it."* (P11, 39, female, AN, treated). The practicability was not clear. The participants doubted whether the self-compassion exercise can change someone's behavior anyway. *"I do not know if I can change my behavior through this exercise."* (P14, 20, female, BEG, not treated). Another participant stated that it is complicated to practice self-compassion alone. The support of a professional is necessary to adjust a self-compassion exercise to individual needs. *"Requires quite [...] guidance to make this your own."* (P6, 42, female, EDNOS, not treated).

Potential Improvement. The code improvement is divided into six themes and contains all potential improvements argued by the participants. The themes were: needs more examples, needs more visual information, needs less text, extension with relaxation, discuss body positivity, and practicing personal appreciation. Multiple participants would make the

instructions for the exercise more concrete by adding examples or specific tasks. *"I would have liked more specific exercises."* (P10, 23, female, BEG, not treated*). "More examples. For visual people, it's just too much text."* (P11, 39, female, AN, treated). Written tasks at home or other behavioral alternatives were required by the participants. "*Maybe also something written. Show yourself compliments and compassion should be practiced more."* (P10, 23, female, BEG, not treated). In addition, one participant would add relaxation exercises. *"Maybe some relaxation exercises first, so you can concentrate properly."* (P1, 22, male, AN, treated). The preoccupation with the movement of body positivity and practicing personal appreciation, in addition to self-compassion, were suggested. Nine participants did not give any potential improvements.

Openness towards the Use of Self-Compassion. To gain insight into the openness towards the future usage of self-compassion following question was asked: "*Would you describe yourself as being accessible to these exercises?".* Two themes, namely positive attitude and negative requirements, emerged. Both, participants with and without experiences would describe themselves as open and willing for the usage of self-compassion training. All participants reported having a positive attitude towards the use of self-compassion. This positive attitude was sometimes attributed to their own curiosity. *"Yes, because I'm curious and open to new."* (P10, 23, female, BEG, not treated). Multiple participants (N= 4) had negative circumstances which make them open for the use of self-compassion. *"I would like to try it out because I notice that I am often too critical against myself."* (P15, 19, female, AN, not treated). The insight that the exercise might be helpful by dealing with certain problems leads to the willingness of future usage. *"Yes, because I am aware of the influence of positive thinking and self-compassion."* (P4, 22, female, AN, not treated).

3.3. Integration of Self-Compassion in Traditional Treatment

To answer the third sub-question, "*What do participants think of an integration of self-compassion in the treatment of AN?*", aspects of pro and contra integration, the target group, and how and when to use the exercise were analyzed. The participants' opinion regarding an integration of self-compassion in traditional treatment is discussed in this paragraph. Table 5 shows an overview of the respective themes.

Table 5

Participants Perspective Regarding Integration of Self-Compassion in Traditional Treatment

Codes	Theme	Amount Theme	Example quotes
Pro integration			
	Utility Integration	16	**P13**: "*An integration of self-compassion exercises in a treatment of people with an eating disorder is very important and also helpful because it is the first step for improvement and triggers more self-confidence in the person.*"
Contra integration			
	No need	2	**P8**: "*No, even when I had bulimia I had self-compassion*."
Target group			
	Everyone	6	**P8**: "*Would recommend the exercise to every person.*"
	Anorexics	11	**P6**: *"Yes [I would recommend it to anorexics], because I think self-love is an important step to get rid of an eating disorder."*
	Open-minded people	2	**P2:** *"[Not recommended to] people who cannot / not want to get oneself into it."*
	People with fewer eating disorder complaints	4	**P5**: *"[Not recommended to] people who are dealing with strong self-criticism."*
When to use the exercise			
	Later (in treatment)	2	**P5**: *"For people who are dealing with very strong self-hate, I might recommend the exercise later because it may not be fully absorbed at first and therefore may not work for the person."*
	Never	2	**P12**: *"No [I will not do the exercise in the future because I have] no more trouble."*
	Occasionally (self-use)	12	**P13**: "*I would not use these exercises much, but a bit to improve my self-criticism."*
How to use the exercise			
	Combination	2	**P1**: *"As an additional task, I would have liked to see it but as a sole therapy, I do not think that's enough."*
	Outside clinical setting	2	**P1**: *"Could do it as an addition in your free time, for example."*
	Prevention	4	**P5**: "*I think you also have fewer relapses if you have a healthy self-compassion."*
	Integration in multicomponent therapy	12	**P2**: "*Sports, healthy food, strengthen self-confidence."*

Note. Amount Theme = Number of participants who mentioned the theme

Pro and Contra Integration. Notable, all participants evaluated an integration of self-compassion in traditional treatment as useful. Multiple participants argued an integration as important and helpful. *"An integration of self-compassion exercises in a treatment with people with an eating disorder is very important and also helpful because it is the first step*

for improvement [recovery]." (P13, 20, female, BEG, not treated). Especially the fact that people with eating disorders are highly critical and less self-kind supported the importance of an integration. *"Very important. I had no self-respect. Everything wrong was vomited […] I felt wrong. Because I was not slim."* (P11, 39, BN, treated). Putting positive concepts in the foreground and focusing on self-kindness was desired when thinking about the treatment of eating disorders. Moreover, long-term benefits were mentioned. *"I think, nowadays, where body shaming is a very big and common topic, it is important to put self-compassion in the foreground. This is also true in therapy. One should not focus only on the eating disorder. Much more you should learn to love yourself as you are. That gives you confidence in the long term."* (P10, 23, female, BEG, not treated).

Although all participants supported the integration of self-compassion in traditional treatment one participant stated that she has no personal need for a self-compassion training. This participant would recommend self-compassion training to people with eating disorders but personally had no shortage of self-compassion. *"No, even when I had bulimia, I had self-compassion."* (P8, 23, female, BN, not treated). Another participant evaluated self-compassion as useful for people with eating disorders but indicated the example exercise as not suitable. According to the participant, the exercise was not concrete enough and the usage raised questions. *"Stop - stop eating. I think that does not work. Here another alternative should be trained. What do I need now to be healthy and vital?"* (P9, 55, female, BEG, not treated).

The Target Group for Self-Compassion Training. The target group for self-compassion interventions was analyzed. The code was divided into four themes: everyone, anorexics, open-minded people, and people with fewer complaints. Six participants would recommend the exercise to everyone, independently from characteristics or disorder. They think that every human being should improve self-compassion. *"You can always recommend it."* (P1, 22, male, AN, treated). 11 out of 16 participants indicated self-compassion as suitable and advisable to AN-patients. They were two reasons for the suitability: (1) self-compassion fits with the high self-criticism of AN-patients (N=8); (2) self-compassion connects well with the therapy and that the exercise will help to gain more self-insight (N=3). In addition, people who are closed against a self-compassion exercise were excluded from the target group. The exercise is not recommended to people who reject their disorder or who cannot get themselves into the exercise. *"People who cannot / not want to get oneself into it."* (P2, 22, female, AN, treated). Some participants (N= 4) indicated that they would recommend

the exercise to people with less "*serious eating complaints"* (P16, 19, female, BEG, not treated). According to the participants, the exercise is not suitable for people with a high amount of self-hate. *"For people with very strong self-hate, I might recommend the exercise at a later moment."* (P5, 23, female, BN, treated).

When to use Self-Compassion. To obtain information about when to use self-compassion, participants mentioned three themes, namely later in treatment, never, and occasionally (self-use). According to two participants, the optimal moment for self-compassion training should be after the problem definition. *"After finding the problem. In the beginning, you do not have your head free for more."* (P11, 39, female, BN, treated). It seems that several participants who have no more problems with their eating behavior do not desire the use of self-compassion anymore. "*Not, no more trouble."* (P12, 19, female, EDNOS, not treated). Furthermore, 12 participants indicated that they preferred self-compassion training on an occasional basis. *"I would not use these exercises much, but a bit to improve my self-criticism."* (P13, 20, female, BEG, not treated).

How to use the Self-Compassion. By analyzing participants perspectives about the kind of using self-compassion, four themes were identified. Themes are: combination, outside clinical settings, prevention from relapse, and multicomponent therapy. First of all, two participants stated that the self-compassion exercise should be only used in combination with therapy. The exercise solely would not be sufficient as treatment. *"As an additional task I would have liked to see it but as a sole therapy I do not think that it is enough."* (P1, 22, male, AN, treated). The second theme refers to a usage outside clinical settings, thus at home and in free time. Two participants indicated that this kind of usage will be the most adequate. Practice after finishing therapy was also mentioned. *"The exercise alone cannot help. But maybe after the therapy or as homework."* (P10, 23, female, BEG, not treated). Four participants stated that the exercise would prevent relapse. *"Sometimes I lie in negative streams of thought about my body again. Maybe then I will try the exercise out as a prevention."* (P1, 22, male, AN, treated). 12 out of 16 participants described a multi-component therapy, for instance consisting of a balanced way of sport and eating, as crucial. "*Sport, healthy food, strengthen self-esteem."* (P2, 22, female, AN, treated). To face up with the self-image and improving self-esteem should be a component of therapy. In addition, how to learn to respect and love the own body is highly valued. *"One should learn to accept oneself as a human being. One should learn how to deal with mistakes and setbacks. "* (P5,

23, female, BN, treated). Another participant mentioned that the ideal therapy depends on the individual self. *"That is quite individual and depends on the severity of the eating disorder."* (P6, 42, female, EDNOS, not treated).

4. Discussion

The purpose of this study was to investigate the needs and preferences of AN-patients regarding self-compassion interventions in traditional treatment. This includes an examination of (1) participants' experiences with self-compassion, (2) the appealing to the concept of self-compassion, and (3) the perspectives of participants concerning a future integration of self-compassion in traditional treatment.

4.1. Discussion of the Results

Experiences with self-compassion. Remarkable, all participants were already familiar with the concept of self-compassion. Self-compassion is a relatively novel concept and literature shows only a slightly usage in the treatment of eating disorders. This is in accordance with Neff who indicated that the concept of self-compassion is relatively new and less common in the Western society, in contrast to the Buddhist philosophy who exercised the idea of self-compassion for centuries (Neff, 2003b). Therefore, it is curious that all participants were confronted with the term in the past. It could be concluded that term has broadened in the Western world for instance through media or famous influencer. It might be the case that the concept is becoming increasingly knowing. However, it should be considered that the definitions and experiences with self-compassion vary. For instance, some participants defined the concept through the components by Neff while others equate a high amount of self-confidence with self-compassion. This leads to the assumption that not every participant knows the concept of self-compassion equally good. Due to the anonymous online questionnaire, an inquiry with more in-depth details was not possible. At this point, it cannot be concluded whether the definitions of the concept were incorrect or not. Notably, distinctness between the experiences was found. Again, it could not be clarified whether participants truly had experiences with self-compassion. A confusion with similar concepts might have influenced the answers of the participants. Although the majority of the participants indicated a familiarity with the concept, the experiences within therapy were sparse. This is consistent with previous research of Seligman, Steen, Park, and Peterson (2005) who indicated that positive psychology is a relatively new field which is only gradually applied in the treatment of mental disorders.

Appealing to the concept of self-compassion. Most of the participants appreciated the concept of self-compassion. In general, the concept was evaluated as important, interesting, well structured, and new. The concept was rated as suitable for AN-patients. Participants expected positive effects, through self-compassion, including an increase in self-kindness and self-acceptance as well as a strengthening of the character. Participants only read a self-compassion exercise and therefore it could not be concluded whether these anticipated positive effects will actually occur. The expected effectivity should be studied in future, experimental studies. Thus far, only one previous pilot study has concluded to examine the effectivity of self-compassion in reducing deviant eating patterns (Kelly & Carter,2005). Results reveal the effectivity of self-compassion and current findings are supplementing in a way that affected people find the concept appealing, important, and interesting. Future studies should also examine whether drop-out from therapy can be reduced with self-compassion interventions.

However, self-reports are always depending on the honesty of the participants and exposed to a phenomenon called response bias - that people answered in a socially desired way (Van der Mortel, 2008). Particularly the fact that the majority of the participants were recruited from the acquittance of the researchers the likelihood of a response bias is high. It might be the case that this bias influenced the results and the expected effects. In this study participants indicated self-kindness as a precondition for self-acceptance which again was seen as a required condition for recovery. To our knowledge, no previous study examined a faster recovery from mental disorders due to a high amount of self-compassion. Though an experimental study by Sbarra, Smith, and Mehl (2012) indicated that self-compassion leads to a significantly faster emotional recovery from stressful live events (e.g. divorce). This supports the fact that self-compassion might play a role in a faster recovery. Still, the function of self-compassion in recovery need to be examined in the future.

Although the positive aspects of the concept outweighed, negative aspects were also mentioned. The difficult explanation, the required perseverance, and the required guidance were the main aspects. The example exercise needs further improvement to reach (complete) user-friendliness. The too theoretical set-up might have confused users. A comprehension without theoretical prior knowledge should be guaranteed. Participants evaluated the length as especially negative. To make the exercise more appealing, it should be pruned. All things considered, adding practical and concrete adjustments would make the exercise more suitable to the needs and preferences of AN-patients. The majority of the participants were open

towards a future usage of self-compassion. The openness can be explained by the fact that participants completed the questionnaire on a voluntary basis. By participating out of own motivation a certain amount of interest and openness regarding the concept might be present.

Integration of self-compassion in traditional treatment. Unsurprising, the majority of the participants rated an integration of self-compassion as useful. The utility and benefits of an integration were seen by all participants. It was described as convenient and important. Once more, a possible response bias might have influenced these results. Self-compassion was recommended to everyone as well as to anorexics. Remarkable, participants indicated self-compassion as less suitable for people with serious eating disorder complaints like strong self-hate. As aforementioned, self-compassion leads to a variety of health benefits and is especially for people with strong self-hate seen as appropriate. Participants resistance might be caused by a fear of self-compassion. This is in keeping with a study by Gilbert and Procter (2006) who examined the fear and stated that mental health patients react doubtful and fearful towards self-compassion. Although patients viewed self-compassion as helpful, a development was seen as difficult because of the illness (Gilbert & Procter, 2006). By addressing the fears, PPIs will be improved which might result in a facilitating development of interpersonal safeness and compassion (Gilbert, McEwan, Matos, & Rivis, 2011)

Participants' view regarding the moment and kind of practicing self-compassion varied, too. In respect to therapy, some participants would display a self-compassion exercise after the problem definition. This is also stated by McMurran and Ward (2010), which claimed that the readiness for treatment is highest after the problem analysis. The problem recognition is an important phase for personal motivation and change. Moreover, several participants would also like to practice self-compassion outside clinical settings. It could be concluded that practicing is versatile usable. It seems that a combination of therapy and self-compassion as well as a multicomponent therapy was most required. This study gives evidence for a preference of self-compassion in the treatment of AN. This is in keeping with a pilot study by Boersma, Håkanson, Salomonsson, and Johannson (2015) who found that participants were especially satisfied with CFT. Self-compassion was suited as helpful for social anxiety disorder, which is characterized by large shame and high self-criticism (Boersma et al., 2015). These characteristics also correspond to AN-patients.

Moreover, self-compassion was seen as a buffer against negative thoughts typically utilized by people with deviant eating behavior. This agrees with existing research. As stated by Rodgers and colleagues (2017) self-compassion works as a protective factor against

appearance concerns and can contribute to the development of a positive self-image. Consistent with previous research, the improvement of self-compassion skills may be useful in promoting body images among both genders (Braun, Park & Gorin, 2016).

Taken all, self-compassion is seen as suitable to the needs and preferences of AN-patients. Current findings indicate that self-compassion interventions are desired by the majority and might be a beneficial supplement to existing treatment. It should be interesting to investigate the preferences of experts, like a therapist, regarding the integration of self-compassion in traditional treatment. Current results in combination with therapists' perspectives could be used to develop a tailored self-compassion intervention.

4.2. Strengths and Limitations of the Study

This study is novel in examining the perspectives of people with deviant eating behavior regarding the integration of self-compassion intervention in traditional treatment. To our knowledge, no previous study has examined the suitability of self-compassion for AN from an affected point of view. The gap in literature was addressed by asking participants about their personal experiences, perspectives, and needs. An innovation or improvement in treatment can be implemented either by a top-down or bottom-up processing. A top-down processing is implemented by a supervisor and everyone has to accept the change. This study focused rather on a bottom-up strategy which refers to adaptions based on the needs of those affected. The patients then show a certain openness and willingness to integrate self-compassion exercises. By using this method, the innovation will better fit patients' desires, which usually results in more effective outcomes (Anderson, 2008). This study generates the basis for the improvement of AN-treatment.

The recruitment of participants faced difficulties. One reason might be that affected people are less open when talking about their experiences and preferences regarding their eating disorder. Burney and Irwin (2000) indicated that people with eating disorders feel shame when talking about topics that surround their eating. By using an anonymous online questionnaire, negative feelings were partly reduced. Social stigmatization of people with mental disorder might have played another role. According to Corrigan and Watson (2002) people with mental disorders are confronted with stereotypes and prejudice that result from misconceptions about the illness. This again leads to negative emotions and shame when talking about personal experiences regarding the disorder. Moreover, the fact that anorexics rarely seek out for treatment out of own initiative, that the willingness to change is low, and that only 50% of anorexics do not undergo treatment might be associated with the recruitment

problems. The problem signifies that a broad range of anorexics are less open and convinced of treatment approaches which might have discouraged those affected to participate.

The revised research method leads to limitations. Visual cues which are normally used in qualitative research (face-to-face interview) were absent. All subtle visual, non-verbal cues which can contextualize the content were missing. Consequently, the obtained data is less broad and deep in quality. Also asking follow-up questions, to obtain more details or examples, were not possible. Thus, important aspects could have been missing by using an online questionnaire.

By gathering and analyzing the data, the saturation point was not reached. This shows that the study is not based on an adequate sample and demonstrate a lack of content validity. For that reason, results are difficult to generalize. Moreover, the quality of the answers mentioned by the participants was quite different. Whereas some participants answered with detailed and somewhat in-depth descriptions in form of multiple sentences, other answered with superficial words or phrases. A possible reason might be a variation in motivation and dedication among the participants. Completing the questionnaire takes relatively much effort and time. Needed reflections and evaluations require much cognitive capacity (Mayer, 2008). Participants had to raise a lot of motivation to fill in the questionnaire. This could be the reason for the less in-depth answers but also for the high number of participants who did not complete the study. A shorter questionnaire might be adopted in the future. Finally, it is noteworthy that only 16 out of 99 persons completed the questionnaire. Apparently was the content of the study appealing so that multiple persons open the link to the questionnaire. However, it looks like the endurance and motivation was not sufficient to complete the questionnaire. This might also reflect in the high amount of people with eating disorders who abandonment treatment.

4.3. Recommendations and Implications for Future Research

On account of the limitations of this study, some recommendations should be implemented in future research. To acquire more insight into patient's perspectives regarding self-compassion, more than one self-compassion exercise should be presented to the participants. This will lead to a broader understanding of the concept. For example, in this study participants were less exposed to the component of mindfulness. Multiple exercises will guarantee a more accurate image of self-compassion.

Another recommendation is the use of the self-compassion scale (SCS) developed by Neff (2003a). This scale is a self-reported questionnaire and consists of six dimensions with

26-item. This reliable measurement gives insight into participants' amount of self-compassion. This scale can be used to make an assertion about the effectiveness of the self-compassion exercise. The scale can be used as before and after measurement in a self-compassion intervention. Future experimental research is needed which investigate the difference between a self-compassion and control condition.

Practical implications might be a practicing of self-compassion in clinical settings by volunteers who can try out the concept. Once the effectivity of self-compassion for AN has verified, self-compassion should be added in traditional treatment. Although the extension of current treatment is essential, self-compassion is equally appropriate for preventing children from deviant eating behavior. Due to the fact that body dissatisfaction and weight concerns affected a broad range of the population, including young children, self-compassion training should be provided to all people at risk.

4.4. Conclusion

This study focusses on a meaningful societal issue. Body dissatisfaction is a huge social problem in Western countries which raises the prevalence of eating disorders as AN. This study indicated self-compassion as preferred and needed by the affected people. However further research is required, the positive results suggest that self-compassion might be a valuable supplementation to enhance traditional treatment.

4. References

Andersen, O. J. (2008). A Bottom-Up Perspective on Innovations: Mobilizing Knowledge and Social Capital Through Innovative Processes of Bricolage. *Administration and Society, 40*(1), 54-78. doi: 10.1177/009539970731177

Albertson, E. R., Neff, K. D., & Dill-Shackleford, K. E. (2014). Self-compassion and body dissatisfaction in women: A randomized controlled trial of a brief meditation intervention. *Mindfulness*, *6*(3), 444-454. doi: 10.1007/s12671-014-0277-3

Barnard, L. K., & Curry, J. F. (2011). Self-compassion: Conceptualizations, correlates, & interventions. *Review of general psychology*, *15*(4), 289. doi: 10.1037/a0025754

Boersma, K., Håkanson, A., Salomonsson, E., & Johansson, I. (2015). Compassion focused therapy to counteract shame, self-criticism and isolation. A replicated single case experimental study for individuals with social anxiety. *Journal of Contemporary Psychotherapy*, *45*(2), 89-98. doi.org/10.1007/s10879-014-9286-8

Bohlmeijer, E. T. & Hulsbergen, M. (2013). Dit is jouw leven. Ervaar de effecten van de positieve psychologie. Amsterdam: Uitgeverij Boom

Braun, T. D., Park, C. L., & Gorin, A. (2016). Self-compassion, body image, and disordered eating: A review of the literature. *Body image*, *17*, 117 131. doi:10.1016/j.bodyim.2016.03.003

Burney, J., & Irwin, H. J. (2000). Shame and guilt in women with eating-disorder symptomatology. *Journal of clinical psychology*, *56*(1), 51-61. doi: 10.1002/(SICI)1097- 4679(200001)56:1<51::AID-JCLP5>3.0.CO;2-W

Carter, J. C., Blackmore, E., Sutandar-Pinnock, K., & Woodside, D. B. (2004). Relapse in anorexia nervosa: a survival analysis. *Psychological medicine*, *34*(4), 671-679. doi: 10.1017/S0033291703001168

Cohn, M. A., & Fredrickson, B. L. (2010). In search of durable positive psychology interventions: Predictors and consequences of long-term positive behavior change. *The journal of positive psychology*, *5*(5), 355-366. doi: 10.1080/17439760.2010.508883

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World psychiatry*, *1*(1), 16.

Davey, G. (2014). *Psychopathology*. Research, assessment and treatment in clinical psychology. Chichester: Wiley

Derenne, J. L., & Beresin, E. V. (2006). Body image, media, and eating disorders. *Academic psychiatry*, *30*(3), 257-261. doi: 10.1176/appi.ap.30.3.257

Duckworth, A. L., Steen, T. A., & Seligman, M. E. (2005). Positive psychology in clinical

practice. *Annual Review of Clinical Psychology*, *1*, 629-651. doi:10.1146 annurev.clinpsy.1.102803. 144154

Fairburn, C. G., Cooper, Z., & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: A "transdiagnostic" theory and treatment. *Behaviour research and therapy*, *41*(5), 509-528. doi:10.1016/S0005-7967(02)00088-8

Fairburn, C. G. (2005). Evidence-based treatment of anorexia nervosa. *International Journal of Eating Disorders*, *37*(1), 26-30. doi: 0.1002/eat.20112

Fairburn, C. G., Cooper, Z., Doll, H. A., O'Connor, M. E., Bohn, K., Hawker, D. M., et al. (2009). Transdiagnostic cognitive-behavioral therapy for patients with eating disorders: a two-site trial with 60-week follow-up. *American Journal of Psychiatry, 166*, 311–319. doi: 10.1176/appi.ajp.

Ferreira, C., Pinto-Gouveia, J., & Duarte, C. (2013). Self-compassion in the face of shame and body image dissatisfaction: Implications for eating disorders. Eating Behaviors, 14, 207–210. doi:10. 1016/j.eatbeh.2013.01.005

Fredrickson, B. L. (2004). The broaden-and-build theory of positive emotions. *Philosophical Transactions of the Royal Society B: Biological Sciences*, *359*(1449), 1367. doi:10.1098/rstb.2004.1512

Gilbert, P. (Ed.). (2005). *Compassion: Conceptualisations, research and use in psychotherapy*. Routledge.

Gilbert, P. (2010). An introduction to compassion focused therapy in cognitive behavior therapy. International Journal of Cognitive Therapy, 3, 97–112.

Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology*, *53*(1), 6-41. doi:10.1111/bjc.12043

Gilbert, P., McEwan, K., Matos, M., & Rivis, A. (2011). Fears of compassion: Development of three self-report measures. *Psychology and Psychotherapy: Theory, research and practice*, *84*(3), 239-255. doi:10.1348/147608310X526511

Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study. *Clinical Psychology and Psychotherapy*, *13*, 353–379. doi:10.1002/cpp.507

Grossman, P., Niemann, L., Schmidt, S., & Walach, H. (2004). Mindfulness-based stress reduction and health benefits: A meta-analysis. *Journal of psychosomatic research*, *57*(1), 35-43. doi:10.1111/j.2042-7166.2003.tb04008.x

Hartmann, A. S., Thomas, J. J., Greenberg, J. L., Rosenfield, E. H., & Wilhelm, S. (2015).

Accept, distract, or reframe? An exploratory experimental comparison of strategies for coping with intrusive body image thoughts in anorexia nervosa and body dysmorphic disorder. *Psychiatry research*, *225*(3), 643-650. doi: 10.1016/j.psychres.2014.11.031

Herzog, D. B., Keller, M. B., Sacks, N. R., Yeh, C. J., & Lavori, P. W. (1992). Psychiatric comorbidity in treatment-seeking anorexics and bulimics. *Journal of the American Academy of Child & Adolescent Psychiatry*, *31*(5), 810-818. doi: 10.1097/00004583-199209000-00006

Kaye, W. H., Bulik, C. M., Thornton, L., Barbarich, N., Masters, K., & Price Foundation Collaborative Group. (2004). Comorbidity of anxiety disorders with anorexia and bulimia nervosa. *American Journal of Psychiatry*, *161*(12), 2215-2221. doi: 10.1176/appi.ajp.161.12.2215

Kelly, A. C., & Carter, J. C. (2015). Self-compassion training for binge eating disorder: A pilot randomized controlled trial. *Psychology and psychotherapy: Theory, research and practice*, *88*(3), 285-303. doi:10.1111/papt.12044

Kezelman, S., Crosby, R. D., Rhodes, P., Hunt, C., Anderson, G., Clarke, S., & Touyz, S. (2018). Anorexia Nervosa, Anxiety and the Clinical Implications of Rapid Refeeding. *Frontiers in Psychology*, *9*, 1097. doi: 10.3389/fpsyg.2018.01097

Konrad, S. (2017). *Das beherrschte Geschlecht – Warum sie will, was er will*. München: Piper.

Kristeller, J. L., Baer, R. A., & Quillian-Wolever, R. (2006). Mindfulness-based approaches to eating disorders. *Mindfulness-based treatment approaches: Clinician's guide to evidence base and applications*, *75*.

Lang, G., & van der Molen, H. T. (2012). *Psychologische gespreksvoering: een basis voor hulpverlening*. Amsterdam: Boom/Nelissen.

Loeb, K. L., Le Grange, D., & Lock, J. (2015). *Family therapy for adolescent eating and weight disorders: new applications*. Routledge.

Mayer, R. E. (2008). *Learning and instruction (second edition).* Upper Saddle River, NJ: Pearson.

McMurran, M., & Ward, T. (2010). Treatment readiness, treatment engagement and behaviour change. *Criminal Behaviour and Mental Health*, *20*(2), 75-85. doi: 10.1002/cbm.762

Mills, A., Gilbert, P., Bellew, R., McEwan, K., & Gale, C. (2007). Paranoid beliefs and self-criticism in students. *Clinical Psychology & Psycho- therapy, 14,* 358–364. doi:10.1002/cpp.537

Morrison, T. G., Kalin, R., & Morrison, M. A. (2004). Body-image evaluation and body-image investment among adolescents: A test of sociocultural and social comparison theories. *Adolescence, 39,* 571–572.

Neff, K. D. (2003a). Development and validation of a scale to measure self-compassion. Self and Identity, 2, 223–250. doi: 10.1080/15298860390209035

Neff, K. D. (2003b). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. Self and Identity, 2, 85–101. doi: 10.1080/15298860309032

Neff, K. D. (2011). Self-compassion, self-esteem, and well-being. *Social and personality psychology compass*, *5*(1), 1-12. doi: 10.1111/j.1751-9004.2010.00330.x

Neff, K. D., & Germer, C. K. (2013). A pilot study and randomized controlled trial of the mindful self-compassion program. *Journal of clinical psychology*, *69*(1), 28-44. doi: 10.1002/jclp.21923

Nordbø, R. H., Espeset, E. M., Gulliksen, K. S., Skårderud, F., & Holte, A. (2006). The meaning of self-starvation: Qualitative study of patients' perception of anorexia nervosa. *International Journal of Eating Disorders*, *39*(7), 556-564. doi: 10.1002/eat

Rodgers, R. F., Franko, D. L., Donovan, E., Cousineau, T., Yates, K., McGowan, K. et al., (2017). Body image in emerging adults: The protective role of self-compassion. *Body image*, *22*, 148-155. doi:10.1016/j.bodyim.2017.07.003

Sbarra, D. A., Smith, H. L., & Mehl, M. R. (2012). When leaving your ex, love yourself: Observational ratings of self-compassion predict the course of emotional recovery following marital separation. *Psychological science*, *23*(3), 261-269. doi: 10.1 177/095679761 1429466

Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist, 55*, 5-14. doi: 10.1007/978-94-017-9088-8_18

Seligman, M. E., Steen, T. A., Park, N., & Peterson, C. (2005). Positive psychology progress. *American psychologist*, *60*(5), 410-421.doi: 10.1037/003-006X.60.5.410

Sim, L. A., Sadowski, C. M., Whiteside, S. P., & Wells, L. A. (2004). Family-based therapy for adolescents with anorexia nervosa. *Mayo Clinic Proceedings, 79*(10), 1305-1308. doi: 10.4065/79.10.1305

Sin, N. L., & Lyubomirsky, S. (2009). Enhancing well-being and alleviating depressive symptoms with positive psychology interventions: A practice-friendly meta-analysis. *Journal of clinical psychology*, *65*(5), 467-487. doi: 10.1002/jclp.20593

Slyter, M. (2012). Treating eating disorders with the Buddhist tradition of mindfulness. *Ideas and Research You Can Use: VISTAS*, *32*(1), 1-12.

Smink, F. R., Van Hoeken, D., & Hoek, H. W. (2012). Epidemiology of eating disorders: incidence, prevalence and mortality rates. *Current psychiatry reports*, *14*(4), 406-414. doi: 10.1007/s11920-012-0282-y

Steck, E. L., Abrams, L. M., & Phelps, L. (2004). Positive psychology in the prevention of eating disorders. *Psychology in the Schools*, *41*(1), 111-117. doi:10.1002/pits.10143

Van de Mortel, T. F. (2008). Faking it: social desirability response bias in self-report research. *Australian Journal of Advanced Nursing, The*, *25*(4), 40.

Westerhof, G. J., & Keyes, C. L. (2010). Mental illness and mental health: The two continua model across the lifespan. *Journal of adult development*, *17*(2), 110-119. doi:10.1007/s10804-009-9082-y

Zipfel, S., Giel, K. E., Bulik, C. M., Hay, P., & Schmidt, U. (2015). Anorexia nervosa: aetiology, assessment, and treatment. *The Lancet Psychiatry*, *2*(12), 1099-1111. doi: 10.1016/ S2215-0366(15)00356-9

6. Appendix

Appendix A

Newsletter, Dutch Version

Ben jij enthousiast de behandeling van Anorexia Nervosa patiënten uit te breiden? - Dan is dit onderzoek zeker interessant voor jou!

Wie zijn wij?
Wij zijn Lea en Franziska, twee Psychologie studenten op de Universiteit Twente in Enschede. Ons afstudeeronderzoek richt zich op de toepasbaarheid van oefeningen uit de Positieve Psychologie in de behandeling van Anorexia Nervosa.

Positieve psychologie- Wat is dat eigenlijk?
Dit is een stroming binnen de psychologie die is gericht op het ontdekken van je sterke kanten, je positieve emoties en persoonlijke groei in plaats van op het verminderen van symptomen en klachten.

Wat gaan wij doen?
Met behulp van jouw deskundigheid op het gebied van Anorexia Nervosa willen we nagaan in hoeverre positieve psychologische oefeningen goed aansluiten bij de belevingswereld van (ex)patiënten en of dit van toegevoegde waarde kan zijn in een behandeling. Hoe doen we dat? - Dit doen we door jou enkele positief psychologische oefeningen voor te leggen tijdens een interview (of telefonisch) waarbij we nagaan wat jouw eerste indruk van deze oefeningen is. Het interview zal in april of begin mei plaatsvinden. Jouw mening als ervaringsdeskundige is hier heel waardevol.

Wie zoeken wij?
Ben jij hersteld van Anorexia Nervosa, ouder dan 16 jaar en heb je zin om de behandeling van Anorexia Nervosa patiënten te verbeteren? Dan is dit jouw kans!
Let op: Als je jonger bent dan 18 jaar, moet er toestemming gegeven worden voor deelname door ouders/verzorgers.

Ben je geïnteresseerd? Stuur ons dan een e-mail (l.k.kretzschmar@student.utwente.nl & f.a.gerlach@student.utwente.nl). Dan nemen we zo snel mogelijk contact met je op om meer informatie te geven en een interview te plannen.

Bedankt voor je interesse!

Groeten,
Lea en Franziska

UNIVERSITY OF TWENTE.

Appendix B

Questionnaire, Dutch Version

UNIVERSITY OF TWENTE.

Beste deelnemer,

Hartelijk bedankt voor je interesse in ons onderzoek. We zijn Lea en Franziska, derdejaars Psychologie studenten op de Universiteit Twente in Enschede.

Ons afstudeeronderzoek richt zich op positieve psychologie. Dit is een stroming binnen de psychologie die is gericht op het ontdekken van je sterke kanten, je positieve emoties en persoonlijke groei in plaats van op het verminderen van symptomen en klachten. Ook het mild en vriendelijk zijn naar jezelf hoort bij positieve psychologie.

Het doel van ons onderzoek is om na te gaan of de actuele behandelmethoden bij patiënten met een eetstoornis kunnen worden uitgebreid met oefeningen uit de positieve psychologie. Daarom vragen wij leeftijdgenoten die ook een (min of meer) problematische relatie met eten hebben of hadden om hulp. We zijn geïnteresseerd of deze oefeningen goed aansluiten en of er mogelijkheden voor verbetering zijn.

Als je vragen hierover hebt kun je ons altijd via e-mail bereiken (l.k.kretzschmar@student.utwente.nl; f.a.gerlach@student.utwente.nl).

Alvast bedankt voor jouw tijd.

Met vriendelijke groeten,
Lea en Franziska

→

UNIVERSITY OF TWENTE.

Het invullen van de vragenlijst duurt ongeveer 30 minuten. Je deelname aan deze studie is volledig vrijwillig. Je bent vrij om het onderzoek op elk moment te stoppen zonder een reden aan te geven. We zijn geïnteresseerd in algemene resultaten, dus er zijn geen goede of foute antwoorden. Je antwoorden zijn volledig anoniem, er zal geen identificerende informatie over je worden verzameld. De gegevens worden alleen voor het doel van deze studie gebruikt.

Ik verklaar op een voor mij duidelijke wijze te zijn ingelicht over het doel van het onderzoek. Ik weet dat de gegevens en resultaten van het onderzoek alleen anoniem en vertrouwelijk aan derden bekend gemaakt zullen worden. Mijn vragen zijn naar tevredenheid beantwoord.

Door op 'Ik ga akkoord' te klikken, bevestig je om deel te nemen aan deze studie. Als je het niet eens bent, beëindigt je de studie nu.

○ Ik ga akkoord

→

UNIVERSITY OF TWENTE.

We willen je vragen eerst een aantal vragen te beantwoorden over je eetgedrag.

Heb je zelf te maken gehad met een afwijkend eetpatroon? (bv. langdurige diëten, heftige eetbuien of verliest van eetlust en hongergevoel)

- ○ Ja
- ○ Nee

→

UNIVERSITY OF TWENTE.

Ben je ooit met een eetstoornis gediagnosticeerd? Zo ja, welke van de onderstaande?

- ○ Anorexia Nervosa/Magerzucht
- ○ Bulimia Nervosa/ Boulimie
- ○ Binge eating/Eetbuien
- ○ Anders, namelijk
- ○ Ik ben nooit gediagnosticeerd

→

UNIVERSITY OF TWENTE.

We willen je nu graag vragen om enkele vragen met betrekking tot de oefening te beantwoorden. Er worden voornamelijk open vragen gesteld. Je mag ook steekwoorden gebruiken bij het invullen van de antwoorden.

Wij vragen jouw om hulp als ervaringsdeskundige en zijn alleen in jouw eerste indruk van deze oefening geïnteresseerd. Er bestaan geen goede of foute antwoorden.

→

Wat is jouw eerste indruk van deze oefening?

	heel ongeschikt	ongeschikt	noch ongeschikt, noch geschikt	geschikt	heel geschikt
Hoe geschikt vond je deze oefening	○	○	○	○	○

Wat vond je positief, belangrijk of zinvol aan deze oefening?

Wat vond je negatief, onplezierig, onduidelijk of slecht aan deze oefening?

Zou je deze oefening graag terug hebben gezien in je eigen behandeling en waarom wel/niet?

In hoeverre ben je met de onderstaande stelling een?

	helemaal me oneens	mee oneens	noch mee oneens, noch mee eens	mee eens	helemaal mee eens
Ik zou deze oefening aan mensen met een eetstoornis aanraden	○	○	○	○	○

Licht je antwoord kort toe. Waarom zou je deze oefening mensen met een eetstoornis aanraden/ Waarom zou je deze oefening niet aanraden?

Welke mensen zou je deze oefening minder aanraden?

Heb je ideeën voor verbeterpunten voor deze oefening?

Wat betekent het begrip zelfcompassie voor je?

Waar associeer je het begrip zelfcompassie mee?

Ben je dit begrip/ zelfcompassie in je behandeling tegengekomen? Zo ja, waar?

Wat vind je van de integratie van zelfcompassie oefeningen in een behandeling voor mensen met een eetstoornis?

Zou je je kunnen voorstellen dat positieve psychologische oefeningen in de behandeling van eetstoornissen waardevol kunnen zijn?

- ☐ Ja, omdat
- ☐ Nee, omdat

Hoe zou volgens jou de ideale therapie voor mensen met een eetstoornis eruit zien?

Op welke moment in de behandeling zou je behoefte hebben (gehad) aan positief psychologische oefeningen?

Zou je je voor kunnen stellen deze oefeningen in je alledaagse leven (in de toekomst) te gebruiken? (waarom wel/niet)

Zou je je zelf toegankelijk voor dit soort oefening beschrijven?

- ☐ Ja, omdat
- ☐ Nee, omdat

Vind je dit soort oefening voor Anorexia Nervosa patiënten (Magersucht) geschrikt?

- ☐ Ja, omdat
- ☐ Nee, omdat

→

UNIVERSITY OF TWENTE.

What is jouw geslacht?

- ○ vrouw
- ○ man
- ○ Zeg ik liever niet

What is jouw leeftijd?

Hoe lang ben je in behandeling geweest voor een eetstoornis?

Wat is je hoogste afgeronde opleiding?

- ○ Basisonderwijs
- ○ VMBO/MAVO
- ○ HAVO
- ○ VWO (Abitur)
- ○ MBO
- ○ HBO
- ○ WO/Bachelor
- ○ WO/Master
- ○ Anders, namelijk

UNIVERSITY OF TWENTE.

We zijn nu aan het einde van de studie gekomen.
Nogmaals bedankt voor je deelname.
Als je vragen of opmerkingen hebt kun je ons altijd via e-mail bereiken (l.k.kretzschmar@student.utwente.nl; f.a.gerlach@student.utwente.nl).

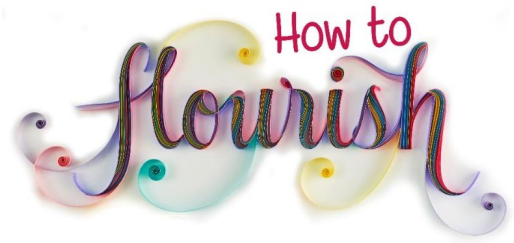
>> We willen je graag vragen, als je nog andere mensen kent die ervaring hebben met afwijkend eetgedrag, om hun de link naar onze studie te sturen.

Bedankt voor het delen!

→

Appendix C

Self-compassion Exercise from Bohlmeijer and Hulsbergen (2003) – Dutch version



Zelfcompassie – stoppen met zelfkritiek

Biologisch gezien gaat onze aandacht veel meer uit naar eventueel gevaar dan naar positieve ervaringen. Dit doen we niet bewust, want voor de overleving was het in vroegere tijden noodzakelijk om alert te zijn. Ons brein is complex en één van de gebieden dat geactiveerd wordt in bedreigende situaties is de amygdalae. Het lastige van dit gebied is dat het geen verschil herkent tussen werkelijk gevaar en ingebeeld gevaar. We zijn bijvoorbeeld gewend om onszelf kritisch te beoordelen op onze prestaties, ons uiterlijk, onze sociale vaardigheden enzovoorts. We denken dat we daardoor meer kunnen bereiken, maar uit onderzoek blijkt juist dat je met een compassievolle en waarderende houding meer bereikt.

De psycholoog Paul Gilbert beschrijft drie emotieregulatiesystemen die we overigens gemeen hebben met alle zoogdieren:

1. Een systeem gericht op zelfbescherming: Ik ben altijd op mijn hoede
2. Een systeem gericht op zelfbehoud (jaagsysteem): Ik ben nooit tevreden en wil altijd meer
3. Een systeem gericht op zelfherstel (kalmeringssysteem): Ik kom tot rust en herstel

Bij dieren zijn deze drie systemen over het algemeen in balans: Wanneer er geen gevaar dreigt, de honger is gestild en de voortplanting geregeld is, dan kan het dier tot rust komen en herstellen. Voor de overleving van de soort is het van belang dat ieder systeem actief kan worden als dat nodig is. Bij mensen zijn de drie systemen echter vaak uit balans. Meestal is het kalmeringssysteem *onder*ontwikkeld en één of beide andere systemen *over*ontwikkeld. Sommige mensen zijn bijvoorbeeld steeds op

Bron: Bohlmeijer, E. T. & Hulsbergen, M. (2013). Dit is jouw leven. Ervaar de effecten van de positieve psychologie. Amsterdam: Uitgeverij Boom

hun hoede en gericht op mogelijke dreiging, of wapenen zich met agressie. Andere mensen zijn vooral gericht op zelfvervulling door het najagen van en streven naar materiële rijkdom, status of macht.

1. Het zelfbeschermingssysteem staat altijd op scherp om te kunnen vechten, vluchten of bevriezen. Het is ontworpen om gevaar te overschatten, om zo het zekere voor het onzekere te nemen. Wanneer de dreiging is geweken komt dit systeem tot rust. Zoals gezegd kan het systeem geactiveerd worden bij werkelijk gevaar maar ook bij ingebeeld gevaar, bijvoorbeeld bij de angst om gekwetst te worden, geen controle te hebben of buitengesloten te worden. Er hoeft soms maar een kleine trigger te zijn, zoals een angstige gedachte, om dit systeem te activeren.

2. Het jaagsysteem is van belang om te overleven en tot bloei te komen. Zonder verlangen naar voedsel zouden we verhongeren, zonder drang om voor nageslacht te zorgen kan ervoor zorgen dat we uitsterven. Dit systeem kan ook geactiveerd worden wanneer de basisbehoeften allang bevredigd zijn. We willen onszelf ontwikkelen! In de huidige consumptiemaatschappij is het echter een kunst geworden om bewust keuzes te maken in overvloed aan mogelijkheden en middelen.

3. Het kalmeringssysteem is van belang voor ons herstel. Het leidt tot plezierige gevoelens op korte termijn en leidt ook op de lange termijn tot de beschikking over hulpbronnen en reserves. Zonder dit systeem kan uitputting optreden. Het druk hebben en stress ervaren is in onze maatschappij overgewaardeerd waardoor er weinig ruimte is voor het kalmeringssysteem. Het goede nieuws is dat het systeem actief kan worden door onszelf zorg en liefde te geven, en te genieten van wat er nu is. Bijvoorbeeld door plezierige beelden en gedachten op te roepen. Wanneer je meer waardering kunt opbrengen voor jezelf zal je meer tevredenheid ervaren, waardoor je kunt herstellen en tot rust kan komen.

2

Bron: Bohlmeijer, E. T. & Hulsbergen, M. (2013). Dit is jouw leven. Ervaar de effecten van de positieve psychologie. Amsterdam: Uitgeverij Boom

Kristin Neff doet veel onderzoek naar zelfcompassie en onderscheidt drie kenmerken:

- Het vermogen om jezelf vriendelijkheid en zorg te geven, ook als je wordt geconfronteerd met je tekortkomingen, falen, ziekte, pijn en onplezierige emoties.
- Begrip voor het feit dat pijn en ongemak gedeelde menselijke ervaringen zijn. Alle mensen krijgen te maken met tegenslag en iedereen maakt fouten. We zitten allemaal in hetzelfde schuitje.
- Het vermogen om op een vriendelijke wijze aanwezig te zijn als deze onplezierige emoties en ervaringen zich voordoen.

Zelfcompassie gaat dus om onvoorwaardelijke vriendelijkheid voor jezelf en aanwezig zijn bij ongemak in je leven, door er niet voor weg te lopen en te beseffen dat het een onderdeel is van mens-zijn. Dit betekent onder meer dat je compassie hebt voor je tekortkomingen. Zelfcompassie hebben betekent niet dat je onplezierige ervaringen wegdrukt, maar op een zorgzame manier jezelf ondersteunt als je het moeilijk hebt.

Waardering hebben voor jezelf is iets anders dan een hoog zelfbeeld. Waardering voor jezelf houdt in dat je trots en plezier ontleent aan je sterke kanten, terwijl je je tekortkomingen aanvaardt. Deze waardering van jezelf gaat niet ten koste van anderen, omdat je ook waardering hebt voor andere mensen en het niet nodig is om hen (in gedachten) onderuit te halen om jezelf beter te voelen.

Wat kun je nu doen om meer zelfcompassie te ontwikkelen? Stop met zelfkritiek en waardeer jezelf om wie je bent! Dat klinkt natuurlijk makkelijker gezegd dan gedaan, het is ook een soort gewoonte geworden. Dus een paar tips:

- Let er eens op wat je tegen jezelf zegt. Zou je deze dingen ook tegen een goede vriendin zeggen?

- Neem jezelf voor om jezelf te waarderen om wie je bent. Dit betekent overigens niet dat je lui wordt of jezelf niet meer kunt aanspreken om iets te doen. Het gaat om de zelfkritiek die te zien is als aanval op jezelf. Wat brengt het jou om jezelf aan te vallen?

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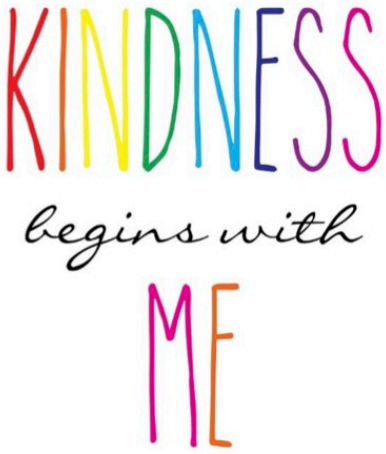
- Probeer jezelf niet te veroordelen als je wel kritisch naar jezelf bent. Het opmerken is al voldoende. Alleen al het voornemen om zelfkritiek te stoppen zal al iets in gang zetten!

- Wanneer je bij jezelf opmerkt dat je zelfkritisch bent, dan word je op dat moment waarschijnlijk geconfronteerd met je tekortkomingen, pijn of tegenslag waarbij onplezierige emoties opkomen (angst, verdriet, boosheid). Vraag jezelf dan af of het jou gaat helpen om jezelf zo aan te vallen. Of kun je jezelf toestaan om vriendelijk te zijn tegen jezelf?

- Het is onmogelijk om gedachten te onderdrukken. Dat geldt ook voor zelfkritische gedachten. Je kunt jezelf bij een kritische gedachte een ludiek advies geven, bijvoorbeeld door heel hard en met een glimlach tegen jezelf te zeggen: “Stop it!” Zie ook het filmpje op youtube van stand-up comedian Bob Newhart – stop it.



4

Bron: Bohlmeijer, E. T. & Hulsbergen, M. (2013). Dit is jouw leven. Ervaar de effecten van de positieve psychologie. Amsterdam: Uitgeverij Boom

Appendix D

Code Schema

Category	Code	Definition Code	Theme	Example Quote Theme
Experience with Self-Compassion	Definition of Self-Compassion	Descriptions and associations with the concept of self-compassion	Self-acceptance	"To *have respect for myself - also for my body.".*
			Self-kindness	*" Trying to be nice to yourself."*
			Acceptance of own imperfection	*"Be aware that it is ok if you are not perfect."*
			Mindfulness	*"Recognize if I don't feel well and allow the feeling."*
			Self-confidence	*"Being self-confident. "*
	Experiences with Self-Compassion	Kind of experiences participants had with self-compassion	No Experiences	*"Most do not practice that."*
			Experiences within therapy	"*In therapy sessions, it was an important topic (especially when asked: why am I eating disturbed?)*
			Experiences outside clinical therapy	"*Kinesiology. Only when things are going well, the rest are doing well too."*
Appealing to the concept of self-compassion	Positive Assessment	Positive evaluations and features regarding the concept of self-compassion	Improving self-kindness	*"Somehow the exercise makes it easier to have got things straightened out with oneself."*
			Improving self-acceptance	*"Yes, because I can learn to accept myself as I am. with all my strengths and weaknesses."*
			Effect on person's character	*"I think this kind of exercise can also strengthen a person's character. This exercise gives people more self-confidence and strengthens the personality. You become less vulnerable."*
			Improving self-confidence	*"Being self-confident."*
			Interesting content	*"The explanation of the three systems was very interesting."*
			Usage is important	*"Very important and I find it very useful to practice that."*
			Well-structured	*"Useful: first the information in the text then the open questions."*
			New information	*"New information and very interesting."*
			Nothing negative	*"Nothing."*
	Negative Assessment	Negative evaluations and features of self-compassion	Too long	"*The text is too long. "*
			Too theoretical	*"Too theoretical."*
			Requires perseverance	*"It is an exercise that you have to apply very consistently, while in my opinion it does not work at all. That costs some perseverance and the real will to get it done."*
			Too difficult	*"Many cannot do that and understand it."*
			Needs guidance	*"Requires quite [...] guidance to make this good."*

	Potential Improvements		Needs more examples	*"More examples."*
			Needs more visual information	*I would define more concrete tasks. Maybe something written*."
			Needs less text	*"For visual people, it's just too much text."*
			Extension with relaxation	*"Maybe only a few relaxation exercises."*
			Discuss body positivity	*"Also discuss body positivity. In the form of lyrics or videos from people who talk about their experiences of not feeling well in their body."*
			Practicing personal appreciation	*"Show yourself compliments and empathy should be practiced more."*
	Openness to the Use of Self-Compassion	Participants standpoint regarding a future practicing of self-compassion	Positive attitude	*"I have always been open to new things."*
			Negative circumstances	*"I would like to try it out because I notice that I am often too critical for myself."*
Integration Self-Compassion and Traditional Treatment	Pro Integration	Aspects regarding the importance and utility of an integration of self-compassion in traditional treatment	Utility Integration	"*An integration of self-compassion exercises in a treatment with people with an eating disorder is very important and also helpful because it is the first step for improvement and more self-confidence in the person triggers. Self-confidence leads to a controlling eating behavior"*
	Contra Integration	Statements against the integration of self-compassion in traditional treatment	No need	"*No, even when I had bulimia self-compassion*."
	Target Group	The group for who self-compassion training is most recommended/ suitable		
			Everyone	*"Would recommend the exercise to every person."*
			Anorexics	*Yes [I would recommend it to anorexics], because I think self-love is an important step to get rid of an eating disorder."*
			Open-minded people	*"[Not recommended to] people who cannot / not want to get oneself into it."*
			People with fewer complaints	*"[Not recommended to] People who are dealing with strong self-criticism."*
	When to use the exercise	The time at which the practice of self-compassion is most suitable	Later in treatment	*"For people who are dealing with very strong self-hate, I might recommend the exercise later because it may not be fully absorbed at first and therefore may not work for the person."*
			Never	*"No [I will not do the exercise in the future because I have] no more trouble."*
			Occasionally self-use	"*I would not use these exercises much, but a bit to improve my self-criticism."*

How to use the exercise	The kind of how self-compassion practice should be adapted	Combination	*“As an additional task, I would have liked to see it but as a sole therapy, I do not think that's enough."*
		Outside clinical settings	*“Could do it as an addition in your free time, for example."*
		Prevention	*I think you also have fewer relapses if you have a healthy self-compassion."*
		Integration in multicomponent therapy	“*Sports, healthy food, strengthen self-confidence."*