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The Impact of Self-sabotage Behavior on the Compliance of Treatment Among Patients with Eating Disorders at Nutri-Health Centers in Ramallah, Hebron and Jenin

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Dedication:

I dedicate this thesis to Palestine, to Jerusalem my beautiful city which I was born in, to the souls of the innocent children, women, and men who lost their lives in the war.

To my father, my supporter, who was with me in every step of my life…

To my mother, my heart, my endless love, and my best friend….

I am grateful to those who provided me with the light to continue and nourish my soul through their care and kindness.

To my brothers, who were my companions in every step in my life...

To my lovely friends, who have helped me and made my educational life easier…

Dr. Dima Akram Miqdad

Declaration

I certify that this thesis was submitted for the degree of masters. It is the result of my own research, except where otherwise is acknowledged. I also certify that this thesis (or any part of the same) has not been submitted for any other university or institution.

Student name: Dr. Dima Akram Ahmad Miqdad

Signature: Dr. Dima Miqdad

Date: 8/1/2025

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Dr. Dima Akram Miqdad

January, 2025

Abstract:

This study investigates the impact of self-sabotage behavior on treatment compliance among patients with eating disorders at Nutri-health centers in Ramallah, Hebron, and Jenin. The research aims to investigate the correlation between self-sabotage and various demographic factors, including gender, age, occupation, social status, economic status, and educational level. The study uses Shirzad Chamine's saboteur assessment to identify 10 types of inner saboteurs, including judge, controller, hyper-achiever, restless, stickler, pleaser, hyper-vigilant, avoider, victim, and hyper-rational.

The results show that most participants have a moderate level of self-sabotage behavior. The avoider dimension exhibits the highest level of self-sabotage, followed by the restless, controller, and hyper-achiever dimensions, respectively. The victim dimension had the highest percentage of participants (47%), followed by the stickler (42.3%), hyper-achiever (39.3%), and controller (38%), respectively. The judge dimension had the lowest percentage of participants (27.3%).

The study found that nearly 50 out of 300 participants had a compliance rate of 70%. The majority of patients were with binge eating disorder (60.3%), with 33% being overweight, 3% stable weight, and 2.7% underweight.

The recommendations include further studies on self-sabotage's impact on treatment compliance, dietary plan and programs combining psychological factors with physical factors, and implementing educational programs to understand psychological factors and self-saboteurs influencing eating patterns and the compliance of the treatment.

Key words: eating disorders, treatment compliance, and self-sabotage.

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The problem of the study and its importance:

1.1 Background:

Feeding and eating disorders (FEDs) are serious mental health disorders that cause impairments in physical health, development, cognition, and psychosocial function. They could be emphasized as disturbed eating behavior associated with concerns about weight and shape or by disinterest in food, phobic avoidance (Derenne et al., 2016).

Self-sabotage is when a person actively or passively takes steps to prevent himself from reaching his goals. This behavior can affect nearly every aspect of life; it could be a relationship, career goal, or personal goal, such as weight loss. Despite its prevalence, this behavior creates a cycle of frustration that diminishes a person's self-confidence and leaves them feeling trapped (Lisa Jeffs et al., 2018). Moreover, the saboteurs are defined as "the internal enemies, a set of automatic and habitual mind patterns, each with its own voice, beliefs, and assumptions that work against your best interest" (Siami, 2019, pp. 127-133). Different types of inner saboteur exist, such as the stickler (perfectionism), the hypervigilant (anxiety), the pleaser (self-worth by pleasing others), the judge (criticism), the restless (mood), the procrastinator (the avoider), the victimization, the hyper achiever (self-worth by achieving more achievements), the controller (controlling), and the hyper-rational (overanalytical).

Self- Sabotage can affect the level of compliance of the treatment. The word “compliance” comes from the Latin word complire, meaning to fill up and hence to complete an action or process and to fulfill a promise (Aronson et. al., 2007). This compliance of the treatment can be affected in patients with eating disorders. The term eating disorders generally refers to psychological disorders involving gross abnormalities in eating. Starvation, rigid dieting, binge eating, and purging, anorexia nervosa, and bulimia are the most dramatic features of eating disorders (Crowther, Janis H., et al. 2017).

The COVID pandemic in the past three years has also impacted the mental health of children and adolescents, leading to an increase in eating disorders during their developmental stages (Pruccoli et al., 2024). In addition, another study demonstrates that adolescents with eating disorders are at increased risk of suicidality, and this study recommends the close screening of people with eating disorders, particularly the ones with bulimia nervosa and anorexia nervosa (Akgül. et al., 2024).

In the Middle East, anorexia affects both men and women, at any age. The most affected people are young women between the ages of 14 and 25. Between 5 to 20% die from complications (Middle East Eating Disorder Association, 2022).

Many previous studies explored the influence of self-esteem on levels of body dissatisfaction among patients (De Sousa Fortes et al., 2014) (Miyawaki et al., 2018). For example, a cross-sectional study in 2014 evaluated the influence of self-esteem on levels of body dissatisfaction among adolescent females. We applied the Body Shape Questionnaire (BSQ) to assess body dissatisfaction. We used the Rosenberg Self-Esteem Scale to assess self-esteem. We also measured the weight, height, and skinfold thickness. The statistical analyses controlled these anthropometric data. This study emphasized that self-esteem influenced the body dissatisfaction in adolescent girls (De Sousa Fortes et al., 2014).

In 2018, an observational cross-sectional descriptive study of 284 female patients aged 13-45 with eating disorders stated that shoplifting may be associated with impulsive behaviors (e.g., alcohol and illicit drug use), depression, and low self-esteem, but not with eating disorder severity (Miyawaki et al., 2018).

Researchers conducted further studies to investigate the connection between suicidal thoughts and self-injurious behaviors in patients with eating disorders (Anderson et al., 2017). For instance, in 2017, Anderson et al. conducted a study in a Barcelona hospital to determine the prevalence of suicidal ideation and self-harm in adolescents with eating disorders. They evaluated 109 participants with eating disorders, whose mean age was 14.47, and 87% of them were female (Anderson et al., 2017). Furthermore, researchers are examining the correlation between self-harming actions and suicidal thoughts, and connecting it to the intensity of eating disorder symptoms, signs of depression and anxiety, drive for change, and the pursuit of perfection (Anderson et al., 2017).

Additional studies explored the hypothesis that self-esteem and depression mediate the effect of body dissatisfaction on eating disordered behavior. For instance, a descriptive study was conducted on 320 students from Norway. This study also hypothesized that body image is associated with lower self-esteem, stronger symptoms of depression, and more disordered eating. The results showed that both self-esteem and depression were significant mediators for the treatment. Depression had a direct effect on binge eating (Brechan et al., 2015).

Self-sabotage is when a person actively or passively takes steps to prevent himself from reaching his goals. This behavior can affect nearly every aspect of life; it could be a relationship, career goal, or personal goal, such as weight loss. Despite its prevalence, this behavior creates a cycle of frustration that diminishes a person's self-confidence and leaves them feeling trapped (Lisa Jeffs et al., 2018).

Another study examined family-based treatment adherence and its association with treatment outcomes for patients with anorexia nervosa. The results of this multicenter study concluded that the percentage of body weight did not correlate with adherence to treatment outcome (Dimitropoulos et. al., 2019).

A low rate of adherence to treatment is a widespread problem of significant clinical relevance among patients with eating disorders (Zendegui et. al., 2014).

This study highlighted the different behaviors of self-sabotage in each participant, such as extreme perfectionism. Moreover, this study investigated the relationship between self-sabotage and other aspects. For instance, this study examined the connections between self-sabotage and anxiety, self-sabotage and self-worth, self-sabotage and self-criticism, self-sabotage and mood, self-sabotage and procrastination, self-sabotage and victimization, and the correlation between self-sabotage and various demographic factors like gender, age, occupation, social status, economic status, and educational level.

The essence of this study is to explore the significance of self-sabotage on the compliance of treatment plans among patients with eating disorders. Individuals with eating disorders often struggle to maintain motivation for recovery. This challenge contributes to high rates of treatment dropout and relapse (Venturo-Conerly et. al., 2020).

This study is important for many reasons. First, few studies were done about this topic. Secondly, in an effort to delve deeper into this topic and identify the nine types of inner saboteurs identified by Shirzad Chamine (judge, controller, hyper-achiever, restless, stickler, pleaser, hyper-vigilant, avoider, victim, and hyper-rational), we conducted a Shirzad Chamine's saboteur assessment for each participant in the research.

1.2 The problem of the study:

Self-sabotage hinders these eating disorder patients from achieving their life goals, thereby preventing them from leading adequate lives. In addition, another problem is the inability to reach for the last steps in the treatment by maintaining compliance to treatment at its adequate levels. These patients struggle with self-sabotage, a condition that can negatively impact every aspect of their lives by instilling feelings of insecurity and unworthiness. There is a lack of studies about self-sabotage and its relationship with anxiety, self-worth, self-criticism, mood, procrastination, and victimization, as well as the association between

self-sabotage and demographics such as gender, age, occupation, social status, economic status, and the level of education. Furthermore, as a medical doctor with a keen interest in neurology and psychiatry and their impact on human behavior, I frequently interact with patients suffering from eating disorders, and I observe the challenges they face in adhering to the treatment plans devised by dietitians. This motivates me to delve deeply into the root cause of eating disorder and to discover the cause of the patients' inability to adhere to their treatment plans. Additionally, I was inspired to do this research from my personal experience with friends and family in our Palestinian society, who have struggled to commit to losing weight within a specific period of time and have shown low compliance with the treatment plan.

1.3 Justifications of the study:

Studies conducted in Palestine revealed that approximately 38.9% of females are at risk of developing eating disorders (Musaiger AO et. al., 2012). Furthermore, another study revealed that approximately 85% of students at Al-Najah National University fall into the high-risk category due to their fear of being overweight (Saleh RN et. al., 2018).

The primary reason for this study is the scarcity of research on self-sabotage in general. During our exploration of this topic, we discovered that the available resources are insufficient to fully understand the essence of self-sabotage. The other justification for the importance of this topic stems from the fact that self-sabotage often hinders patients from achieving their treatment goals. Furthermore, the recommendations from previous studies in the literature about self-sabotage motivate the researcher to conduct a more in-depth investigation into this topic. The idea of combining self-sabotage and eating disorders stems from the lack of previous studies in Palestine on this topic. We found that many Palestinians suffer from eating disorders, such as being overweight, underweight (anorexic), or with binge eating disorder. Typically, dietary plans treat these disorders without taking into account the patient's inner psychology, which can lead to self-sabotage and impact treatment compliance. For this reason, we decided to conduct this study.

This study explores the challenges facing people with eating disorders in Ramallah, Jenin, and Hebron. The study's findings will provide policymakers and service providers with valuable insights into the psychology of self-sabotage and its impact on eating disorders. This will facilitate the development of more effective treatments, enhance compliance and commitment to treatment, and provide high-quality services that integrate physical and spiritual aspects, thereby improving the lives of individuals with eating disorders.

1.4 The importance of the study:

Theoretical Importance: The study's theoretical significance emerged from its examination of self-sabotage, including its components and behaviors. In addition, the study explored self-sabotage and its relationship to its types, such as stickler (perfectionism), hypervigilant (anxiety), pleaser (self-worth by pleasing others), judge (criticism), restless (mood), avoider (procrastination), victim (victimization), hyper-achiever (self-worth by achieving more), controller (controlling), and hyper-rational (overanalytical), among patients with eating disorders in Nutri-health centers. Therefore, this study investigated the correlation between self-sabotage, self-worth, self-criticism, mood, procrastination, victimization, controller behavior, and overanalytical behavior among patients with eating disorders in Nutri-health centers. Moreover, the study focused on the association between self-sabotage and demographics such as gender, age, occupation, social status, economic status, and the level of education.

Practical importance: Understanding the causes of self-sabotage within patients with eating disorders is crucial as it prevents them from reaching their final treatment goals and affects their compliance with the treatment. Therefore, this study can provide valuable insights for mental health professionals, leading to improved outcomes for patients with eating disorders. This study is very important because it is the first study in Palestine that combines eating disorders and their emotional effects together in one of the biggest centers about eating disorders in Palestine (Nutri-health) from different regions in Palestine such

as Ramallah, Jenin, and Hebron. This study will play a significant role in guiding professionals in developing innovative treatment methods for individuals with eating disorders. It will consider the emotional aspects of eating disorders and their impact on treatment compliance. This approach will lead to more effective treatment, increased compliance and commitment to treatment, and the provision of high-quality services that integrate physical and spiritual aspects, thereby improving the lives of individuals with eating disorders.

1.5 The aims of the study:

The study aimed to identify the impact of self-sabotage on the compliance of the treatment among patients with eating disorders in Nutri-health centers in Ramallah, Hebron, and Jenin.

This aim has specific objectives:

1. The aim is to identify the level and types of inner saboteurs among patients with eating disorders in Nutri-health centers.
2. The aim is to identify the effect of self-sabotage on the compliance of treatment plans among patients with eating disorders in Nutri-health centers.
3. The aim of this study is to determine whether there are significant differences between various types of self-sabotage among patients with eating disorders in Nutri-health centers.
4. We aim to determine whether self-sabotage and socio-demographic factors, such as gender, age, occupation, social status, economic status, and education level, significantly differ among eating disorder patients at Nutri-health centers.

1.6: The questions of the study:

1. What are the types and levels of inner saboteurs among patients with eating disorders at Nutri-health centers?
2. What is the impact of self-sabotage on the treatment compliance of patients with eating disorders in Nutri-health centers, as perceived by the dietitians working there?
3. Are there significant differences at ($\alpha \leq 0.05$) between self-sabotage and its types?
4. Are there significant differences ($\alpha \leq 0.05$) between self-sabotage and socio-demographics, such as gender, age, occupation, social status, economic status, and the level of education?

1.7 Hypothesis of the study:

1. The first Hypothesis: "There is no significant difference in the mean score of self-sabotage due to the patient characteristics (gender, age, occupation, material status, level of education, and economic status)."

A. First sub hypothesis: there is no significant difference in the mean score of self-sabotage due to gender.
B. second sub-hypothesis, "There is no significant difference in the mean score of

self-sabotage due to the age."

C. Third sub hypothesis: “there is no significant difference in the mean score of self-sabotage due to the patient's occupation.”
D. Fourth sub hypothesis “There is no significant difference in the mean score of self-sabotage due to marital status.”
E. Fifth sub hypothesis "There is no significant difference in the mean score of self-sabotage due to the education level."
F. sixth sub-hypothesis, which asserts, "There is no significant difference in the mean score of self-sabotage due to the economic status."

2. **The second hypothesis: "There is no significant impact of self-sabotage on the compliance of the treatment of patients with eating disorders in Nutri-health centers, as perceived by the dietitians in these centers."**

1.8 The limits of the study:

This study aims to examine the impact of self-sabotage on treatment compliance in patients with eating disorders at Nutri-health centers located in Ramallah, Hebron, and Jenin. This study is subject to numerous limitations, including:

Human limits: Patients with eating disorders are above the age of eighteen.

Time limits: The study focuses on self-sabotage in the treatment compliance of patients with eating disorders in the years 2022 and 2023.

Location: Nutri-health centers in Ramallah, Jenin, and Hebron.

The researcher faces numerous challenges during data collection. For instance, the head of Nutri-Health centers prohibits the researcher from directly contacting participants, asking them questions, or conducting interviews with them. The researcher can only establish a direct connection with the institute, but the researcher cannot access the patient files and records. Participants' poor response rate to the questionnaire is another limitation despite requesting from the dietitians to make sure that the participants filled all the questionnaire. Finally, the lack of studies about the relationship between self-sabotage and eating disorders. In Palestine, no studies at all were found about this topic.

1.9 Definitions:

Self-sabotage: Self-sabotage is when a person actively or passively takes steps to prevent himself from reaching his goals. This behavior can affect nearly every aspect of life; it could be a relationship, career goal, or personal goal, such as weight loss. Despite its prevalence, this behavior creates a cycle of frustration that diminishes a person's self-confidence and leaves them feeling trapped (Lisa Jeffs et al., 2018).

Compliance of Treatment: The word “compliance” comes from the Latin word complire, meaning to fill up and hence to complete an action or process and to fulfill a promise (Aronson et. al., 2007).

Eating disorders: The term eating disorders generally refers to psychological disorders involving gross abnormalities in eating. Starvation, rigid dieting, binge eating, and purging, anorexia nervosa, and bulimia are the most dramatic features of eating disorders (Crowther, Janis H., et al. 2017).

The Saboteurs: are defined as "the internal enemies, a set of automatic and habitual mind patterns, each with its own voice, beliefs, and assumptions that work against your best interest" (Siami, 2019, p. 127).Different types of inner saboteur exist, such as the stickler (perfectionism), the hypervigilant (anxiety), the pleaser (self-worth through pleasing others), the judge (criticism), the restless (mood), the procrastinator (the avoider), the victimization, the hyper achiever (self-worth through achieving more achievements), the controller (controlling), and the hyper-rational (overanalytical).

The Judge Saboteur: According to Chamine, Judge Saboteur is the greatest internal enemy that activates other Saboteurs. The Judge Saboteur holds the individual accountable for their mistakes, instilling in them a sense of anxiety about potential future risks. This can lead to stress and unhappiness, which in turn can result in ineffectiveness. The judge's key responsibility is to exaggerate the negatives and act as a pessimist (Siami, 2019, p. 129). Chamine categorized this pattern as criticism (Siami, 2019, p. 129).

The Stickler Sabotage is "constant frustration and disappointment with oneself and others for not living up to ideal standards and a strong need for self-control." Chamine categorized this pattern as perfectionism (Siami, 2019, p. 130).

The Pleaser Saboteur: This Saboteur attempts to gain the acceptance of others and offers affection through "helping, pleasing, rescuing, or flattering others constantly. This behavior can lead to a loss of focus on the individual's own needs. Chamine identified this pattern as being associated with self-worth (Siami, 2019, p. 130).

The Hyper-Achiever Saboteur: it is characterized by a strong focus on external success, rather than internal criteria for happiness. Individuals with strong hyper-achiever tendencies often exhibit unsustainable workaholic tendencies, leading them to lose sight of their deeper emotional and relationship needs. Chamine categorized this pattern as related to self-worth (Siami, 2019, p. 130).

The Victim Saboteur: it employs the victim voice as a strategy to garner attention and affection. It focuses on painful internal feelings that lead to wasting mental and emotional energy and consequently cause others to become frustrated when trying to reverse these sentiments. Chamine categorized this pattern as victimization (Siami, 2019, p. 131).

The Hyper-Rational Saboteur: is characterized by an intense and exclusive focus on the rational processing of everything, including relationships. Chamine categorized this pattern as overanalytical (Siami, 2019, p. 131).

The Hyper-Vigilant Saboteur: is characterized by its extreme sensitivity to danger signals. This Saboteur causes you to feel intense and continuous anxiety about all the surrounding dangers and what could go wrong. This Saboteur leads to persistent stress, which negatively impacts both the individual and those around them. Chamine classified this pattern as anxiety (Siami, 2019, p. 132).

The Restless Saboteur: it is an ongoing distraction that seeks greater excitement. He named it as the Restless Saboteur. Chamine categorized this pattern as related to mood changes (Siami, 2019, p. 132).

The Controller Saboteur: tends to take charge and control situations and others' actions to suit their own will; otherwise, they become anxious and impatient. Chamine categorized this pattern as controlling (Siami, 2019, p. 132).

The Avoider Saboteur: is characterized by an overemphasis on positive, pleasant emotions. Thus, it causes a person to avoid difficult and unpleasant tasks and conflicts and downplay the importance of real problems. Chamine categorized this pattern as procrastination (Siami, 2019, p. 133).

Chapter Two:

Literature review

2.1. Introduction:

This chapter explored the connection between eating disorders and self-sabotage. Eating disorders are characterized by eating and appetite disorders, which develop on a mental basis. There is an increase in the frequency of these disorders, especially among adolescents. The types of eating disorders include anorexia nervosa and bulimia nervosa (Górski et. al., 2020).

There are many types of inner saboteurs, according to Shirzad Chamine, in 2022: judge, controller, hyper-achiever, restless, stickler, pleaser, hyper-vigilant, avoider, victim, and hyper-rational. Each person possesses one or more of these inner saboteurs, which control their self-destructive behaviors.

There are many studies about eating disorders that were done in Palestine; for instance, a study about eating disorders was done in Polytechnic University. This study examines the prevalence of binge eating symptoms and their relationship with selected variables, such as socio-demographics, nutritional status, and dietary habits. The study involved 150 female undergraduate students from Palestine Polytechnic University, who were assessed for weight status using body mass index, dietary habits, and medical profile. The results showed that half of the participants (50%) had binge eating symptoms (Badrasawi & Zidan, 2019). No association was found between binge eating symptoms and socio-demographic variables. However, binge eating symptoms were associated with eating between meals and the number of snacks. A significantly higher score on depression, stress, and anxiety was found among binge eaters than non-binge eaters (Badrasawi & Zidan, 2019).

Moreover, another study was done in Palestine about the relationship between internet and binge eating disorder; the results of this study, support previous studies that indicated that problematic Internet use was significantly and positively correlated with eating disorder

behaviors, while it was significantly and negatively correlated to well-being among Palestinian university students (Mahmid et al., 2021)

In addition, another study was done in Palestine which examined the prevalence of disordered eating attitudes among female university students at An-Najah National University, Palestine. The study used a screening questionnaire and the Eating Attitudes Test (EAT-26) to survey 2000 female students. Results showed a high prevalence of disordered eating attitudes, with age, academic specializations, and body weight being important factors. Younger females had higher disordered eating attitudes than older students, and female students in non-scientific fields had higher disordered eating attitudes than those in scientific fields. The study suggested that awareness regarding appropriate nutrition in relation to body weight is needed among female university students (Saleh et al., 2018).

Furthermore, a study conducted among 475 undergraduates from three universities in southern Palestine examined the prevalence of Night Eating Syndrome (NES) among them. The study found that NES was significantly related to factors such as gender, major, personal income, source of funding, and mental health. Males, those studying scientific majors, with a monthly income between 500 and 1000 Israeli shekel, and those with mental health problems were significantly associated with NES (Hamdan et al., 2023).

There is a difference between eating problems and eating disorders. The term “Eating problems” is used as general term that can affect the eating such as increase or decrease in weight but it is not necessarily diagnosed as psychiatric disorder. However, eating disorders are related to psychiatric disorders that are diagnosed by a psychiatrist. The diagnosis of eating disorders is based on the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM5). For example, according to the DSM5, anorexia nervosa is diagnosed when the individual experiences low body weight due to restricted energy intake, fear of weight gain, body image disturbance, and denial of the severity of their current weight. However, Bulimia nervosa is diagnosed according to DSM5 when the patient has Recurrent binge eating episodes, characterized by large food intake and lack of control, often occur weekly for three months, with inappropriate recurring compensatory behavior (vomiting, laxatives, exercise, diet pills) along with self-evaluation influenced by body shape and weight. On the other hand, Binge eating disorder is diagnosed according to DSM5 when the patient has Binge episodes as recurring episodes of eating large amounts of food, often beyond fullness, marked with distress, and a sense of lack of control over eating, occurring at least once a week for three months. (Kocsis, 2013)

2.2 Self-sabotage theories:

Self-Sabotage from the Jungian point of view:

Jung frequently references the Heraclitus-derived concept of "enantiodromia". That can be seen as a process of "self-sabotage"; in a few words, it says that everything will turn to its contrary eventually.

We can view this as a method to "self-sabotage" our own "conscious" goals, projects, beliefs, and so on (D’cruz et. al., 2017).

Another similar Jungian concept could be the Shadow. The shadow is the part of ourselves that we don't like, that we don't want to become, or that we fear. However, the Shadow remains an integral

part of us, and we must integrate it with the rest to achieve a more or less 'complete' psyche, a concept Jung referred to as the Self. "Self-sabotage" may appear as a persistent intrusion of the Shadow into our lives, and the more we attempt to resist it, the more prominent it becomes (again, 'enantiodromia'). However, Jung's thought emphasizes that the Shadow is not fighting to destroy; rather, it is merely pressing and pushing to gain recognition and fully express its dynamics. This is why it's crucial to reevaluate all those instances of "self-sabotage," not as a means of eradication, but rather as an opportunity to uncover a more comprehensive aspect of ourselves (D'cruz et. al., 2017). Another view about self-sabotage was done by Melanie Klein who connected the object relation theory with the self-sabotage.

Self-sabotage from Kleinian point of view:

Melanie Klein has had a major impact on the development of psychoanalytic thought since Freud. She made highly original contributions to the development of object relations theory (Ives et. al., 2017).

Object relations theory is the full realization of Freud's attempt to move "beyond the pleasure principle." The human psyche is recognized as not simply governed by a need to satisfy its basic drives (Ives et al., 2017).

For the infant, the first object is a partial object, such as the mother's breast. The infant does not respond to the mother as a whole person, but simply as a "breast," a supplier of its needs. In turn, the breast becomes an object of desire in its own right. Finding "good" objects strengthens the ego. Their internalization (introjection and identification) is important for the development of psychic structure and mental functioning. These objects populate an "internal world" that in effect shapes the infant's mind (Cox et al., 2017).

Central to the theory is the distinction between part/whole objects, good/bad objects, idealized objects, object constancy, and transitional objects. Through projection, the psyche attributes or places unacceptable feelings onto objects, and through a primitive mental mechanism known as splitting, it can distinguish between the pleasurable and non-pleasurable aspects of the same object. These processes serve both an adaptive and defensive function (Cox et al., 2017).

Envy stems from an immature intolerance to frustration. Melanie Klein discovered in her research that the initial object of envy was the breast. This is primary envy, and if it is tolerated and worked through, it will lead to normal development (Cox et al., 2017).

Defenses against envy quickly lead to psychopathology because they fail to prevent the destructive operation of envy. Unresolved primary envy can lead to psychotic symptoms in later life. Envy is commonly accompanied by self-destructiveness. Self-sabotage can be viewed as a form of punishment for harboring forbidden desires, feelings, and thoughts; it serves to relieve the individual from tolerating these destructive aspects of themselves. Freud described the superego as an internalized version of our parents, capable of punishing us if we disobey their commands (Gois et al., 2021).

Withdrawal of a good object, when not dealt with in rage and outward destructiveness, will turn inward. The ego can implode and destroy itself. Suicide could be a later manifestation of the early need for self-destruction, which the infant is unable to express on its own (Ives et al., 2017). On the other hand, Fairbairn's perspective about the self-sabotage was different.

Self-sabotage from Fairbairn's point of view:

Fairbairn's perspective perceives parental failures as intolerable to the child, which in turn triggers a splitting defense. This defense isolates, through repression, the frustrating aspects of the object and the part of the child's ego that is exclusively related to that object. This fundamental defense protects the child from the knowledge that he is dependent on indifferent objects and preserves his attachment (Cox et al., 2017).

Fairbairn's theory relates to the internalized rejecting object (the antilibidinal ego); however, the separate part-self that relates to the exciting object (the libidinal ego) is different. Actual memories of the parent's frustrating, abusive, or negligent behavior form the internalized rejecting object, which the child associates with their antilibidinal ego (Celani et. al., 2007). Moreover, many studies connected the self-sabotage with the low self-esteem.

Self-esteem:

Self-esteem refers to *the positive (high self-esteem) or negative (low self-esteem) feelings that we have about ourselves.* We experience the positive feelings of high self-esteem when we believe that we are competent and worthy and that others view us positively. We experience the negative feelings of low self-esteem when we believe that we are inadequate and less worthy than others (D'cruz et al., 2017).

Many factors, including how well we view our own performance and appearance and how satisfied we are with our relationships with others, determine our self-esteem. Self-esteem is in part a trait that is stable over time, with some people having relatively high self-esteem and others having lower self-esteem. But self-esteem is also a state that varies day to day and even hour to hour. Our self-concept will contain many positive thoughts when we succeed at an important task, perform something we believe is useful or important, or feel accepted and valued by others, leading to high self-esteem. Negative aspects of our self-concept become more accessible when we have failed, done something harmful, or feel ignored or criticized, leading to low self-esteem (D'cruz et al., 2017). The study concluded that adolescents with eating disorders exhibit suicidal ideation and self-injurious behaviors, which exacerbate their self-sabotaging behaviors (Varela et. al., 2017).

The desire to portray oneself positively can influence measures like the Rosenberg scale. People naturally try to portray themselves as having very high self-esteem, which may lead to somewhat inflated observed scores on the Rosenberg scale (D'cruz et al., 2017).

There are studies that test a structural model of the mediating roles of self-esteem and perfectionism in the relationship between personality traits and eating disorders (ED). The findings validate the correlation between schizoid, paranoid, self-destructive, and borderline personality traits and eating disorders, the primary mediating role of self-esteem in the impact of specific personality traits on eating disorders, and the mediating role of perfectionism in the influence of borderline personality traits on eating disorders and self-esteem (Mas Mercedes et. al., 2011). Self-sabotage and Self-esteem can affect the compliance of the treatment.

Compliance for patients with eating disorders:

It is challenging for individuals with eating disorders to maintain motivation to recover. This challenge contributes to high rates of treatment dropout and relapse (Venturo-Conerly et. al., 2020).

Another study examined family-based treatment adherence and its association with treatment outcomes for patients with anorexia nervosa. The results of this multicenter study concluded that the percentage of body weight did not correlate with adherence to treatment outcome (Dimitropoulos et. al., 2019). A low rate of adherence to treatment is a widespread problem of significant clinical relevance among patients with eating disorders. The present study aims to investigate the correlation between adherence and treatment outcomes. For instance, a previous study examined the effectiveness of cognitive behavioral guided self-help in treating recurrent binge eating in patients with eating disorders. This study used session-by-session assessments of regular eating adherence and weekly binge totals. The results demonstrated that higher regular eating adherence (3 meals and 2–3 planned snacks daily) was associated with a lower weekly binge frequency (Zendegui et al., 2014).

2.3: Previous studies:

Many previous studies explored the influence of self-esteem on levels of body dissatisfaction among patients. For example, a cross-sectional study in 2014 evaluated the influence of self-esteem on levels of body dissatisfaction among adolescent females. This study employs a group of 397 school adolescents, ranging in age from 12 to 17 years. We selected the sample based on the location of schools in the socio-geographic regions of Juiz de Fora (North, Central, and South), as well as the type of school (public or private), and then divided it into primary and secondary education. We performed the selection randomly in two stages, using simple drawing techniques. We first drew the schools in each region, followed by the adolescents in these units. We divided the final study sample into six different sampling sites (schools) and included randomly selected female adolescents who were present in the schools on the collection days. (De Sousa Fortes et al., 2014). We applied the Body Shape Questionnaire (BSQ) to assess body dissatisfaction. We used the Rosenberg Self-Esteem Scale to assess self-esteem. We also measured the weight, height, and skinfold thickness. The statistical analyses controlled these anthropometric data. This study emphasized that self-esteem influenced body dissatisfaction in adolescent girls (De Sousa Fortes et al., 2014).

Another scoping review study examined the instruments used in multi-component weight management interventions, focusing on children and adolescents who were overweight or with binge eating disorder, as they were at risk of experiencing a decline in self-esteem compared to individuals of healthy weight. An electronic search, from 2007, identified multicomponent weight-management interventions that included a measure of self-esteem. A second search identified studies that reported validation assessments of the questionnaires identified in the first search (Tirlea et al., 2019). The methods that were used were the Rosenberg Self-Esteem Scale, Marsh's Self-Description Questionnaire-I, Beck Youth Inventory II, Piers-Harris Self-Concept Scale, and Children and Youth Physical

Self-Perception Profile. The study's results revealed the use of seven validated self-esteem questionnaires in 36 studies, including the study setting (Tirlea et al., 2019), in descending order of use.

Other cross-sectional studies explored the relationship between body mass index (BMI) and self-reported eating-related behaviors. We used a sample of 73 people with a BMI of less than 25 and the scale. We measured body weight and height in a private room using a calibrated scale and a calibrated wall-mounted stadiometer. BMI was calculated as kg/meters2. A statistical analysis was preformed using ANOVA. The study's results revealed an association between binge eating and increased suggestibility (Ray et al., 2020).

Moreover, a previous study focused on the relationship between childhood trauma and medically self-sabotaging behaviors (intentional exaggeration and exacerbation of medical symptoms). The methods involved surveying a cross-sectional sample of 120 psychiatric inpatients about childhood sexual, physical, and emotional abuses, along with 19 medically self-sabotaging behaviors, including intentional actions aimed at undermining medical care. The study's results revealed statistically significant relationships between sexual abuse, physical neglect, and medically self-sabotaging behaviors in this sample. Through multiple regression analysis, only physical neglect remained a unique predictor of medically self-sabotaging behaviors. This study concluded that there is a relationship between physical neglect in childhood and the generation of medically self-sabotaging behaviors in adulthood (Sansone et al., 2008).

In 2018, an observational cross-sectional descriptive study of 284 female patients aged

13-45 with eating disorders stated that shoplifting may be associated with impulsive behaviors (e.g., alcohol and illicit drug use), depression, and low self-esteem, but not with eating disorder severity (Miyawaki et al., 2018).

Researchers conducted further studies to investigate the connection between suicidal thoughts and self-injurious behaviors in patients with eating disorders (Anderson et al., 2017). For instance, in 2017, Anderson et al. conducted a study in a Barcelona hospital to determine the prevalence of suicidal ideation and self-harm in adolescents with eating disorders. They evaluated 109 participants with eating disorders, whose mean age was 14.47, and 87% of them were female (Anderson et al., 2017). Furthermore, researchers are examining the correlation between self-harming actions and suicidal thoughts, and connecting it to the intensity of eating disorder symptoms, signs of depression and anxiety, drive for change, and the pursuit of perfection (Anderson et al., 2017). This study employed various methods such as the eating disorder inventory, the Beck depression scale, the state-trait anxiety inventory, the child and adolescent perfectionism scale, and the anorexia nervosa stages of change questionnaire. This study emphasized that there was a significant percentage of adolescents with eating disorders who had suicidal ideation and self-injurious behavior and had a more severe psychopathological profile (Anderson et al., 2017).

Additional studies explored the hypothesis that self-esteem and depression mediate the effect of body dissatisfaction on eating disordered behavior. For example, a descriptive study was conducted on 320 students from Norway. We recruited participants voluntarily at the end of class, and they promptly completed a questionnaire. This study suggested that treatment will be more beneficial if we focus on self-esteem and depression than body dissatisfaction (Brechan et al., 2015). This study also hypothesized that body image is associated with lower self-esteem, stronger symptoms of depression, and more disordered

eating. The results showed that both self-esteem and depression were significant mediators for the treatment. Depression had a direct effect on binge eating (Brechan et al., 2015). This effect was significantly stronger among women. Depression also had a direct effect on restrained eating. This effect was positive among women but negative among men. The results support emotion regulation and cognitive behavioral theories of eating disorders, indicating that self-esteem and depression are the most proximal factors (Brechan et al., 2015). The results point out the importance of distinguishing between different symptoms of bulimia. Depression may cause binge eating, but compensatory behavior depends on self-esteem and body image importance (Brechan et al., 2015). The results suggest that women may turn to both binge eating and restrained eating to escape awareness of negative emotions, whereas men focus on eating to a lesser extent than women. Existing treatment focuses on eating behavior first and second on other mechanisms such as self-esteem and depression. This study's results suggest that treating disordered eating may require an earlier focus on self-esteem and depression (Brechan et al., 2015). Males and females are different in their sabotage behaviors; males are twice as likely to sabotage than females (Simon Dato et al. 2014).

2.4 Compliance to Treatment:

Patients with bulimia nervosa report significant improvements when they comply with self-monitoring at home. The results of this study confirm that compliance with self-monitoring and behavioral homework predicts improvements in bulimia nervosa symptoms during behavioral treatment. These findings reinforce the importance of self-monitoring and behavioral homework compliance, which can be effective treatment for bulimia nervosa patients (Srivastava, Paakhi, et al., 2023). Another study found that the use of cognitive behavioral therapy significantly improved treatment compliance for about 62% of bulimia patients after 6 weeks of treatment. This study concluded, after analyzing the results of a randomized control trial, that cognitive behavior therapy produced more rapid and effective treatment results than interpersonal psychotherapy (G Terence Wilson et. al., 2002). It is important to mention that there is a significant lack of compliance in treatment for patients with eating disorders, and this lack is linked to self-sabotage.

2.5 Commenting on previous studies:

Considering the earlier research conducted in 2017, (Cox et al., 2017)

Researchers discovered lack in research on the subject; some studies explored the relationship between object relation theory and self-sabotage, examining how self-sabotage impacts all facets of life, including interpersonal relationships and the patient's potential for self-destructive behaviors that undermine treatment objectives.

By assessing the level of self-sabotage in these patients and attempting to comprehend its fundamental causes, we can enhance their treatment by concentrating on psychological issues like low self-esteem, which may have a connection to self-sabotage.

In Palestine, there are no studies examining the connection between self-sabotage and eating disorders, nor a treatment approach that addresses both the body and the soul. This

is why the researcher is keen to delve deeper into this topic. Moreover, even in the Arab world, there are no studies about the relationship of self-sabotage and eating disorders.

2.6 Conceptual Framework:

A conceptual framework is a tool formulated from a set of different and broad ideas, theories, assumptions, concepts, expectations, and beliefs taken from relevant fields of inquiry that can support the researchers to properly identify the problem that they are looking for, direct their investigation, form their questions, and search for suitable literature (Levien, 2006).

In the conceptual framework, we examined the influence of self-sabotage on treatment compliance in patients with eating disorders.

Operational Definition of study variables:

Independent Variables:

We collected demographic information such as gender, age, the family's economic status, and marital status. After that, we measured the level of self-sabotage behavior using ten dimensions: stickler, hyper-vigilant, pleaser, judge, restless, avoider, victim, hyper-achiever, controller, and hyper-rational as independent variables. Specific questions in the questionnaire were asked for each dimension to measure each type of the self-sabotage and in the methodology section, we explained in details the questions to measure each saboteur in the questionnaire that was used. These variables were collected from patients with eating disorders through self-administered questionnaire after getting their agreement to participate and after signing the informed consent.

Dependent Variables:

Compliance is the dependent variable, the compliance section, was the third part of the questionnaire which was filled only by the dietitians. In the methodology and results chapters, we explained in details the equation of compliance that we used along with the tools of the study, including the questionnaire that we used to measure the impact of self-sabotage on the compliance of patients with eating disorders.

Chapter Three:

Methodology

3.1 Introduction:

This chapter describes the methodology used to assess the impact of self-sabotage behavior on the compliance of treatment among patients with eating disorders at Nutri-health Centers. To answer the research aims and objectives, the study relies on descriptive and inferential analysis. The study describes the study design, study setting, study population, sampling frame, sample criteria, sampling process, data collection procedures, ethical considerations, and statistical analysis. It also examines the study tool's selection and construction, as well as the changes made and procedures used to ensure the questionnaire's validity and consistency. The study also addressed the various statistical methods and tests used in data processing.

3.2 Study design:

This study employed a descriptive design, incorporating quantitative, the researcher selected this design to evaluate the impact of self-sabotage on the compliance of treatment among eating disorder patients in Nutri-health centers located in Ramallah, Hebron, and Jenin. This study also statistically examined the relationship between self-sabotage and other aspects, enabling us to develop more effective treatment plans for these patients in the future. Additionally, we included a section in the questionnaire for the dietitians to verify each patient's level of compliance based on patients' records.

This research employed a descriptive design using quantitative techniques, with the aim of identifying the results of the research problem and examining the research hypotheses. The information which gathered and analyzed was quantitative in nature, with the goal of studying the relationship between variables in numerical and statistical terms. The study relies on primary cross-sectional data, as we gathered research information from the study sample using a semi-structured questionnaire.

3.3 Study setting:

The researcher conducted this study at Nutri-Health centers in Ramallah, Hebron, and Jenin. Nutri Health Centers are among the largest centers for eating disorders in Palestine. The Nutri-Health Institute has many centers all around Palestine, such as in Hebron, Ramallah, Jenin, Bethlehem, Al-Ram, Tulkarm, and Nablus. The researcher did the study in the three main branches of Nutri-health, which were Ramallah, Hebron, and Jenin. A large team of qualified and professionally trained nutritionists is available to assist participants in losing weight healthily by emphasizing a healthy lifestyle. Additionally, they prioritize the quality of food the patient consumes during their weight loss journey, complementing the weekly advice and support provided by the center to help participants achieve a slim and healthy body. On the other hand, participants who suffer from anorexia can also obtain help from Nutri-health centers to help them gain weight. It is important to mention that psychiatrists diagnose the patients with eating disorders before transferring them to the Nutri-health centers. The Nutri-health centers exclusively assist patients suffering from eating disorders with their dietary plans. Only psychiatrists, who are qualified and specialized doctors, diagnose patients with eating disorders such as anorexia nervosa, bulimia nervosa, and binge eating disorder. The diagnosis of eating disorders is based on the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM5). For example, according to the DSM5, anorexia nervosa is diagnosed when the individual experiences low body weight due to restricted energy intake, fear of weight gain, body image disturbance, and denial of the severity of their current weight. However, Bulimia nervosa is diagnosed according to DSM5 when the patient has Recurrent binge eating episodes, characterized by large food intake and lack of control, often occur weekly for three months, with inappropriate recurring compensatory behavior (vomiting, laxatives, exercise, diet pills) along with self-evaluation influenced by body shape and weight. On the other hand, Binge eating disorder is diagnosed according to DSM5 when the patient has Binge episodes as recurring episodes of eating large amounts of food, often beyond fullness, marked with distress, and a sense of lack of control over eating, occurring at least once a week for three months. (Kocsis, 2013)

3.4 Study population

This study's target population includes all individuals with eating disorders over the age of 18, registered at Nutri-health centers in Ramallah, Hebron, and Jenin, totaling 3079 patients (Nutri-health, 2023). Table 3.1 illustrates the population distribution according to the area of Nutri-health centers.

Table 3.1: Population distribution

Centers	**N**	**Percentage (%)**
Ramallah	1572	51.06
Hebron	815	26.47
Jenin	692	22.47
Total of all population	3079	100.00

3.5 Sampling frame

- **Inclusion criteria:**

1. Between February and March 2023, Nutri-health centers in Ramallah, Hebron, and Jenin will host patients with eating disorders who are above 18 years old.
2. Dietitians in the Nutri-health center confirm the level of compliance in each patient.

- **Exclusion criteria:**

1. Individuals who are under the age of 18.
2. People without eating disorders.
3. People who are not from Nutri-health centers in Ramallah, Jenin, and Hebron.

3.6 Study Sample

The efficient way to choose the sample that represents the population is a proportional stratified random sampling because the Nutri-health centers don't have the same number of patients. We chose three main centers to do our sample in Ramallah, Jenin and Hebron. Hair et al. (2007) defined stratified random sampling as a process that selects certain sub-groups or strata for the sample in the same proportion as they exist in the population. Since there are three centers selected, this research design would increase the likelihood of representativeness. We used Slovin's Formula to calculate and gain a more accurate result on the sample size; equation (1) illustrates the basis for determining the sample size through Slovin's Formula (Thompson, 2012).

$$n = \frac{N}{1 + Ne^2} \qquad eq.(1)$$

$$n = \frac{3079}{1 + 3079 * 0.05^2} = 354 \qquad eq.(1)$$

Where n is the sample size, N represents the population size, and e represents the desired margin of error. The Slovin's formula indicates that, using a 0.05 desired margin of error (e), the efficient sample size to represent the population in this study is 354, while the population of patients in the selected centers is 3079. The Slovin's formula shows that the number of 354 observations can efficiently represent the population in this study. We constructed a sampling frame to illustrate the accessible population in three selected areas.

We selected the 354 respondents based on the accessibility of the three centers. Next, we randomly distributed the questionnaire to a sample of 354 patients selected from these centers. Table 3.2 illustrates the distribution of the sample based on the selected centers.

Table 3.2: Distribution of respondents from selected centers

	Population		Sample	
Centers	N	Percent (%)	N	Percent (%)
Ramallah	1572	51.06	181	51.1
Hebron	815	26.47	94	26.6
Jenin	692	22.47	79	22.3
Total of all population	3097	100.00	354	100.00

Out of the 354 questionnaires, 300 questionnaires were filled completely, and the response rate was 84.7%. Table 3.3 represents the final distribution of respondents from selected centers.

Table 3.3: Distribution of final sample from selected centers

	Sample		Final Sample	
Centers	N	Percent (%)	N	Percent (%)
Ramallah	181	51.1	156	52.00
Hebron	94	26.6	76	25.3
Jenin	79	22.3	68	22.7
Total of all sample	354	100.00	300	100.00

3.7 Tools for data collection

Shirzad Chamine (2012) used a well-structured questionnaire about self-sabotage, with mostly closed-ended questions. Semi-structured interviews collected the data. It is important to mention that the researcher translated this questionnaire from English to Arabic. After that, back translation was done from Arabic to English by a fluent English physician and also it was presented after that to a committee of mental health experts who reviewed it to measure the validity of the tool, this committee of experts was composed of Dr. Salam Al-Khatib, Dr. Najah Al-Katib and Dr. Mohammad Al-Amri. The researcher took their recommendations into consideration (See appendix 2 for the list of the experts).

We have divided the questionnaire into three main sections:

1. **Section one includes** questions related to personal data that were filled out by the participants with eating disorders in Nutri-health centers. This part consists of the patient's profile and demographic factors such as age, the center's area, gender, marital status, education level, income, and occupation.

2. **The participant with eating disorders filled out Section 2, which represented a questionnaire about self-sabotage based on research by Stanford University researcher Shirzad Chamine (2012).** The questionnaire consists of 41 questions. We rate the questions using a 5-point Likert scale, which ranges from 0 (strongly disagree) to 4 (strongly agree). Each question represents a mode of self-sabotage. The questionnaire will assess perfectionism, anxiety, self-worth, self-criticism, mood, procrastination, and victimization. Table 3.4 shows the number of questions for each type of inner saboteur.

Table 3.4: Inner saboteur types and their related questions

Types of inner saboteur	Number of questions (questions' number in the questionnaire)
Perfectionism (stickler)	3 Questions (Q2, Q24,Q32)
Anxiety (Hyper-vigilant)	8 Questions (Q1, Q3, Q4,Q17,Q22,Q25,Q28, Q35)
Self-worth (Pleaser)	7 Questions (Q9, Q11, Q19,Q21,Q26,Q30 ,Q40)
Criticism (Judge)	7 Questions: -Self-criticism :3 Questions (Q10, Q23, Q37) -Others criticize you: One Question (Q27) -You criticize others: 3 Questions (Q5, Q18, Q 33)
Mood (Restless)	2 Questions (Q8, Q41)
Procrastination (The avoider)	5 Questions (Q12, Q13, Q20, Q34, Q36)
Victimization (The victim)	One Question (Q 38)
Self-worth (Hyper-achiever)	2 Questions (Q31,Q39)
Controlling (Controller)	2 Questions (Q6, Q16)
Overanalytical (Hyper-rational)	2 Questions (Q7,Q29)

3. Section three contained the clinical information completed by the dietitians who follow-up with patients with eating disorders at Nutri-health centers in Ramallah, Jenin, and Hebron. **Only the dietitians at Nutri-health centers, who had access to patient records, completed this section to assess the patients' adherence to the treatment plan.**
Additionally, the researcher asked the dietitians to ensure that all participants filled out all sections of the questionnaire in order to obtain reliable and comprehensive data.

3.8 Pilot Study

We conducted a pilot study prior to the actual data collection. This stage's goal was to find out how well the study tool works for this study, how long it took to fill out the questionnaire, where the questions were unclear, and where the wording was weak. The researcher chose 25 people from the Al 'Eizariya Center for Nutrition and Health. The study sample didn't include the pilot participants. Therefore, the researcher implemented the necessary changes to the questionnaire following the piloting phase. After reviewing the answers provided by the patients in the pilot sample, the researcher incorporated open-ended questions about age and monthly income to accurately measure these variables and obtain accurate results in the predicted model. Additionally, the researcher examined the questionnaire's reliability and validity.

3.9 Reliability and validity of the instrument

The validity of an instrument is often defined as the extent to which it measures what it purports to measure, and validity requires that an instrument is reliable (Akib et al. 2015). This instrument wasn't used in Palestine before. It also wasn't used in the Arab world in previous studies.

We used Cronbach's coefficient (CA) and the composite reliability to check the instrument's (CR) reliability. We used construct validity and convergent validity to assess the tool's validity. We used Exploratory Factor Analysis (EFA) and varimax rotation to verify its validity. The Researcher applied exploratory factor analysis, a statistical technique, to a single set of variables to determine which variables form coherent subsets that are relatively independent of each other (Tabachnick, 2014). Hair Jr. et al. (2013) said that exploratory factor analysis shows if all of the items in a construct are highly related and represent the same construct.

In this section, the researcher assesses the reliability and validity of the instrument in the pilot and actual samples.

3.9.1 Reliability and validity of the pilot study:

We used the Kaiser-Meyer-Olkin (KMO) and Bartlett tests to determine the suitability of the data sample for factor analysis. The KMO score is 0.865, which is higher than 0.60. This indicates that the items adequately measure the construct (factors). The Bartlett's test confirms this once more, yielding a p-value of 0.000, which falls below 0.05 and is deemed significant. This means that the assumption of the factor analysis was correct.

Table 3.5 displays the results. The Cronbach's coefficients range from 0.555 to 1.000, and the CA values are between 0.702 and 1.000. This means that the factors are very consistent with each other, which means the instrument is reliable (Hair et al., 2017; George and Mallery, 2010).

Fornell et al. (1981) recommend using the item in the study if it has a factor loading of more than 0.40. This is to check the validity of the instrument. According to the results in table 3.6, all of the items' factor loadings were between 0.526 and 0.907. This means that all of the items are good.

Table 3.5: Results of exploratory factor analysis of the instrument in pilot sample

No.	Items	Factor loading
	Perfectionism (stickler) (CR=0.774, Cronbach's α=0.555)	
2.	I can be too much of a stickler or perfectionist.	0.783
24.	I feel restless and rarely at peace with what I am doing in the moment	0.819
32.	I often find faults and mistakes within others	0.577
	Anxiety (Hyper-vigilant) (CR=0.921, Cronbach's α=0.897)	
1.	I have discomfort with conflict and avoid .	0.711
3.	I am usually more anxious and worried than others around me.	0.696
4.	I criticize others a lot more often than praise them..	0.865
17.	I am annoyed by faults with others.	0.757
22.	I criticize myself a lot	0.681
25.	I am confrontational and forceful when I need to get things done	0.832
28.	I tend to threaten others with the intensity of my analytical mind	0.792
35.	I get impatient with others easily	0.810
	Self-worth (Pleaser) (CR=0.896, Cronbach's α=0.858)	
9.	I have strong criticism for myself	0.837
11.	I procrastinate my work and responsibilities	0.907
19.	I avoid dealing with conflicts to a point where they accumulate and become real problems.	0.807
21.	I am very anxious	0.843
26.	When I am criticized or unfairly treated, I tend to withdraw	0.614
30.	Life is about achieving and producing results for me	0.624
40.	The circumstances of work or life significantly affect how happy I feel	0.526
	Self-criticism (CR=0.702, Cronbach's α=0.599)	
10.	I am a "pleaser."	0.609
23.	I like things to be very organized	0.674
37.	I feel like a victim	0.704
	Others criticize you (CR=1.000, Cronbach's α=1.000)	
27.	When bad things happen, I tend to stay upset for some time	1.000
	You criticize others (CR=0.845, Cronbach's α=0.684)	
5.	I have a strong need to take charge and be in control	0.747
18.	Pleasing others and having them like me is very important to me	0.818
33.	I procrastinate on dealing with important but unpleasant tasks	0.843
	Mood (Restless) (CR=0.835, Cronbach's α=0.816)	
8.	I measure my self-worth through my achievements	0.790
41.	I can't rest and need to be constantly busy	0.900
	Procrastination (The avoider) (CR=0.899, Cronbach's α=0.854)	
12.	I need to do different things at the same time to prevent boredom	0.889
13.	When things go wrong, I tend to stay upset for some time	0.844
20.	My social status and public image are important to me	0.843

Table 3.5b: Results of exploratory factor analysis of the instrument in pilot sample

34.	Others tell me that I worry too much	0.719
36.	When I make a mistake, I punish myself over it	0.697
No.	**Items**	**Factor loading**
	Victimization (The victim) (CR=1.000, Cronbach's α=1.000)	
38.	I feel worthy when I am successful and achieving	1.000
	Self-worth (Hyper-achiever)(CR=0.851, Cronbach's α=0.724)	
31.	Others tell me I am too much of a perfectionist	0.645
39.	I am so into helping others that I sometimes lose of my own needs and feel bad.	0.838
	Controlling (Controller) (CR=0.825, Cronbach's α=0.851)	
6.	I proud of being rational and analytical.	0.891
16.	I have a tendency to feel sorry for myself	0.830
	Overanalytical (Hyper-rational) (CR=0.788, Cronbach's α=0.748)	
7.	I have a tendency towards being moody	0.787
29.	Compared to others, I do more pleasing for other people	0.825

3.9.2 Reliability and validity of the actual study

The KMO score is 0.716, which is higher than 0.60. This indicates that the items adequately measure the construct (factors). The Bartlett's test confirms this once more, yielding a

p-value of 0.000, which falls below 0.05 and is deemed significant. This means that the assumption of the factor analysis was correct. Table 3.7 displays the results. The Cronbach's coefficients range from 0.602 to 0.838, and the CA values are between 0.759 and 1.000. This indicates that the factors exhibit high consistency with each other, indicating the reliability of the instrument (Hair et al., 2017). According to the results, all of the items' factor loadings were between 0.459 and 0.892. This means that all of the items are good (Fornell et al., 1981).

Table 3.6-a: Results of exploratory factor analysis of the instrument

No.	**Items**	**Factor loading**
	Perfectionism (stickler) (CR=0.811, Cronbach's α=0.653)	
2.	I can be too much of a stickler or perfectionist.	0.777
24.	I feel restless and rarely at peace with what I am doing in the moment	0.771
32.	I often find faults and mistakes within others	0.754
	Anxiety (Hyper-vigilant) (CR=0.876, Cronbach's α=0.838)	
1.	I have discomfort with conflict and avoid .	0.658
3.	I am usually more anxious and worried than others around me.	0.737
4.	I criticize others a lot more often than praise them..	0.682
17.	I am annoyed by faults with others.	0.646
22.	I criticize myself a lot	0.700

Table 3.6-b: Results of exploratory factor analysis of the instrument

No.	Items	Factor loading
25.	I am confrontational and forceful when I need to get things done	0.618
28.	I tend to threaten others with the intensity of my analytical mind	0.745
35.	I get impatient with others easily	0.686
	Self-worth (Pleaser) (CR=0.808, Cronbach's α=0.721)	
9.	I have strong criticism for myself	0.652
11.	I procrastinate my work and responsibilities	0.720
19.	I avoid dealing with conflicts to a point where they accumulate and become real problems.	0.645
21.	I am very anxious	0.663
26.	When I am criticized or unfairly treated, I tend to withdraw	0.627
30.	Life is about achieving and producing results for me	0.459
40.	The circumstances of work or life significantly affect how happy I feel	0.503
	Self-criticism (CR=0.808, Cronbach's α=0.634)	
10.	I am a "pleaser."	0.764
23.	I like things to be very organized	0.778
37.	I feel like a victim	0.740
	Others criticize you (CR=1.000, Cronbach's α=1.000)	
27.	When bad things happen, I tend to stay upset for some time	1.000
	You criticize others (CR=0.826, Cronbach's α=0.684)	
5.	I have a strong need to take charge and be in control	0.763
18.	Pleasing others and having them like me is very important to me	0.797
33.	I procrastinate on dealing with important but unpleasant tasks	0.788
	Mood (Restless) (CR=0.814, Cronbach's α=0.631)	
8.	I measure my self-worth through my achievements	0.870
41.	I can't rest and need to be constantly busy	0.786
	Procrastination (The avoider) (CR=0.759, Cronbach's α=0.602)	
12.	I need to do different things at the same time to prevent boredom	0.670
13.	When things go wrong, I tend to stay upset for some time	0.580
20.	My social status and public image are important to me	0.517
34.	Others tell me that I worry too much	0.688
36.	When I make a mistake, I punish myself over it	0.646
	Victimization (The victim) (CR=1.000, Cronbach's α=1.000)	
38.	I feel worthy when I am successful and achieving	1.000
	Self-worth (Hyper-achiever)(CR=0.853, Cronbach's α=0.703)	
31.	Others tell me I am too much of a perfectionist	0.892
39.	I am so into helping others that I sometimes lose of my own needs and feel bad.	0.832
	Controlling (Controller) (CR=0.825, Cronbach's α=0.608)	
6.	I proud of being rational and analytical.	0.823
16.	I have a tendency to feel sorry for myself	0.853
	Overanalytical (Hyper-rational) (CR=0.830, Cronbach's α=0.625)	
7.	I have a tendency towards being moody	0.811
29.	Compared to others, I do more pleasing for other people	0.873

3.10 Data collection methods and Procedure

The researcher purposefully selected people with eating disorders from Nutri-health centers in Ramallah, Hebron, and Jenin. In order to safeguard the confidentiality and privacy of the participants in Nutri-health centers, the researcher refrained from accessing the names and files of patients in the center. Instead, the researcher maintained contact with the institute itself, avoiding direct interaction with the participants. The participants completed the questionnaire within the Nutri-health centers, which Shirzad Chamine had previously used for self-sabotage. Furthermore, dietitians in nutria-health centers assessed each patient's level of adherence to the treatment plan based on their medical records.

3.11 Data analysis

We conducted the data analysis using version 23 of the Statistical Package for Social Sciences (SPSS). The assumption of normality needs to be checked for many statistical procedures, namely parametric tests, because their validity depends on it, so before determining the statistical tools that the research must use, the Kolmogorov-Smirnov test was used to check the factor distribution; Table 3.7 clarifies that all study variables had non-normal distribution with p-values less than the significance level (α=0.05).

Table 3.7: Kolmogorov-Smirnov test for normal distribution

Dimensions	Statistic	Df	Sig./p-value
Perfectionism (stickler)	0.110	300	0.000
Anxiety (Hyper-vigilant)	0.088	300	0.000
Self-worth (Pleaser)	0.057	300	0.022
Self-criticism	0.082	300	0.000
Others criticize you	0.222	300	0.000
You criticize others	0.098	300	0.000
Criticism (Judge)	0.056	300	0.025
Mood (Restless)	0.144	300	0.000
Procrastination (The avoider)	0.096	300	0.000
Victimization (The victim)	0.188	300	0.000
Self-worth (Hyper-achiever)	0.115	300	0.000
Controlling (Controller)	0.127	300	0.000
Overanalytical (Hyper-rational)	0.149	300	0.000

In this study, the researcher employed nonparametric statistical tools to examine the hypothesis and questions.

- Frequencies and percentages are used to describe the characteristics and responses of the sample.
- Mann-Whitney The U test is used to examine the differences between the mean scores of study factors with non-normal distributions or non-equal variance in two groups, such as gender.

- The Kruskal-Wallis test is the non-parametric alternative to one-way analysis of variance (ANOVA), which is appropriate when there is a need to compare data that have more than two groups to determine if there is a significant difference between the tested groups or not.
- We used the Pearson correlation coefficient to examine the relationships between the study variables.
- Before applying the regression model, the dietitians at Nutri-health centers must assess four diagnosis tests to determine the impact of self-sabotage on the treatment compliance of patients with eating disorders.

1. We used the multicollinearity, correlation coefficient, and variance inflation factor (VIF). Kennedy (1985) suggested that a correlation coefficient between two independent variables in the same model of more than 0.8 shows the existence of multicollinearity, and Hair et al. (2017) suggested that a VIF of more than 10 shows the existence of multicollinearity, which is a serious problem.
2. When autocorrelation problems arise, the standard errors of the coefficients tend to be smaller than their actual values, leading to higher R-squared values. To verify this, we used Durbin Watson, ensuring its value falls between 1.5 and 2.5.
3. There is heteroskedasticity when the residuals' variance is not the same across a range of measured values. The Breusch-Pagan/Cook-Weisberg test was used to check for heteroscedasticity; if the p-value is less than the significant level (± = 0.05), there is a problem.
4. Distribution of residuals: The Kolmogorov-Smirnov test was used; if the p-value is more than the significant level (α=0.05), the problem exists.

To solve these problems. We used robust standard error estimation (Rogers, 1993; Hoechle, 2007).

- To describe the participant's response, the researcher uses three main classes for easier response interpretation. To figure out the range of each class, the researcher took the difference between the highest value (4) and the lowest value (0) of the scale and divided it by the number of categories needed (5), so the result becomes 4/5=0.8, and thus continue to increase the value starting from the lowest value. Table 3.9 illustrates the distribution of the mean value in one of the agreement classes.

Table 3.8: Distribution of mean value into one of the agreement classes

Class	Mean Range	Agreement class
1	Less than 0.80	Very low
2	0.80 -1.59	Low
3	1.60-2.39	Moderate
4	2.40-3.19	High
5	3.20-4.00	Very high

3.12 Ethical Considerations:

1. Nutri-health centers have granted us ethical permission to conduct our research within their facilities in Ramallah, Jenin, and Hebron.
2. The proposal received academic approval from the Al-Quds University ethical committee through the School of Public Health.
3. Before completing the questionnaire, participants received written informed consent; they received all the necessary information about the study and its objectives; they also received assurances that the study would not negatively impact their physical, social, psychological, or financial well-being, nor pose any risks.
4. The questionnaires were totally confidential. The contact was directly between the researcher and the institute, and the institute did not allow the researcher to contact the participants. Dietitians who followed up with patients with eating disorders at Nutri-health centers in Ramallah, Jenin, and Hebron accessed the name and identity of each participant, as well as the records of their files.
5. We discussed the importance of voluntary participation and assured them that they could withdraw at any time without incurring any penalties.

Chapter Four:

Results

4.1 Introduction

This chapter covers data analysis, testing the research hypotheses by answering the research questions, and reviewing the main results of the questionnaire, which were obtained by analyzing the various variables. We used the SPSS program to generate the research findings for this chapter's presentation and analysis. Once the study tool has collected the necessary data, the researcher presents the study results to address the questions posed in the questionnaire, which represent the study's problem. Researchers in the same field, both at universities and other organizations, received advice for future research after achieving several of the outcomes.

4.2 Sample Characteristics:

Through the questionnaire, the researcher observed certain demographic characteristics of patients, which included seven variables. These variables are listed in Table 4.1, which contains the frequency and percentage for each variable according to the survey categories. According to the result in Table 4.1, 300 patients participated in the questionnaire; 67 (22.6%) were males, and 230 (77.4%) were females. Regarding the age categories, 83 (28.3%) of the patients were aged between 18 and 25 years, 92 (31.4%) of them were aged between 26 and 35 years, and 81 (27.6%) of them were aged between 36 and 45 years, 27 (9.2%) between 46 and 55 years, 9 (3.2%) between 56 and 65, and only 1 (0.30%) was aged more than 65 years. Furthermore, 97 (33.9%) of patients are housewives, 71 (24.8%) are self-employed, 31 (10.8%) are teachers, 23 (8%) are working in health services, and 17 (5.9%) are administrative, while 47 (16.5%) are working. In terms of material status, the

majority of patients (n=176, 59.3%) are married, 101 (34%) are single, 11 (3.7%) are divorced, and 9 (3%) are widows.) are widowed.

Also, Table 4.1 illustrates that 89 (31.6%) of patients get a monthly income between 2600 and 3500 NIS, 79 (28.0%) get a monthly income between 1500 and 2500 NIS, 74 (26.2%) get more than 3500 NIS, and 40 (14.2%) of them get less than 1500 NIS. More than fourteen (n=127, 42.4%) of the patients had a bachelor's degree, 34 (11.4%) had a diploma, 92 (30.8%) had a secondary, and 29 (9.7%) had less than a high school.

Table 4.1: patients Characteristics (N=300)

Variable	Options	Frequency	percentage%	Missing
Age categories	18- 25 years	83	28.3	7
	26 – 35 years	92	31.4	
	36 – 45 years	81	27.6	
	46 – 55 years	27	9.2	
	56- 65 years	9	3.2	
	65 and above	1	.3	
Gender	Male	67	22.6	3
	Female	230	77.4	
Occupation	housewife	97	33.9	14
	teacher	31	10.8	
	I work in the health services	23	8.0	
	self-employed	71	24.8	
	administrative	17	5.9	
	other	47	16.5	
Material status	Single	101	34.0	3
	Married	176	59.3	
	Divorced	11	3.7	
	Widowed	9	3.0	
Economic status	less than 1500	40	14.2	18
	1500-2500	79	28.0	
	2600-3500	89	31.6	
	more than 3500	74	26.2	
Education level.	Less than high school	29	9.7	1
	Secondary	92	30.8	
	Diploma	34	11.4	
	Bachelor degree	127	42.4	
	Postgraduate	17	5.7	

4.3 Assessment of self-sabotage behavior

We measured the self-sabotage behavior using ten dimensions: stickler, hyper-vigilant, pleaser, judge, restless, the avoider, the victim, hyper-achiever, controller, and hyper-rational. This section answers the main research question, which states, “What is the level of self-sabotage in patients with eating disorders from nutri-health centers?”. We

calculated the means and standard deviations to answer the research question. Table 4.2 shows that the sample responses' mean and standard deviation scores for the self-sabotage level are 2.28 and 0.50, respectively, indicating a moderate level of self-sabotage. Also, the avoider dimension has the largest level (mean = 2.41) with a high level, followed by the restless (mean = 2.40) with a high level, the controller (mean = 2.38), and the hyper-achiever (mean = 2.37), respectively, while the hyper-rational had the lowest level (mean = 2.16).

Table 4.2: Descriptive statistics for dimensions on the self-sabotage scale

Dimensions	Mean	S.D	Range	Agreement Level
Perfectionism (stickler)	2.28	0.88	0.00-4.00	Moderate
Anxiety (Hyper-vigilant)	2.17	0.83	0.00-3.88	Moderate
Self-worth (Pleaser)	2.32	0.75	0.14-4.00	Moderate
Criticism (Judge)	2.24	0.66	0.14-3.86	Moderate
Mood (Restless)	2.40	1.01	0.00-4.00	High
Procrastination (The avoider)	2.41	0.74	0.40-4.00	High
Victimization (The victim)	2.26	1.28	0.00-4.00	Moderate
Self-worth (Hyper-achiever)	2.37	1.07	0.00-4.00	Moderate
Controlling (Controller)	2.38	1.02	0.00-4.00	Moderate
Overanalytical (Hyper-rational)	2.16	1.06	0.00-4.00	Moderate
Total score of self-sabotage	**2.28**	**0.50**	**0.24-3.46**	**Moderate**

On the other hand, most of the participants had a moderate level of self-sabotage

(75%, n = 225); 22.3% (n = 67) had a high level, and 2.7% (n = 8) had a low level. Figure 4.1 illustrates the distribution of participants' responses to dimensions on the self-sabotage scale. After calculating the mean score of the perfectionism scale, the victim dimension had the highest percentage of participants who had a high level on it (47%, n = 141), followed by sticklers (42.3%, n = 127), hyper achievers (39.3%, n = 118), and controllers

(38%, n = 114), respectively. While the judge dimension had the lowest percentage of participants' who had a high level on it (27.3%, n=82) (see Appendix 3).

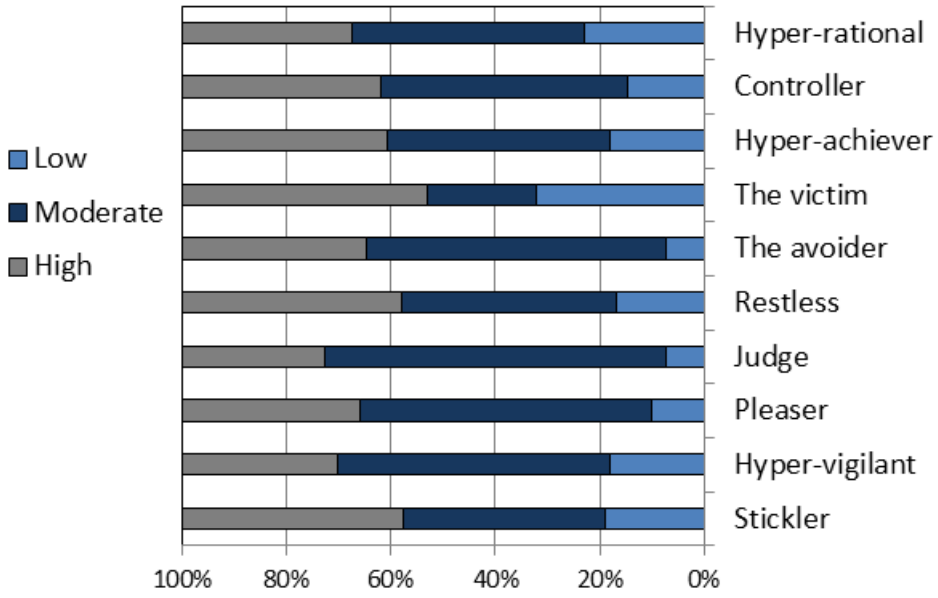

Figure 4.1: Participant's responses distribution of dimensions on the self-sabotage scale

4.3.1 Assessment of perfectionism (stickler) scale:

This section addresses the first sub-question, which asks, "What is the level of perfectionism (stickler) in patients with eating disorders from nutri-health centers?" The questionnaire consists of three items designed to measure stickler levels. Table 4.3 showed that the mean score of stickler in patients with eating disorders from nutri-health centers was 2.28 with a standard deviation of 0.88, which means patients with eating disorders from nutri-health centers had a moderate level of stickler. In addition, participants had the highest agreement with item 2, which states, "I can be too much of a stickler" (mean = 2.46, SD = 1.06) with a high level, followed by item 32, which states, "I often find faults and mistakes within others" (mean = 2.30, SD = 1.12) with a moderate level, while they had the lowest agreement for item 24, which states, "I feel restless and rarely at peace with what I am doing in the moment" (mean = 2.08, SD = 1.25) with a moderate level.

Table 4.3: Descriptive statistics for items on the stickler scale

No.	Items	Mean	S.D	Range	Agreement Level
2	I can be too much of a stickler or perfectionist.	2.46	1.06	0-4	High
32	I often find faults and mistakes within others	2.30	1.12	0-4	Moderate
24	I feel restless and rarely at peace with what I am doing in the moment	2.08	1.25	0-4	Moderate
Total score of stickler scale		2.28	0.88	0-4	Moderate

Figure 4.1 shows how the participants answered to the items on the perfectionism scale. The majority of participants strongly agreed or agreed with the statement "I can be too much of a stickler or perfectionist." This statement got the most positive responses (n=162, 54%). It was followed by "I often find faults and mistakes in others" (n=149, 49.7%) and "I feel restless and rarely at peace with what I am doing at the moment" (n=114, 38%) (see Appendix 3).

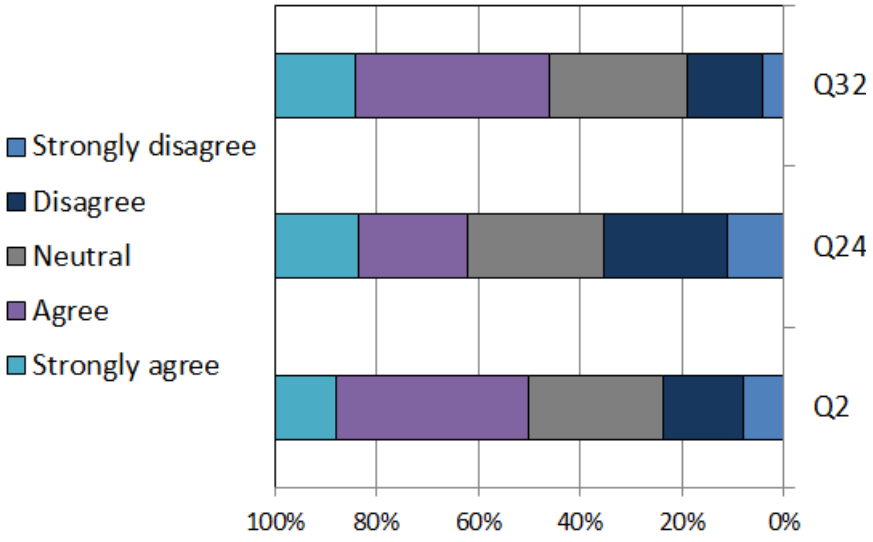

Figure 4.2: Participant's responses distribution of items on the stickler scale

4.3.2 Assessment of anxiety (hyper-vigilant) scale:

This section addresses the second sub-question, which asks, "What is the level of anxiety (hyper-vigilant) in patients with eating disorders from nutri-health centers?" The questionnaire has 8 items used to assess hyper-vigilance. Table 4.4 showed that the mean score of anxiety in patients with eating disorders from nutri-health centers was 2.17 with a standard deviation of 0.83, which means patients with eating disorders from nutri-health centers had a moderate level of anxiety. In addition, participants had the highest agreement with item 25, which states, "I am confrontational and forceful when I need to get things done" (mean = 2.55, SD = 1.16) with a high level, followed by item 1, which states, "I have discomfort with conflict and avoid it" (mean = 2.40, SD = 1.20) with a high level, while they had the lowest agreement with item 4, which states, "I criticize others a lot more often than praise them" (mean = 1.63, SD = 0.83) with a moderate level.

Table 4.4: Descriptive statistics for items on the anxiety (hyper-vigilant) scale

No.	Items	Mean	S.D	Range	Agreement Level
25	I am confrontational and forceful when I need to get things done	2.55	1.16	0-4	High
1	I have discomfort with conflict and avoid	2.40	1.20	0-4	High
35	I get impatient with others easily	2.34	1.20	0-4	Moderate
28	I tend to threaten others with the intensity of my analytical mind	2.15	1.27	0-4	Moderate
3	I am usually more anxious and worried than others around me.	2.15	1.16	0-4	Moderate
22	I criticize myself a lot	2.12	1.21	0-4	Moderate
17	I am annoyed by faults with others.	2.02	1.23	0-4	Moderate
4	I criticize others a lot more often than praise them.	1.63	1.23	0-4	Moderate
Total score of anxiety (hyper-vigilant) scale		2.17	0.83	0-4	Moderate

Figure 4.3 illustrate the distribution of participants' responses to items on the hyper-vigilant scale, after calculating the mean score of hyper-vigilant scale, participants indicated that they strongly agreed or agree to item 25, which states "I am confrontational and forceful when I need to get things done", where it represents the highest positive agreement (n=175, 58.6%), followed by " I have discomfort with conflict and avoid " (n=148, 49.3%), while the lowest positively agreement for "I criticize others a lot more often than praise them." (n=76, 25.3) (see Appendix 3).

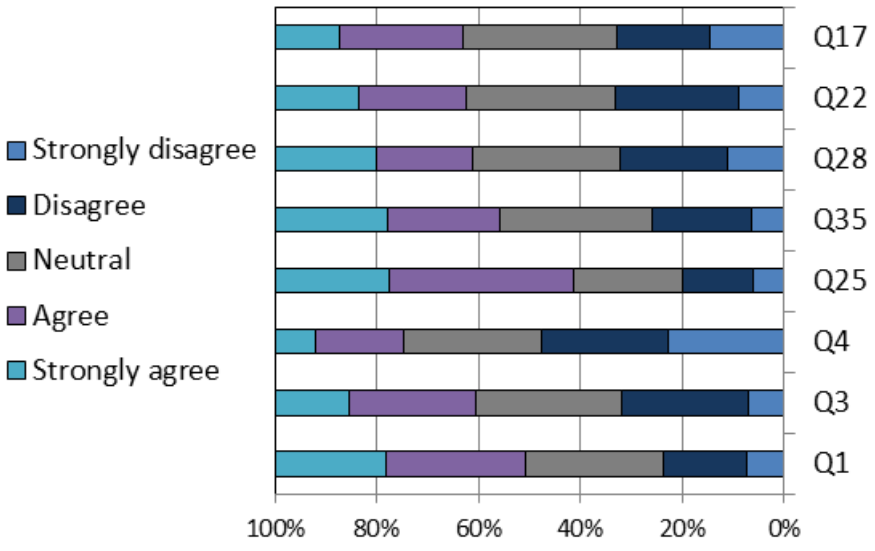

Figure 4.3: Participant's responses distribution of items on the hyper-vigilant scale

4.3.3 Assessment of self-worth (pleaser) scale:

This section answers the third sub-question that states “what is the level of self-worth (pleaser) in patient with eating disorders from nutri-health centers?”. The questionnaire has 7 items used to assess pleaser. Table 4.5 showed that the mean score of pleaser in patient with eating disorders from Nutri-health centers was 2.32 with a standard deviation of 0.75, which means patient with eating disorders from Nutri-health centers had a moderate level of pleaser. In addition, participants indicate that they had a moderate agreement for all items of the pleaser scale. Participants had the highest agreement with item 30, which states “Life is about achieving and producing results for me” (mean=2.64, SD=1.19) with high level, followed by item 40, which states “The circumstances of work or life significantly affect how happy I feel” (mean =2.46, SD=1.19) with high level, while they had the lowest agreement for item 19, which states “I avoid dealing with conflicts to a point where they accumulate and become real problems” (mean =2.10, SD=1.28) with moderate level.

Table 4.5: Descriptive statistics for items on the self-worth (pleaser) scale

No.	Items	Mean	S.D	Range	Agreement Level
30	Life is about achieving and producing results for me	2.64	1.19	0-4	High
40	The circumstances of work or life significantly affect how happy I feel	2.46	1.19	0-4	High
9	I have strong criticism for myself	2.38	1.12	0-4	Moderate
26	When I am criticized or unfairly treated, I tend to withdraw	2.30	1.33	0-4	Moderate
11	I procrastinate my work and responsibilities	2.19	1.19	0-4	Moderate
21	I am very anxious	2.14	1.27	0-4	Moderate
19	I avoid dealing with conflicts to a point where they accumulate and become real problems.	2.10	1.28	0-4	Moderate
Total score of pleaser		2.32	0.75	0-4	Moderate

To find the average score on the pleasure scale, participants said that they strongly agreed or agreed with item 30: "Life is about achieving and producing results for me." This item got the most positive responses (n=179, 59.7%), followed by "The circumstances of work or life significantly affect how happy I feel" (n=167, 55.7%). The item with the least positive responses was "I am very anxious," which got 119 positive responses (39.6%); see Appendix 3 for more information.

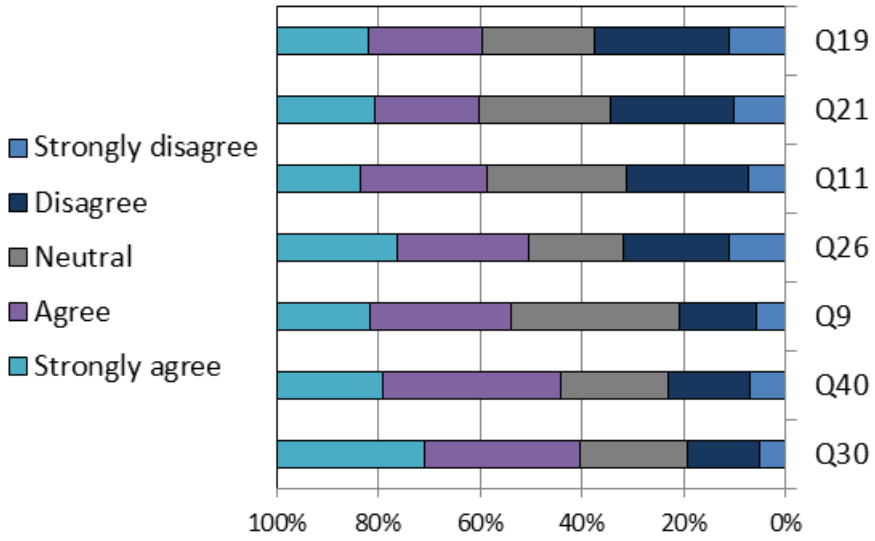

Figure 4.4: Participant's responses distribution of items on the pleaser scale

4.3.4 Assessment of criticism (judge) scale:

This section addresses the fourth sub-question, which asks, "What is the level of criticism (judge) among patients with eating disorders from nutri-health centers?" The questionnaire contains seven items that assess criticism (judge), which are distributed into three dimensions: self-criticism, others' criticism of you, and your own criticism of others. Table 4.6 showed that the mean score of criticism (judge) in patients with eating disorders from nutri-health centers was 2.24 with a standard deviation of 0.66, which means patients with eating disorders from nutri-health centers had a moderate level of judge. Additionally, the dimension of others criticizing you has the highest level (mean=2.46), indicating a high level. This is followed by you criticizing others (mean=2.22) and self-criticism (mean=2.18), both of which have a moderate level.

Table 4.6: Descriptive statistics for dimensions on the judge scale

	Dimensions	Mean	S.D	Range	Agreement Level
1	Self-criticism	2.18	0.94	0-4	Moderate
2	Others criticize you	2.46	1.16	0-4	High
3	You criticize others	2.22	0.93	0-4	Moderate
	Overall score of the criticism (judge)	**2.24**	**0.66**	**0.14-3.86**	Moderate

In addition, participants indicate that they had a moderate agreement for all items of the judge scale. Participants had the highest agreement with item 23, which states, "I like

things to be very organized" (mean = 2.54, SD = 1.19) with a high level, followed by item 27, which states, "When bad things happen, I tend to stay upset for some time" (mean = 2.46, SD = 1.16) with a high level, while they had the lowest agreement for item 27, which states, "I feel like a victim" (mean = 1.86, SD = 1.31) with a moderate level (see table 4.7).

Table 4.7: Descriptive statistics for items on the judge scale

No.	Items	Mean	S.D	Range	Agreement Level
23	I like things to be very organized	2.54	1.19	0-4	High
10	I am a "pleaser."	2.15	1.21	0-4	Moderate
37	I feel like a victim	1.86	1.31	0-4	Moderate
27	When bad things happen, I tend to stay upset for some time	2.46	1.16	0-4	High
5	I have a strong need to take charge and be in control	2.37	1.18	0-4	Moderate
33	I procrastinate on dealing with important but unpleasant tasks	2.27	1.14	0-4	Moderate
18	Pleasing others and having them like me is very important to me	2.03	1.24	0-4	Moderate

As you can see in Figure 4.5, the responses of the participants to the judge scale items were spread out. The majority of participants strongly agreed or agreed with item 23 of the self-criticism scale, which says, "Life is about achieving and producing results for me." This item got the most positive responses (n=165, 55%), followed by "When bad things happen, I tend to stay upset for some time" (n=163, 54.3%), and "I feel like a victim" (n=92, 30.7%) (see Appendix 3).

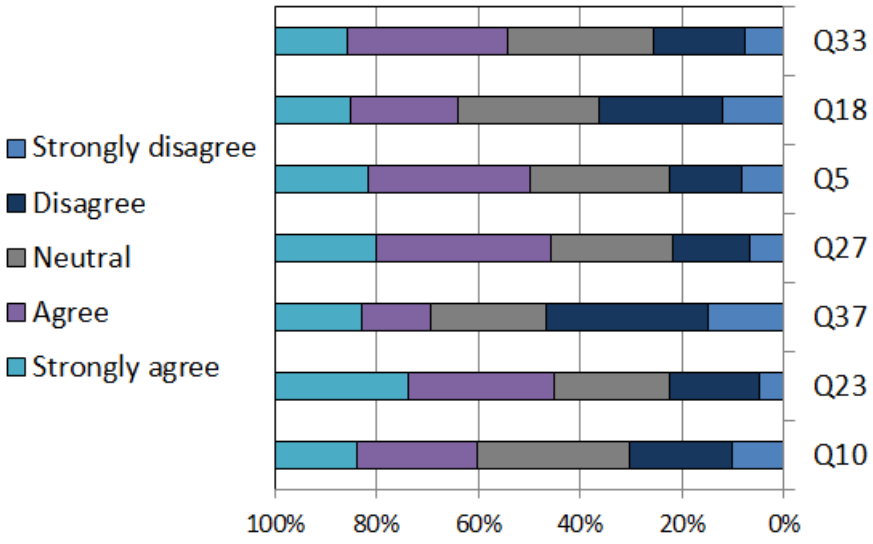

Figure 4.5: Participant's responses distribution of items on the judge scale

4.3.5 Assessment of Mood (Restless) Scale:

This section provides an answer to the fifth sub-question, which asks, "What is the level of mood (restless) in patients with eating disorders from nutri-health centers?" The questionnaire has two items used to assess mood. Table 4.8 showed that the mean score of restlessness in patients with eating disorders from nutri-health centers was 2.40 with a standard deviation of 1.01, which means patients with eating disorders from nutri-health centers had a high level of restlessness. Participants had the highest agreement with item 8, which states, “I measure my self-worth through my achievements” (mean = 2.54, SD = 1.17), with a high level, followed by item 41, which states, “I can’t rest and need to be constantly busy” (mean = 2.25, SD = 1.20), with a moderate level.

Table 4.8: Descriptive statistics for items on the mood (restless) scale

No.	Items	Mean	S.D	Range	Agreement Level
8	I measure my self-worth through my achievements	2.54	1.17	0-4	High
41	I can’t rest and need to be constantly busy	2.25	1.20	0-4	Moderate
Total score of restless		2.40	1.01	0-4	High

The responses to the restless scale items are shown in Figure 4.6, which shows how the participants' answers were spread out. The majority of participants (n=172, 58.4%), strongly agreed or agreed with item 8: "I measure my self-worth through my achievements." This was followed by "I can't rest and need to be constantly busy" (n=130, 43.3%); for more information, see Appendix 3.

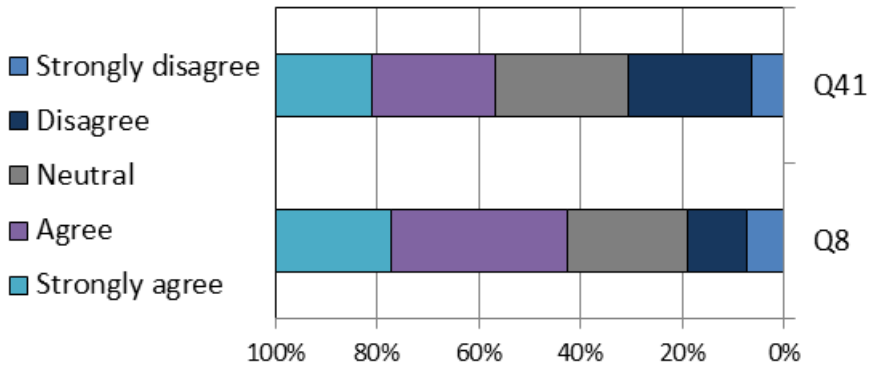

Figure 4.6: Participant’s responses distribution of items on the restless scale

4.3.6 Procrastination Assessment (The Avoider) Scale:

This section provides an answer to the sixth sub-question, which asks, "What is the level of procrastination (the avoider) in patients with eating disorders from nutri-health centers?" The questionnaire has 7 items used to assess the avoider. Table 4.9 showed that the mean score of the avoider in patients with eating disorders from nutri-health centers was 2.41 with a standard deviation of 0.74, which means patients with eating disorders from nutri-health centers had a high level of the avoider. In addition, participants had the highest agreement with item 13, which states, “When things go wrong, I tend to stay upset for some time” (mean = 2.74, SD = 1.17) with a high level, followed by item 20, which states, “My social status and public image are important to me” (mean = 2.51, SD = 1.24) with a high level, while they had the lowest agreement for item 36, which states, “When I make a mistake, I punish myself over it” (mean = 2.15, SD = 1.23) with a moderate level.

Table 4.9: Descriptive statistics for items on the procrastination (the avoider) scale

No.	Items	Mean	S.D	Range	Agreement Level
13	When things go wrong, I tend to stay upset for some time	2.74	1.17	0-4	High
20	My social status and public image are important to me	2.51	1.24	0-4	High
12	I need to do different things at the same time to prevent boredom	2.50	1.13	0-4	High
34	Others tell me that I worry too much	2.16	1.22	0-4	Moderate
36	When I make a mistake, I punish myself over it	2.15	1.23	0-4	Moderate
Total score of the avoider		2.41	0.74	0.40-4	High

When the mean score of the avoider scale was calculated, the majority of participants strongly agreed or agreed with item 13. This item, "When things go wrong, I tend to stay upset for some time," got the most positive responses (n=210, 70%). It was followed by "My social status and public image are important to me," which got 168 positive responses (56%). On the other hand, “When I make a mistake, I punish myself over it” got the fewest positive responses (n=116, 38.7%) (see Appendix 3).

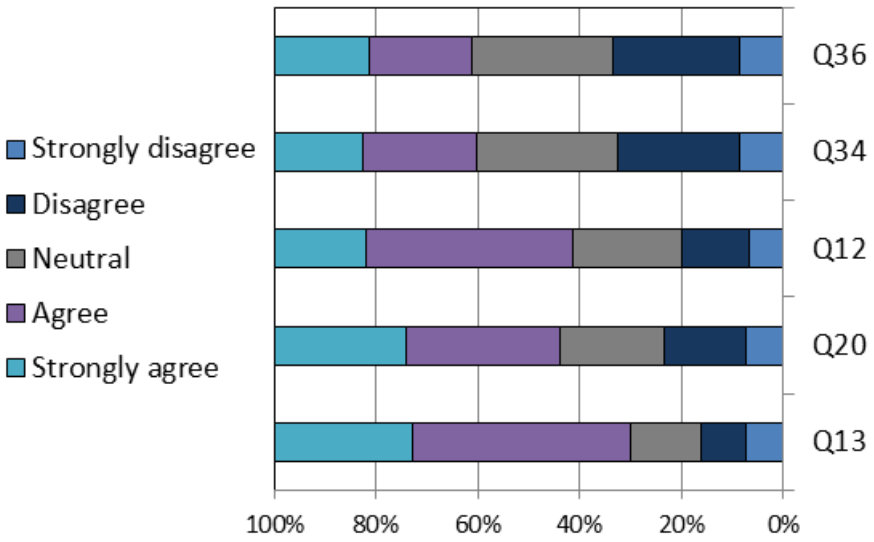

Figure 4.7: Participant's responses distribution of items on the avoider scale

4.3.7 Assessment of victimization (the victim) scale:

This section answers the seventh sub-question that states "what is the level of victimization (the victim) in patient with eating disorders from nutri-health centers?" The questionnaire has the statement "I feel worthy when I am successful and achieving". Table 4.10 showed that the mean score of the victim in patient with eating disorders from nutri-health centers was 2.37 with a stander deviation of 1.24, which means patient with eating disorders from nutri-health centers had a high level of the victim. In addition, 46.3% (n=141) of participants had a high level of the victim, 21% (n=63) of them had a moderate level, while 32% (n=96) of them had a low level.

Table 4.10: Descriptive statistics for items on the victimization (the victim) scale

No.	Item	Mean	S.D	Range	Agreement Level	High level	Moderate level	Low level
38	I feel worthy when I am successful and achieving	2.74	1.17	0-4	High	46.3 (141)	21 (63)	32 (96)

4.3.8 Assessment of self-worth (hyper-achiever) scale

This section answers the eight sub-question that states "what is the level of self-worth (hyper-achiever) in patient with eating disorders from nutri-health centers?" The questionnaire has two items used to assess hyper-achiever. Table 4.11 showed that the mean score of hyper-achiever in patient with eating disorders from nutri-health centers was 2.37 with a standard deviation of 1.01, which means patient with eating disorders from nutri-health centers had a moderate level of hyper-achiever. Participants had the highest

agreement with item 39, which states “I am so into helping others that I sometimes lose of my own needs and feel bad” (mean=2.42, SD=1.21) with high level, followed by item 31, which states “Others tell me I am too much of a perfectionist” (mean =2.32, SD=1.24) with moderate level.

Table 4.11: Descriptive statistics for items on the self-worth (hyper-achiever) scale

No.	Items	Mean	S.D	Range	Agreement Level
39	I am so into helping others that I sometimes lose of my own needs and feel bad.	2.42	1.21	0-4	High
31	Others tell me I am too much of a perfectionist	2.32	1.24	0-4	Moderate
Total score of the hyper-achiever		2.37	1.07	0-4	Moderate

Figure 4.8 illustrate the distribution of participants’ responses to items on the hyper-achiever scale, after calculating the mean score of hyper-achiever scale, participants indicated that they strongly agreed or agree to item 39, which states “I am so into helping others that I sometimes lose of my own needs and feel bad”, where it represents the highest positive agreement (n=149, 49.7%), followed by "Others tell me I am too much of a perfectionist" (n=137, 45.6%) (see Appendix 3).

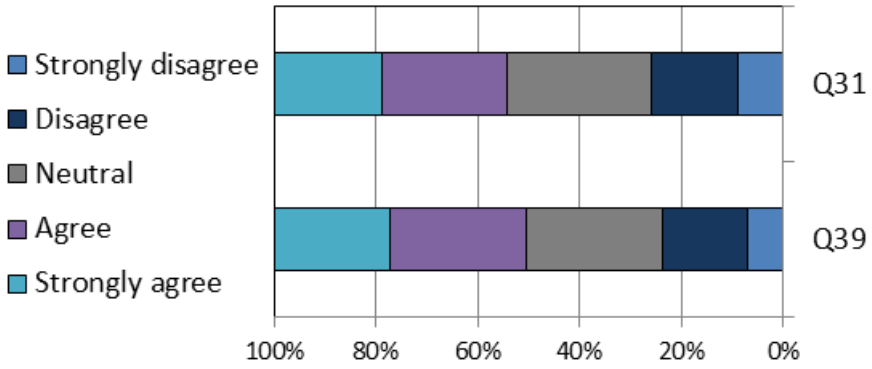

Figure 4.8: Participant’s responses distribution of items on the hyper-achiever scale

4.3.9 Assessment of controlling (controller) scale

This section answers the ninth sub-question that states “what is the level of controlling (controller) in patient with eating disorders from nutri-health centers?” The questionnaire has two items used to assess controller. Table 4.12 showed that the mean score of controller in patient with eating disorders from nutri-health centers was 2.38 with a standard deviation of 1.02, which means patient with eating disorders from nutri-health centers had a moderate level of controller. Participants had the highest agreement with item 6, which states “I proud of being rational and analytical” (mean=2.65, SD=1.18) with high level, followed by item 16, which states “I have a tendency to feel sorry for myself ” (mean =2.11, SD=1.22) with moderate level.

Table 4.12: Descriptive statistics for items on the controlling (controller) scale

No.	Items	Mean	S.D	Range	Agreement Level
6	I proud of being rational and analytical.	2.65	1.18	0-4	High
16	I have a tendency to feel sorry for myself	2.11	1.22	0-4	Moderate
Total score of the controller		2.38	1.07	0-4	Moderate

Figure 4.9 illustrate the distribution of participants' responses to items on the controller scale, after calculating the mean score of controller scale, participants indicated that they strongly agreed or agree to item 6, which states "I proud of being rational and analytical" (n=137, 45.6%), where it represents the highest positive agreement, followed by " I have a tendency to feel sorry for myself " (n=184, 61.4%) (see Appendix 3).

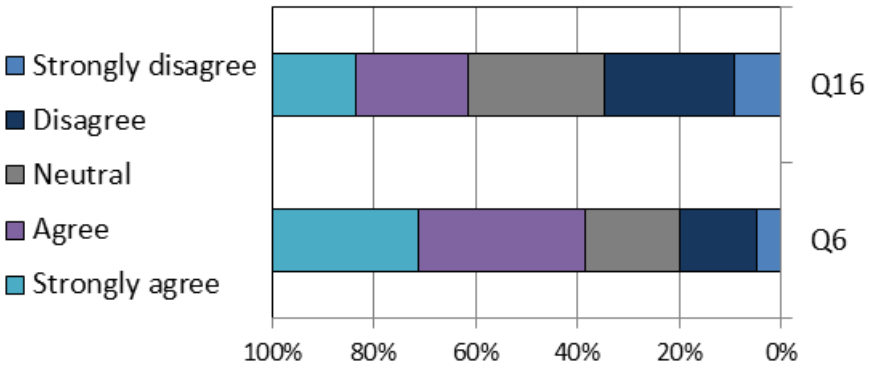

Figure 4.9: Participant's responses distribution of items on the controller scale

4.3.10 Assessment of overanalytical (hyper-rational) scale:

This section answers the tenth sub-question that states "what is the level of overanalytical (hyper-rational) in patient with eating disorders from nutri-health centers?" The questionnaire has two items used to assess hyper-rational. Table 4.13 showed that the mean score of hyper-rational in patient with eating disorders from nutri-health centers was 2.16 with a standard deviation of 1.06, which means patient with eating disorders from nutri-health centers had a moderate level of hyper-rational. Participants had the highest agreement with item 6, which states "I proud of being rational and analytical" (mean=2.65, SD=1.18) with moderate level, followed by item 16, which states "I have a tendency to feel sorry for myself " (mean =2.11, SD=1.22) with moderate level.

Table 4.13: Descriptive statistics for items on the overanalytical (hyper-rational) scale

No.	Items	Mean	S.D	Range	Agreement Level
7	I have a tendency towards being moody	2.34	1.21	0-4	Moderate
29	Compared to others, I do more pleasing for other people	1.98	1.29	0-4	Moderate
Total score of the hyper-rational		2.16	1.06	0-4	Moderate

Figure 4.10 shows how the participants' answers to the hyper-rational scale were spread out. Based on the mean score of the scale, the majority of participants (n=144, 48%) said they strongly agreed or agreed with item 7, which says "I tend to be moody." This was the item with the highest level of positive agreement, followed by "Compared to others, I do more pleasing for other people" (n=105, 35%) (see Appendix 3).

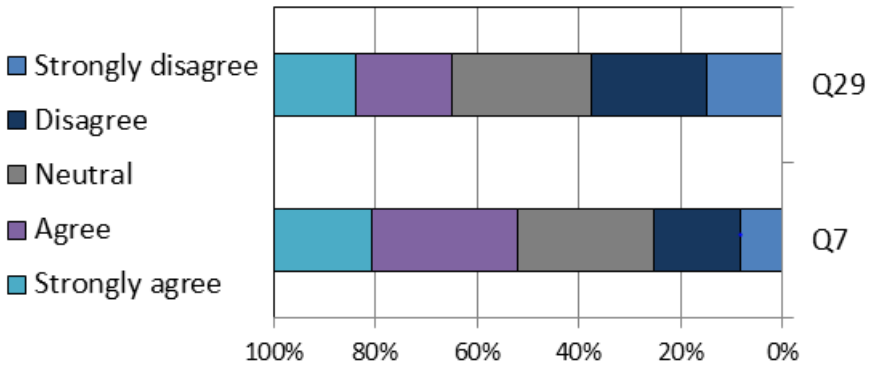

Figure 4.10: Participant's responses distribution of items on the hyper-achiever scale

4.4 Assessment of participants' level of compliance and continuity of the treatment plan

The majority of the patients were with binge eating disorder (60.3%, n=181); 33% (n=99) of the patients were overweight, 3% (n=9) of the patients were stable weight, and 2.7% (n=9) of the patients were underweight. Only one participant, accounting for 0.3%, was severely underweight. Additionally, two participants did not respond to this question, accounting for 0.7% of the sample.

In terms of patient commitment to the treatment plan, 4% (n = 12) of patients did not commit to it at all, while 288 patients did. Figure 4.11 Figure 4.11 reveals that the average number of patients adhering to the treatment plan is 53.69% (n=155), with 43.7% (n=126) committing to the plan for 50% or less, and 56.3% (n=162) committing to the plan for more than 50%. 28.13% (n=81) of patients were withdrawn from treatment, while 35.8% (n=102) were withdrawn from treatment and then returned to it, 27.7% (n=28) withdrew

from treatment previously once, 31.7% (n=32) twice, 22.8% (n=23) three times, and 17.8% (n=18) more than three times.

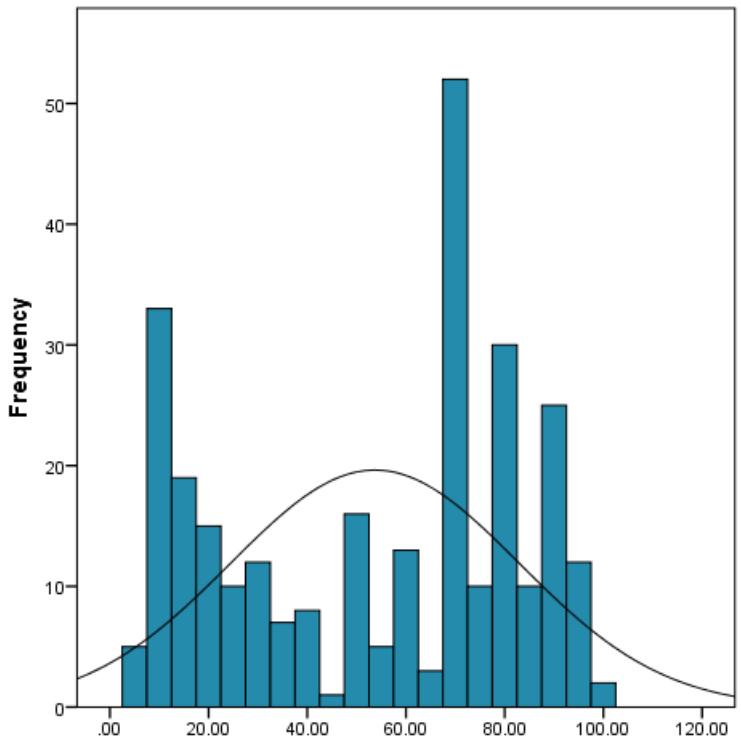

Figure 4.11: The distribution of percentage of patients who adhere to the treatment plan

4.5 Assessment of self-sabotage behavior by demographic factors

This section displays the result of the first main hypothesis, which states, **"There is no significant difference in the mean score of self-sabotage due to the patient characteristics (gender, age, occupation, material status, level of education, and economic status)." We used the Mann–Whitney U-test and Kruskal–Wallis test to answer this hypothesis.**

4.5.1 Result of the first sub-hypothesis of the first hypothesis:

This section displays the first sub-hypothesis, which asserts that there is no significant difference in the mean score of self-sabotage due to gender. We can see from table 4.14 that the p-value (0.411) is higher than the significant level of 0.05, which means that there is no significant difference in the level of self-sabotage between the female and male among patients with eating disorder at Nutri-Health Centers. This indicates a lack of support for the first sub-hypothesis. Also, the self-sabotage level of both male patients (mean = 2.26) and females (mean = 2.28) is moderate.

Furthermore, the result indicates there is a significant difference in the avoider level between the female and male patients with eating disorders at Nutri-health centers, since the p-value (0.004) is less than the significant level of 0.05 in favor of the female (mean = 2.47). However, the result indicates there is no significant difference in the level of nine dimensions of self-sabotage score (stickler, hyper-vigilant, pleaser, judge, restless, the avoider, the victim, hyper-achiever, controller, hyper-rational) between female and male, since all p-values are more than the significant level of 0.05.

Table 4.14: Result of the first sub-hypothesis

Dimensions	Gender	Mean	SD	Mean rank	Level	Test statistic	Sig .
Stickler	Male	2.38	0.91	159.97	Moderate	-1.197	0.231
	Female	2.26	0.87	145.8	Moderate		
Hyper-vigilant	Male	2.28	0.86	161.16	Moderate	-1.319	0.187
	Female	2.13	0.82	145.46	Moderate		
Pleaser	Male	2.28	0.63	141.74	Moderate	-0.788	0.431
	Female	2.33	0.79	151.12	Moderate		
Judge	Male	2.21	0.63	145.54	Moderate	-0.375	0.708
	Female	2.25	0.67	150.01	Moderate		
Restless	Male	2.30	1.15	142.36	Moderate	-0.728	0.467
	Female	2.42	0.98	150.93	High		
The avoider	**Male**	**2.20**	**0.69**	**122.43**	Moderate	**-2.888**	**0.004****
	Female	**2.47**	**0.75**	**156.74**	High		
The victim	Male	2.03	1.28	134.13	Moderate	-1.651	0.099
	Female	2.31	1.27	153.33	Moderate		
Hyper-achiever	Male	2.41	1.26	156.99	High	-0.874	0.382
	Female	2.35	1.02	146.67	Moderate		
Controller	Male	2.34	1.00	144.75	Moderate	-0.466	0.641
	Female	2.39	1.03	150.24	Moderate		
Hyper-rational	Male	2.21	1.16	156.21	Moderate	-0.789	0.43
	Female	2.13	1.03	146.9	Moderate		
self-sabotage	Male	2.26	0.46	141.41	Moderate	-0.822	0.411
	Female	2.28	0.51	151.21	Moderate		

**: Result significant at 5%.

4.5.2 The Results of the Second Sub-hypothesis of the First Hypothesis:

The results of the second sub-hypothesis, "There is no significant difference in the mean score of self-sabotage due to the age," are displayed in this section. Table 4.15's Kruskal-Wallis test result shows no significant difference in self-sabotage levels based on patient age categories, as the p-value (0.239) exceeds the significant level of 0.05, contradicting the second sub-hypothesis's claim. Additionally, all patients exhibit a moderate level of self-sabotage, regardless of their age categories.

Furthermore, the results show a significant difference in the judge level based on the patient's age category, as the p-value (0.019) falls below the significant level of 0.05, favoring patients in the 36-45 years age group with a high level. However, the results show that the ten dimensions of the self-sabotage score (stickler, hyper-vigilant, pleaser, the

avoider, restless, the avoider, the victim, hyper-achiever, controller, and hyper-rational) do not significantly differ based on age category, as all p-values exceed the significant level of 0.05.

Table 4.15-a: The Results of the second sub-hypothesis

Dimensions	Age	Mean	SD	Mean rank	Level	Test statistic	Sig .
Stickler	18-25 years	2.09	0.86	131.39	Moderate	4.698	0.320
	26-35 years	2.30	0.83	147.76	Moderate		
	36-45 years	2.35	0.94	156.50	Moderate		
	46-55 years	2.38	0.90	159.02	Moderate		
	above 55 y	2.43	0.72	160.20	High		
Hyper-vigilant	18-25 years	2.08	0.82	137.50	Moderate	2.338	0.674
	26-35 years	2.24	0.86	153.96	Moderate		
	36-45 years	2.22	0.83	151.42	Moderate		
	46-55 years	2.16	0.78	145.85	Moderate		
	above 55 years	1.98	0.85	129.15	Moderate		
Pleaser	18-25 years	2.26	0.78	141.98	Moderate	8.378	0.079
	26-35 years	2.22	0.70	137.50	Moderate		
	36-45 years	2.48	0.78	169.18	High		
	46-55 years	2.25	0.64	138.61	Moderate		
	above 55 y	2.07	0.58	119.10	Moderate		
Judge	18-25 years	2.17	0.67	143.27 [a]	Moderate	11.756†	0.019**
	26-35 years	2.15	0.65	136.46 [a]	Moderate		
	36-45 years	2.43	0.61	172.54 [b]	High		
	46-55 years	2.12	0.76	131.11 [a]	Moderate		
	above 55 y	1.99	0.43	111.05 [a]	Moderate		
Restless	18-25 years	2.51	0.91	156.94	Moderate	2.929	0.570
	26-35 years	2.44	1.00	149.97	High		
	36-45 years	2.27	1.13	138.58	Moderate		
	46-55 years	2.26	1.13	139.09	Moderate		
	above 55 y	2.25	0.82	126.75	Moderate		
The avoider	18-25 years	2.48	0.67	158.11	High	5.899	0.207
	26-35 years	2.31	0.78	139.79	Moderate		
	36-45 years	2.47	0.73	153.02	High		
	46-55 years	2.36	0.71	136.28	Moderate		
	above 55 y	2.02	0.58	101.25	Moderate		
The victim	18-25 years	2.52	1.29	165.04	High	8.914	0.063
	26-35 years	2.17	1.31	143.01	Moderate		
	36-45 years	2.21	1.17	144.38	Moderate		
	46-55 years	2.00	1.36	131.70	Moderate		
	above 55 y	1.50	0.85	96.50	Low		
Hyper-achiever	18-25 years	2.18	1.06	132.30	Moderate	5.393	0.249
	26-35 years	2.33	1.01	144.82	Moderate		
	36-45 years	2.47	1.12	156.67	High		
	46-55 years	2.54	1.15	161.17	High		
	above 55 y	2.65	0.97	172.55	High		

Table 4.15-b: The Results of the second sub-hypothesis

Dimensions	Age	Mean	SD	Mean rank	Level	Test statistic	Sig .
Controller	18-25 years	2.37	0.95	143.49	Moderate	5.742	0.219
	26-35 years	2.53	1.04	158.81	High		
	36-45 years	2.40	1.05	149.16	High		
	46-55 years	2.11	0.93	123.13	Moderate		
	above 55 y	2.00	1.15	114.40	Moderate		
Hyper-rational	18-25 years	2.11	1.12	143.68	Moderate	2.25	0.690
	26-35 years	2.11	1.01	142.95	Moderate		
	36-45 years	2.30	1.04	158.43	Moderate		
	46-55 years	2.06	1.30	142.17	Moderate		
	above 55 y	2.00	0.85	132.25	Moderate		
self-sabotage	18-25 years	2.23	0.55	142.05	Moderate	5.508	0.239
	26-35 years	2.25	0.44	142.42	Moderate		
	36-45 years	2.37	0.49	163.31	Moderate		
	46-55 years	2.23	0.51	142.50	Moderate		
	above 55 y	2.08	0.37	110.30	Moderate		

†: Different letters within a row indicate a significant difference at the level 5%.
**: Result significant at 5%.

Figure 4.12 elucidates the sources of differences in the mean score of judges due to age categories, as determined by the pairwise test of the Kruskal–Wallis test. The result reveals a significant difference in the mean score of the judge level between patients aged between 36 and 45 years (mean rank = 172.54) and other patients in different age categories, with the patients in the 36 and 45years category having a high level.

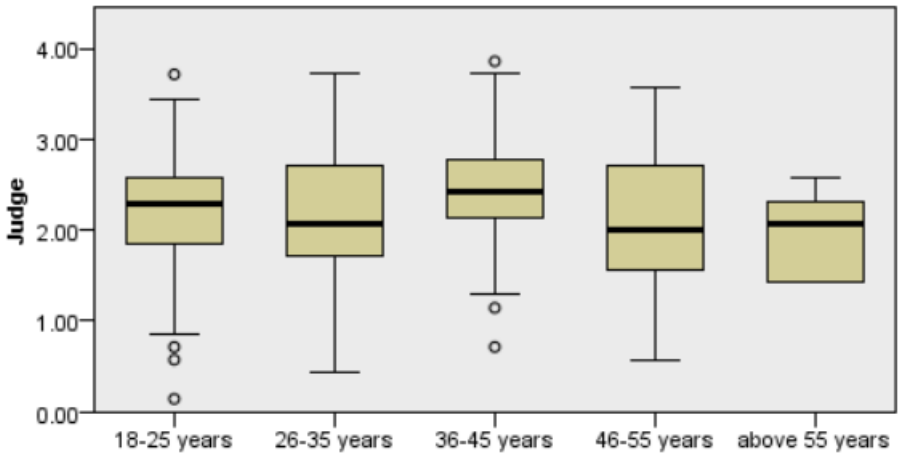

Figure 4.12 shows the mean and standard deviation of the judge scale's mean score according to the patient's age category.

4.5.3 The Results of the Third Sub-hypothesis of the First Hypothesis:

This section presents the results of the third sub-hypothesis, which asserts that there is no significant difference in the mean score of self-sabotage due to the patient's occupation. The Kruskal-Wallis test result in table 5.16 indicates no significant difference in self-sabotage level due to patient occupation, as the p-value (0.163) exceeds the significant level of 0.05, a finding that contradicts the third sub-hypothesis. Additionally, all patients exhibit a moderate level of self-sabotage, regardless of their occupation.

Furthermore, the results show a significant difference in the avoider level due to the patient's occupation, with the p-value (0.004) falling below the significant level of 0.05. However, the results show that the nine dimensions of the self-sabotage score (stickler, hyper-vigilant, pleaser, judge, restless, the avoider, the victim, hyper-achiever, controller, and hyper-rational) do not significantly differ based on age category, as all p-values exceed the significant level of 0.05.

Table 4.16-a: Result of the third sub-hypothesis

Dimensions	Occupation	Mean	SD	Mean rank	Level	Test statistic	Sig.
Stickler	Housewife	2.31	0.83	143.11	Moderate	1.983	0.851
	Teacher	2.30	0.75	140.73	Moderate		
	Health services	2.22	1.02	138.02	Moderate		
	Self-employed	2.41	0.88	153.92	High		
	Administrative	2.29	0.75	142.24	Moderate		
	Other	2.17	0.95	133.52	Moderate		
Hyper-vigilant	Housewife	2.19	0.79	144.64	Moderate	5.516	0.356
	Teacher	2.27	0.80	154.06	Moderate		
	Health services	2.14	1.05	142.85	Moderate		
	Self-employed	2.30	0.83	154.99	Moderate		
	Administrative	1.92	0.83	118.71	Moderate		
	Other	2.03	0.78	126.11	Moderate		
Pleaser	Housewife	2.42	0.82	158.13	High	8.097	0.151
	Teacher	2.29	0.63	141.94	Moderate		
	Health services	1.99	0.73	106.35	Moderate		
	Self-employed	2.28	0.68	137.73	Moderate		
	Administrative	2.31	0.65	143.53	Moderate		
	Other	2.31	0.80	141.22	Moderate		
Judge	Housewife	2.32	0.66	152.34	Moderate	8.728	0.120
	Teacher	2.21	0.62	141.76	Moderate		
	Health services	1.89	0.80	99.11	Moderate		
	Self-employed	2.21	0.55	138.99	Moderate		
	administrative	2.24	0.63	147.59	Moderate		
	Other	2.29	0.69	153.46	Moderate		
Restless	Housewife	2.39	0.98	144.49	Moderate	5.851	0.321
	Teacher	2.35	0.93	141.40	Moderate		
	Health services	2.20	1.12	128.70	Moderate		
	Self-employed	2.35	1.09	142.95	Moderate		
	administrative	1.97	0.94	111.79	Moderate		
	Other	2.63	1.06	162.37	High		

Table 4.16-b: Result of the third sub-hypothesis

Dimensions	Occupation	Mean	SD	Mean rank	Level	Test statistic	Sig.
The avoider	Housewife	2.55	0.71	160.96 [a]	High	17.077	0.004**
	Teacher	2.45	0.74	148.66 [ac]	High		
	Health services	2.05	0.87	107.20 [cb]	Moderate		
	Self-employed	2.30	0.71	129.93 [cbd]	Moderate		
	administrative	2.04	0.57	100.00 [b]	Moderate		
	Other	2.54	0.77	158.05 [da]	High		
The victim	Housewife	2.27	1.25	146.17	Moderate	3.414	0.636
	Teacher	2.10	1.16	134.11	Moderate		
	Health services	1.83	1.47	119.50	Moderate		
	Self-employed	2.35	1.25	150.71	Moderate		
	administrative	2.12	1.27	135.91	Moderate		
	Other	2.30	1.28	147.78	Moderate		
Hyper-achiever	Housewife	2.58	0.93	157.95	High	9.145	0.103
	Teacher	2.13	1.03	123.34	Moderate		
	Health services	2.07	1.29	121.48	Moderate		
	Self-employed	2.38	1.10	145.20	Moderate		
	administrative	1.94	1.14	112.26	Moderate		
	Other	2.43	1.06	146.48	High		
Controller	Housewife	2.32	1.10	137.63	Moderate	6.170	0.290
	Teacher	2.37	0.94	137.19	Moderate		
	Health services	2.35	0.87	136.61	Moderate		
	Self-employed	2.56	0.98	157.23	High		
	administrative	2.03	0.91	111.79	Moderate		
	Other	2.55	0.98	153.88	High		
Hyper-rational	Housewife	2.19	1.06	145.50	Moderate	3.383	0.641
	Teacher	2.02	1.04	131.82	Moderate		
	Health services	2.15	1.08	140.35	Moderate		
	Self-employed	2.30	1.10	155.14	Moderate		
	administrative	2.21	0.75	145.35	Moderate		
	Other	1.97	1.12	130.36	Moderate		
self-sabotage	Housewife	2.34	0.48	155.02	Moderate	7.876	0.163
	Teacher	2.27	0.47	145.58	Moderate		
	Health services	2.07	0.65	113.39	Moderate		
	Self-employed	2.31	0.45	145.70	Moderate		
	administrative	2.11	0.34	109.59	Moderate		
	Other	2.28	0.52	142.03	Moderate		

†: Different letters within a row indicate a significant difference at the level 5%.
**: Result significant at 5%.

Figure 4.13 clarifies the sources of differences in the mean score of the avoider due to the patient occupation by the pairwise test of the Kruskal–Wallis test; the result indicates there is a significant difference in the mean score of the avoider of administrative patients (mean rank = 100) and both housewives (mean rank = 160.96) and other patients in other sectors

(mean rank = 158.05). In addition, there is a significant difference in the mean score of the avoider among housewives (mean rank = 160.96), self-employed individuals

(mean rank = 129.93), and patients working in health services (mean rank = 107.20), favoring the housewives. Finally, there is a significant difference in the mean score of the avoider between patients working in health services (mean rank = 107.20) and those working in other sectors (mean rank = 158.05), favoring the last category.

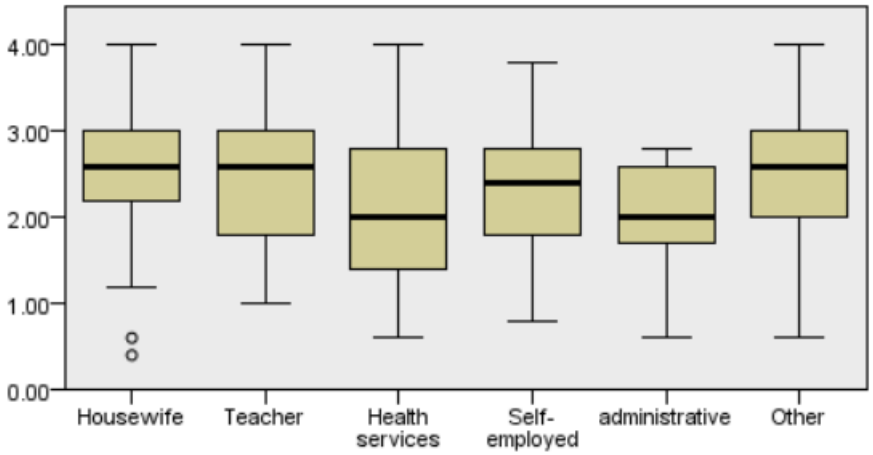

Figure 4.13: Mean and standard deviation of the mean score of the avoider scale due to patient occupation

4.5.4 The following are the findings from the fourth sub-hypothesis of the first hypothesis:

This section displays the result of the fourth sub-hypothesis, which states, “There is no significant difference in the mean score of self-sabotage due to marital status.” The Kruskal-Wallis test result in table 4.17 indicates no significant difference in self-sabotage level due to marital status, as the p-value (0.201) exceeds the significant level of 0.05, contradicting the fourth sub-hypothesis. Additionally, all patients exhibit a moderate level of self-sabotage, with the exception of those who are widowed, with a mean score of 2.46.

Furthermore, the result indicates there is a significant difference in the hyper-achiever level due to marital status, since the p-value (0.027) is less than the significant level of 0.05. However, the results show that the other nine dimensions of the self-sabotage score (stickler, hyper-vigilant, pleaser, judge, restless, the avoider, the victim, controller, and hyper-rational) do not significantly differ based on marital status, as all p-values exceed the significant level of 0.05.

Table 4.17: The Results of the fourth sub-hypothesis

Dimensions	Marital status	Mean	SD	Mean rank	Level	Test statistic	Sig.
Stickler	Widowed	2.20	0.87	141.61	Moderate	3.948	0.267
	Divorced	2.32	0.86	152.53	Moderate		
	Single	2.67	0.67	184.05	High		
	Married	1.85	1.32	120.17	Moderate		
Hyper-vigilant	Widowed	2.12	0.85	145.04	Moderate	5.164	0.160
	Divorced	2.19	0.80	151.78	Moderate		
	Single	2.47	0.84	182.18	High		
	Married	1.64	1.00	98.50	Moderate		
Pleaser	Widowed	2.26	0.68	141.55	Moderate	2.368	0.500
	Divorced	2.32	0.76	151.53	Moderate		
	Single	2.65	0.83	179.95	High		
	Married	2.24	1.08	145.22	Moderate		
Judge	Widowed	2.12	0.65	136.45	Moderate	3.806	0.283
	Divorced	2.31	0.64	156.78	Moderate		
	Single	2.22	0.73	138.09	Moderate		
	Married	2.14	0.96	151.00	Moderate		
Restless	Widowed	2.52	0.94	161.03	High	4.212	0.239
	Divorced	2.30	1.02	140.98	Moderate		
	Single	2.59	1.16	168.86	High		
	Married	2.28	1.35	146.56	Moderate		
The avoider	Widowed	2.42	0.74	150.92	High	5.146	0.161
	Divorced	2.39	0.74	147.40	Moderate		
	Single	2.82	0.79	192.00	High		
	Married	2.00	0.73	106.17	Moderate		
The victim	Widowed	2.44	1.29	160.86	High	4.324	0.229
	Divorced	2.16	1.27	142.52	Moderate		
	Single	1.91	1.38	127.36	Moderate		
	Married	2.56	1.13	169.00	High		
Hyper-achiever	Widowed	2.36	1.40	131.75 [a]	Moderate	9.184	0.027**
	Divorced	1.94	1.07	160.54 [b]	Moderate		
	Single	2.34	0.97	153.36 [ab]	Moderate		
	Married	2.39	1.04	111.56 [ab]	Moderate		
Controller	Widowed	2.41	1.09	144.84	High	0.478	0.924
	Divorced	2.44	1.10	151.05	High		
	Single	2.03	1.11	146.27	Moderate		
	Married	2.25	1.07	158.83	Moderate		
Hyper-rational	Widowed	2.09	0.70	139.06	Moderate	4.367	0.224
	Divorced	1.83	0.83	157.00	Moderate		
	Single	2.22	0.50	138.00	Moderate		
	Married	2.30	0.47	117.50	Moderate		
self-sabotage	Widowed	2.46	0.52	140.99	High	4.626	0.201
	Divorced	2.05	0.71	153.70	Moderate		
	Single	2.20	0.87	179.27	Moderate		
	Married	2.32	0.86	110.06	Moderate		

†: Different letters within a row indicate a significant difference at the level 5%.

**: Result significant at 5%.

Figure 4.14 elucidates the sources of differences in the mean score of the hyper-achiever due to the material status, as determined by the pairwise test of the Kruskal–Wallis test. The results show a significant difference in the mean score of the hyper-achiever between patients who are widowed (mean rank = 131.75) and those who are divorced

(mean rank = 160.54), favoring the widowed.

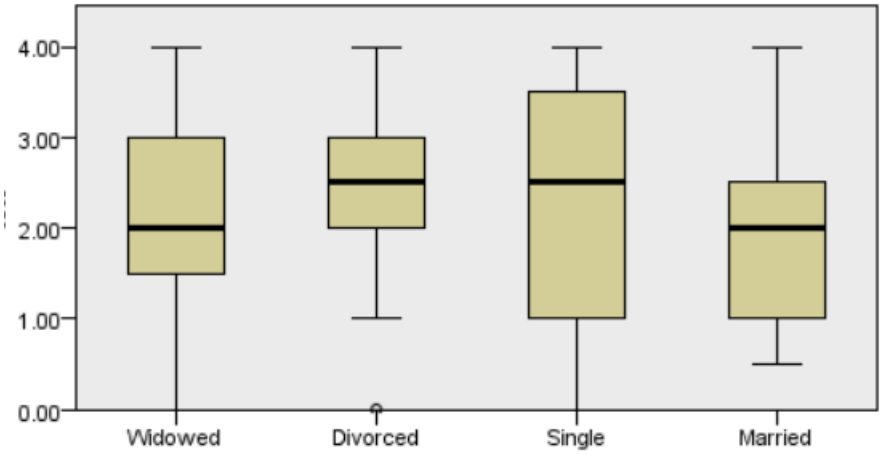

Figure 4.14: Mean and standard deviation of the mean score of the hyper-achiever scale due to marital status

4.5.5 The Results of the Fifth Sub-hypothesis of the First Hypothesis:

This section presents the outcome of the fifth sub-hypothesis, which asserts, "There is no significant difference in the mean score of self-sabotage due to the education level." The Kruskal-Wallis test result in table 4.18 indicates no significant difference in self-sabotage level due to education level, as the p-value (0.453) exceeds the significant level of 0.05, a finding that contradicts the fifth sub-hypothesis. Additionally, all patients exhibit a moderate level of self-sabotage, regardless of their education level.

Furthermore, the results show a significant difference in the hyper-achiever, victim, and hyper-rational levels based on education level, with the p-values (0.027, 0.030, and 0.011, respectively) being less than the significant level of 0.05. However, the results show that there is no significant difference in the seven dimensions of the self-sabotage score (stickler, hyper-vigilant, pleaser, judge, restless, the avoider, and controller) due to education level, as all p-values exceed the significant level of 0.05.

Table 4.18-a: The Results of the fifth sub-hypothesis:

Dimensions	Education level	Mean	SD	Mean rank	Level	Test statistic	Sig.
Stickler	Less than high school	2.49	0.75	171.62	High	6.290	0.179
	Secondary	2.36	0.93	159.47	Moderate		
	Diploma	2.25	0.90	148.41	Moderate		
	Bachelor degree	2.15	0.86	136.93	Moderate		
	Postgraduate	2.49	0.87	162.74	High		
Hyper-vigilant	Less than high school	2.22	0.72	155.47	Moderate	5.613	0.230
	Secondary	2.31	0.86	166.52	Moderate		
	Diploma	2.14	0.76	141.99	Moderate		
	Bachelor degree	2.07	0.85	140.19	Moderate		
	Postgraduate	2.11	0.78	140.59	Moderate		
Pleaser	Less than high school	2.45	0.86	161.57	High	4.249	0.373
	Secondary	2.29	0.79	146.83	Moderate		
	College	2.09	0.79	126.03	Moderate		
	Bachelor degree	2.37	0.67	157.07	Moderate		
	Postgraduate	2.27	0.83	142.53	Moderate		
Judge	Less than high school	2.31	0.66	161.09	Moderate	2.899	0.575
	Secondary	2.31	0.67	155.79	Moderate		
	Diploma	2.18	0.64	145.53	Moderate		
	Bachelor degree	2.21	0.68	148.30	Moderate		
	Postgraduate	2.03	0.58	121.44	Moderate		
Restless	Less than high school	2.34	0.99	144.67	Moderate	1.677	0.795
	Secondary	2.45	1.07	155.01	High		
	Diploma	2.19	1.06	134.90	Moderate		
	Bachelor degree	2.41	0.97	150.44	High		
	Postgraduate	2.53	1.11	158.85	High		
The avoider	Less than high school	2.34	0.76	146.34	Moderate	2.508	0.643
	Secondary	2.51	0.80	159.51	High		
	Diploma	2.32	0.72	137.25	Moderate		
	Bachelor degree	2.39	0.73	149.50	Moderate		
	Postgraduate	2.31	0.53	134.00	Moderate		
The victim	Less than high school	2.10	1.29	139.83 ab	Moderate	10.710	0.030**

Table 4.18-b: The Results of the fifth sub-hypothesis:

Dimensions	Education level	Mean	SD	Mean rank	Level	Test statistic	Sig.
	Secondary	2.61	1.24	173.61 [a]	Moderate		
	Diploma	1.97	1.42	132.94 [b]	Moderate		
	Bachelor degree	2.13	1.23	141.54 [b]	Moderate		
	Postgraduate	2.06	1.25	136.88 [ab]	Moderate		
Hyper-achiever	Less than high school	2.07	1.10	127.97 [a]	Moderate	10.981	0.027**
	Secondary	2.55	1.11	165.09 [b]	High		
	Diploma	2.38	1.09	151.90 [ab]	Moderate		
	Bachelor degree	2.23	1.03	138.20 [a]	Moderate		
	Postgraduate	2.91	0.87	190.26 [b]	High		
Controller	Less than high school	2.24	0.96	137.36	Moderate	1.332	0.856
	Secondary	2.37	1.09	149.71	Moderate		
	Diploma	2.46	1.12	161.35	High		
	Bachelor degree	2.40	0.98	150.86	Moderate		
	Postgraduate	2.38	0.88	144.03	Moderate		
Hyper-rational	Less than high school	1.86	1.20	128.69 [b]	Moderate	12.957	0.011**
	Secondary	2.40	1.16	171.88 [a]	High		
	Diploma	1.90	1.01	128.00 [b]	Moderate		
	Bachelor degree	2.17	0.96	149.62 [ab]	Moderate		
	Postgraduate	1.76	0.83	114.79 [b]	Moderate		
self-sabotage	Less than high school	2.29	0.50	152.66	Moderate	3.669	0.453
	Secondary	2.35	0.51	162.63	Moderate		
	Diploma	2.19	0.48	134.79	Moderate		
	Bachelor degree	2.25	0.49	145.98	Moderate		
	Postgraduate	2.25	0.48	137.59	Moderate		

†: Different letters within a row indicate a significant difference at the level 5%.

**: Result significant at 5%.

Figure 4.15 elucidates the sources of differences in the victim's mean score based on their education level, as determined by the pairwise test of the Kruskal-Wallis test. The results show a significant difference in the victim's mean score between patients with secondary level education (mean rank = 173.61) and those with a bachelor's degree (mean rank = 141.54) and diploma (mean rank = 132.94), in favor to the secondary category.

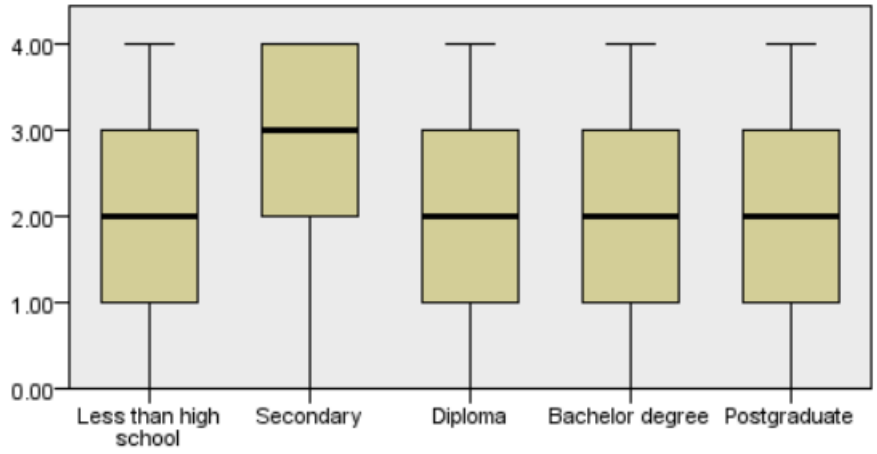

Figure 4.15: Mean and standard deviation of the mean score of the victim scale due to education level

Furthermore, figure 4.16 elucidates the sources of differences in the hyper-achiever's mean score based on education level, as determined by the pairwise test of the Kruskal-Wallis test. The results show a significant difference in the hyper-achiever's mean score between patients with secondary education (mean rank = 165.09) and those with bachelor's degrees (mean rank = 138.20), favoring the secondary category. Additionally, there is a significant difference in the hyper-achiever's mean score between patients with secondary education (mean rank = 165.09) and those with less than high school (mean rank = 127.97). There is also a significant difference in the mean score of the hyper-achiever between patients with postgraduate degrees (mean rank = 190.26) and those with bachelor's degrees (mean rank = 138.20), favoring postgraduate degrees. Additionally, there is a significant difference in the mean score of the hyper-achiever between patients with postgraduate degrees (mean rank = 190.26) and those with less than high school (mean rank = 127.97), favoring postgraduate education.

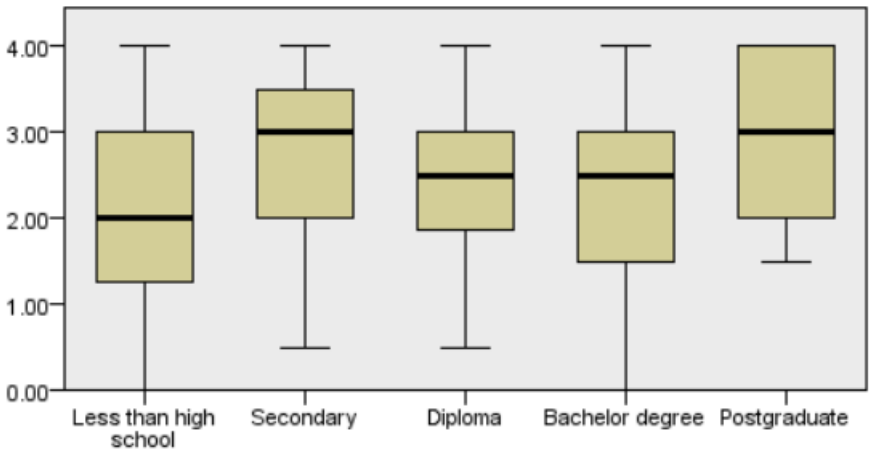

Figure 4.16: Mean and standard deviation of the mean score of the hyper-achiever scale due to education level

Furthermore, figure 4.17 elucidates the sources of differences in the mean score of the hyper-rational due to education level, as determined by the pairwise test of the Kruskal-Wallis test. The results show a significant difference in the mean score of the hyper-rational between patients with secondary degrees (mean rank = 171.88) and those with diploma degrees (mean rank = 128.0), favoring a secondary category. Similarly, there is a significant difference in the mean score of the hyper-rational between patients with secondary degrees (mean rank = 171.88) and those with postgraduate degrees (mean rank = 114.79), again favoring a secondary category. Also, there is a significant difference in the mean score of the hyper-rational between patients who had secondary degrees (mean rank = 171.88) and other patients who had less than high school (mean rank = 128.69) in favor of a secondary category.

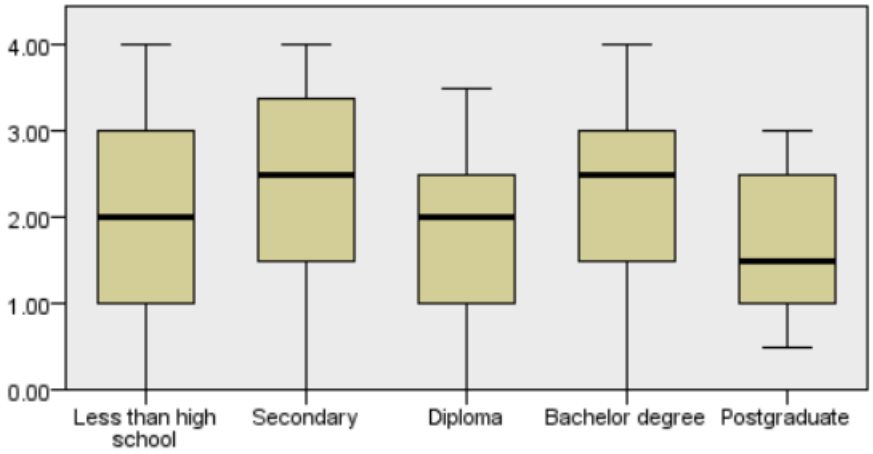

Figure 4.17: Mean and standard deviation of the mean score of the hyper-rational scale due to education level

4.5.6 The following are the results of the sixth sub-hypothesis of the first hypothesis:

This section presents the outcome of the sixth sub-hypothesis, which asserts, "There is no significant difference in the mean score of self-sabotage due to the economic status." The Kruskal-Wallis test result in table 4.19 indicates that there is no significant difference in self-sabotage level due to economic status, as the p-value (0.122) exceeds the significant level of 0.05, contradicting the sixth sub-hypothesis. Additionally, all patients exhibit a moderate level of self-sabotage, regardless of their economic status.

Furthermore, the results show a significant difference between the avoider and victim levels due to economic status, with the p-values (0.000 and 0.004, respectively) being less than the significant level of 0.05. However, the results show that the eight dimensions of the self-sabotage score (stickler, pleaser, judge, restless, hyper-vigilant, controller, hyper-achiever, and hyper-rational) do not significantly differ based on economic status, as all p-values exceed the significant level of 0.05.

Table 4.19: The Results of the sixth sub-hypothesis:

Dimensions	Statistic	Mean	SD	Mean rank	Level	Test statistic	Sig.
Stickler	Less than 1500 NIS	2.37	0.91	147.05	Moderate	0.545	0.909
	1500-2500 NIS	2.33	0.78	143.61	Moderate		
	2501-3500 NIS	2.28	0.88	141.45	Moderate		
	More than 3500 NIS	2.21	0.98	136.31	Moderate		
Hyper-vigilant	Less than 1500 NIS	2.25	0.92	150.64	Moderate	7.031	0.071
	1500-2500 NIS	2.19	0.75	142.61	Moderate		
	2501-3500 NIS	2.30	0.84	153.35	Moderate		
	More than 3500 NIS	1.95	0.85	121.12	Moderate		
Pleaser	Less than 1500 NIS	2.48	0.82	161.39	High	5.469	0.140
	1500-2500 NIS	2.39	0.71	150.23	Moderate		
	2501-3500 NIS	2.20	0.69	130.29	Moderate		
	More than 3500 NIS	2.23	0.79	134.91	Moderate		
Judge	Less than 1500 NIS	2.36	0.79	155.39	Moderate	3.709	0.295
	1500-2500 NIS	2.27	0.60	149.18	Moderate		
	2501-3500 NIS	2.22	0.59	138.81	Moderate		
	More than 3500 NIS	2.13	0.75	129.02	Moderate		
Restless	Less than 1500 NIS	2.51	1.01	151.54	High	0.898	0.826
	1500-2500 NIS	2.32	0.96	138.13	Moderate		
	2501-3500 NIS	2.34	1.13	138.65	Moderate		
	More than 3500 NIS	2.44	0.99	143.1	High		
The avoider	Less than 1500 NIS	2.65	0.73	166.36 [a]	High	20.884	0.000**
	1500-2500 NIS	2.62	0.70	167.71 [a]	High		
	2501-3500 NIS	2.21	0.73	120.23 [b]	Moderate		
	More than 3500 NIS	2.27	0.74	125.66 [b]	Moderate		
The victim	Less than 1500 NIS	2.65	1.37	169.93 [a]	High	13.500	0.004**
	1500-2500 NIS	2.46	1.28	156.95 [ac]	High		
	2501-3500 NIS	2.00	1.22	128.08 [cb]	Moderate		
	More than 3500 NIS	1.96	1.22	125.78 [b]	Moderate		
Hyper-achiever	Less than 1500 NIS	2.29	1.25	137.41	Moderate	2.781	0.427
	1500-2500 NIS	2.35	0.98	139.42	Moderate		
	2501-3500 NIS	2.25	1.18	134.35	Moderate		
	More than 3500 NIS	2.56	0.98	154.53	High		
Controller	Less than 1500 NIS	2.64	1.05	161.54	High	5.212	0.157
	1500-2500 NIS	2.47	0.97	147.75	High		
	2501-3500 NIS	2.34	1.10	138.28	Moderate		
	More than 3500 NIS	2.25	0.94	127.86	Moderate		
Hyper-rational	Less than 1500 NIS	2.06	1.17	134.54	Moderate	5.357	0.147
	1500-2500 NIS	2.20	1.02	144.59	Moderate		
	2501-3500 NIS	2.33	0.99	154.52	Moderate		
	More than 3500 NIS	1.93	1.15	126.3	Moderate		
self-sabotage	Less than 1500 NIS	2.39	0.53	155.59	Moderate	5.802	0.122
	1500-2500 NIS	2.34	0.46	153.43	Moderate		
	2501-3500 NIS	2.25	0.48	137.54	Moderate		
	More than 3500 NIS	2.17	0.52	125.91	Moderate		

The pairwise test of the Kruskal–Wallis test in Figure 4.19 shows that there is a significant difference in the mean score of the avoider between patients who make less than 1500 NIS a month (mean rank = 166.36), those who make more than 3500 NIS a month (mean rank = 125.66), and those who make between 2501 and 3500 NIS a month (mean rank = 120.23), with patients who make less than 1500 NIS a month having a higher mean score. Additionally, the mean score of the avoider significantly differs between patients who receive between 1500 and 2500 NIS monthly (mean rank = 167.71), those who receive more than 3500 NIS (mean rank = 125.66), and those who receive between 2501 and 3500 NIS (mean rank = 120.23), favoring those who receive between 1500 and 2500 NIS.

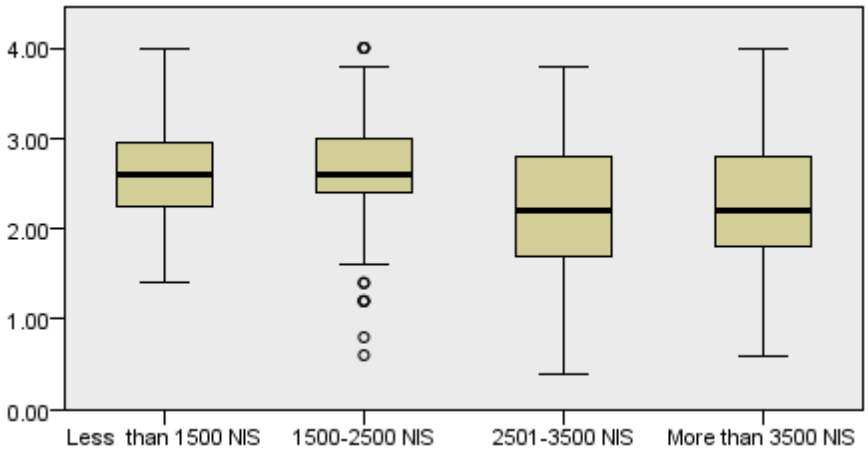

Figure 4.18: Mean and standard deviation of the mean score of the avoider scale due to economic status

Figure 4.19 elucidates the sources of differences in the victim's mean score due to their economic status, as determined by the pairwise test of the Kruskal-Wallis test. The results show a significant difference in the victim's mean score between patients who receive less than 1500 NIS (mean rank = 169.93), those who receive between 2501 and 3500 NIS monthly (mean rank = 128.08), and those who receive more than 3500 NIS (mean rank = 125.78), with the patients who receive less than 1500 NIS benefiting from this difference. Additionally, the mean score of the victim significantly differs between patients who receive between 1500 and 2500 NIS monthly (mean rank = 128.08) and those who receive more than 3500 NIS (mean rank = 125.78), favoring those who receive between 1500 and 2500 NIS.

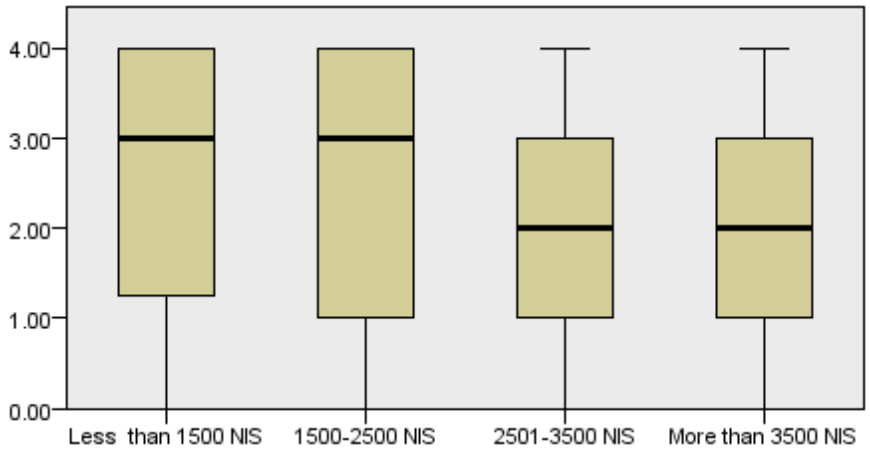

Figure4.19: Mean and standard deviation of the mean score of the victim scale due to economic status

4.6 The Results of the second hypothesis

This section presents the results of the second hypothesis, which asserts: "There is no significant impact of self-sabotage on the compliance of the treatment of patients with eating disorders in Nutri-health centers, as perceived by the dietitians in these centers." Multiple linear regression was used to test the idea of making a regression model that would show how self-sabotage affects the people with eating disorders who go to Nutri-health centers and follow their treatment plans, from the point of view of the dietitians who work there.

The specification of the regression model is as follows**:**

$$\begin{aligned} \boldsymbol{compliance_i} = \boldsymbol{B_0^1} + \boldsymbol{B_1^1}\ \boldsymbol{stickler_i} + \boldsymbol{B_2^1 Hyper - vigilant_i} \\ + \boldsymbol{B_3^1}\ \boldsymbol{Pleaser_i} + \boldsymbol{B_4^1 Judge_i} + \boldsymbol{B_5^1}\ \boldsymbol{Restless_i} + \boldsymbol{B_6^1}\ \boldsymbol{The\ avoider_i} \\ + \boldsymbol{B_7^1}\ \boldsymbol{The\ avoider_i} + \boldsymbol{B_8^1}\ \boldsymbol{The\ avoider_i} + \boldsymbol{B_9^1}\ \boldsymbol{The\ avoider_i} \\ + \boldsymbol{B_{10}^1}\ \boldsymbol{The\ avoider_i} + \boldsymbol{u_i^1} \end{aligned}$$

Before applying the multiple regression model to answer the second hypothesis, the researcher must verify four important assumptions, the first of which is related to multicollinearity. Table 4.20 shows that the Pearson correlation coefficient between any two predictor variables is less than 0.80, and all variance inflation factor (VIF) values are less than 10, indicating that multicollinearity among the predictor variables does not pose a problem. Furthermore, we arranged the Pearson correlation coefficients between the self-sabotage dimensions between 0.069 and 0.481, indicating the highest significant positive relationship between the pleaser and the avoider (0.481) and the lowest significant relationship between the avoider and the hyper-vigilant (0.105).

Table 4.20: The Results of multicollinearity test:

Dimensions	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	VIF
1. Stickler	1.000										1.343
2. Hyper-vigilant	0.465*	1.000									1.509
3. Pleaser	0.269*	0.377*	1.000								1.620
4. Judge	0.297*	0.340*	0.476*	1.000							1.594
5. Restless	0.091	0.105*	0.225*	0.123*	1.000						1.170
6. The avoider	0.202*	0.258*	0.481*	0.396*	0.257*	1.000					1.459
7. The victim	0.156*	0.129*	0.240*	0.306*	0.228*	0.241*	1.000				1.178
8. Hyper-achiever	0.231*	0.189*	0.224*	0.270*	0.191*	0.194*	0.171*	1.000			1.160
9. Controller	0.161*	0.273*	0.226*	0.252*	0.213*	0.197*	0.178*	0.153*	1.000		1.164
10. Hyper-rational	0.153*	0.278*	0.264*	0.325*	0.139*	0.069	0.161*	0.204*	0.107*	1.000	1.222

Furthermore, the model suffered from homoscedasticity, autocorrelation, and a non-normal residual distribution, as indicated by the results of the Breusch-Pagan/Cook-Weisberg test, Durbin-Watson test, and Shapiro-Wilk test (see Table 4.21). To address these issues, we used multiple linear regression with robust standard error (Rogers, 1993).

Additionally, the results presented in Table 4.21 demonstrate a significant impact of self-sabotage on the compliance of patients with eating disorders in Nutri-health centers, as perceived by the dietitians. This impact is confirmed by the p-value of 0.000, which is less than the significant level of 0.05, thereby supporting the second hypothesis. Additionally, according to the perspectives of the dietitians in Nutri-health centers, self-sabotage accounts for 28.95% of the variation in compliance with the treatment of patients with eating disorders in these centers.

Table: 4.21: result of the second hypothesis

	B Coefficients	Std. Error	t	Sig.
Constant	**109.978**	**6.031**	**18.24**	**0.000***
Stickler	**-8.499**	**1.931**	**-4.40**	**0.000***
Hyper-vigilant	**-6.874**	**2.348**	**-2.93**	**0.004***
Pleaser	0.382	2.282	0.17	0.867
Judge	4.085	2.917	1.40	0.162
Restless	**-3.810**	**1.564**	**-2.44**	**0.015***
The avoider	**-4.933**	**2.359**	**-2.09**	**0.037***
The victim	**-2.572**	**1.264**	**-2.03**	**0.043***
Hyper-achiever	**3.110**	**1.518**	**2.05**	**0.041***
Controller	-0.539	1.457	-0.37	0.712
Hyper-rational	**-5.277**	**1.538**	**-3.43**	**0.001***
Model test (F(10,277)=11.292, sig.= 0.000*)				
Breusch-pagan / Cook-Weisberg test (chi-square=7.85, sig.=0.005)				
Shapiro–Wilk test (test statistic=0.062, sig.=0.010)				
Durbin-Watson=1.856				
R-squared= 0.2895				

According to the result in Table 4.21, self-sabotage can explain 28.95% of the variation of compliance with the treatment of patients with eating disorders in Nutri-health centers from the perspectives of the dietitians in Nutri-health centers, so there are other factors can explain 71.05% of the variation of compliance of the treatment of patients with eating disorders, according that the researcher inserts four demographic variables in regression model to develop the model and increase the explanation percentage as follows:

From the perspective of the dietitians at Nutri-health centers, the impact of self-sabotage dimensions on the compliance with the treatment of patients with eating disorders is evident.

1. There is a significant negative impact of stickler on compliance of the treatment of patients with eating disorders (p-value = 0.000 < 0.05). If the stickler level increases by one degree, the compliance with the treatment of patients with eating disorders decreases by approximately 8.5%.

2. There is a significant negative impact of hyper-vigilance on compliance with the treatment of patients with eating disorders (p-value = 0.004 < 0.05). If the hypervigilant level increases by one degree, the compliance with the treatment of patients with eating disorders decreases by 6.874%.

3. There is a significant negative impact of the restless on compliance of the treatment of patients with eating disorders (p-value = 0.015 < 0.05). If the restless level increases by one degree, the compliance with the treatment of patients with eating disorders decreases by 3.81%.

4. There is a significant negative impact of the avoider on compliance of the treatment of patients with eating disorders (p-value = 0.037 < 0.05). If the avoider level increases by one degree, the treatment compliance of patients with eating disorders decreases by 4.933%.

5. There is a significant negative impact of the victim on compliance of the treatment of patients with eating disorders (p-value = 0.043 < 0.05). If the victim level increases by one degree, the treatment compliance of patients with eating disorders decreases by 2.572%.

6. There is a significant negative impact of the hyper-achiever on compliance with the treatment of patients with eating disorders (p-value = 0.041 < 0.05). If the hyper achiever level increases by one degree, the compliance with the treatment of patients with eating disorders increases by 3.11%.

7. There is a significant positive impact of the hyper-rational on compliance of the treatment of patients with eating disorders (p-value = 0.010 < 0.05). If the hyper-rational level increases by one degree, the treatment compliance of patients with eating disorders decreases by 5.277%.

8. There is no significant impact of the pleaser, judge, and controller on compliance with the treatment of patients with eating disorders (p-value = 0.867, 0.162, and 0.712, respectively).

$$compliance_i = B_0^2 + B_1^2\ stickler_i + B_2^2 Hyper - vigilant_i + B_3^2\ Pleaser_i + B_4^2 Judge_i + B_5^2\ Restless_i + B_6^2\ The\ avoider_i + B_7^2\ The\ avoider_i + B_8^2\ The\ avoider_i + B_9^2\ The\ avoider_i + B_{10}^2\ The\ avoider_i + B_{11}^2\ age_i + B_{12}^2\ gender_i + B_{13}^2\ income(1500 - 2500)_i + B_{14}^2\ income(2600 - 3500)_i + B_{15}^2\ income(more\ than\ 3500)_i + u_i^2$$

The result in Table 4.22 indicates that the model built is significant (sig. = 0.000 < 0.05) after adding the demographic variables (age, gender, income). From the perspectives of the dietitians at Nutri-health centers, the independent variables (self-sabotage dimensions, age, gender, and income) can explain 37.13% of the variation in compliance in treating patients with eating disorders. This underscores the significance of incorporating demographic variables into the regression model. Also, there is a significant negative impact of being a stickler, hyper-vigilant, restless, and hyper-rational on compliance with the treatment of patients with eating disorders, and there is a significant positive impact of being a hyper-achiever on compliance with the treatment of patients with eating disorders. In addition, there is a significant positive impact of patient age on compliance of the treatment of patients with eating disorders, and if the patients' age increases by one year, the compliance of the treatment of patients with eating disorders decreases. Additionally, there is a significant difference in the mean score of treatment compliance between patients who receive less than 1500 NIS and those who receive more than 3500 NIS monthly, favoring those who receive more than 3500 NIS.

Table :4.22: The results of the second hypothesis

	B Coefficients	**Std. Error**	**t**	**Sig.**
Constant	**76.81**	**9.77**	**7.86**	**0.000****
Stickler	**-8.99**	**1.86**	**-4.83**	**0.000****
Hyper-vigilant	**-6.44**	**2.21**	**-2.91**	**0.004****
Pleaser	-0.79	2.22	-0.36	0.723
Judge	0.87	1.40	0.62	0.533
Restless	**-3.26**	**1.52**	**-2.14**	**0.033***
The avoider	-1.62	2.26	-0.72	0.475
The victim	-1.80	1.26	-1.43	0.154
Hyper-achiever	**4.75**	**2.64**	**1.79**	**0.074**
Controller	-0.36	**1.47**	-0.24	0.808
Hyper-rational	**-4.97**	**1.53**	**-3.25**	**0.001***
Gender	0.191	3.36	0.06	0.955
Age	**0.56**	**0.14**	**4.00**	**0.000***
Income‡ (less than 1500NIS)				
Income (1500-2500 NIS)	7.45	4.97	1.50	0.135
Income (2600-3500 NIS)	8.27	5.29	1.56	0.119
Income (more than 3500 NIS)	14.31	5.59	2.56	0.011
Model test (F(15,249)=17.37, sig.= 0.000*)				
Breusch-pagan / Cook-Weisberg test (chi-square=3.50, sig.=0.0614)				
Shapiro–Wilk test (test statistic=0.064, sig.=0.011)				
Durbin-Watson=1.897				
R-squared= 0.3713				

‡: reference category of income, * and **: Result significant at 10% and 5% respectively, age variable in this model is quantitative variable.

Chapter Five:

Discussion of the Results

5.1 Introduction

The following chapter discusses the results of our quantitative study, which was done in Nutri health centers to explore the relationship between variables in numerical and statistical terms and to interpret and integrate the results of our study with the reviewed literature and previous studies.

5.2 Discussion of Results

The results of our study, based on primary cross-sectional data, show that out of the 300 patients who participated in the questionnaire, 67 (22.6%) were males and 230 (77.4%) were females. This research set out to examine the impact of self-sabotage behavior on treatment compliance among patients with eating disorders at Nutri-Health Centers in Ramallah, Hebron, and Jenin.

Ramallah has the highest percentage of the participants, 52%, as an area of the study, followed by Hebron, 25.3%, while Jenin has the lowest percentage, 22.7%.

We measured the self-sabotage behavior using a questionnaire as a study tool, which is reliable and valid according to our results. We measured the self-sabotage behavior using ten dimensions: stickler, hyper-vigilant, pleaser, judge, restless, the avoider, the victim, hyper-achiever, controller, and hyper-rational. In data analysis, the researcher uses version 23 of the Statistical Package for Social Sciences (SPSS). The Kolmogorov-Smirnov test

was used to check the factor distribution, and the results clarify that all study variables had a non-normal distribution with p- values less than the significance level ($\alpha = 0.05$).

The researcher wants to discuss the results of our study and to dig deep in order to answer this research question, which states, **"What is the level of self-sabotage in patients with eating disorders from Nutri-health centers?"** After answering this question, we want to answer the main research question, which is, "**What is the impact of self-sabotage on the compliance of the treatment?"**

According to the results, the mean and standard deviation scores of sample responses about the self-sabotage level are 2.28 and 0.50, respectively, which indicates a moderate level of self-sabotage. The avoider dimension has the highest level (mean = 2.41 with a high level), followed by the restless (mean = 2.40 with a high level), the controller (mean = 2.38), and the hyper-achiever (mean = 2.37), respectively, while the hyper-rational has the lowest level (mean = 2.16).

On the other hand, most of the participants had a moderate level of self-sabotage (75%, n=225); 22.3% (n=67) of participants had a high level, and 2.7% (n=8) had a low level.

The victim dimension had the highest percentage of participants who had a high level on it (47%, n = 141), followed by sticklers (42.3%, n = 127), hyper achievers (39.3%, n = 118), and controllers (38%, n = 114), respectively. The judge dimension had the lowest percentage of participants with a high level (27.3%, n = 82).

The descriptive statistics for the self-sabotage scale in our study reveal that the participants primarily suffer from the restless and avoider saboteur types, exhibiting the highest levels. Previous studies link the Restless Saboteur to mood changes, while the Avoider Saboteur leads to procrastination by avoiding difficult or unpleasant tasks (Saimi, 2019). Other studies also emphasized that disturbed eating behavior is associated with concerns about weight and shape or phobic avoidance (Derenne J. et al., 2016).

The result of the Mann–Whitney U-test indicates in general that there is no significant difference in self-sabotage level between the females and males among patients with eating disorders at Nutri-Health Centers, since the p-value (0.411) is more than the significant level of 0.05. Furthermore, the mean self-sabotage level for both male and female patients at Nutri-Health Centers is 2.26. (mean=2.28) is moderate. On the other hand, a significant difference exists in the avoider saboteur between males and females, as evidenced by the p-value of 00.004, which falls below the significant level of 0.05. This indicates that the females have the avoider saboteur more than men, especially in our society, because many of the women have fears, and this reflects the avoiding pattern within them, and this is consistent with other studies that connect the avoidance behavior with the eating disorders; for instance, this study about anorexia nervosa studied the relationship between avoidance behavior of not eating and restricting the food as an obstacle for patients with anorexia nervosa, which blocks the treatment (Melles et al., 2021).Furthermore, our study's results align with previous studies that link self-sabotage to low self-esteem, which in turn influences body dissatisfaction (De Sousa Fortes et al., 2014).

In general, all the different age groups exhibit moderate self-sabotage; however, there is no significant difference in the mean score of self-sabotage based on age. The result of the Kruskal–Wallis test indicates there is no significant difference in self-sabotage level due to patient age categories. The results show that the nine dimensions of self-sabotage score (stickler, hyper-vigilant, pleaser, the avoider, restless, the avoider, the victim, hyper-achiever, controller, and hyper-rational) do not significantly differ based on patient age category, as all p-values exceed the significant level of 0.05. On the other hand, the only difference is in the judge saboteur; the researcher finds that the age group of 36–45 years suffers the most from the judge saboteur because, according to the results, this age group has the highest level of judge saboteur with a p-value of 0.019, which is less than the

significance level ($\alpha = 0.05$). According to Chamine, the Judge Saboteur serves as the primary internal enemy, activating other saboteurs. The judge, Saboteur, blames the person for mistakes that cause them to worry about future risks. This can lead to stress and unhappiness, which in turn can result in ineffectiveness. The judge's key responsibility is to exaggerate the negatives and act as a pessimist (Saimi, 2019). Chamine categorized this pattern as criticism (Saimi, 2019), and this is related and supports the results of our study since middle-aged individuals are the ones who criticize the people and the environment around them the most; in addition, this is also related to the 6th stage of psychosocial development in Erikson's 8 stages, intimacy vs isolation, because in general the people who criticize others are the people who feel separation from others and can't accept them the way they are (Crain et al., 2024).

The result of the Kruskal–Wallis test confirms that there is no significant difference in self-sabotage level due to patient occupation, since the p-value (0.163) is more than the significant level of 0.05.

The results show that self-sabotage has a big effect on how well people with eating disorders follow their treatment plans in Nutri-health centers, according to the dietitians who work there. This is because the p-value (0.000) is less than the 0.05 level of significance. Furthermore, it is evident that self-sabotage accounts for 28.95% of the variation in compliance with the treatment of patients with eating disorders in Nutri-health centers, as perceived by the dietitians in these centers.

Eating disorders (p-value = 0.041 < 0.05). If the hyper-achiever level increases by one degree, the treatment compliance of patients with eating disorders increases by 3.11%.

According to the results, there is a significant positive impact of the hyper-rational on compliance of the treatment of patients with eating disorders (p-value = 0.010 < 0.05). If the hyper-rational level increases by one degree, the treatment compliance of patients with eating disorders decreases by 5.277%. However, there is no significant impact of the pleaser, judge, and controller on compliance with the treatment of patients with eating disorders (p-value = 0.867, 0.162, and 0.712, respectively). The results clearly indicate that the stickler saboteur has the highest impact on treatment compliance, followed by the hypervigilant, hyper-rational, avoider, hyper-achiever, and victim, respectively. The researcher concludes that the victim saboteur has the least influence on treatment compliance in his study. This makes sense, as if an individual lacks responsibility for their actions and decisions, they will struggle to commit to and maintain the commitment of the treatment plan, which is closely linked to the victim mentality. Additionally, other studies have revealed that eating disorders are characterized by eating and appetite disorders, which are mental in nature (Górski et. al.,2020).

Based on the results, the researcher observes that self-sabotage accounts for only 28.95% of the variation in patient compliance with treatment for eating disorders in Nutri-health centers, as perceived by the dietitians working there. Therefore, other factors can explain 71.05% of the variation in compliance with the treatment of patients with eating disorders. Because of this, the researcher incorporates four demographic variables into the regression model to enhance the model's development and boost the explanation percentage. The researcher then incorporates the demographic variables (age, gender, and income). Along with the independent variables. From the perspectives of the dietitians at Nutri-health centers, the researcher is able to explain 37.13% of the variation in compliance when treating patients with eating disorders. This indicates the significance of incorporating demographic variables into the regression model. Also, there is a significant negative impact of being a stickler, hyper-vigilant, restless, and hyper-rational on compliance with the treatment of patients with eating disorders, and there is a significant positive impact of

being a hyper-achiever on compliance with the treatment of patients with eating disorders. In addition, there is a significant positive impact of patient age on compliance of the treatment of patients with eating disorders, and if the patient's age increases by one year, the compliance of the treatment of patients with eating disorders decreases by 0.56%. Additionally, there is a significant difference in the mean score of treatment compliance between patients who receive less than 1500 NIS and those who receive more than 3500 NIS monthly, favoring those who receive more than 3500 NIS.

According to the evaluation of the dietitians, the results of our research indicate that nearly 50 out of 300 participants had a compliance rate of 70%. Our study's compliance results differ from previous studies, which have established that low treatment adherence is a widespread issue of significant clinical relevance among patients with eating disorders (Zendegui et al., 2014). Furthermore, it's crucial to note that other studies indicate a notable deficiency in treatment compliance among patients with eating disorders, which is closely linked to self-sabotage (Srivastava, Paakhi, et al., 2023).

The majority of the patients were with binge eating disorder (60.3%, n=181); 33% (n=99) of the patients were overweight, 3% (n=9) of the patients were stable weight, and 2.7% (n=9) of the patients were underweight. Only one participant, accounting for 0.3%, was severely underweight. Additionally, two participants did not respond to this question, accounting for 0.7% of the total.

In terms of patient commitment to the treatment plan, 4% (n = 12) of patients did not commit to it at all, while 288 patients did. The mean percentage of patients who adhere to the treatment plan is 53.69% (n=155), with 43.7% (n=126) of patients committed to the treatment plan for 50% or less and 56.3% (n=162) committed to the treatment plan for more than 50%.Furthermore, we found that 28.13% (n=81) of patients withdrew from treatment, whereas 35.8% (n=102) withdrew and then returned to it; 27.7% (n=28) withdrew from treatment once, 31.7% (n=32) twice, 22.8% (n=23) three times, and 17.8% (n=18) more than three times. The results of our study align with previous research, highlighting the difficulty individuals with eating disorders face in maintaining motivation for recovery. This challenge contributes to high rates of treatment dropout and relapse (Venturo-Conerly et. al., 2020).

In our study, 67 (22.6%) were males, and 230 (77.4%) were females. In general, females suffer from eating disorders more than males, and this was reflected in our sample, because the number of females as participants is significantly higher than males. I believe this reflects our culture in Palestine, where women are more concerned about their appearance and health, while men are less concerned about their appearance. This raises an intriguing question: does the concern for weight stem from a lack of self-worth, or is it a genuine effort to improve health, which in turn enhances their appearance? Furthermore, 97 (33.9%) of the participants are housewives, 71 (24.8%) are self-employed, 31 (10.8%) are teachers, 23 (8%) work in the health service, 17 (5.9%) are administrative, and 47 (16.5%) are employed in other sectors. These results may indicate that 33.9% of patients are housewives, who may experience more weight instability than their working counterparts. This instability could be attributed to factors such as low self-esteem, depression, and various self-sabotage strategies. Conversely, the fact that they have more time than working women may enable them to prioritize their weight and achieve their ideal weight. Furthermore, based on the results, the researcher discovered that housewives experience higher levels of self-sabotage than others, particularly from avoider sabotage, which has a significantly high level. Additionally, teachers exhibit a high level of avoider sabotage, with a p-value of 0.004. Regarding marital status, the majority of patients are married

(n=176, 59.3%); 101 (34%) are single, 11 (3.7%) are divorced, and 9 (3%) are widowed. In addition, the results indicate that there is a significant difference in the mean score of the hyper-achiever between patients who are widowed (mean rank = 131.75) and others who are divorced (mean rank = 160.54) in favor of the widowed. This also could represent the relationships in the Palestinian culture, for example, when the woman doesn't find support, she depends on herself and she tries to achieve more. In addition, the relationship between the members of the family can affect the level of self-sabotage, because the less confidence and the less self-esteem levels can raise people more susceptible to higher level of self-sabotage.

The result of the Kruskal–Wallis test indicates there is no significant difference in self-sabotage level due to the education level, since the p-value (0.453) is more than the significant level of 0.05. Furthermore, the self-sabotage level of all patients is moderate in terms of differences in education.

Additionally, the results show a significant difference in the hyper-achiever, victim, and hyper-rational levels based on education level, as evidenced by the p-values (0.027, 0.030, and 0.011, respectively), which are all less than the significant level of 0.05. However, the results show that there is no significant difference in the seven dimensions of the self-sabotage score (stickler, hyper-vigilant, pleaser, judge, restless, the avoider, and controller) due to education level, as all p-values exceed the significant level of 0.05.

Ramallah has the highest percentage of the participants, 52%, as an area of the study, followed by Hebron, 25.3%, while Jenin has the lowest percentage, 22.7%.

We used a questionnaire as a study tool to measure the self-sabotage behavior, and our results confirm its reliability and validity. We measured the self-sabotage behavior using ten dimensions: stickler, hyper-vigilant, pleaser, judge, restless, the avoider, the victim, hyper-achiever, controller, and hyper-rational. In data analysis, the researcher uses version 23 of the Statistical Package for Social Sciences (SPSS). The Kolmogorov-Smirnov test was used to check the factor distribution, and the results clarify that all study variables had a non-normal distribution with p- values less than the significance level ($\alpha = 0.05$).

We want to discuss the results of our study and dig deep in order to answer this research question, which states, **"What is the level of self-sabotage in patients with eating disorders from Nutri-health centers?"** After answering this question, we want to answer the main research question, which is, "**What is the impact of self-sabotage on the compliance of the treatment?"**

The results show that the sample respondents' mean and standard deviation scores for the self-sabotage level are 2.28 and 0.50, respectively, indicating a moderate level of self-sabotage. Also, the avoider dimension has the largest level (mean = 2.41) with a high level, followed by the restless (mean = 2.40) with a high level, the controller (mean = 2.38), and the hyper-achiever (mean = 2.37), respectively, while the hyper-rational had the lowest level (mean = 2.16).

On the other hand, most of the participants had a moderate level of self-sabotage (75%, n=225); 22.3% (n=67) of participants had a high level, and 2.7% (n=8) had a low level.

The victim dimension had the highest percentage of participants who had a high level on it (47%, n = 141), followed by sticklers (42.3%, n = 127), hyper achievers (39.3%, n = 118), and controllers (38%, n = 114), respectively. The judge dimension had the lowest percentage of participants with a high level (27.3%, n = 82).

The descriptive statistics for the self-sabotage scale in our study reveal that the participants primarily suffer from the restless and avoider saboteur types, exhibiting the highest levels. Previous studies link the Restless Saboteur to mood changes, while the Avoider Saboteur leads to procrastination by avoiding difficult or unpleasant tasks. (Saimi, 2019). Additionally, other studies have linked low dysthymic mood to depression, which can lead to binge eating. However, compensatory behavior is dependent on self-esteem and the importance of body image (Brechan et al., 2015).

Moreover, other previous studies confirmed that there is an association between the severity of eating disorder symptoms and symptoms of depression and anxiety, motivation to change, and perfectionism; this is connected to the saboteur types in our study (Anderson et al., 2017).

The result of the Mann–Whitney U-test indicates in general that there is no significant difference in self-sabotage level between the females and males among patients with eating disorders at Nutri-Health Centers, since the p-value (0.411) is more than the significant level of 0.05. Moreover, the self-sabotage level of both male patients (mean = 2.26) and females (mean = 2.28) is moderate. On the other hand, there is a significant difference in avoider sabotage between males and females, as evidenced by the p-value of 0.004, which falls below the significant level of 0.05. This suggests that females are more likely to be avoider saboteurs than men, particularly in our society, as many women tend to have fears, which is reflected in their avoidance behaviors. This also reflects the differences in upbringing between males and females in our Palestinian society. Typically, males in our society start working at a younger age than females, and they rely on their own finances. This makes them less prone to avoidance as types of sabotage, as they experience life more fully and have fewer fears than females. On the other hand, most females in our Palestinian culture depend financially on their parents until they graduate from the university, and they have more restrictions than males in experiencing and travelling and going to various places. This makes females with a high avoider saboteur because they have more fears than males, and they are afraid to experience new experiences due to our conservative community. Furthermore, in the Palestinian culture, they give significant emphasis to the reputation of females and judge their actions and behaviors more than males and this can reflect higher avoider saboteur in females because they are afraid to do mistakes and to be judged from the society.

In general, all the different age groups exhibit moderate self-sabotage; however, there is no significant difference in the mean score of self-sabotage based on age. The result of the Kruskal–Wallis test indicates there is no significant difference in self-sabotage level due to patient age categories. The results show that the nine dimensions of self-sabotage score (stickler, hyper-vigilant, pleaser, the avoider, restless, the avoider, the victim, hyper-achiever, controller, and hyper-rational) do not significantly differ based on patient age category, as all p-values exceed the significant level of 0.05. On the other hand, the only difference is in the judge saboteur; the researcher finds that the age group of 36–45 years suffers the most from the judge saboteur because, according to the results, this age group has the highest level of judge saboteur with a p-value of 0.019, which is less than the significance level ($\alpha = 0.05$). The results in our study are different from other studies; for example, in the Middle East, anorexia affects both men and women, at any age. The most affected people are young women between the ages of 14 and 25. Between 5 to 20% die from complications (Middle East Eating Disorder Association, 2022).

The result of the Kruskal–Wallis test confirms there is no significant difference in self-sabotage level due to patient occupation, since the p-value (0.163) is more than the significant level of 0.05.

5.3 Conclusion:

This study aimed to decipher the impact of self-sabotage on the compliance of the treatments in patients with eating disorders in Ramallah, Hebron, and Jenin by measuring the level of self-sabotage in ten dimensions. Next, we investigated the influence of self-sabotage on the adherence of patients suffering from eating disorders. According to the results in our study, which is based on primary cross-sectional data, 300 patients participated in the questionnaire; 67 (22.6%) were males, and 230 (77.4%) were females in Nutri-Health Centers in Ramallah, Hebron, and Jenin.

We measured the self-sabotage behavior using a questionnaire as a study tool, which is reliable and valid according to our results. We measured the self-sabotage behavior using ten dimensions: stickler, hyper-vigilant, pleaser, judge, restless, the avoider, the victim, hyper-achiever, controller, and hyper-rational. In data analysis, the researcher uses version 23 of the Statistical Package for Social Sciences (SPSS). The Kolmogorov-Smirnov test was used to check the factor distribution, and the results clarify that all study variables had a non-normal distribution with p values less than the significance level ($\alpha = 0.05$).

The statistical analysis showed that the majority of sample members (75%), 22.3% of participants, had a high level of self-sabotage behavior, and 2.7% had a low level.

Additionally, the avoider dimension exhibits the highest level of self-sabotage, followed by the restless, controller, and hyper-achiever dimensions, respectively, while the hyper-rational dimension displays the lowest level of self-sabotage behavior.

The victim dimension had the highest percentage of participants who had a high level on it (47%, n = 141), followed by sticklers (42.3%, n = 127), hyper achievers (39.3%, n = 118), and controllers (38%, n = 114), respectively. The judge dimension had the lowest percentage of participants with a high level (27.3%, n = 82).

The results of the descriptive statistics for dimensions on the self-sabotage scale in our study show that the participants suffer the most from the restless and the avoider saboteur types; they are the ones with the highest level.

Regarding the age, all the different group ages have moderate self-sabotage; in general, the result of the Kruskal–Wallis test indicates there is no significant difference in self-sabotage level due to patient age categories.

The result of the Kruskal–Wallis test confirms there is no significant difference in self-sabotage level due to patient occupation.

This study shows that self-sabotage has a big effect on how well people with eating disorders commit to their treatment plans in Nutri-health centers, according to the dietitians who work there. This is because the p-value (0.000) is less than the 0.05 level of significance. Furthermore, it is evident that self-sabotage accounts for 28.95% of the variation in compliance with the treatment of patients with eating disorders in Nutri-health centers, as perceived by the dietitians in these centers.

Based on the results, the researcher observed that, from the perspective of the dietitians at Nutri-health centers, self-sabotage explains only 28.95% of the variation in compliance with the treatment of patients with eating disorders. Therefore, there are other factors that can explain 71.05% of the variation in compliance of the treatment of patients with eating disorders. Due to that, the researcher adds the four demographic variables in the regression model to develop the model and to increase the explanation percentage. The demographic variables (age, gender, and income) are then incorporated. Along with the independent variables. The researcher is able to explain 37.13% of the variation of compliance in treating patients with eating disorders in Nutri-health centers from the perspectives of the dietitians in Nutri-health centers. That means that there is importance in adding the demographic variables in the regression model. Also, there is a significant negative impact of being a stickler, hyper-vigilant, restless, and hyper-rational on compliance with the treatment of patients with eating disorders, and there is a significant positive impact of being a hyper-achiever on compliance with the treatment of patients with eating disorders. In addition, there is a significant positive impact of patient age on compliance of the treatment of patients with eating disorders, and if the patient's age increases by one year, the compliance of the treatment of patients with eating disorders decreases by 0.56%. In addition, there is a significant difference in the mean score of the compliance of the treatment between patients who get less than 1500 NIS and others who get more than 3500 NIS monthly in favor of patients who get more than 3500 NIS.

The results of our research indicate that nearly 50 out of 300 participants had a compliance rate of 70%, as evaluated by the dietitians.

The majority of the patients were with binge eating disorder (60.3%, n=181); 33% (n=99) of the patients were overweight, 3% (n=9) of the patients were stable weight, and 2.7% (n=9) of the patients were underweight. Only one participant, accounting for 0.3%, was severely underweight. Additionally, two participants did not respond to this question, accounting for 0.7% of the sample.

In terms of patient commitment to the treatment plan, 4% (n = 12) of patients did not commit to it at all, while 288 patients did. The mean percentage of patients who adhere to the treatment plan is 53.69% (n=155), with 43.7% (n=126) of patients committed to the treatment plan for 50% or less and 56.3% (n=162) committed to the treatment plan for more than 50%. Furthermore, 28.13% (n=81) of patients were withdrawn from treatment, while 35.8% (n=102) were withdrawn from treatment and then returned to it, 27.7% (n=28) withdrew from treatment previously once, 31.7% (n=32) twice, 22.8% (n=23) three times, and 17.8% (n=18) more than three times.

5.4 Recommendations:

For Dietitians:

- Collaboration with psychologists to implement dietary programs that integrate psychological and physical aspects. This approach ensures the most effective dietary plan for patients and more compliance to the treatment plan.
- The implementation of dietary programs for patients along with considering their saboteurs and combining the psychological factors of self-sabotage with the dietary plan.

For mental health practitioners

- We implement counselling programs and individual therapy using cognitive behavioral therapy, psychoanalytical therapy and dialectical therapy to assess

individuals' self-sabotage levels, enabling them to comprehend their self-saboteurs and enhance their lives.

- To implement Psychoeducation programs to educate educators about self-sabotage and its benefits in work-life balance, dealing with challenging individuals, setting boundaries for these saboteurs after understanding them, and managing stress.

For policy-makers

Working to educate people about considering self-sabotage as a manifestation of psychopathology. Moreover, using specific tests and valid questionnaires such as Shirzad Chamine questionnaire to measure and assess the level of self-sabotage. Those who have a high level of self-sabotage require psychological support and individual therapy and discipline to achieve and function in their lives.

For researchers and academics

- Around the world, there is a severe lack of literature on self-sabotage, and in Palestine, there are no studies examining the relationship between self-sabotage and treatment compliance in patients with eating disorders. Therefore, it is crucial to conduct further studies on the impact of self-sabotage and its relationship to treatment compliance in patients with eating disorders.
- To conduct more qualitative, mixed, and experimental research on self-sabotage, its types and its correlation with treatment compliance in patients with eating disorders, and to explore its connections with various aspects of life, particularly work-life balance and stress management, to enhance our comprehension of self-sabotage.

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Appendices

Appendix 1: Study tool after Validation:

عنوان البحث:" أثر الايذاء الذاتي على نتائج خطة العلاج للأشخاص الذين يعانون من زيادة أو نقصان الوزن في مراكز نيوترهيلث في كل من مناطق رام الله, الخليل, و جنين"

عزيزي/تي المشارك/ة،

أنا ديما مقداد طالبة ماجستير في كلية الصحة العامة بجامعة القدس فرع العلاج النفسي، وأود أن أدعوكم للمشاركة في البحث المسمى: " **أثر الايذاء الذاتي على نتائج خطة العلاج للأشخاص الذين يعانون من زيادة أو نقصان الوزن في مراكز نيوترهيلث في كل من مناطق رام الله, الخليل, و جنين**"".

تهدف الدراسة إلى دراسة التحديات النفسية الذاتية التي تواجه الأشخاص الذين يعانون من زيادة الوزن أو نقصان الوزن في مراكز نيوترهيلث في كل من مناطق رام الله, الخليل, و جنين من وجهة نظر هؤلاء الاشخاص بشكل مباشر و تأثير هذه التحديات على عدم الوصول الى خطة العلاج أو الوزن المثالي الذي يتمنونه و أيضا من وجهة نظر مقدمي الخدمة أخصائي/يات التغذية لاقتراح التوصيات الممكنة لتحسين جودة حياة هؤلاء الاشخاص وتسهيل الالتزام بخطة العلاج و تسهيل وصولهم الى الوزن المثالي.

لقد تم اختيارك لهدف الدراسة من ضمن جميع الاشخاص الذين يعانون من زيادة أو نقصان الوزن في مراكز نيوترهيلث. لذا ندعوك للمشاركة للاستفادة من خبرتك كشخص عانى من زيادة أو نقصان الوزن، وسيكون دورك هو ملء استبيان بالمعلومات ذات الصلة بأهداف الدراسة.

المشاركة طوعية تمامًا في البحث، ولك مطلق الحرية في الرفض. إذا قلت لا، فلن يكون لذلك عواقب سلبية عليك. يمكنك أيضًا الانسحاب من الدراسة في أي وقت، حتى إذا كنت قد وافقت على المشاركة مسبقًا.

سيتم الاحتفاظ بالمعلومات التي تم جمعها منك في ملف مغلق وسري. لا يوجد خطر في المشاركة في هذه الدراسة.

لن يتم الدفع لك مقابل المشاركة في البحث، ولن تتحمل أي تكاليف إذا قمت بذلك.

يرجى التوقيع على إعلان الموافقة المرفق إذا كنت توافق على المشاركة في هذه الدراسة بالتوقيع

شكرا لتعاونك

مع فائق الاحترام والتقدير

أوافق على المشاركة في الدراسة البحثية بعنوان "" **أثر الايذاء الذاتي على نتائج خطة العلاج للأشخاص الذين يعانون من زيادة أو نقصان الوزن في مراكز نيوترهيلث في كل من مناطق رام الله, الخليل, و جنين**" وأجريت من قبل: ديما مقداد

التوقيع _____ التاريخ_____ مركز نيوتري هيلث / اسم الفرع الذي يتبع للمركز مدينة _____

يرجى منك التكرم بالإجابة على الأسئلة التالية بعد التمعن فيها، بوضع دائرة في الخانة التي تتفق معك، كمساعدة منك لإنجاح هذه الدراسة، علماً أن اجابتك ستحاط بالسرية التامة ولغاية البحث العلمي فقط.

القسم الأول: البيانات الشخصية:

أرجو ***وضع دائرة*** *في الخانة التي تتفق معك:*

1. ***العمر:*** *( ) 18-25 ( ) 26-35 ( ) 36-45 ( ) 46-55*

( ) 56-65 ( ) 65 فأعلى

2. ***الجنس :*** *( ) ذكر ( ) أنثى*

3. ***الوظيفة:*** *( ) ربة منزل ( ) معلم/ة ( ) أعمل في القطاع الصحي ( ) عمل حر ( ) مراسل/ة ( ) اداري/ة ( ) أخرى اكتب/ي نوع العمل ----------*

----

4. ***الحالة الاجتماعية:*** *( ) أعزب/عزباء ( ) متزوج/ة ( ) أرمل/ة ( ) مطلق/ة*

5 .**الوضع الاقتصادي:** ( ) أقل من 1500 ( ) 1500_2500 ( ) 2600_3500 ( ) أكثر من 3600

6 .**مستوى التعليم:** ( ) أقل من ثانوي ( ) ثانوي ( ) كلية ( ) بكالوريس ( ) دراسات عليا

7 . **مركز نيوترهيلث الذي تتابع عنده في :** ( ) منطقة رام الله ( )منطقة جنين ( )منطقة الخليل

( ) أخرى ----------

القسم الثاني: استبيان حول الايذاء الذاتي للأشخاص الذين يعانون من زيادة أو نقصان الوزن:

يرجى منك التكرم بالإجابة على الأسئلة التالية بعد التمعن فيها، بوضع علامة" X " في الخانة التي تتفق معك، كمساعدة منك لإنجاح هذه الدراسة، علماً أن اجابتك ستحاط بالسرية التامة ولغاية البحث العلمي فقط.

	الفقرة	موافق بشدة	موافق	محايد	معارض	معارض بشدة
1	أعاني من عدم ارتياح في اوقات الصراع وأتجنب التعامل معه.					
2	- انا متمسكً بالكمال أو منشدًا للكمال					
3	لا أستطيع الشعور بالارتياح وأحتاج ان أكون مشغولا باستمرار					
4	أشعر بالقلق بنسبة أكثر من الآخرين من حولي					
5	أنتقد الآخرين أكثر من الثناء عليهم					
6	لدي حاجة قوية لتولي المسؤولية والتحكم					
7	أفخر بشكل خاص بكوني احلل الأمور					
8	أميل إلى التقلب المزاجي					
9	أقيس تقديري لذاتي في الغالب من خلال إنجازاتي					

10	لدي نقد قوي للذات					
11	أنا أميل الى ارضاء الآخرين					
12	أنا أقوم بالتأجيل كثيرا					
13	أحتاج إلى الموازنة بين الكثير من الأشياء طوال الوقت لمنع الملل					
14	بشكل عام عندما تسوء أموري ، أميل إلى الشعور بالضيق لبعض الوقت					
15	أنا شديد اليقظة					
16	يصفني الآخرون بأنني متحكم للغاية					
17	أميل إلى الشعور بالأسف على نفسي					
18	تزعجني عيوب الآخرين					
19	إرضاء الآخرين وجعلهم مثلي أمر مهم جدًا بالنسبة لي					
20	أتجنب التعامل مع النزاعات إلى درجة تجعلها تتراكم وتصبح مشاكل حقيقية					
21	وضعي الاجتماعي وصورتي العامة مهمان بالنسبة لي					
22	أنا قلق للغاية					
23	أنتقد نفسي بشدة					
24	أحب أن تكون الأشياء منظمة للغاية					
25	أشعر بالقلق ونادراً ما أشعر بالسلام مع ما أفعله في الوقت الحالي					
26	يمكنني أن أكون مواجهة وقويةعندما أحتاج إلى إنجاز الأمور					
27	عندما أتعرض للنقد أو المعاملة بشكل غير عادل من الاخرين، أميل إلى الانسحاب					
28	عندما تحدث أشياء سيئة ، أميل إلى البقاء مستاء لبعض الوقت					
29	أميل إلى تخويف الآخرين عن طريق ان اكون تحليليا للامور					
30	مقارنة بالآخرين ، فأنا أفعل المزيد لارضاء الناس					

31	الحياة تقاس بالنسبة لي عن طريق الانجازات و تحقيق الاهداف التي أريدها					
32	يعتقد الاخرون إنني منشد للكمال					
33	أجد أخطاء وعيوب في الآخرين					
34	أنا اؤجل واماطل في التعامل مع مهام مهمة عندما تكون غير محببة الي قلبي و لا اريد اتمامها					
35	يقول لي الناس إني قلق للغاية					
36	ينفذ صبري بسهولة واشعر بالملل					
37	عندما أخطئ ، اعاقب نفسي					
38	أشعر بأنني ضحية					
39	أشعر بأنني ذو قيمة عالية فقط عندما أكون ناجحًا وأحقق النجاح					
40	أنا أساعد الآخرين لدرجة أنني أحيانًا أغفل عن احتياجاتي وأشعر بالاستياء					
41	ظروف العمل أو الحياة تؤثر بشكل كبير على مدى سعادتي					

القسم الثالث: :هذا القسم يتم تعبئته من أخصائية التغذية التي تتابع المشارك: أسئلة خاصة بمتابعة مدى الالتزام بالخطة العلاجية و الاستمرارية بها :

يرجى منك كأخصائي/ة تغذية مقدم/ة للخدمة التكرم بالإجابة على الأسئلة التالية بعد التمعن فيها، بوضع دائرة في الخانة التي تتفق مع المشارك حسب متابعة ملفه، كمساعدة منك لإنجاح هذه الدراسة، علماً أن اجابتك ستحاط بالسرية التامة ولغاية البحث العلمي فقط.

1- *حسب مؤشر كتلة الجسم هذا الشخص يعاني :من( ) بدانة ( ) زيادة بالوزن ( ) ثبات بالوزن ( ) نقصان بالوزن ( ) نحافة مفرطة*

2- *ما هي النسبة التي يقدر بها مدى التزام هذا الشخص بالخطة العلاجية :*

( ) لا يلتزم نهائيا بالخطة العلاجية ( ) 1-10% ( ) 11% - 20% ( ) 21%-30% ( ) 31% -40% ( ) 41%-50% ( ) 51%-60% ( ) 61%-70% ( ) 71%-80% ( ) 81% -90% ( ) 91%-100%

3- *هل قام هذا الشخص بالانسحاب من العلاج؟ نعم لا*

4- *هل قام هذا الشخص بالانسحاب ثم العودة اليه مجددا*

( )لا ( )نعم

5- **فقط اذا كانت الاجابة نعم على السؤال السابق (رقم 4)أكمل السؤال التالي :**

كم عدد مرات انسحابه من العلاج سابقا:

( )مرة ( ) مرتين ( ) ثلاثة ( )اكثر من ثلاثة مرات

النهاية .... شكرا جزيلا لكم

Appendix 2: List of Experts Consulted for Instrument Validity

Table: List of Experts who contributed to Validation of Study Tools

	Field	**Place of Work**
Assoc Prof Salam Al-Katib	Mental Health	Al-Quds University
Asst Prof Najah Al-Katib	Mental Health	Al-Quds University
Mohammad Al-Amri	Postgraduate Research Program Manager	Cardiff University/ UK

Appendix 3: Participant's responses distribution of items on self-sabotage:

No.	Items	Strongly disagree	disagree	Neutral	agree	Strongly agree
1	I have discomfort with conflict and avoid dealing with it.	22 (7.3)	49 (16.3)	81 (27.0)	83 (27.7)	56 (21.7)
2	I can be too much of a stickler or perfectionist.	13 (4.3)	44 (14.7)	81 (27.0)	115 (38.3)	47 (15.7)
3	I am usually more anxious and worried than others around me.	21 (7.0)	75 (25.0)	86 (28.7)	74 (24.6)	44 (14.7)
4	I criticize others a lot more often than praise them.	68 (22.7)	75 (25.0)	81 (27.0)	52 (17.3)	24 (8.0)
5	I have a strong need to take charge and be in control	25 (8.3)	43 (14.3)	82 (27.3)	95 (31.8)	55 (18.3)
6	I proud of being rational and analytical.	14 (4.7)	46 (15.3)	56 (18.7)	98 (32.6)	86 (28.7)
7	I have a tendency towards being moody	28 (8.3)	51 (17.0)	80 (26.7)	86 (28.7)	58 (19.3)
8	I measure my self-worth through my achievements	22 (7.3)	35 (11.7)	71 (2.7)	104 (34.6)	68 (22.7)
9	I have strong criticism for myself	17 (5.7)	46 (15.3)	99 (33.0)	83 (27.7)	55 (18.3)
10	I am a "pleaser."	31 (10.3)	60 (20.0)	90 (30.0)	71 (23.7)	48 (16.0)
11	I procrastinate my work and responsibilities	22 (7.3)	72 (24.0)	82 (27.4)	75 (25.0)	49 (16.3)
12	I need to do different things at the same time to prevent boredom	20 (6.7)	40 (13.3)	64 (21.3)	122 (40.7)	54 (18.0)
13	When things go wrong, I tend to stay upset for some time	22 (7.3)	27 (9.0)	41 (13.7)	128 (42.7)	82 (27.3)
14	I am always hyper-vigilant	21 (7.0)	33 (11.0)	84 (28.0)	116 (38.7)	46 (15.3)

15	Others have described me as too controlling	34 (11.3)	72 (24.0)	87 (29.0)	75 (25.0)	32 (10.7)
16	I have a tendency to feel sorry for myself	28 (9.4)	76 (25.3)	80 (26.7)	67 (22.3)	49 (16.3)
17	I am annoyed by faults with others	44 (14.7)	55 (18.3)	90 (30.0)	73 (24.3)	38 (12.7)
18	Pleasing others and having them like me is very important to me	36 (12.0)	73 (24.3)	83 (27.7)	63 (21.0)	45 (15.0)
19	I avoid dealing with conflicts to a point where they accumulate and become real problems.	33 (11.0)	80 (26.7)	66 (22.0)	67 (22.3)	54 (18.0)
20	My social status and public image are important to me	22 (7.3)	48 (16.0)	62 (20.7)	90 (30.0)	78 (26.0)
21	I am very anxious	31 (10.3)	72 (24.0)	78 (26.0)	61 (20.3)	58 (19.4)
22	I criticize myself a lot	27 (9.0)	72 (24.0)	88 (29.4)	64 (21.3)	49 (16.3)
23	I like things to be very organized	14 (4.7)	53 (17.7)	68 (22.7)	86 (28.6)	79 (26.3)
24	I feel restless and rarely at peace with what I am doing in the moment	33 (11.0)	73 (24.3)	80 (26.7)	65 (21.7)	49 (16.3)
25	I am confrontational and forceful when I need to get things done	18 (6.0)	42 (14.0)	64 (21.3)	109 (36.4)	67 (22.3)
26	When I am criticized or unfairly treated, I tend to withdraw	33 (11.0)	63 (21.0)	56 (18.6)	77 (25.7)	71 (23.7)
27	When bad things happen, I tend to stay upset for some time	20 (6.7)	45 (15.0)	72 (24.0)	103 (34.3)	60 (20.0)
28	I tend to threaten others with the intensity of my analytical mind	33 (11.0)	64 (21.3)	87 (29.0)	56 (18.7)	60 (20.0)
29	Compared to others, I do more pleasing for other people	45 (15.0)	68 (22.7)	82 (27.3)	57 (19.0)	48 (16.0)
30	Life is about achieving and producing results for me	16 (5.3)	42 (14.0)	63 (21.0)	92 (30.7)	87 (29.0)
31	Others tell me I am too much of a perfectionist	27 (9.0)	51 (17.0)	85 (28.4)	73 (24.3)	64 (21.3)

32	I often find faults and mistakes within others	24 (8.0)	47 (15.6)	80 (26.7)	113 (37.7)	36 (12.0)
33	I procrastinate on dealing with important but unpleasant tasks	23 (7.7)	54 (18.0)	86 (28.7)	94 (31.3)	43 (14.3)
34	Others tell me that I worry too much	26 (8.7)	71 (23.7)	84 (28.0)	67 (22.3)	52 (17.3)
35	I get impatient with others easily	19 (6.3)	59 (19.7)	90 (30.0)	66 (22.0)	66 (22.0)
36	When I make a mistake, I punish myself over it	26 (8.6)	74 (24.7)	84 (28.0)	60 (20.0)	56 (18.7)
37	I feel like a victim	45 (15.0_)	95 (31.6)	68 (22.7)	41 (13.7)	51 (17.0)
38	I feel worthy when I am successful and achieving	29 (9.7)	67 (22.3)	63 (21.0)	79 (26.3)	62 (20.7)
39	I am so into helping others that I sometimes lose of my own needs and feel bad.	21 (7.0)	50 (16.7)	80 (26.6)	81 (27.0)	68 (22.7)
40	The circumstances of work or life significantly affect how happy I feel	21 (7.0)	48 (16.0)	64 (21.3)	105 (35.0)	62 (20.7)
41	I can’t rest and need to be constantly busy	19 (6.3)	73 (24.3)	78 (26.0)	73 (24.4)	57 (19.0)

أثر سلوك التدمير الذاتي على الالتزام بالعلاج لدى مرضى اضطرابات الأكل في مراكز نيوتري–هيلث للصحة الغذائية في رام الله والخليل وجنين

إعداد: د. ديمه أكرم أحمد مقداد

المشرف: د. سلام الخطيب

الملخص:

تبحث هذه الدراسة في تأثير سلوك التدمير الذاتي على الالتزام بالعلاج لدى المرضى الذين يعانون من اضطرابات الأكل في مراكز نيوتري هيلث للصحة الغذائية في رام الله والخليل وجنين. ويهدف البحث إلى التحقق من العلاقة بين التدمير الذاتي والعوامل الديموغرافية المختلفة، بما في ذلك الجنس، والعمر، والمهنة، والحالة الاجتماعية، والحالة الاقتصادية، والمستوى التعليمي. تستخدم الدراسة تقييم شيرزاد شامين للتدمير الذاتي لتحديد 10 أنواع من المدمرين الداخليين، بما في ذلك القاضي، والمتحكم، ومفرط الإنجاز، والقلق، والمتشدد، والمرضي، و المفرط في اليقظة ، والمتجنب، والضحية، والمفرط في العقلانية.

أظهرت النتائج أن معظم المشاركين لديهم مستوى معتدل من سلوك التدمير الذاتي. يُظهر بُعد المتجنب أعلى مستوى من التدمير الذاتي، يليه القلق، والمتحكم، والفائق الإنجاز، على التوالي. حقق بُعد الضحية أعلى نسبة من سلوك التدمير الذاتي عند المشاركين (47%)، يليه المتشدد (42.3%)، والمتفوق (39.3%)، والمتحكم (38%)، على التوالي. وكان لبعد القاضي أقل نسبة من سلوك التدمير الذاتي عند المشاركين (27.3%).

وجدت الدراسة أن ما يقرب من 50 من أصل 300 مشارك حصلوا على معدل التزام بحطة العلاج بنسبة 70%. كان غالبية المرضى يعانون من اضطراب الشراهة عند تناول الطعام (60.3%)، وكان 33% منهم يعانون من زيادة الوزن، و3% وزن ثابت، و2.7% نقص الوزن.

وتشمل التوصيات إجراء المزيد من الدراسات حول تأثير التدمير الذاتي على الالتزام بخطة العلاج، وعمل خطط و برامج غذائية تجمع بين العوامل النفسية والعوامل الجسدية، وتنفيذ برامج تعليمية لفهم العوامل النفسية والمدمرين الذاتيين عند الشخص و الذين يؤثرون على أنماط الأكل و الالتزام بالعلاج.

الكلمات المفتاحية: اضطرابات الأكل، الالتزام في خطة العلاج، والتدمير الذاتي.