PART I

Background
Chapter 1
Guiding Principles

Introduction

Psychological treatments of whatever kind are based on differing theories and understandings of human development and functioning and incorporate value systems that focus on different aspects of human behaviour. Our judgement is that these theories often privilege the understanding of one aspect of human behaviour over others so, for example, person-centred theory has privileged feelings, psychodynamic theory has privileged insight, cognitive behavioural theory has privileged thinking, behavioural theory has privileged behaviour. In what follows we have described briefly the range of theories and accompanying value systems that we have found useful. We have also provided a short account of the particular relevance of these theories to our client group of obese women. We do not pretend to have developed a comprehensive account of human functioning, rather our understanding has been pragmatically driven to use what works. We have also been influenced by recent research that seems to demonstrate fairly conclusively what has come to be known as the ‘dodo’ effect (reviewed usefully by O’Brien & Houston, 2000). The ‘dodo’ effect supports the idea that what works in therapy is not the particular modality in which it is delivered (e.g. psychodynamic, CBT) but characteristics that are transmodal. These appear to focus on ‘the ability to engage the client in a cooperative participation with regard to the goals and tasks of therapy, to provide an opportunity for the client to express emotion and to create a healing, therapeutic bond’ (O’Brien & Houston, 2000, p. 37). In our discussion of the conduct of the group and the training of the group leaders these transmodal elements are stressed.

We are also aware of research which suggests that there are different learning styles. These seem to correspond to people who learn more easily from words as opposed to those who learn more easily from diagrams and illustrations and, secondly, to those who have a grasp of a whole subject as opposed to those who focus on the detail of a part of a subject (Riding & Rayner, 1998). The integration of different modalities in our programme may give room for these differences. We have tried to use a combination of verbal and visual activities although the weight of the programme is certainly towards the verbal.

Similarly we have tried to provide a balance between the detail of individual sessions and activities and a picture of the whole. Each session begins with its overview and a recapitulation of the previous session. At the beginning of the programme we provide an overview of the whole programme (Appendix 2). Similarly at the end of each 12 week block there is the opportunity for review and an overview.
It may be that different clients make use of some elements of our programme more than others. We are hoping to provide a range of ways of understanding eating behaviour so that the participants in our groups can make use of those elements that have most resonance for them. Much of the language of different theories is metaphorical. It may be that, in time, neuroscience (Schore, 1997a, 1997b, 1997c, 2000, 2002, 2003) will be able to help us to understand more exactly how different interventions impact on the brain and inform our choices so that psychotherapy of all kinds can be delivered more effectively. In the meantime we are offering a buffet.

In what follows we describe the range of theories we have employed. They are all based on the assumption that human beings are capable of emotional growth and development; as the British Association for Counselling and Psychotherapy says ‘Counselling is a way of enabling choice or change or of reducing confusion’ (www.bacp.co.uk/education/whatiscounselling.html).

### Carl Rogers and Person centred theory

We have been concerned in carrying out our research and in developing the programme, to ensure that our participants are treated with respect and empathy. This may seem a self-evident principle for working with patients of any kind. However the literature reveals, and the evidence provided by our participants confirms, that respect and empathy cannot be assumed in the treatment of obese people.

Discrimination against obese people is common (Garner & Wooley, 1991; Fabricatore & Wadden, 2004) and has been identified in areas including employment, housing and healthcare (Friedman & Brownell, 2002; Harvey et al., 2002b). Puhl and Brownell (2002) describe discrimination in employment, healthcare and education. A study by Carryer (2001) describes the experience of nine ‘large bodied women’ which reports discrimination by nurses and suggests strategies for improving their responses to large women. Obese people themselves report significant difficulty in continuing a normal social life and find themselves discriminated against in both work and social situations (Crisp, 1988; Lee & Shapiro, 2003). Women in particular are stigmatised for being obese (Rothblum, 1994; Cogan & Ernsberger, 1999). One study confirmed widespread prejudice against overweight women when eating out (Zdrodowski, 1996).

Our own research has supported the findings that obese people experience prejudice and discrimination. In a study conducted with a community sample of obese people, participants were explicit about the prejudice they encountered:

People, if you’re fat, don’t take you seriously and they don’t have much respect for you either.
I don’t like going out. I like to sit at home . . . because I know people talk about me behind my back.
If you’re waiting to be served, you can be overlooked . . . big as you are, you can be invisible. People make snide comments to each other in lifts. In passing they will stare.
[People] seem to think you’re fair game to be treated like garbage and talked to like rubbish—you don’t have feelings. I may be very big on the outside, but on the inside I’ve got the feelings of a size 10 and if anything I’m as fragile, if not more fragile.

(Bidgood & Buckroyd, 2005, p. 224)

The participants in our study encountered prejudice and stigmatisation in a wide range of situations: in shops, restaurants, places of entertainment and recreation, public transport, and even in hospitals in one case. Apparently the National Health Service wheelchair is not strong enough for anyone weighing more than 22 stone/140 kilograms (White, 2002). Participants felt that the needs of large people are ignored: seats on buses, coaches and aircraft were too narrow, seatbelts were almost impossible to use. Job prospects for the participants were diminished, for men as well as women, due to the difficulty of overcoming the immediate hurdle of gaining acceptance into the job in the first place. In many cases such widespread prejudice and stigmatisation had resulted in the participants withdrawing from social life and hiding away at home as much as possible (Bidgood & Buckroyd, 2005). A Cochrane Review (Harvey et al., 2002b) on improving health professionals’ management and the organisation of care for overweight and obese people concluded, rather depressingly, that there was little to suggest how the management of obesity might be improved.

Our recognition of all the deeply felt hurt that results from this prejudice and stigmatisation has made us determined to offer a different environment in which to work with our participants. We have taken Carl Rogers (1979, 1981) and, more recently, Tudor et al. (2004) as valuable guides to placing the women we work with at the centre of our concern. Rogers’ supreme insight, explored in many different ways in his published work, was that change is more likely to take place in an environment of safety and respect. He codified this understanding in what he called the ‘core conditions’. These include congruence, empathy and unconditional positive regard. When troubled people are met with these conditions they tend to be able to resolve their difficulties and embark on a process of change. Rogers believed that given this facilitating environment, the inherent capacity for change in positive directions that all of us possess, can be activated. This theory fits in well with the research on transmodal counselling described above (O’Brien & Houston, 2000).

**Psychodynamic theory**

This basic framework of respect for our participants is amplified by psychodynamic ideas, that is to say, those ideas that derive from Freud and his successors over the past hundred years. We have both trained extensively as psychodynamic practitioners and, although we have both since developed an integrative approach to our therapeutic work, we make use of a good many psychodynamic ideas. Most basic of these is the idea that symptoms (in this case obesity) have meaning. Our fundamental understanding of obesity in the subgroup of obese people that we have identified is that it results from eating behaviour that is, in part, emotionally driven. We regard the symptom (i.e. the eating
behaviour and resultant obesity) as evidence of emotional distress. In other words, we believe that obesity is not simply the result of a poor diet or a lack of exercise, but has emotional meaning.

A second fundamental psychodynamic idea that is important to our work is the conviction that the past has a powerful effect on the present and that many of our habits of all kinds are formed by early experience. To this basic understanding we add a particular respect for attachment theory (Sroufe, 1995; Bowlby, 2000a, 2000b, 2000c; Stern, 2000; Holmes, 2003; Howe, 2003). We consider that attachment theory, one of the best evidenced elements of modern psychodynamic theory, is extremely helpful in describing the patterns of relationship which derive from the past and get re-enacted in the present. It has been our clinical experience that coming to a better awareness of the influence of the past on the present can be a huge relief to our participants. An initial suspicion, voiced by most of our participants that their eating behaviour is influenced by feelings and life events, is developed so that their behaviour becomes more meaningful to them. They can then often stop describing themselves as greedy or lacking willpower, for example, and acknowledge that their eating and their obesity make sense (Buckroyd et al., 2006). When they are less hostile to themselves they have more space in which to make choices about their behaviour.

We also make use of the psychodynamic understanding of an inner self which is composed of different ‘voices’ or parts. It seems helpful to think that the different parts of the self (popularised, for example, in phrases such as ‘the inner child’) are in relationship with each other and that at different times one or other part of the self may be more powerful or influential (Summers, 1994). Again it has been our experience that to talk in metaphors of this kind can be helpful, especially to women who find self-care difficult. The idea of the development of an internal good mother, for example, can often help them to offer support to parts of themselves that would otherwise seek solace in food.

A related area of psychodynamic thinking that we have found particularly helpful is the work of Heinz Kohut (Kohut, 1984; Siegel, 1996; Mollon, 2001; Lessem, 2005). Kohut was interested in the development of the self and in the conditions necessary to create a strong sense of self in the child and young person. He is sometimes seen as a theorist who bridges psychoanalytic and person-centred theory (Kahn 1997). He believes that conditions rather similar to those that Rogers describes as the Core Conditions, develop a robust sense of self. Since our participants uniformly demonstrate very poor self-esteem we have been influenced by Kohut’s ideas of how this early damage can be repaired in a therapeutic relationship. So, for example, we have emphasised the acknowledgement of participants’ strengths and successes and recognised that they need to experience the group leader as a positive figure who acknowledges their feelings and their struggle.

**Feminist theory**

Issues concerning eating behaviour and body esteem have, at least in the past, been seen to concern women far more than men. (Currently, in the UK, rates of obesity for men lag only a couple of percentage points behind those for women). Feminist writers have interested themselves in providing an account of women’s relationships with their bodies
and with food in a patriarchal society (e.g. Orbach, 1978; Lawrence & Dana, 1990; Polivy & Herman, 1992; Burgard & Lyons, 1994; Fallon et al., 1994; Bloom et al., 1999; Heenan, 2005). Our experience of working with women suffering from eating disorders, and with obese women, has not persuaded us that the feminist account of these issues is to be preferred above other accounts. We do think their contribution is valuable for some women but not meaningful for all.

However, there are aspects of feminist theory that we have adopted. One important element derives from the feminist conviction that the personal is political. It is common in therapeutic circles for distress to be seen entirely as the product of the individual’s experience. Feminists have been as interested in how the culture limits and shapes women’s experience, and consequently their behaviour. Among our participants, for example, there was great reluctance to engage in exercise or swimming in a mixed sex environment. The women felt unwilling to be subject to the gaze of men. An uninformed observer might accuse them of being unwilling to exercise and, therefore, failing to take responsibility for their own health but, from a feminist perspective, the culture deprives them of that freedom (McElroy, 2002). We have tried to listen carefully to our participants’ experience of their own environment and to be attentive to their needs from that perspective. We have, for example, run the groups in term time, recognising that otherwise childcare obligations would prevent some of our participants from attending.

A second aspect of feminist practice that we have adopted has been to diminish the power differential between group leader and participant as far possible. The hierarchies of a patriarchal society are the common experience of women, especially those from a deprived background. We seek to provide a different experience. We have done this by seeking opportunities to empower our participants to devise their own remedies. So, for example, we have not drafted in ‘expert’ nutritionists or dieticians or exercise specialists (as is commonly done in weight maintenance groups) because our experience has been that our group members have, between them, a vast store of latent knowledge of these issues. They do not need an expert to tell them what to do; they need encouragement to make active what they already know. Similarly, the group leader we see as providing the facilitating environment for the group to work rather than functioning as the expert. Our image is of collaboration.

Cognitive behavioural therapy

Cognitive behavioural therapy (CBT) is an exceedingly well-known therapy that has demonstrated its value via research much more than most other methods. It is based on the premise that we all view our current experience through the prism of the past. In our formative years we develop beliefs as a result of our experience and we continue to act on those beliefs whether or not they are appropriate in the light of current experience. So, the person who has learned that no one will be interested in her distress as a child and that food is a more reliable comforter, will tend to act on this belief even if her experience of people in the present does not reflect her earlier experience.

It is the task of the CBT practitioner to engage the client in a series of ‘experiments’ to find out whether her thinking is accurate or not. It is a therapy that has little interest in the
past or how clients may have arrived at the convictions they hold but instead it focuses on changing those convictions in the present. Common faults in thinking such as all or nothing thinking (I’ve eaten a cream bun and spoiled my diet so I may as well eat 10 cream buns) or catastrophising (I’ve eaten a cream bun so I’m never going to lose any weight) can be challenged and explored using CBT. For that reason it has been widely adopted for many different client populations, including obese people. Shaw et al. (2005) reviewed CBT as an adjunct to dietary and exercise strategies for achieving weight loss but unfortunately were not able to comment on its value for achieving maintained weight loss.

Cooper et al. (2003) have published a CBT programme for obese people in individual treatment. This programme begins with a conventional calorie-counting, food-restricting diet programme based on a daily intake of 1,500 calories. It is followed by close attention to problems in keeping to this diet and encouragement to increase activity using largely behavioural strategies. Attention is focused on challenging failure to conform to the programme’s requirements. Recommendations for healthy eating are included. The second phase of the programme addresses obstacles to maintaining weight loss, including improving body image using cognitive strategies. Patients are supported to pursue their life goals whether or not they have lost weight. The authors stress the value of the final phase of the programme, which teaches strategies for monitoring weight, anticipating problems in maintaining their diet programme and developing a personal weight maintenance plan. Although the authors are researching the long-term effectiveness of their plan for weight loss maintenance, results were not available at the time of writing. However, the programme incorporates areas of functioning that have been demonstrated to be involved in the process of weight loss and weight loss maintenance. These include a reduction in calorific intake and increase in activity, attention to body esteem, strategies for managing situations likely to trigger overeating and, most particularly, attention to ways of thinking that undermine the patients’ belief in their capacity for maintained weight loss.

We have also used many of the above strategies to engage our participants’ cognitive strengths to support the emotional growth that we are trying to encourage in our groups. So, for example, when we explore the emotions associated with eating particular foods and the memories these foods evoke, we then invite participants to consider whether they need to continue with the patterns they have carried over from the past. We also challenge participants’ convictions that they, for example, cannot plan their eating, cannot choose healthy food and cannot find strategies to manage situations such as eating out. Most fundamentally, we challenge their conviction, born of repeated weight loss and regain, that they are unable to achieve the changes in their lives that will enable them to maintain weight loss.

We have been influenced by Yalom’s belief that a cognitive structure is desirable as part of a group therapy (Yalom, 2005). For this reason we have provided an overview of the intervention to be given to participants in the first session, as well as opportunities for review after each 12-week section. We have adopted CBT strategies of homework setting and have also provided throughout, a rationale for the activities in the group, although this has not necessarily been provided first. Sometimes we have wanted the group members to experience something emotionally before we talked about it.