Therapeutic Groups for Obese Women

A Group Leader’s Handbook

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Preface

We are sure we are not alone as health professionals in our experience of the difficulty in helping obese people lose weight. Permanent weight loss has been impossible to achieve for about 80% of overweight people, yet the serious consequences of being very overweight are well documented. The obese women with whom we have worked have tried repeatedly, but without success, to lose weight and keep it off; by the time they come to us they are desperate. The response to them, which this book describes, has evolved over about eight years and is built on our work as therapists with women with disordered eating. It will not be suitable for all those who want to lose weight. We present, in the first part of what follows, our argument for thinking that within the total group of obese people there is a subgroup of perhaps 30–50% whose eating is driven by emotional issues and who have a background of psychological distress. It is for the women in this group that our programme has evolved.

In what follows we discuss the research literature that has brought us to these conclusions and consider how this group of patients can be identified. We describe how the research literature has influenced the shape and content of the intervention and its five themes. We discuss the context of the research we are undertaking in which the programme evolved and share with readers the experience of running the groups. We also discuss the skills that will be required of those who wish to conduct the programme. We then present the programme in detail week by week over 36 sessions. Ample freedom is given to the group leader to modify the pace of the programme according to her clinical judgement. Illustrative examples are provided of responses to the various elements of the programme.

Although we are in the process of testing the programme we do not yet have results to demonstrate its effectiveness. We offer it to health professionals on the basis that it has been devised in accordance with the research literature and offers an innovative approach to a patient group whose needs are plainly not being met by current interventions. We are committed to the publication of results as they become available and would also welcome feedback from those who make use of the programme.

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The workbook appendices included in this book are available online, free to purchasers of the print version. Visit the website www.wiley.com/go/obesity to find out how to access and download this material.

Geliebter and Aversa (2003) reported that overweight individuals overate during negative emotional states and situations. Byrne et al. (2003) identified the use of eating to regulate mood, or to distract from unpleasant thoughts and moods, as one characteristic of obese women who had lost a substantial amount of weight and then regained it. Walfish (2004) found that 40% of a sample of bariatric surgery patients could be identified as ‘emotional eaters’ and recommended treatment to address this problem to increase the likelihood of long-term maintenance of weight loss.

There is substantial evidence to suggest that those who use food for affect regulation may have significant psychological issues relating to their history. Attachment history has been studied extensively for its relationship to affect regulation. Schore has developed a clear model for the relationship between attachment history, its neurological consequences and the person’s capacity to regulate affect, using the term ‘enduring structural changes’ as a result of traumatic attachments] lead to the development of stress coping mechanisms that lie at the core of . . . post traumatic stress disorders’ (Schore, 2002, p. 11; see also Raynes et al., 1989; Zimmerman, 1999; Schore, 2000, 2001, 2003). A review of attachment research in eating disorders (Ward et al., 2000) concluded that insecure attachment is common in eating-disordered populations. Maunder and Hunter (2001) have extended the scope of the enquiry to evaluate the evidence linking attachment insecurity to illness generally. They cautiously proposed that overeating, leading to obesity, may be a means of managing insecure attachment. Flores (2001) related attachment difficulties to addiction and substance abuse as a means of self-repair. Trombini et al. (2003) found that obese children and their mothers had a significant prevalence of insecure attachment style and recommended that treatment of obesity in children needed to include a psychological intervention with the mother. Vila et al. (2004) similarly identified disturbance in the families of obese children and recommended family treatment. Ciechanowski et al. (2004) found that avoidant attachment patterns were associated with poorer self-management in patients with diabetes – there is an 85% association of Type 2 diabetes and obesity (Eberhardt et al., 2004). Troisi et al. (2005) commented that ‘persons with eating disorders are expected to have a high frequency of adverse early experiences with their attachment figures and a high prevalence of insecure attachment . . .. The insecure attachment style has been also considered as a risk factor for the development of an eating disorder’ (p. 89). Tasca et al. (2006) reported that both attachment anxiety and attachment avoidance were related to poorer outcomes in group treatment for binge eating disorder.

Attachment difficulties may well be associated with difficult early experiences (Prior & Glaser, 2006). Felitti (one of the first researchers to explore these themes) observed a 55% dropout rate in a weight loss programme despite the fact that dropouts had been
The question remains: How can that proportion of obese people to whom these issues are relevant be identified or, in other words, how can we match individuals to the treatment we are offering? At the moment there is no good answer to this question, identified by Rössner, Brownell and Wadden as early as 1992, reiterated by Schwartz and Brownell in 1995 and also thought important by Jeffery et al. (2000). However, it seems likely that those who score highly on measures of binge eating and emotional eating are likely to fall into this category. As Felitti remarked in 2003, the use of food to manage psychological issues may be unconscious, and responses to questionnaires on emotional eating will therefore be unreliable. Nevertheless there seems to be a strong correlation between emotional eating and binge eating (Eldredge & Agras, 1996; Telch & Agras, 1996), so that binge eating may be a useful proxy measure.

Elfhag et al. (2003) have also been concerned to identify subgroups among the population of obese people. She thought that two subgroups could be identified: one characterised by difficulties with emotions, binge eating and experiencing body size as having psychological meaning. This sounds very much like the group we have been working with. The other group was characterised by coping liabilities, a lower socio-economic level and irregular or chaotic meal patterns. She suggested that this second group might need to find a structure for eating and lifestyle changes. It may well be that these two groups overlap to some extent, but the treatment for those who need a structure for eating and lifestyle changes might well be a shorter and more factual behaviour modification treatment than the programme we are proposing. It is possible that those who benefit from commercial weight loss programmes may do so because of the structures that are imposed by them.

Our conclusion is, therefore, that we seek to identify a subgroup among treatment-seeking obese women who acknowledge binge eating and are receptive to the idea that their eating behaviour may be influenced by their emotions.

**Research on psychological treatments for obesity**

In 2004 Hay et al. carried out a Cochrane Review on psychotherapy for bulimia nervosa and bingeing, which concluded that there was some support for the use of CBT but that these treatments did not contribute to weight loss. Another recent Cochrane Review by Shaw et al. (2005) assessed the effects of psychological interventions for overweight or obesity as a means of achieving sustained weight loss. They concluded that psychological interventions, particularly behavioural and cognitive behavioural strategies, enhance weight reduction and that they are predominantly useful when combined with dietary and exercise strategies. They commented that other psychological interventions have been less rigorously evaluated for their efficacy as weight loss treatments. Unfortunately this review comments principally on weight loss. For inclusion, follow-up was required for only three months, and few studies were long term. As the authors comment, without longer term studies the true effect of psychological interventions on weight is difficult to determine.

This authoritative review therefore takes us very little further forward in identifying an appropriate psychological treatment for maintained weight loss. Although we are
Objectives

- Weight loss ≥ 5–10 % of baseline weight sustained for two years post-intervention.
- Stabilisation of blood pressure within the normal range.
- Reduction of emotional eating as measured by the Emotional Eating Scale (Arnow et al., 1995).
- Reduction of binge eating as measured by the Binge Eating Scale (Gormally et al., 1982).
- Improvement of the emotional well-being of the participants as measured by CORE (Evans et al., 2000).

Subsidiary objectives

- Improvement of food choice towards a standard appropriate diet, as reported by participants.
- Improvement in activity levels as measured by stepmeters and reported by participants.

As you read through the programme you will have to decide how much outcome measurement you want to include. The judgement you make may well relate to the specifics of your client group and the circumstances in which the course is conducted. We recommend at least an audit of participants. We would be interested in creating a central data pool of any results you may gather. Contact us at the University of Hertfordshire: j.buckroyd@herts.ac.uk, or s.m.rother@herts.ac.uk

The five major themes of the programme are described below. The first three themes—developing emotional intelligence, developing the capacity for self nurture and developing relationships—are intended to enable participants to identify their feelings, take better care of themselves emotionally and make better use of others. We anticipate that the development of these three functions will lead to a lessening dependence on food and make it more possible for participants to change their behaviour. For this reason these three themes are addressed first. The last two themes are improving food choice and increasing activity. They are intended to address obesogenic behaviour by first recognising why participants find lifestyle change so difficult and then enabling them to develop better habits.

Developing emotional intelligence

You may well be familiar with the term ‘emotional intelligence’ from the book by Daniel Goleman (1995). Here we are particularly concerned with the development of emotional language. There is evidence to suggest that people with eating disorders of all kinds find it difficult to express their feelings in words, a condition known as alexithymia. The relationship between alexithymia ‘a default in the ability to identify and express emotions and a prevalence of externally oriented thinking’ (Pinaquy et al., 2003) and eating disorders (anorexia and bulimia) has already been demonstrated (Cochrane et al., 1993; Schmidt et al., 1993; de Zwaan et al., 1995; Råstam et al., 1997) however its relationship with obesity has been less researched. Clerici et al. (1992) found a high prevalence of alexithymia in obese people. De Chouly De Lenclave et al. (2001) found
This is not the place to discuss the subject of the integration of trauma but we believe it is very important for group leaders to be well informed about it. Herman (1992), Matsakis (1994) and Mollon (1996) are good guides to the subject. Nor are we suggesting that the programme is capable of doing enough psychological work in a group setting to heal serious trauma. We want to propose rather that group members can be helped to control the degree of affect to which they expose themselves using affect management. Group leaders should ensure that they are well informed on this subject (e.g. Zlotnick et al., 1997; Omaha, 2004, www.april-steele.ca/nurturing.php, www.april-steele.ca/self.php, www.sensorymotorpsychotherapy.org/articles.html).

Omaha’s Affect Management Skills Training, for example, is a strategy to try to put in place some of the most basic capacities for self-soothing and regulation of affect: ‘a formulaic approach to remediating impaired affect regulation resulting from childhood deficit experience’ (2004). These skills are taught early in the programme for use, not just during the programme but at any time.

We also consider that it is helpful for participants to be taught the basic outline of how affect management is internalised in ordinary situations and how it is impeded in difficult situations. We have decided to give an outline of these processes for group leaders since the literature describing them is complex. What follows gives a basic account of how a child in a good situation learns affect management.

- In the beginning the child is entirely contained psychologically within the mother (see Figure 3.1). The child’s difficult feelings (hunger, pain, anger) are entirely managed by the mother. So, for example, a hungry child who cries is picked up by the mother, soothed and fed.

- At a slightly later stage of development, the mother soothes the distressed child and down-regulates the feelings but is herself capable of managing her own feelings (see Figure 3.2).
• Over time the mother takes in the child’s upset feelings and returns them to the child as soothed feelings (see Figure 3.3).

• Over time this system becomes internalised within the child and leads to unconscious automatic emotional regulation (see Figure 3.4).
These skills, collectively, are ways of enabling group members to manage feelings and to resist being overwhelmed by memories of if they are no longer in the present. As a strategy it relies on the idea of an adult self which can take care of hurt child parts.

When participants have affect management skills at their disposal, the process of developing the capacity for self-nurture depends, first of all, on supporting participants in the exploration of how they perceived the nurturing they had received, so that a considerable amount of time is spent using experiential exercises to help them to identify their experience of their mothers, other family members, friends and their support network in general. We begin by asking group members to reflect upon their experience of family mealtimes. Our reasoning is that these occasions provide a snapshot of the family dynamic and an opportunity to identify the quality of the relationships within the family. This exercise (which is often very powerful) also connects food and nurture and frequently demonstrates how charged the subject of food and eating has been for the participants for many years.

We follow the family mealtime exercise with work on mothers. The principal exercise asks participants to create an image of themselves and their mother/principal caregiver, using art materials. The choice of a non-verbal medium is deliberate. As art therapists have always known, the creation of an image can express ideas that are not yet in consciousness. It is a particularly useful strategy for those who would otherwise use food (Buckroyd, 1994; Dokter, 1994; Hinz 2006). Reflection by the group members on the images they have produced offers a strategy for voicing thoughts and feelings about their nurture of which many will previously have been unaware.

These exercises are the preliminary to inviting the group to consider how they nurture themselves and other people. We have found that our participants very often give others a quality of care which they neither received, nor give themselves. The next step therefore is to encourage them in better physical and emotional self-care. We ask them to identify in detail qualities of a good mother or a good friend and to consider when and from whom
obese people even when weight loss was not substantial. A total of 30 minutes moderate activity undertaken on three or more days per week was suggested to be enough to reduce the risk of cardiovascular disease substantially (ACSM, 1995). However, more recent consensus (Saris et al., 2003; Schoeller et al., 1997) suggests that “prevention of weight regain in formally obese individuals requires 60–90 minutes of moderate intensity activity [per day] or lesser amounts of vigorous intensity activity” (Saris et al., 2003, p. 101). Whether this is an attainable goal is another question, however, any activity will have desirable effects. Mobility is improved, with a corresponding decrease in aches and pains and metabolic rate is increased with a corresponding benefit for calorific consumption. Appetite is reduced through lowering of insulin levels.

In order to lose weight, as opposed to maintaining weight loss, group members would need to undertake vastly more exercise than these relatively minimum amounts. A review by Miller et al. (1997) concluded that exercise programmes were not effective in producing weight loss compared to diet alone or exercise and diet, but even a small increase in activity will help to maintain weight loss, or go some way to stabilising existing weight (Shaw et al., 2002). In terms of obesity even stabilising of weight can be seen as a positive outcome.

Psychological benefits

The psychological benefits of increased activity are also substantial. The release of endorphins promotes improved mood and reduces depression. The successful undertaking of activity promotes empowerment and self-efficacy and, thus, improvements in self-esteem (Shaw et al., 2002).

Changing attitudes and behaviour

All of this is well known and well understood. The problem is how a group of seriously overweight and almost completely inactive women can be supported to improve their activity levels when it is known that overweight people have particular difficulty maintaining exercise (Wing & Jakicic, 2000). What change needs to take place to allow them to begin to move more? Our first answer to this question is that women have to get over the feelings and associations to exercise that they carry with them. It is known that, by puberty, most girls have ceased to engage in physical activity (Goran et al., 1998). Sport is seen as unfeminine and the usual accompaniments of unflattering sports wear and activity taking place in public, when girls are acutely self-conscious and conscious of their bodies, are not likely to recommend it. Many of our participants had excruciating memories of humiliation and embarrassment from school sport. We felt it was necessary to get all these feelings out of the way before we could start to talk about increasing activity in the present.

It was then necessary to evaluate the group members’ readiness for change using the Prochaska and DiClemente model of change. Identifying their place in the change process meant that individuals could be encouraged to move along that process rather than assume that they were ready to increase their activity (Wing & Jakicic, 2000).
behaviour, greater detachment from food and dietary changes. Although this study placed less emphasis on improving food choices and increasing activity than the programme described in this book, the CBT and psychotherapeutic elements had many similarities. Weight changes were not reported for this group but it is reasonable to assume that changes in attitude reported will lead to sustained weight loss. Issues such as the necessary length of a group of this kind and whether it needs to include material on food choice and increased activity have not, as yet, been researched. Our feeling is that weight gain developed over a good number of years is unlikely to be reversed and maintained in a short time, however desirable that would be for funders.

**Obese people’s understanding of their eating behaviour**

There is a lack of studies which investigate obese people’s own understanding of their eating behaviour and attempts at weight loss. We undertook a study of this kind (Bidgood & Buckroyd, 2005) which confirmed the experience of prejudice and stigmatisation reported by other researchers. It also revealed that excessive eating can feel like addiction; that prejudice and stigmatisation restrict lifestyles and hinder treatment; that dieting has limited success; that our participants felt unheard, and that they needed ongoing help. Their self-esteem was uniformly poor. This study confirms the findings of other qualitative investigations (e.g. Lyons, 1998; Goodspeed-Grant & Boersma, 2005) and has strengthened our resolve to develop interventions that respond to the needs of service users.

**Population study**

It is already known that emotional eating and binge eating correlate (Eldredge & Agras, 1996; Telch & Agras, 1996) and that binge eating is characteristic of up to 46% of obese people (Marcus & Wing, 1987; Gluck et al., 2004). Furthermore it is known that binge eating is associated with weight regain (Fichter et al., 1993; Foreyt & Goodrick, 1994; Agras et al., 1997). What is not known is how emotional eating and binge eating relate to BMI within the general population. It seems likely that there is a continuum from little or no binge and emotional eating for people of normal weight to greatly increased binge and emotional eating for obese people. If this relationship is demonstrated it will provide further evidence that emotional factors need to be considered in the treatment of obese people. We are in the process of researching this hypothesis.

**Trauma and attachment difficulties in obese women**

Fairburn et al. (1998) demonstrated that women with BED had rates of trauma equal to those in a psychiatric population. We are carrying out a study which compares trauma and attachment difficulties in two groups of women, 60 with a BMI ≥ 35, and 60 women consistently slender for five years. Our hypothesis is that the obese women will show greater levels of trauma and attachment difficulties. Our focus, again, is on the use of such a result for informing treatment options.
Champion slimmers

In association with the BBC we carried out a survey of 74 winners of slimming competitions who were examined with respect to their relationship with food. They had lost an average of 40% of their body weight during dieting. Weight regain after the dieting phase increased as time went on. However, even those who had lost the weight more than five years previously were on average about a third lighter than at the start of their diet.

These relatively good results were modified by measures of disordered eating. The women showed significantly higher levels of emotional eating, eating concern, shape concern, weight concern and restraint than the general population: 70% had binged in the last three months and 31% binged four or more times in the past month. These figures are comparable to the prevalence of binging found in those seeking clinical treatment for obesity, despite the fact that only 20% were obese (at the time of data collection). Bingeing was more common among those with high restraint, eating, shape and weight concern. These findings suggest that weight loss by itself is no indication that difficulties with food, shape and size have been overcome. They confirm our conviction that weight loss strategies, for a significant proportion of women, need to be accompanied by attention to psychological issues (Buckroyd et al., in preparation).

Future intentions

We are currently planning to continue to develop the intervention used in this book for specific populations and hope to win funding to work with morbidly obese diabetic women who fulfil our criteria and also with a student population. We hope that the work we have described above will make a contribution to the search for more successful interventions for obesity. At the moment an obese person has very little chance of sustained weight loss without undergoing surgery. We would like to help develop other alternatives.
We also think that it is important that you are equipped for the management of very powerful feelings in the group. There is no merit whatever in having group members retraumatised and, besides, the effect is likely to be that they leave the group. The groups are deliberately recruited from women who have difficult histories; it is very likely that this will become apparent during the life of the group. Ideally you should have training in the management of post-traumatic stress. Furthermore, you should ensure that you have appropriate supervision for this work. It is strenuous to lead a group of this nature and you need support.

**Men as group leaders**

As discussed previously this programme is in the process of being researched with women. Similarly all group leaders so far have been women. The rationale for female group leaders has been that women’s experience of food and nurturing and their bodies is very different to male experience. Since one of our primary goals has been to develop empathy in our group leaders it has seemed more appropriate to train women. However, we recognise that there are men within the therapeutic world who are more than capable of empathic understanding. McKisack and Waller (1997) found no advantage attached to the gender of the therapist in groups for bulimics. We suspect that men’s relationship with alcohol may have more commonalities with women’s relationship with food than with men’s relationship with food, but that may enable them to empathise with women. We have also noted that many of the women in our groups have exceedingly difficult histories of relationships with men and we wonder how easy it would be for a man to run a group in these circumstances. We hope that men who would like to run one of these programmes will prepare themselves appropriately to do so and let us know about their experience.

The University of Hertfordshire runs training courses totalling 30 hours for this programme and also offers supervision. If you contact us at j.buckroyd@herts.ac.uk or s.m.rother@herts.ac.uk we can give you details.
PART II
The Programme
Session 1

**Time split**
- Introductions and boundary setting 25 minutes
- Hopes and fears / outline programme 35 minutes
- Listening exercise 25 minutes
- Sharing information 25 minutes
- Ending 10 minutes

**Aims and objectives**
- To begin to establish the group as a protected space within which emotional exploration and sharing is possible.

The necessary preliminary is the housekeeping and setting of boundaries:
- Venue - toilets - escape routes, etc.
- 36-week group over a calendar year – agree dates if not already established.
- Weekly meetings of 2 hours.
- Emphasis on importance of attendance.
- Notification of Absence – a system devised by each group leader to allow participants to contact the group leader. (Give out written details.)
- Contacting group members. (Circulate a list of names and ask all members to indicate how they wish to be contacted, e.g. letter, e-mail, telephone, mobile, text.)
- Notebook, envelope file and pen given out, named if possible.
- Use labels for names.
- Group confidentiality statement: give out and get it signed and returned (see Appendix 1).
- Rules for behaviour, i.e. no harming themselves or others or damaging the environment.

**Introductory exercise**
Suggest they say their name and one thing about themselves or use some other very simple introductory device.

**Hopes and fears**
This exercise allows for the expression of the inevitable feelings that will have been aroused before the group even begins. The logic of getting them into the open is that they
Homework

- For this first session the homework should be nothing more demanding than inviting them to think about what has been said during the session and how it might apply to them.
Ask them about the monitoring as an exercise and how they feel about it. Recognise that it is very tedious, but be alive to more substantial objections. Hand out more monitoring sheets, either now or later, if it feels more appropriate.

- I think I've slipped back. I think I've gone back to preparation.
- I thought I was really keen to get on with sorting all this out but it's harder than I thought.
- I feel pleased it's the first time in a long time that I've actually managed to do anything for myself.
- I think it's really hard to accept that it's all down to me and that I'm the one that has to do something. I think I've been waiting for a miracle.

Then ask how they managed with the strategies for avoiding overeating. How successful were they; are there any additions to be made to the list?

Then ask them about the group and their feelings about it. Try to address all the negative things. We would guess that already some will be disappointed that they haven’t had diet sheets and that it is not already fixing them and their weight. Ask them how long it has taken them to get to the size they are and how many times they have tried to lose weight before. Try to get them to see that they are attempting something different and more permanent this time, which will take longer.

- I see now how many food snacks of sugar I eat and how few meals I eat in a week.
- I have done so many diets before I don’t know how to eat properly.
- I realise I eat because I get hungry. I panic if I feel hungry. I will eat anything and everything until I feel sick.
- I take food with me everywhere I go just in case I’m held up and don’t get home in time. I’m really scared of being hungry and having no food.

- I'm such a perfectionist I daren't start to change anything in case I fail.
- I'm going to ask for a stomach staple. This talking stuff isn't working.
- It's wonderful being among a group of people who've experienced the same difficulties as I have.
Ending

This session has covered a wide range of material and has introduced the difficult concepts of buddying and meal planning. You have provided them with another skill for affect management but it is possible that the whole session has been quite powerful. Try to soothe and calm them. Congratulate them on all the hard work they are doing.

Homework

- Complete meal planning sheets. Think about what has been said about the possibility of buddying. Practise using the safe place strategy.
5. Look at your diagram of the room and think about each person in turn.

- What might each person be saying and to whom?
- What would be said to you, and what would you say, if anything?
- Write those things on the diagram.

6. What was your feeling memory of these occasions?

- What sort of an occasion was it for you?
- What sorts of things went on that you remember?

7. When you think about all of this – do you think that what went on at mealtimes was a picture of what went on in the family as a whole?

- Do you think it is an illustration of the relationships in the family?
- Was that how your family behaved generally?

8. Do you think you had any power?
9. Who did have the power?

Take no more than 25 minutes for these questions. Give each participant a copy of the questions as a reminder (see Appendix 7). Ask them to get into groups of three and discuss their answers, taking about half an hour, as it takes 10 minutes for each person. Remind them to share the time evenly. There will be a moment to remind them of listening skills. Get one person in each group to keep the time.

Take at least 15 minutes for a more general discussion in the whole group, including:

- How members felt doing the exercise?
- What kind of memories it raised for them?
- Asking them to name the feelings.
- Asking them how they reacted to what other people said?
- Asking them what they learned about themselves and whether they can see any connection with their present behaviour?

You should be aware that this exercise often produces very strong feelings among group members. Be prepared to use the exercises for managing feelings that you have been teaching them. People often cry and are surprised by the ease with which memories and feelings are recovered. Remember that group members are very likely to be new to this kind of reflection and taken by surprise by the strength of their feelings. On the other hand, there may be people who cannot remember much, if anything, about their childhood.

You want them to come back next week so make sure this experience is contained and that the courage of group members is validated. Be sure to include some material about how this exercise might make them change things in the present.
Session 13

Time split

- Review 40 minutes
- Making a menu 25 minutes
- Food choice in your family of origin 45 minutes
- Ending 10 minutes

Aims and objectives

- To review how they feel about returning to the group and how they managed over the break.
- To do a meal planning/food choice exercise.
- To investigate food choice in their family of origin and now.
- To start the process of improving food choice.

Review

Session 12 was spent reviewing the whole of the work of the last term so there should not be any need to go over that work again, however your participants may have had a break during which they were asked to continue the work of meal planning and buddying. This needs to be followed up in the usual way. They will also have feelings about returning to the group which need to be explored. This is also a moment when group members may have dropped out. At this stage in the group their absence will really be noticed and will be unsettling for those who remain. All sorts of questions will be provoked by their absence. It is the group leader’s job to manage this situation and to contain the feelings aroused. This will be particularly difficult if people have left without saying goodbye or in an angry way. It is particularly important to identify ambivalence at this point (reluctant returnees) since there may be people who have not yet started to lose weight and who are discouraged or feel that the group is not helping. You might want to return to the hopes and fears exercise from Session 1. You could use the posters that they made then and talk about them in terms of where they are now. Or you could do the exercise again, or you could do it more informally as a brainstorming on the flip chart exercise. You may also want to point out that they have tried rapid weight loss before and that it hasn’t worked and that it has taken them years to get to their present weight and will take some time to alter. If it seems appropriate, you can also go back to talking about how the group tries to alter their relationship with food to make a change that will be permanent and will not depend on will power. When you feel that group solidarity and energy have been
Session 16

Time split

- Review 20 minutes
- Food choice 1 hour 25 minutes
- Ending 15 minutes

Aims and objectives

- To review the last session.
- To brainstorm problems in making good food choices.
- To address ambivalence in making changes.

Review

My guess is that there will be quite a lot to say about last week and the intervening time when they have been asked to make better food choices.

Be prepared for a torrent of reasons why they can’t/won’t change. Be sure to enquire how they have used their buddies to help them.

Food choice

This is the last session when food choice will be the focus of the whole meeting, so try to use it to review the whole subject. The fundamental principle behind it is that if they are going to lose weight they have to take in fewer calories. One way to do this is to restrict, which we know from all sorts of evidence and experience doesn’t work in the long term. This programme seeks to identify the emotional purposes for which our participants use food and to free them from that way of managing their emotional lives. In the matter of food choice I have been suggesting that food choice is, to a significant extent, emotionally determined. It is much easier to eat fewer calories by changing food choice than by restricting. If food choice can be made less emotionally compulsive, participants can be freed to choose differently. This will have health benefits anyway.

The big danger is that talking directly about changing food choice is seen as an external imposition, rather than an internal choice. If you think about weight loss programmes on television, the participants constantly refer to their anxiety about what will happen if they don’t do what they’re told. And then the danger is that change will not be sustained. Use all your ingenuity to make the ideas and the solutions to the problems come from the group. Emphasise the use of the buddy system. Go back to the readiness to change wheel (p. 58)
if you think it would be useful. Try to address the whole subject in the spirit of interest and exploration rather than ‘should’ and ‘ought’.

You might want to go back to the whole issue of how emotion determines eating behaviour. Are they, for example, in the grip of emotion when they choose what to eat? How does their mood affect them when they go shopping? Are they maintaining eating patterns that relate to other periods of their lives? Partners and children may cause real problems. Support them to engage with their families in discussing what they eat as a family and how they can make good choices. Children will generally come along if they can be involved in the project. As with our participants, families will react better if they don’t feel coerced.

Try to ensure that the discussion results in concrete intentions. If the meal planning system continues to be used it will help with making food choices at the next level, of shopping. You might want to make a group resource, e.g. a shopping guide or a collection of recipes.

Before you finish this session, review what they have learned and what they have changed in the past four sessions. You should find a greatly enhanced awareness of what they choose and why, which we would expect to be translated into action.

**Ending**

This is a tricky moment because of the difficulty of changing. Try to strengthen and support them before they go, and encourage them on having the courage to change. Remind them that choice is empowering and that they have the power to choose well for themselves.

**Homework**

- To use all the resources available to them, including buddying to put what they have learned about food choice into action.
- To use the meal planner to help to structure food choices.
Session 19

**Time split**
- Review: 30 minutes
- Food choice: 25 minutes
- Guided fantasy: 50 minutes
- Ending: 15 minutes

**Aims and objectives**
- To continue to pursue improving food choice.
- To continue to explore the meanings of fat and thin.

**Review**
See if you can find out how the work of the last session has affected them during the week. You might want to ask if they have been more aware of how they talk to themselves and whether they have been able to find a more positive way to do it. How have they used their buddies for this task?

**Food choice**
Let’s not lose sight of the continuing need for maintaining improved food choice. Make sure you check that out during the review and how/whether the group is using their meal planners and buddies to support their changes. Use the wheel of change if necessary and talk about empowerment.

**Guided fantasy**
This is an exercise which draws on one originally devised by Susie Orbach (1978) and is designed to get to some of the less conscious meanings of fat and thin. Get your group to settle down and close their eyes while you read the following text.

Imagine yourself going to a party:
- What image do you want to convey when you get yourself dressed?
- What do you want to convey by the clothes you wear?
- How are you feeling on the way to the party?
- What would you like to happen at the party?
- What are you afraid will happen?
Session 26

**Time split**

- Review: 20 minutes
- History of activity: 50 minutes
- Food in your family revisited: 40 minutes
- Ending: 10 minutes

**Aims and objectives**

- To explore the history of their relationship with activity and exercise.
- To revisit the subject of food in their family of origin and enquire to what extent that still affects their food use and choices now.

**Review**

Your participants were asked to commit to themselves to increasing their activity in some way during the week. Ask them what they did, what they did, how it felt, etc. This is an area where the buddy can easily be of use (going for a walk together; agreeing to walk to school with the children together; meeting to go somewhere together, etc.). Be especially on the look out for reports of improved well-being and equally for difficulties caused by size. (“I want to do more, but I get so hot and sweaty if I even walk to the shops that I feel a freak”). Get the group to produce the ideas and solutions.

**History of group members’ relationship with activity and exercise**

Many, many people have horrid memories of being mocked or rejected for their difficulties with physical activity. Many more have bad memories of exercise as uncomfortable or even painful. Much formal exercise training in schools has been (and maybe still is, in some places) directed at the naturally slim and athletic and everyone else has been made to feel bad. You may want to revisit the management of feelings before the group does this exercise.

Ask the group members to think about these issues. You might want to prompt them by getting them to think about:

- Their families’ attitude to activity. Did they come from sporty and active families? What was the role model provided by their mothers? Was there encouragement and support for activity? How was activity seen in relation to femininity?
• What was their experience in junior school? Often children quite enjoy activity at this stage and have good memories of skipping, running, etc. Junior school sports days are often rather nice occasions. However, this isn’t always so and fat children, in particular, may have a miserable time.

• Problems often start, for girls, with puberty. Most girls abandon all formal exercise at around the age of 13. This means that even when they have enjoyed being on the hockey team or doing judo or dancing class, they drop out and never again engage in regular exercise. This is usually prompted by changes in body shape, increasing self-consciousness and peer pressure. Explore all this with the group.

• In late adolescence and young adulthood a lot of girls get at least some exercise from dancing, but it is highly likely that your group members will have been overweight by this stage and more likely to be sitting holding their mates’ handbags than being on the dance floor themselves. Explore these issues.

• Children make most women more active, but serious overweight will make this difficult. Find out what has happened to them in relation to activity since their early twenties. Expect to hear a story of steadily declining fitness.

The point of this exploration is not just to hear the story, but to think about how the history has affected their attitudes to exercise and activity now. For many women these are poisoned areas. Go back to the idea of activity as opposed to exercise and get them to revisit both its benefits and how increased activity could be built into their day.

Food in the family revisited

Get the group to think about the work you did in relation to the social and emotional experience of food and meals in their family of origin. Talk about what they have come to realise about how that experience affected what they did with food in adult life. Talk also about food choice in their family of origin and the meanings of their favourite and least favourite foods. Where are they in relation to all of this now? Do they feel that they can leave those memories and habits behind? Can they make choices about how meal-times are conducted, that result from choice in the present?

There may be a temptation to give easy quick answers to these questions. Given that we are trying to change the relationship our clients have with food, try to stick with it long enough to uncover the difficulties. It may be helpful to think about a process of growing out of bad old habits, even especially where those had good associations, into some more adult relationship with food.
buddying. You might want to begin with asking the group about the qualities of a person they can trust. Try to make this a concrete rather than abstract exercise: e.g. think of someone you trust; what is it about that person that makes it possible to trust her? It may also be useful to talk about the impossibility of absolute trust— we want to be able to trust someone 100% but 95% is a more realistic goal. Get them to think about whether they themselves are trustworthy. Are there limits and hiccups in their trustworthiness? Can that be all right? Is it even rather realistic and human? What have they learned about trust from the experience of being in the group?

Take the opportunity for a painting exercise. Ask the participants to paint a trusting relationship in their own lives (past or present, but preferably present). Remind them that trust is in all relationships, not just the closest and most intimate. Reassure them, as usual, that this is not about their artistic skills but about using something other than words to explore feelings. Then follow the usual format of giving them time to paint, viewing the paintings and discussing them one by one. If necessary/desirable the discussion can continue in the following week.

Remember, you are trying to foster their capacity to trust other people and to be able to determine who can be trusted.

**Ending**

This exercise may have left some people feeling a little shaky. Remind them about strategies for affect management. Take some time to soothe and calm the group before they leave. Remind them of how far they have come. Encourage and congratulate them on their courage and perseverance. Allow them to feel proud of themselves and each other.

**Homework**

- In their ongoing attempts to use people instead of food, ask the group members to think about trust and how they can find people that they can trust to support and help them.
- Ask them how they can be people who can be trusted by others.
- Mention the stepometers and food choices.
whole business of the influence of the past. Because we are very close to the end, focus more on the power to choose, as an adult, in the present. You might want to repeat the exercise of getting members to write down what they now think of as a desirable menu for the day, bearing in mind all they have learned, and then getting them to write down what they ate yesterday. I would be surprised if the contrast was as great as when they first did this exercise four or five months previously. You might want to get them to look it up in their notebooks to check.

**Ending**

Only three more sessions to go! Spend a bit of time on how they will prepare themselves to manage on their own.

**Homework**

- Ask the members to focus on consolidating their ability to make good food choices and to think about how they will maintain that when they no longer have the group to support them.
Appendix 3
Process of Change

WHEEL OF CHANGE

PRE-CONTEMPLATION

CONTEMPLATION

PREPARATION

ACTION

RELAPSE

MANTENANCE

PRE-CONTEMPLATION

RELAPSE

RELAPSE

RELAPSE

RELAPSE

RELAPSE
# Appendix 10

## Overview of First 24 Weeks

<table>
<thead>
<tr>
<th>Session</th>
<th>Action</th>
</tr>
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</table>
| 1       | Hopes and fears  
Listening  
Sharing information |
| 2       | Weightline/lifeline  
Food monitoring  
Motivational enhancement |
| 3       | Strategies for managing overeating  
Names for feelings  
Managing feelings |
| 4       | Food monitoring  
Reviewing motivation  
Feeling safe in the family  
Managing feelings |
| 5       | Buddying  
Meal planning  
Managing feelings |
| 6       | Buddying  
Managing feelings  
Use of food in your family of origin |
| 7       | Meal planning  
Managing feelings  
Mothers |
| 8       | Mothers |
| 9       | Beliefs about food  
Mothers continued |
| 10      | Circle of support  
Patchwork mother |
| 11      | Who you can trust  
Trusting each other |
| 12      | Review of sessions to date |


British Association for Counselling and Psychotherapy. www.bacp.co.uk/education/whatiscounselling.html


Index

Chapman, I. 41
childhood mealtime scenario 74–7
childhood sexual abuse (CSA) xxi, xxii
Chua, J.L. xix
Ciarrochi, J. 13
Ciechanowski, P. xx
Ciliska, D. 23
circle of support exercise 89–90
Clark, M. 42
Clerici, M. 16
Clinical Outcomes in Routine Evaluations (CORE) 15, 16
Cochrane, C. 16
Cogan, J. xvi, 4, 23, 42
cognitive behavioural therapy (CBT) xv, xxiii, 7–8, 87
Cognolato, S. 12
Colantuoni, C. xxii
Collins, P. xvi, xviii
Colvin, R.H. xvii, 11
comfort eating xvii, xviii, xx, xxii
commercial weight loss programmes 41
Commissioning Obesity Services 43
confidentiality 44
congruence 5
Connelly, J.C. 29
Conner, M. 9
consolidation 158
contact 27, 38, 45
Conway, B. xv, xvi
Cooper, Z. 8, 31
core conditions 5, 6
cortisol xx
Courcoulas, A.P. 40
Crisp, A.H. 4
cultural pressures 123
Dallman, M.F. xxii
dana, M. 7
Davis, E. xxii
De Chouly De Lenclave, M.B. 16
de Zwaan, M. 16
Deaver, C.M. xix
depression xxi, 33
Despré, J.-P. xvi
Devlin, M.J. xv, 17
diabetes, Type 2 xx, 25, 31, 40
DiClemente, C.C. 9, 10, 39, 40
diet sheets 38
discrimination 4
dodo effect 3
Dokter, D. 22
douketis, J.D. xv
dryden, W. 12, 38, 43
eating behaviour, obese people’s understanding of 35
Eberhardt, M.S. xx
Egolf, B. xviii
Eldredge, K.L. xxiii, 35
Elfhag, K. xxiii
Emotional Eating Scale 15, 16
emotional eating xx, xxiii, 35, 134
emotional intelligence, developing 16–18
emotional language 17
empathy 5
failure of 49
in group leaders 50
employee assistance programme 38
empowerment 24, 63
Encinosa, W.E. xv
equipment for group members 40–1
Emnsberger, P. xvi, 4, 23, 42
emotions 25, 16
exclusion criteria 40–1
exercise see activity
Fabricatore, A.N. 4
Fairburn, C.G. 35
Fallon, P. 7
family
attitudes to exercise 135
dysfunction xxi
feelings 67–8
food and 136
fat and thin exercise 117–18
fears see hopes and fears
feelings 140
family 67–8
managing 64, 68, 71, 74, 80–1, 171–2
names for 63–4
Felitti, V.J. xx, xxi, xxii, xxiii
feminist theory 6–7
Fichter, M.M. xvi, xix, 25, 35
Field, A.E. xv
Flores, P.J. xx
Florin, I. xix
food
beliefs about 87–8
family and 136