Utilizing the Miracle Question in Weight Control Treatment

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Abstract

Obesity is a growing epidemic that increases morbidity-related health risk factors. As the overweight population increases, so does the need for treatment options. Studies show that individuals who undergo weight reduction treatment utilizing nutrition and behavior modification have greater long-term success. This paper will discuss the obesity epidemic and therapeutic applications for treatment. The writer developed a training to increase trainees’ skill and understanding in identifying and assisting discouraged clients in a weight loss environment. The workshop will train them on different ways to use the miracle question and specific times when this technique could be most effective. The training will further the trainees understanding of visualization, encouragement, and solution-focused therapy techniques to optimize applications for weight control.

*Keywords:* Obesity, Weight Loss, Solution Focused Therapy, Miracle Question
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The Growth of Obesity

Obesity has transformed into a worldwide health epidemic. In the United States, the prevalence of overweight adults has increased dramatically over the past 30 years. According to the Centers for Disease Control and Prevention (CDC), not a single state reported an obesity percentage over 30% prior to the year 2000. Since 2000, a total of 12 states have experienced 30% or more of adults reporting to be obese (Zhao, Ford, Dhingra, Strine, & Mokdad, 2009). Ogden, Carroll, Kit, and Flegal (2012) reported that by 2010, about 30% of all U.S. adults were considered to be overweight or obese. The CDC equates that to about 40.6 million women and 37.5 million men in the United States who are categorized as obese. Furthermore, an estimated two thirds of the adult population in the U.S. can be classified as overweight (Ogden et al., 2012).

Obesity is defined using the Body Mass Index (BMI), a chart comparing an individual’s body mass to height. A BMI of 30 or higher in an individual indicates possible obesity, while a BMI of 25 or higher can indicate being overweight. A normal, healthy BMI falls in the range of 18.5 to 25. Because BMI is calculated using only height and weight, it has some limitations (Zhao, Ford, Dhingra, Strine, & Mokdad, 2009). Those with increased musculature, such as athletes, may weigh more and thus have an increased BMI. However, these individuals would not necessarily face many of the same health risks that accompany a higher BMI in others. Because of the limitations of the BMI chart, it has become increasingly controversial in recent years (Kerkhoffs et al., 2012). 1998, The CDC and the National Institutes for Health (NIH) restructured the categorization of a healthy weight to align with international standards. The NIH
explained this change was necessary due to the link between weight and health problems. The adjustment reduced a healthy weight by an average of ten pounds for your height from the previous BMI chart.

Greater BMI can indicate an individual has increased risk for chronic comorbidity (Zhao, Ford, Dhingra, Strine, & Mokdad, 2009). The CDC explains that research indicates those classified as overweight or obese are at increased risk of morbidity due to higher risk of cancer, heart disease, hypertension, dyslipidemia, stroke, liver disease, sleep apnea, osteoarthritis, and gynecological problems. The CDC references the NIH’s publication *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults* (1998).

Internationally — especially in Europe — doctors are trending toward associating an individual’s waist circumference compared to height with overall health indications. Leone et al., (2009) found that waist size is more indicative of health risks than Body Mass Index. A recent study consisting of examining the health records of 121,965 Parisians to further understand overall health conditions. Leone et al., (2009) found a correlation between waist size and lung function. Specifically, the researchers found a relationship between decreased lung function and abdominal obesity. The research continued to explain that even individuals within a normal BMI range with increased abdominal obesity had decreased lung function. (Leone et al., 2009), illustrating how waist circumference can be a more accurate gauge for overall weight-related health risks.

Regardless of the method used to determine obesity, those with increased weight have increased health-related morbidity. Aballay, Eynard, Díaz, Navarro, and Muñoz (2013) examined the increase in obesity rates in South Amer. Furthermore Aballay et al.,
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(2013) sought to understand how changes in the prevalence of chronic comorbid disease was effected by obesity. Finding a relationship between the increase in obesity and the increase in comorbid disease. South America has experienced a decrease in infectious diseases but an increase in diseases associated with longevity. Examining this shift, the authors propose a possible causation in the form of population changes due to an influx of immigrants from other, more “Western” countries. This cultural shift includes a departure from more traditional and indigenous eating behaviors. Chronic comorbid disease are largely influenced by lifestyle, so when lifestyle is shifted with cultural changes diseases are affected (Aballay et al., 2013). Aballay et al., (2013) reasoned with lifestyle changes such as diet and behavior comes obesity rate increases. Furthering the understanding of the common causal factors between obesity and morbidity-related health risks.

Mathes, Kelly and Pomp (2011) discussed obesity as a multifactorial disease that is an amalgamation of environment and genetic influences. They explained that having genic predisposition for weight gain influenced and increased health risk factors. Traditionally weight gain was linked to a decrease in exercise and poor dietary intake. However, a shift in understanding has occurred that moves beyond understanding weight in terms of diet and exercise alone. Mathes et al., (2011) discussed the many influences in this disease epidemic such as environment, social structures, diet, genetics, and behaviors. The authors (2011) argued that genetics not only influence a predisposition for weight gain, but also have an influence on treatment response. Seeing those who have a family history of obesity have decrease success rates in obesity treatment (Mathes et al., 2011)
Weight Loss and Therapeutic Techniques

Today, obesity has developed into a major health risk as well as a social concern and challenge. Weight not only increases morbidity-related health risk; as a social construct, it affects the individual socially. Although being of a greater weight has not always historically been viewed negatively, in current Western society having increased weight is often viewed negatively and even discriminated against (Zhao et al, 2009).

Sutin and Terracciano (2013) discuss how both behavior and physiological mechanisms influence weight discrimination. Their research looked at the influence weight discrimination has on individuals, including whether it increases the likelihood of becoming obese. They discussed how weight is a publicly visible attribute in some ways similar to race. Race and weight discrimination clearly have distinctive historical differences. Race discrimination has historical development with the color of skin slavery and classism. Obesity discrimination has been compared to racism because perceived behaviors are associated with how the individuals appearance. Vines et al., (2007) reported African American women reported experiencing racism had increase weight. Vines et al., discussed the effects psychological stress related to perceived racism has on weight gain. The commonality of race and weight discrimination effects weight gain and psychological stress (Vines et al., 2007).

Sutin and Terracciano (2013) explained that weight discrimination often grows from negative connotations society holds against those that are overweight or obese. Often those who are overweight are perceived as being “lazy, unsuccessful, and weak-willed” (Sutin & Terraciano, 2013, pp. 2). According to the authors, these negative connotations are causing discrimination including nonverbal, verbal, and sometimes
physical. This discrimination leaves lasting effects on those who are overweight that can lead to a continued increase in weight, eventually evolving into obesity. Sutin’s findings illustrate how social factors are perpetuating the obesity epidemic.

Svenningsson, Björkelund, Marklund, & Gedda (2012) studied depression in patients with type 2 diabetes mellitus comparing those with a healthy weight to those who are classified obese. They found that those with type 2 diabetes are at increased risk for anxiety and depression, and adding obesity further decreases quality of life by increasing this anxiety and depression. Their research can help raise awareness among healthcare professionals that diabetic patients who are overweight or obese have a predisposition to anxiety and depression. Research was seeking to find significant differences between male and female participants. However, they found that both males and females had a significant link between depression and both type 2 diabetes and obesity, with no significant differences between genders (Svennigsson et al., 2012).

Given that two thirds of the U.S. population is currently overweight or obese, a huge variety of weight loss treatments have emerged over the past decade (Berg, 1999). Studies have found that individuals who follow a nutritional and behavior intervention lasting for at least two years have the most lasting success. By following a program that includes nutritional and behavior modification counseling, patients reduces the risk of future weight gain (Ditschuneit, Flechtner-Mors, Johnson, & Adler 1999). It is most common for those who do not follow a lasting intervention to regain weight within five years, resuming the original increased health risks.

Research shows that being overweight indicates an increase likelihood of anxiety and depression. Weight has many effects on individuals both physical and emotional.
Many of the effects of weight are multi-dimensional; often the direct causes of weight are layer beneath other social emotional symptoms. Svennigsson et al., participants reported decreased self-confidence and overall happiness (Svennigsson et al., 2012; Fletcher, Hanson, Page & Pine, 2011). Effective treatments that are not fad diets utilize clinically proven approaches that assist in developing new habitual behaviors.

Caldwell, K. L., Baime, M. J., & Wolever, R. Q. (2012) found that using a mindfulness-based approach during weight loss treatment helped individuals visualize success. In turn, visualizing success and being mindful of actions during treatment increased the amount of active participation from the individual.

Caldwell et al., (2012) examined the benefits of mindfulness in a randomized study, which found those who participated in a mindfulness workshop had decreased BMI compared to the control group. The mindfulness training specifically pinpointed obesity-related stigma. By combating the stigma and negative effects of weight discrimination on mental health, the individual can create positive change with lasting weight loss (Sutin & Terraciano, 2013 and Caldwell et al., 2012)

Weight-related discrimination can cause an individual who is overweight to feel put down and discouraged (Sutin, 2013). Studies support that weight discrimination and stigma reinforce negative behaviors and support weight gain. Looking at the negative effects of being discouraged in Adlerian Therapy, you could use the model of encouragement to support weight loss and healthy behaviors.

From her experience in a weight loss environment, this writer can see a strong correlation between those living with obesity and being discouraged. Adlerian Therapy techniques for weight loss could look at an individual who has struggled weight as having
a possible mistaken lifestyle belief. Laser (1985, pp. 511) suggests to combat a mistaken belief of “fat and thin” and promote encouragement. In his research, “chipping away at these and other discouragements though education, group reinforcement, and behavioral techniques permitted some individuals to begin to develop new decisions about themselves and their bodies.”

Adlerian approach to weight loss examines how the individual developed an understanding of weight and weight-related behaviors growing up as they constructed a view of the world. Dinkmeyer, Dinkmeyer, & Sperry (1987) wrote that health beliefs are impacted by the way the individual constructs views of themselves, others, and the social and physical world.

Behavior modification is a way in which encouragement is carried beyond the therapeutic setting. Many weight loss techniques place an emphasis on face-to-face contact to increase accountability. Considering that frequency of face-to-face contact is a predictor for weight loss success, increasing accountability away from the weight loss center can increase effectiveness (Armstrong et al., 2011). Armstrong et al., (2011) by educating individuals and helping them develop behavior modification techniques, weight loss counselors are furthering their encouragement.

Brownell (1979) suggests an extensive list of behavior modification techniques that can be effective in weight loss. This supports the importance of behavior modification but also illustrates how so many varying programs can be successful while offering different services. Ultimately Brownell (1979) is supporting the idea that when an individual implements behavior modification they can feel more encouraged, leading to more successful weight loss.
Behavior modification techniques that can be effective for weight loss include diary, increasing intake awareness, exercise, goal setting, slowing food consumption time, impulse eating awareness, increasing education on obesity, social support, eliminating negative weight loss behaviors, and increasing accountability (Brownell, 1979). This list is extensive and encompasses many behaviors that can assist in weight loss. Due to the vast variety of behavior modification techniques that can be used for weight loss, it is clear that weight loss needs to be personalized to the individual. Looking at that personalization is important in helping the individual understand behaviors they need to change (Brownell, 1979).

Reinehr (2011) looked at weight loss treatment for obese children using the premise that behavior and diet treatment combined with nutrition education was the most effective in childhood obesity treatment. Although a further longitudinal study was suggested by Reinehr (2011), the research illustrated behavioral therapy, systemic and solution-focused treatment to be instrumental in combating childhood obesity.

Solution-focused therapy looks as the desired outcome as a way to focus and structure therapy (Bonnington, 1993). Developing solutions to a problem is a way to motivate the client forward. The therapy is only focused on present and future desires for the client rather than past problems. By focusing on the future, they are focusing on what is possible for the client rather than understanding the past. Solution-focused therapy explores the possibilities of what could be over what was or how the individual arrived at the current state. By examining the possibilities, the client becomes more motivated about how he or she could fix the problem and starts to visualize life with out the problem.
Problem-focus therapy is inherently based more on the medical model of diagnosing. This therapy spends more time analyzing complex problems; uncover root causes, and securing a pathology-based diagnosis (de Shazer et al., 1986). Solution-focused therapy does at time use past experiences as a way to illustrate how individuals have succeeded previously and identify resources they have available to assist them. Understanding the tools immediately helps the individual visualize the solution as being tangible. Grant’s (2012) study compared solution-focused verses problem-focused coaching by randomizing 225 participants into the respective groups. The study found that those in the problem-focused group did not experience a positive or a negative effect, while those in the solution-focused group had a significant increase to the positive effect. This study further illustrates the effectiveness of having an individual look at the solution rather than examining the problem.

The Miracle Question

Statistics show a serious growth in obesity, and developing effective treatments is crucial for battling this epidemic. It is more common for individuals who have lost weight to regain all of their weight within five years than maintain weight loss. This illustrates the crucial need to enhance long-term treatments for weight loss. This writer developed a training for those working in a weight loss setting to enhance the quality of their treatment.

During the weight loss process, an individual’s motivation changes. In the beginning, the individual is often so frustrated with the current situation that the need for change is pressing and constant. As the process continues, individuals begin to see benefits of the work they are doing. This can further encourage them, but it can also
decrease motivation to continue working toward the ultimate goal: to develop healthy habits and reduce health risks.

Looking at the effectiveness of mindfulness and a solution-focused therapeutic approach, the writer developed a training to educate those in a weight loss environment to utilize the miracle question (Grand, 2012; De Jong & Berg, 2002).

The miracle question was originally designed as an intervention technique by Insoo Kim Berg. Berg observed a client who appeared to be completely blocked and unable to visualize a different future (De Jong & Berg, 2002). The miracle question was developed as part of solution-focused brief therapy with the primary purpose of creating a tangible solution to a problem. When a client is unable to imagine what the future could look like, it limits the effectiveness and possibility of developing a solution. The miracle question invites clients to construct an alternate reality in which their problems do not exist (De Jong & Berg, 2002; Perry, Hickson, & Thomas, 2011).

Berg and de Shazer (1988) developed the technique further from Berg’s original session in which she started to create the miracle question. As they continued to create this technique, they observed that it not only assisted clients who were stuck in one mindset, but rather assisted all clients in developing a complete view of what life could look like without their problems.

The miracle question has many forms, and the technique can be referred to by other names. This writer wrote examples of the miracle question drawn from examples by Berg and de Shazer (1988). The following examples of the miracle question were used during the training:

“Tonight as you sleep a miracle occurs. When you wake up you don’t know anything has happened. What would be different that would give you an
indication that this miracle happened? How would your day look different? What would your husband/wife/children notice about you?

“You go to bed tonight and a miracle happens overnight. You wake up tomorrow and your body is exactly the way you want it. What would you do differently? How would your life be different? How would you maintain that life?”

“If I waved a magic wand and all of your problems disappeared, what would your life look like? How would you know a miracle happened?”

Taking this approach to weight loss treatment assists clients to understand what life could look like without a problem — in this case, their excess weight. However, it is important to acknowledge that in weight loss treatment the “problem” being fixed is often much more than just weight. By visualizing a life without the problem, clients are able to see that weight is not the only problem being addressed during weight loss treatment and are able to identify other factors that are changing during treatment (Armstrong et al., 2011).

de Shazer, Dolan, Korman, McCollum, Trepper, and Berg (2007) discussed other benefits to the miracle question when helping the client to visualize life without the problem. First, clients can begin to recognize when the problem is not occurring. A possible example in weight loss treatment could be when clients notice positive behaviors occurring. They can start to see changes before they get to the ultimate goal of weight loss. The miracle question helps the client view the future in a positive rather than negative way (de Shazer et al., 2007). The Adlerian theory discusses discouragement and how it is the root of dysfunction (Page, 2005) By utilizing the miracle question, one can take a client who has been previously very discouraged by their weight to a place of being encouraged with a solution that is not just positive, but possible.
The training for the miracle question will discuss how to recognize times to utilize the question, how to implement the question, and what to do with the miracle the client describes. De Shazer et al., (2007) discuss how the effectiveness of the miracle question is not that clients develop a perfect life, but that they can see tangible solutions that they have the ability to achieve. The goal is moving the client to feel positive and encouraged (Laser, 1984; Britzman, & Henkin, 1992).

During weight loss treatment, the therapist has an opportunity to shift the reality of the client (Perry et al., 2011). By shifting the reality, the therapist can hopefully assist the client in creating a new reality where he or she feels empowered to accomplish the goals and develop healthy habitual behaviors. It is important to remember that the questions asked of clients during sessions are helping in defining the reality.

In the miracle question training, the importance of asking better, higher-quality questions will be emphasized. It is critical to understand and feel confident in asking questions that help the client develop positive behavior changes. Strong and Pyle (2009) research analyzed how counselors implemented the miracle question. The verbal langue used to structure the process directly influences the effectiveness. The sequence Strong and Pyle analyzed involves the counselors introducing the miracle, asking the miracle question, and developing a resolution between the client and therapist (2009). Looking at these key stages in implementing the miracle question, this writer was careful to follow those three points during training as a way for the trainees to feel confident in using the technique.
Training Participants

In a weight control center, counselors often have a variety of educational backgrounds. This is intended to help clients in different aspects of their treatment. Counselors have training in nutrition, dietetics, exercise and behavior.

The training was implemented in three small groups to individuals working in a weight loss setting. The training groups contained only three or four trainees to individualize the focus of the training. The trainees included registered dietitians, nutritionists, a registered nurse, a personal trainer, a weight control director, and two assistant directors. During the training the individuals were educated on when and how to implement the miracle question technique and were given time to practice the technique and ask follow up questions. The individuals were also instructed how to document this technique in progress notes. Each member of the training will receive follow up observation and feedback.

Miracle Question Training Limitations and Possibilities

A few procedures are set up to fully support the consultants as a follow-up to the miracle question training. The counselors will receive observations and feedback. The observation will focus on how the individual uses the miracle question. The ways they transition into the question, explain the miracle, and develop a solution with the client will all be specifically observed.

Stith, Miller, Boyle, Swinton, and Ratcliffe (2012) conducted a very detailed study to examine graduate students implementing the miracle question. They broke down the therapeutic sessions word by word to truly see the possible limitations someone recently trained on the technique could encounter. They recorded key points in the
technique that needed improvement or would challenge the participant. Stith et al., (2012) described specific steps of this technique: the introduction of the miracle question, abrupt or not transition, timing, phrasing, follow up and question, lack of commitment, focus on the elimination of behaviors, non interactional, and ineffective use of scaling questions. This writer similarly wants to take careful note of the possible locations for improvement. In that way, those who participated in the training and are observed can get further instruction to more effectively implement the question.

A possible limitation of training individuals to use this technique is that these individuals are novice in understanding what to do with the information the client gives them (Strong & Pyle, 2009). Without having full therapeutic training and knowledge to utilize the client’s miracle to develop a solution, they could limit the positive encouragement and overall benefits of the session. Even with the limitation, this writer finds that some training is better then none. Adding new knowledge to the toolbox of the weight loss center can enhance the quality of the individual sessions. Overall, the feedback this writer has received to date has been positive and indicates the technique has been used to further develop the depth of each session.
References


