Women's Mental Health and Weight

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Abstract

This paper discusses issues in mental health of women who may be overweight or obese and the effects and influences society has on them. Society places a lot of pressure on being the perfect size and this can have negative effects on women physically, psychologically, socially, and in many cases can lead to depression. This paper explores solutions to help overcome obesity and risks associated with the extremes often taken by people who try to battle the weight issues. Controversy into whether food can lead into addiction is discussed. In light of eating disorders, this paper gives practical ways to help steer away from that method of losing weight and focuses on losing weight the healthy way. This paper discusses Adlerian Theory, Choice Theory, and relative insightfulness into one being overweight or obese, concluding with ideas for future interventions into the obesity epidemic.
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Women's Mental Health and Weight

Currently in the United States, obesity is increasing, with approximately 40 to 70% of men and women attempting weight loss. Even with Americans following an exercise or diet plan, obesity is a prominent problem in Western society and continues to escalate. Restraints that are put on some diets can worsen the problem and lead to eating disorders. Research also shows the dangers of having one's weight go up and down likely affecting one's mental health, resulting in lower self-esteem which can lead to anxiety and neuroticism (Georgiadis, 2006). One possible reason for one's mental health fluctuating is discouragement stemming from failure to maintain weight. Just as one's weight goes up and down so could one's mood.

Because of the health threats associated with obesity, many years of one's life are lost annually within the United States. This could decrease the average life expectancy in the coming years (Muennig, et al., 2008). This preventable epidemic results in 2.8 million deaths each year worldwide. Many people with obesity have health problems and diseases, such as strokes, diabetes, heart problems, joint problems, and a higher risk for some cancers. World Health Organization (WHO) calculates the reason for the increase in weight is due to sedentary lifestyles and too much caloric intake (World Health Organization, 2011).

WHO cautions the obesity epidemic has doubled since 1980 with the number of women being obese constituting 300 million worldwide. WHO cautions this epidemic is avoidable (World Health Organization, 2011). Muennig and colleagues maintain prejudice against obesity is prevalent in all social settings, and even in one's own home (Muennig, et al., 2008).

Defining obesity and overweight the WHO cautions that those who have extra weight will most likely experience adverse affects on their health. Overweight and obesity are defined as extra weight that can possibly cause health problems. Body mass index (BMI) is a ratio of
height to weight and categorizes individuals as obese or overweight. A BMI that is 25 or over is overweight, and a BMI over 30 is considered obese (World Health Organization, 2011).

The Mayo Clinic concurs with the WHO in listing the different physical problems that can result from obesity (Hensrud, 2005). Hensrud maintains that one's mental health can be greatly affected as well. Certain individuals may develop mental health issues such as binge eating. Binge eating manifests in eating uncontrollably and having psychological consequences following an episode of binge eating. Determining a healthy weight should come from one's physician. Hensrud advises not looking to media for what one should look like or the ideal weight, but to seek recommendations of medical professionals or someone in the weight control field. Not only does overweight cause physical implications, but affects women's health psychologically as well (Hensrud).

Rubinstein (2006) concurs overweight and obesity is prevalent today and puts women at risk both psychologically and physically. Women are often concerned about their outward appearance which can manifest psychologically as well. Often times, women with BMI elevated in the overweight and obese range, are dissatisfied with their bodies because of how others view them. This can lead to psychological distress in comparison to “normal” weight women (Rubinstein).

This paper will discuss the affect society has on weight and body image, especially in women. Looking at one’s self and how self-esteem is affected will be researched. Going deeper into a more clinical aspect of depression and addiction will be reviewed. Monetary consequences of obesity will be addressed. Viewing practical ways to lose weight and maintaining a healthy weight will unveil solutions to losing and maintaining weight loss. Integrating Adlerian view with other theories will be researched. Concluding thoughts will
include possible solutions for the future in treating persons dealing with overweight and obesity issues.

**Western Culture and Perception on Weight**

**Media Influence**

Everyday one is bombarded with images in all media venues of what the perfect women should look like. Most women are not able to live up to this expectation and may feel they are not beautiful in comparison to these images. It is interesting that the value is to be thin, in America, when women's weight continues to elevate each year. Feelings of failure or lower self-esteem could easily coincide with one not feeling they are living up to Western cultural standards (Clabaugh, Karpinski, & Griffin, 2008).

Western culture is filled with visions of what the perfect female should look like. For example, what the media depicts as the perfect model has become more slender as the years progress (Polivy & Herman, 2004). How a woman is looked at from others, especially in terms of her weight, can have an affect on her physical, mental, and financial well-being. Evidence shows the connections between mental health and body image, especially when being overweight (Fredrickson, 1997).

Women with excessive weight are often considered socially undesirable (Muennig, 2009). Muennig's research questioned whether a group of women would be stigmatized in the Dominican Republic because there are certain locations in the Dominican Republic where women are not judged by whether or not they are overweight or obese. Contrary to Western culture, in the Dominican Republic it is considered favorable to be heavy. Muennig’s research demonstrated that BMI did not affect one's mental perception negatively, although this was problematic physically, demonstrated by high blood pressure, in this group of individuals
(Muennig, 2009). This demonstrates the cultural differences regarding what is valued as beautiful. In Western culture this would not be favorable. This could possibly be true in different parts of the United States, perhaps within different socioeconomic groups, race, or overtime as the dynamics within the United States continually changes.

Western culture often dictates what is considered "normal" in society. The inner thoughts one has of whether they are overweight is not necessarily related to what the scale reports, but what the perception is of the ideal weight which is especially prevalent in Western culture. Consequently, often overweight individuals or those who may not be overweight technically, but believe they are, report negative feelings about themselves. Having the belief that one is overweight affects self-esteem as much as if one is actually overweight (Quinn & Crocker, 1999).

**Psychological Stress**

**Overweight and Self-Esteem**

Reported by Quinn and Crocker the National Center for Health Statistics, Center for Disease Control and Prevention 1997 found that Americans are gaining more weight each year with 33% of men and 36% of women deemed above normal weight (Quinn & Crocker, 1999). Interestingly, as Americans get heavier, the standard for beauty is still measured against the ideal weight of the ultra slighter build. Discriminating against overweight individuals continues with prejudices ranging from one’s looks to psychological judgements. One of the main reasons the overweight are looked down upon is because weight is viewed as something one can control.

Quinn and Crocker’s study explores the protestant work ethic, which attributes one’s lack of ability to not striving enough, such as, a person that is overweight not succeeding at maintaining a healthy weight. Ultimately, this view explains change is possible through hard
work, and if one fails, it is from lacking in self-control. This study included 257 college aged women maintaining that women are more adversely affected because of weight.

This study hypothesizes the belief in having control over one’s destiny may negatively affect self-esteem. Study One concluded the greater one upholds the protestant work ethic view determines the extent one feels accountable for success or failure in attempted weight loss. After evaluating one's view of the protestant work ethic, there was a correlation between that view and the belief that one should maintain adequate weight. Also when one upholds this belief there is a greater judgement and detest for people who are overweight (Quinn & Crocker, 1999).

When mental health was measured against weight there was a correlation between overweight and a lower measurement of psychological well-being. Also noted was that protestant work ethic was high for overweight people when their mental health declined. For “normal” weight people who uphold the protestant work ethic mental health was reported higher.

In conclusion, this study noted those considered very overweight had less self-esteem, higher anxiety, and depression than those within "normal" weight guidelines. This sample demonstrated a weakness issue. Overweight people demonstrated just as much belief in the protestant work ethic as those of normal weight, and overweight subjects also had prejudice against other women who were overweight. Being of similar status did not prevent this group from holding judgement against one another. Those who were overweight did not fall in the healthy range of well-being. "Normal" weight women had better mental health when they endorsed the protestant work ethic. Quin and Crocker speculate that this may be the belief they are in control of their weight and this affects self-esteem in a positive light. As for the overweight women who uphold the protestant work ethic they may see themselves as weak and fail to achieve the ideals of society. When women look to what is expected of their appearance it
affects self-esteem. Also noted was a woman's perception of her weight and not her actual BMI that manifested in better or worse mental health (Quinn & Crocker, 1999).

Study Two moved from examining the inner beliefs one exhibits to the thought of what society views as the ideal or normal weight. In American culture high value is placed on what success looks like. The second study measured this ideal against influence and sense of worth and weight. Quinn and Crocker maintain messages given in the United States are individual choice which coincides with the protestant ethic. Therefore, overweight women may exhibit lower self-esteem, and move to hopelessness because of the stigmatized group they find themselves in. Many hold the belief that weight is changeable versus some disease one has no control over, resulting in judgement against overweight individuals (Quinn & Crocker, 1999).

Contrary to the obesity epidemic in the United States, standards of slenderness are still considered to be the norm. Because of the mental stress being overweight may cause, eating disorders could manifest in some individuals (Stice, 1994). Quinn and Crocker caution women may attempt to lose weight through eating disorders, and because they uphold the protestant work ethic view, when they fail to succeed, their mental health is adversely affected (Quinn & Crocker, 1999). Women also may feel inadequate when they are comparing themselves to other women or the societal ideal.

Humans have an internal disposition to judge themselves when comparing others to oneself (Richins, 1991). Judging one-self by others' view is found throughout research. Miller’s (1999) research evaluates whether when viewing heavier models women rated themselves more positively than when they viewed thin models. By studying how 62 female participants viewed themselves in comparison to media images this research evaluates whether self-esteem is affected by media viewing (Miller, 1999). Research in the past aligns with the fact that
appearance self-esteem is affected by media (Richins, 1991; Clabaugh, Karpinski, & Griffin, 2008; Fredrickson, 1997).

Self-esteem and overweight are interrelated often because of the stereotypes of society (Miller, 1999). Miller documented the weight as self-perceived weight versus actual weight. When women viewed themselves as overweight in comparison with actually having excessive weight, this was linked with reported lower self-esteem. Miller stressed that excessive weight is looked down upon in society today and affects self-esteem, contrary to what several researches reported in the past. Miller maintains this is especially true for women belonging to high socioeconomic status (SES). Women are expected to be thin in this social class especially when they have money for gym memberships, healthy food, and fitness trainers. This study shows that being overweight is rare and more stigmatized within high SES groups which when overweight has a negative affect on self-esteem. Culture most always predicts how and if one is stigmatized for having excessive weight. For example, Miller predicted Mexican research participants would not denote a negative relation to self-esteem, as compared to Caucasian participants. Interesting is that there is more prevalence in obesity among African American women in comparison to White women, with the African American women reporting more contentment with their weight. It is unclear why overweight or appearance affect self-esteem, but Miller concludes in the studies from the meta-analysis there is some correlation between self-esteem and appearance. Along with the weight on one's body it is apparent that weight is manifested psychologically as well (Miller, 1999). This could possibly be because of the pressure within the United States to be thin, and not living up to these expectations one is psychologically affected by one’s physical appearance. Also the media’s portrayal of beauty being correlated with thinness.
Body Image and Self-Esteem

Today's view often measures beauty with younger women, and advertisements aimed at fighting aging signs (Wilcox, 1997). Donaghue & Smith (2008) speculate that as women age into their 60s they no longer have the high standard targeting middle-aged women. Also, suggesting that Western culture influences other areas globally is predicted in how one perceives weight related image. This study does not predict a relation to self-esteem and body image, but on the unrealistic expectations society depicts as standard. Some research suggests that women's body weight regulates self-esteem. Donaghue and Smith argue that other physical features would affect self-esteem as well. Also argued is the fact that when women judge themselves against what is defined as normal, it is hard to predict because of the unrealistic media images. Donaghue's and Smith's current study views the positive and negative judgements of three physical attributes (weight, looks, and, sexiness) (Donaghue & Smith, 2008).

Donaghue and Smith maintain that it is society’s expectation on body size and not one’s low self-esteem that determines how one judges body image. Donaghue's and Smith's Australian based study reiterates how women in Western culture have negative body images. Past studies have shown that women in Western culture are more judgemental of body image than women in other regions.

Donaghue and Smith question if people have negative body image resulting from the media and the perfect bodies personified on television, advertisement, and magazines. Possibly, people consider the perfect body against these media standards. Middle-aged women judged themselves more unforgiving (Donaghue & Smith, 2008). This coincides with other studies that report middle-age women view themselves with more negativity than older and younger women (Wilcox, 1997).
In Donaghue's and Smith's study, 60 men and women from Australia, varying in age from 18 to 88 years old participated in this study. Participants viewed images of themselves, and rated how they viewed their body image, as well as that of other participants. Subjects were notified they would not know how others evaluated them, speculating that it is the comparison of others and influence of society that affects body image and not necessarily self-esteem.

Interestingly, this study demonstrated that subjects had negative perception of their body size, but denoted positive perceptions on looks and sexuality. This research revealed how people, especially women, viewed themselves more negatively than others viewed their body weight (Donaghue & Smith, 2008).

**Body Contingency of Self-Worth**

In a similar study body weight contingency of self-worth (body weight CSW) is the likelihood of people to base their self-esteem on body image (Clabaugh, Karpinski, & Griffin, 2008). In separate studies this was compared to general appearance contingency of self-worth (appearance CSW) to decipher if one's self-esteem is based on weight or looks in general. When low self-esteem is found due to outside factors, self-esteem is threatened, which can significantly affect one’s mental health. According to Clabaugh and colleagues it is apparent women's internal worth is often based specifically on weight when dealing with overall looks. Particularly, this research desires to address if sense of worth is based on body fat. Measuring overall ratings of looks, researchers used the Contingencies of Self-Worth Scale (CSWS). Two studies were used. The first was to examine whether the relation of self-esteem and weight existed. Predicting this would be true, these individuals would be trying to attain self-esteem through trying to lose weight. This study included 247 female college students (Clabaugh et al., 2008).
The goal of Study Two predicts body image and not appearance in general will affect more than physical related self-worth, but will carry into self-esteem, and more mental health problems are predicted. Also, comparing males to females value of self-worth was analyzed. Lastly, the second study wanted to answer if there is a difference in Caucasian and African American women basing self-esteem on body image. Participants in this second study included 119 males and 250 females from diverse cultures. This study subsequently limited the findings to Caucasian and African American subjects because of the small number of subjects from other cultures (Clabaugh et al., 2008).

Results in both studies demonstrated that women tend to base their body CSW on more than weight related worries that could lead to anorexia or bulimia, and base their self-worth on what the scale reflects. Both studies acknowledged that women's overall psychological well-being is reflected by what the scale reflects. Results also revealed when comparing race and sex White women displayed lower self-esteem than White males, African American males, and African American females (Clabaugh et al., 2008).

Appearance and Weight

The problem of feeling undesirable with one's body has been researched worldwide. Western cultural influence could possibly be a reason for unrealistic body expectations since media influence is prevalent internationally. Another journal researching how one feels when appearance matters was researched in the Netherlands where 50% of the people claim they are overweight (Telegraaf, 2006 as cited in Gordijn, 2010). Gordijn argues with past research that self-esteem is not affected by overweight, predicting people are more affected when they think others are evaluating them, referred to as meta-sterotypes versus self-sterotypes (Gordijn, 2010). Study One considered women are only dissatisfied with weight when they believe others are
viewing them, specifically in a dating situation. Sixty-nine regular size women were tested to find if they have negative body image when they believe they are being evaluated by the opposite sex. Results indicated there was dissatisfaction with body weight, but only when one believed they were evaluated by eye-catching males and thinking they may ask them out.

Study Two evaluated meta-stereotyping versus Study One evaluating self judgement. Subjects consisted of 27 females within normal guidelines of weight. Here participants were told to visualize an attractive man asking them on a date. Measuring self-perception and view of body weight were addressed. Gordijn predicted individuals who had self-perception of being overweight would report lower self-esteem when figuring in society's view on body weight. Results demonstrated those who rated themselves with poor body image relied more on society's view. Study Three positioned 79 normal weight women in a positive light, and asking them to write positive attributes about their body. Another group of subjects were told to write negatively about their body image. When the women were made to believe they were fat they had negative views of themselves, but only when they thought an attractive man was evaluating them.

Study Four concentrated on separating evaluation from visibility. The results showed a lower self-esteem when people were evaluated while visible to their evaluator. This study also measured different levels of self-esteem. Those who felt unhappy about their body had a positive correlation to looks in relation to self-esteem, and were deemed socially more inadequate. One's self-esteem on body image manifests in other aspects of women's self-esteem. Gordijn's findings show the influence meta-stereotyping has over body image and self-esteem (Gordijn, 2010).

This study demonstrated how normal weight women, when they feel they are overweight, are affected when they are concerned how another person is viewing them. This also
demonstrated lower self-esteem. Gordijn predicts that if a person with obesity or an extremely overweight women were evaluated, the link between self-esteem and meta-stereotyping would be stronger. Gordijn cautions that just believing you are being judged can lead to feelings of insignificance (Gordijn, 2010). This study demonstrated that normal weight women are affected by the influence of others and may feel more discontent with their body image. This could possibly be related to one finding significance in comparing one-self to other women.

Finding significance when one is overweight may be within each individual’s reach of success at controlling one's weight (Laliberte et al., 2007). This study questioned whether one can or cannot control weight. The connection of disordered eating, body dissatisfaction, and self-esteem were measured. Predicted is that accepting one's natural weight and enlisting a healthy lifestyle will have a positive relation to self-esteem, whereas, feeling one should control weight will demonstrate negative correlation. One hundred and thirty females were selected for this study from a university in Canada with a mean age of 23 years. Tests were conducted to reveal if one believed in controlling weight versus controlling how one lives. Self-esteem was measured using the Rosenberg Self-Esteem scale. Other instruments were used to test where subjects believed they belonged on weight measurement (Laliberte, et al., 2007).

The first study found that subjects who believed they should control their weight had more negative self-esteem when they failed to achieve this position. The more powerful these beliefs were the more this group was likely to have eating disorders. In addition, when goal weight is not achieved, self-esteem is affected because they believe failure occurred. When subjects believed in striving for a healthy lifestyle, this demonstrated more positive self-esteem and acceptance of one's body. Believing in a healthy lifestyle and accepting of one's weight also helped avert eating disorders (Laliberte et al., 2007).
Study Two predicted using weight control, in comparison to lifestyle, will demonstrate a higher degree of eating disorder. Findings demonstrated those with a weight control belief had higher incidences of eating disorders versus subjects striving for a healthy lifestyle and accepting their weight had less pathology weight issues. The weight control belief coincides with the belief of society that individuals have control over their body size. The subjects that believe in this view have more incidences of uncontrollable eating. Individuals who were in a clinical setting for eating disturbances believed in control over eating and weight, and the non-clinical subjects reported a belief in striving for a healthy lifestyle and having acceptance over one's body. The weight control group had lower self-esteem and unsatisfactory body image. This test relied on the Weight Control Beliefs Questionnaire which help to uncover the roots of eating disorders (Laliberte et al., 2007).

Although Lalibert and colleagues study demonstrated that belief in control over weight affected self-esteem negatively, previous research affirmed people who thought they could control their weight are more likely to have successful weight loss and view themself more positively, contrary to those viewing weight loss beyond one's control (Tiggemann & Rothblum, 1997). This research examines the inner thought that one can control weight versus the outside thinking that one has no control over weight. Tiggemann initially predicted of his sample of 71 men and 122 women that controlling one's weight would not have a negative correlation to self-esteem. Another presumption is that people who viewed their weight problem internally would have social consequences. Part of the loss of self esteem is due to the fact that many diets do not produce lasting weight loss results. When one continues to diet and fails this can lead to low self-esteem. Measures included Weight and Dieting; Weight Locus of Control; Self-Esteem; Sterotyping Weight of Others; and Weight Locus of Control. Results demonstrated self-esteem
was lower for women in comparison to the male subjects. Also noted is women received more negative judgement than the male subjects for being overweight (Tiggemann & Rothblum).

Final conclusion of this report regarding self-esteem concur with the hypothesis that positive correlation to self-esteem was reported for normal size women in comparison to overweight women who showed a negative association. This also carries over into stereotypes that people hold against overweight individuals, especially females holding judgement against other females. Women who were overweight did not hold the same judgements as those who were normal weight had against overweight individuals. This may be due to sympathy within one’s own population according to Tiggemann and Rothblum. Overweight men did not display lower self-esteem. Furthermore, predicting social judgement on individuals who are obese with an internal belief that weight is controllable, had a negative correlation against overweight people. The study found that women's self-esteem was affected negatively, whereas, for men this was not true (Tiggemann & Rothblum, 1997).

Research is copious on the discouragement throughout society on the issue of weight (Teixeira et. al., 2002). According to Teixeira, 80% of middle-aged women report they are attempting to lose weight or concentrating on not gaining weight. Although the desire to lose weight is prevalent, the success rate is not. Teixeira’s study consisted of 112 clinically assessed overweight and obese middle-aged women. The goal was to study the correlation of women's mental health before starting a weight loss program in body weight after four months of dieting intervention. A number of batteries were used including assessing mental health within several of the tests, i.e. the Beck Depression Inventory (BDI) and Rosenberg's Self-Esteem/Self-concept Questionaire, to name a couple. Women were given instruction on exercise, eating properly, mental health, and action to incorporate a healthier way of living. Dietary and exercise directions
were given, with the expectation to lose a half a pound per week. Educating clients on behavioral changes and increasing mental health well-being was taught (Teixeira).

At base-line, 19% of the women were considered clinically depressed per the Beck Depression Inventory. Binge eating was associated with 38% of the women according to the Binge Eating Scale. The test noted that 21% of the women did not complete the measurement. The findings in weight loss varied from 15.7 kg of weight loss to four members weight going up after the study was complete. More successful weight loss occurred when the subject had not tried dieting as much in the past, had recently lost weight, or for subjects displaying less interest in losing weight. Subjects that tested healthier psychologically also did better at the conclusion of the study (Teixeira et. al., 2002). Deciphering readiness to lose weight may be knowledge one needs in helping someone to lose weight. More studies are needed in this area of readiness to make changes specifically in weight loss.

Judging one's own body is often influenced negatively or positively about what one believes is standard and often found in the social context (Adami et al., 1998). Referring to the body image construct this is defined as how one views one's body personally. This is the picture one holds in one's mind contrary to using the scale or a mirror for that image. Participants consisted of individuals struggling with obesity prior to losing weight and had elective surgery for weight loss. Subjects consisted of 110 extremely overweight participants and 131 individuals who had previously been obese. Three self-evaluating batteries were utilized in this study, including psychological character. This study compares those who are currently obese to those who were formerly obese (now considered to be at proper weight), and subjects of "normal" weight. Also compared are patients who have been overweight all of their lives versus those who became obese as adults (Adami et al., 1998).
Results depicted that participants with obesity are affected emotionally and psychologically in respect to body image construct. Findings demonstrated that subjects who had lost weight continued to view themselves in a negative light in comparison to subjects who had never been obese. Adami and colleagues advocated this could possibly be from personality traits and not the obesity. Findings between subjects with adult onset obesity versus those who were obese during childhood showed little differences in regard to weight related self-esteem. Participants who had become obese as adults and had weight loss surgery, and those who had never been overweight, demonstrated similarity to body image satisfaction. Subjects who had lost weight via surgery and had been obese in childhood did not have positive body satisfaction. On the contrary, subjects who became heavy during adulthood, but then were able to lose weight, regarded positive body image. Researchers suggested this was likely apparent because these adults now felt accepted once again by society. Whereas, those who were heavy as children or had early onset obesity did not demonstrate more positive body image because this becomes apparent in early adolescence (Offman & Bradley, 1992, as cited in Adami et al., 1998). This is demonstrated in one of the instruments used in testing how one feels about weight. Interesting is how the subjects that had been obese as children still had poor body image. When women who were overweight or obese have poor self-esteem and body image, research warns this could turn into a clinical diagnosis of depression.
Depression and Body Image

Depression is a major mental health problem affecting 121 million people worldwide according to WHO. If depression is chronic, and not treated, it can lead to the tragedy of suicide which is connected with 850,000 deaths each year (World Health Organization, 2011).

Finding a link between depression and body image was studied in Spain (Pimenta, et al. 2009). This study included 10,286 subjects who were followed for 4.2 years. Prior research reports depression is associated with negative body weight, but some argue depression brings about poor body image. The goal of this research was to determine the link between body image disturbance and incidence of depression.

Information from the Third National Health and Nutrition Examination Survey (1988-1994) was deciphered to determine the link between overweight and depression. Obesity was defined using the definition from the National Heart, Lung, and Blood Institute. Obesity is measured by one's BMI and categorized into three levels, three being the most severely obese (Pimenta, et al. 2009).

The study found that depression was related to individuals displaying extreme overweight versus those who are somewhat overweight. Subjects displayed more depression the more obese they were, with a BMI over 40. Depression in women was more prevalent than in men. The Diagnostic and Statistical Manual of Mental Disorders III (DSM) was used to define depression. The findings found that being overweight was alone linked with depression. Using the medical definition of obesity greatly influenced the probability of depression (Onyike, Crum, Lee, Lyketsos, & Eaton, 2003) Onyike and colleagues caution the relation to obesity and depression may be bidirectional and less research is known in this area.
Familial Relation to Obesity

Research confirms the physical problems associated with obesity, and more needs to be learned about the mental disorder (Dong, Sanchez, & Price, 2004). Specifically, depression and the relationship with obesity are in the forefront. Dong et al. maintain the studies are mixed whether depression and obesity are linked especially with men not displaying depression with obesity. Dong and colleagues explored the relation to the family, depression, and obesity.

Subjects consisted of 482 families mixing both elevated and normal weight. Demographic information was collected, both groups of subjects reporting health-wise and social status information. Validity of depression was measured. Dong and colleagues found that obesity was linked with mood disorder. Factors adjusted for testing included race, marital status, gender, to name several, and no significance was noted. Dong and colleagues concluded that depression is family related and a history of depression in one's family has no relation to being obese. After controlling health factors, familial depression, and across various diverse groups, it was determined obesity and depression is significantly linked. Ultimately, the greater the BMI, the more depression was observed (Donaghue & Smith, 2008).

Weight and Depression

An article on obesity and weight gain in relation to depression explored the link between depression and weight gain in subjects with obesity in comparison to subjects of normal weight (Murphy et al., 2009). Particularly if weight is gained during a period of depression is the answer Murphy and colleagues are determined to uncover. The sample involved 1300 individuals and their relationship to depression was considered. Batteries on both depression and anxiety were used to answer if weight is gained during depressive episodes.
In this sample it was determined that obesity and mood disorder are not related. Realizing that a feeling of hopelessness occurred in people with obesity was uncovered. When participants with obesity were in a state of depression, they were more likely to overeat which lead to weight gain compared to the normal weight subjects. Many studies have reported a positive correlation between depression and obesity, unlike this study. Murphy and associates speculate that the findings of hopelessness may bring about the diagnosis of depression. Findings also stated that during times of depression the subjects who were overweight were five times more likely to gain weight than the non-obese subjects. The findings noted that when depressed, the subjects with obesity were apt to sleep more than usual and gain weight in comparison to those of normal weight. Another finding brought to light was that the episodes of a depressive episode lasted longer in those that were obese in comparison to non-obese subjects. Of concern is the notion that people with obesity have more thoughts about death than the non-obese, making suicidal ideation a concern. Of even greater concern is the hopelessness the obese display when having Major Depressive Episode as hopelessness is related to suicide (Murphy et al., 2009).

Murphy and colleagues noted that some of the subjects, without prompt, articulated when they are feeling down they turn to food. Factoring in the outside view on obesity could also lead one to feeling more depressed. Not having advantageous social advances could lead to more hopelessness (Murphy et al., 2009).

Murphy and colleagues noted several restrictions to this study. Notably was the desire to have had more subjects for this study. Participants used medication for mental illness in both obese and non-obese participants, but the type of medication was not distinguished. Finding a link as to which medicine was taken would be beneficial, as some antidepressants can induce
weight gain. Answering the question is depression and obesity bidirectional is also of interest for later studies. Murphy and colleagues cautions clinicians to be aware that weight gain could be a sign of depression (Murphy et al., 2009).

Finding an association between depression and anxiety was analyzed with 177,047 subjects self-reporting in the 2006 Behavioral Risk Factor Surveillance System. Current depression was assessed via a patient questionnaire. Prior depression or anxiety was self-reported. Studies are mounting that obesity is rampant in the United States and globally and is related to other mental health disorders (Zhao et al., 2009). This study noted that past studies have inefficiently evaluated the co-morbidities, habits, physical health, and social support of people struggling with obesity and overweight. Zhao and colleagues emphasized some reports are null with the existence of obesity related co-morbidities. This study included subjects that were told by a doctor they had diabetes, heart attack, or myocardial infarction, angina pectoris, stroke and asthma. Demographics were collected on physical characteristics and social characterizations (Zhao et al., 2009).

Results demonstrated that women had more diagnoses of depression and anxiety than men in most BMI categories. Although an elevated BMI results in more depression and anxiety, it is independent from diseases. Results from this large study conclude depression and anxiety are independent from one’s weight. Unlike other studies, this study demonstrated that people with serious health problems, including heart problems and diabetes, have a higher rate of anxiety and depression than people without these conditions. Advantageous in this study is looking at multiple risk factors, such as, other related diseases, age, and sex, to name several, in this large population (Zhao et al., 2009).
Limitations in this study included all respondents who gave answers without any medical verification of their health history. BMI was not accurately given, and was often more than subjects actually reported, not all medical conditions connected to overweight/obesity were provided, and lastly the cross-sectional direction of this study was not able to decipher the relation between obesity and mental well-being. Zhao et al. caution it could be that physical symptoms cause depression. Also mentioned is that people with obesity are treated unfairly within society which could cause depression. As the years progress stigma from being obese could affect one’s mental health. The link with obesity and some health problems, such as, diabetes may affect mental health. Also noted is people with mental disorders, such as, depression are more likely to eat too much and be diagnosed with Binge Eating Disorder (BED) (Zhao et al., 2009). Ultimately, disassociating the co-existence of depression and physical problems is dually noted.

**Obesity and Possible Mental Disorders**

Suggesting obesity is not only a medical problem, but constitutes a brain disorder is a concept coming into the mental health arena. Experts believe because of the mental health component, obesity should be included in the DSM-V. Other eating disorders are categorized in the current DSM, unlike obesity which also has psychological consequences. Mirroring other additional criteria, obesity could be considered a food addiction. The American Journal of Psychology supports obesity being considered as a mental disorder and not just a physical problem (Volkow & O'Brien, 2007).

Since the 2007 article by the American Journal of Psychology to consider obesity as a mental disorder, it has been reported that defining obesity as a mental health disorder may be updated in the DSM-V. This will be defined as having a substance-use disorder that greatly
affects mental health. Substance use demonstrates an obsession an individual has with food in the case of obese individuals. Studies have proven the addictive force of obesity both physiologically and behaviorally. For example, studies have shown the drug like affect in carbohydrate cravings in women. Obesity being classified as a mental health disorder will be classified in the DSM with one of the most prevalent eating disorders, BED (Blumenthal & Gold, 2010).

**Binge Eating Disorder**

BED is classified in the DSM-IV recurrent binge eating without extreme compensatory weight-control behaviors. BED is more common than other eating disorders, Bulimia Nervosa (BN) and Anorexia Nervosa (AN) combined. BED is often diagnosed with other mental disorders or problems. BED is known to be associated with obesity. In this study 404 persons with BED, three-fourths women, were used to study mental disorders with BED. Those with BED are more apt to have problems in one's lifetime with Major Depression, Panic Disorder, and other food disorders in comparison to those without BED in a study noted (Grilo, White, & Masheb, 2008).

Grilo and colleagues maintain there is not enough information to decipher the correlation of BED with other psychiatric disorders. This current study used subjects adamently meeting the DSM-IV definition of BED and several other batteries were used to discriminate eating disorders, including the Eating Disorder Examination (EDE). Depression measured using the Beck Depression Inventory and Self-Esteem was assessed by using the Rosenberg Self-Esteem Scale. Comorbidity included other mental health diagnoses. Most common were mood disorders, followed by anxiety disorders, most notably panic disorder within anxiety disorders,
and substance use disorders were also likely. Collectively 74% of subjects diagnosed with BED had been diagnosed with other psychiatric disorders (Grilo, White, & Masheb, 2008).

In addition to comorbidity, participants had lower levels of self-esteem and greater depression calculated. This study is contrary to studies that claim persons with BED have a history of mental health issues. Grilo and colleagues claim that past psychological problems do not predict or precede BED, but that BED seems to bring about other psychological problems (Grilo et al., 2008). Helping clients with BED may include education in overcoming this eating disorder.

Exploring weight loss and psychological affects after entering an educational program, women reported healthier mental health (Annesi, 2007). Annesi’s study included 52 obese women in a 20 week program educating them on proper diet and exercise intervention. Subjects were able to attend a fitness center located in Atlanta, Georgia. These women were given instruction on utilizing the equipment, and also behavioral suggestions to stay with an exercise program. Testing body size and mental health was accessed before and after the 20 week period. At the conclusion of the study there was notable mood improvement within the subjects (Annesi, 2007).

When people are unable to lose weight, self-esteem is affected which could lead to more serious diagnosis of depression (Pagoto, 2008). This empirical study notes one-third of heavy individuals in search of counseling are clinically depressed. This study hypothesizes that treating overweight clients with behavioral activation (BA), which is known for being effective in treating depression, may also assist with weight loss. The purpose of this study is to find out if using BA with psycho-education for patients also diagnosed with Major Depressive Disorder (MDD) is effective. Fourteen patients diagnosed with MDD were checked at the beginning of
the study using the Beck Depression Inventory (BD-II) and Hamilton Depression Rating Scale (HDRS) (Pagoto, 2008).

Pagoto maintains there is a significant relation between depression and obesity. Depression affects 16.2% U.S. citizens and with the obese samples 35% were diagnosed with depression. Pagoto stressed when obese patients with depression are in a weight reduction program they are half as successful as those without depression. This information demonstrates that depression and obesity may have commonality. Finding the relations between frame of mind, food consumption, and ways of dealing with one's actions could be effective in working with depressed patients. Assisting individuals with skills to find a behavior other than overeating when dealing with negative feelings could be beneficial. This could benefit both depression and weight loss. Pagoto reports BA has not been deciphered whether it works for weight loss and this is an initial study.

Pagoto's study was 12 weeks in duration and included self-monitoring each day, understanding negative mood actions, understanding the affect of actions on feelings, exercise expectations, and investigating behavior were assessed. BA was explained to demonstrate that eating too much was a depressive behavior, and finding pleasure in something outside of eating was encouraged. Encouraging physical activity was also encouraged. Participants were given a pedometer to keep track of their steps which gave rapid reward. Subjects were given counseling by an expert in nutrition who encouraged eating less unhealthy foods, but increasing healthy foods.

At the end of the study 10 patients were effectively treated. Patients lost weight with the assistance of counseling in the effectiveness of physical activity and proper nutrition. Pagoto and associates emphasized BA is a viable treatment of the comorbidity of depression and
obesity. This study demonstrated the majority of client's depression was alleviated. Former studies have found BA to be effective for depression and seeking clients with both depression or obesity could be an effective treatment. Researching for effective treatment in the future could greatly help this clientele. Overall, weight loss was low, with the average loss being five pounds in three months. Pagato suggested more studies are needed with longer duration to demonstrate the efficacy of BA with depression and weight loss clients (Pagoto, 2008).

**Food Addiction**

Questioning whether food can be addictive is contentious (Taylor, Curtis, & Davis, 2010). When food consumption is out of control, one is defined as having a food addiction. Experts agree it is problematic that even with the health and social consequences people continue to over eat. Food addiction mirrors what the DSM-IV stipulates about drug use and often when one tries to decrease amount of food consumption, depression or suffering occurs, as with drug withdrawal. This has argument that food addiction should be considered a mental illness. In the past, addiction was linked with drugs, but now there are behavioral addictions. Scientists have discovered similar parts of the mesolimbic system are activated comparably in food and drug consumption. Both food and drug addictions are challenging to manage. Both also have chemical releases in the brain which are part of the reward system (Taylor, Curtis, & Davis, 2010).

This reward system which activates dopamine is part of the reason drugs and food addiction occurs. Research is beginning to look more into the relation to obesity (Volkow, Wang, Fowler, & Telang, 2008). Drug addiction and obesity can be understood when viewing habits in individuals become harder to control. The person using food or drugs continue to do so even with adverse affects on one's life. Both drugs and food get rewards from the release of
brain chemicals. The repeated overuse of these brain chemicals can manifest changes in the
brain. Some people are predisposed to addictive factors. When food addiction occurs it often
manifests into obesity. Much of overeating occurs because of the rewards associated with this
behavior (Volkow et al., 2008).

Persons with obesity also tend to eat when dealing with emotional problems. This is
confirmed scientifically by brain receptor availability. It is difficult to control food addiction in
the readily available environment in which one lives. This study concludes that there are
numerous neurobiologies that could manifest into a food addiction (Volkow et al., 2008).

The American Institute of Nutrition asserts food addiction is getting attention in both the
media and scientifically (Corwin & Grigson, 2009). Although debatable, food addiction is
further being studied to determine the addictive effects on individuals. One thing that makes it
hard to decipher is that food cannot be avoided. Corwin and Grigson question whether food may
or may not be addictive; the higher calorie food becomes the food that people tend to overeat or
binge eat. They may not be addictive but may become habitual. Addiction occurs when one is
out of control and this can be associated with BED (Corwin & Grigson, 2009).

Food addiction is being looked at more frequently and being compared to cravings
mimicking that of a drug addiction (Pelchat, 2009). Eating disorders, such as, BE or BN have
for some time been associated with cravings. When one has such cravings it can most likely be
that they have a higher BMI. Neurochemistry demonstrates that food is addictive and similar to
wanting drugs. DSM-IV stipulates two of the criteria, tolerance and withdrawal are correlated
with food addiction. It is complicated to label one as having a food addiction because experts
caution food does not produce the negative effects as that of drugs. This is different for the
individuals who are overweight or obese because they likely meet the diagnosis of food
addiction. Therefore, people who are overweight or obese continue to overeat which can affect physical and psychological health. In comparing food to alcohol, some people can drink where it is not addiction, where others are unable to. Similarly, some people can eat responsibly, whereas others find this challenging or uncontrollable. Pelchat suggested using what is known about drug addiction to help combat food addiction in the obese population.

Scientists are looking at the study of rats to find better evidence in the correlation of food addiction. Some reports suggest food is not addictive, but the way in which food is put in front of one. For example, the abundance of food in America, and numerous additives to this food could contribute to the addiction. This argument suggests it is the behavior which is addictive. Studies will continue to deliberate on this controversial topic (Pelchat, 2009).

**Weight Loss Information**

**Practical Solutions**

Practical ways to change being overweight and suffering from obesity is offered from the Mayo Clinic. Simply to begin the process one needs to start losing weight by eating properly. This does not mean one has to eliminate favorite foods, but will need to lessen the amount of some of those foods. For example, foods high in saturated fats which are not only high in fat and lead to weight gain, but contribute to many physical diseases, need to be avoided. Heart disease, high blood pressure, and numerous cancers can be part of the cause when a diet is high in fat and contains too many sugars. It is valuable to make sure one's eating plan is geared for lifetime, not a restricted diet one can become bored with. This is imperative to make healthy changes that will last (Hensrud, 2005).

Hensrud maintains this does not require one to be hungry when trying to lose weight. One should find foods with volume to help satisfy hunger, for example, fruits and vegetables,
considered low in energy density versus having a candy bar considered high in energy density. Both can be equally filling with a difference of roughly 200 calories. Making healthy choices such as drinking plenty of water and eating foods high in fiber are important to lifelong healthy eating. Following the Mayo Clinic Healthy Weight Pyramid is structured to help with weight loss whereas MyPyramid, the United States Department of Agriculture's (USDA) symbol for separating food groups does not instill weight loss (Hensrud, 2005).

As of June 2, 2011 the USDA has instigated a new icon to assist Americans in making healthy choices. MyPlate was introduced by First Lady Michelle Obama to promote a simplistic measure to assist one in making healthier choices (United States Department of Agriculture, 2011). Along with making healthy food choices, Hensrud purports the effectiveness of the exercise component.

Hensrud suggests not only eating healthy, but exercising regularly. If one is greatly overweight it is highly recommended to consult with a physician before starting to increase physical activity. Exercising can greatly increase health while reducing the risk of numerous diseases or an early death (Hensrud, 2005).

Having a healthy state of mental health is helpful to losing weight. But changing behaviorally is imperative to losing weight. Making positive behavioral changes will increase the likelihood of success. Remembering that stress is one of the reasons people overeat and finding more effective ways to deal with stress is imperative to losing weight. Many find that having support can contribute to effective weight loss; this could be a friend or family member. Some find support in outside groups such as Weight Watchers or Overeater Anonymous (Hensrud, 2005).
Contrary to the media image of the perfect body one must come to the realization that this is unrealistic. It is important to get the fictitious perfect body out of one's mind and concentrate on a healthy body and a different mindset to what that perfect body looks like. Using positive self-talk is an effective way to help mentally. Hensrud maintains building one's self-esteem is important to weight loss effectiveness (Hensrud, 2005).

Physical Activity and Weight Loss

Jeffrey, et al. (2003) concur with Hensrud, the vital role physical activity plays in improving the outcome of keeping weight off long-term. Two hundred and two subjects between the ages of 25-50 years of age made up this study. Mandatory was that the subjects pass an exercise stress test. Those in the Standard Behavior Therapy (SBT) group were in behavioral therapy for losing pounds. Meetings were initially weekly, and by the end of the study once a month. Goals for exercise, behavior, and calorie intake were given. Participants were asked to walk for 210 minutes a week (Jeffrey et al., 2003).

This design looked at overweight individuals to test SBT energy expenditure of kcal/wk versus high physical activity (HPA) management utilizing 2500 kcal/wk as the goal. Incorporating exercise with weight loss has been shown in prior research to assist individuals with keeping weight off more effectively over time (Jeffrey et al., 2003).

Stressing the same amount of time to meet, the HPA group met the same amount of times as the SBT group. This group was instructed to lessen their caloric intake even more than the SPT group, and walk 525 minutes a week. Differences included the HPA subjects were asked to invite others they knew to participate in the study because research has proven individuals lose more weight when making positive exercise and food choices and doing so socially. Another difference was the HPA group was able to utilize fitness experts. These experts guided subjects
especially when in need of support. Lastly HPA subjects were given simple monetary rewards for making their goal or going beyond the initial goal.

Results of this study demonstrated that there was not much difference until the end of an 18 month period, with the HPA group losing more weight than the SPA subjects. Concerns in the study were that those in the HPA group had more injuries incurred than the SPA subjects. Secondly, some weight gain occurred between the last six months, suggesting the effects were affected by time. Following the subjects after 30 months will clarify this question of time (Jeffrey et al, 2003). Similar research was done in Australia educating participants with instruction for losing weight.

**Prescriptive Advice versus General Lifestyle Advice**

Research was done demonstrating prescriptive advice versus general lifestyle advice which was conducted in Australia with a group of overweight young women with obesity over a 12 week period (Lim, Norman, Clifton, & Noakes, 2009). Participants in the lifestyle advice group were instructed to follow a specific diet. There was a network via computer for encouragement. Strictly keeping track of exercise and consumption of food was advised and reviewed every two weeks by an expert in the field (Lim, et al., 2009).

General lifestyle advice was specified by the guidelines of the *Australian Guide to Healthy Eating and National Physical Activity Guidelines for Australian Adults* developed by the Australian Department of Health and Aging. Subjects were given vague directions to follow on eating and exercise routines. No definitions were given to these participants. This group was instructed to take the metformin (diuretic) or placebo pill by the study direction. Of the 203 women who started the study 130 remained at the end of the study. Those who did not complete
the study had higher incident of mental health suffering, and a link between lower senses of worth in comparison to the subjects that completed the study.

At 12 weeks, the lifestyle prescribed subjects had lost 4.2 kg in comparison to the subjects given limited instruction who lost .6 kg. The lifestyle prescribed group reported less caloric intake than the general lifestyle group reported. Physical exercise was reported more frequently than at the inception of the study, and demonstrated no significant differences in both groups.

The prescriptive lifestyle group demonstrated better mental health and improved self-worth contrary to the subjects given less direct guidelines. Those in the directed guidelines did have a drop-out rate more significant than those in the non-directive group. The prescribed lifestyle group did not utilize the support system on the web-site, less than 30% did for support, but did utilize one-on-one counseling sessions for support.

Findings significantly support the fact that having more direction on following an eating and exercise plan positively influences mental and physical health. Combining this with behavioral change displays an effective plan for one's health. These findings are contrary to other research which suggests non-directional lifestyle changes are better or close to directional lifestyle changes. Interesting, those with the directed guidelines are more apt to drop out of the study. Lim suggests this is due to greater feelings of failure when directions are not followed. The directed group also reported less help psychologically, possibly explaining the greater drop-out rate. Another explanation could be the young population, median age 23, which they may do better with a flexible regimen. Lim suggests finding ways to be more flexible with narrow advice could assist in helping one achieve goals more successfully (Lim et al., 2009).
Weight Maintenance

Losing weight and dealing with addiction is just the beginning of dealing with obesity. There is knowledge that most people do not maintain a weight loss (Wing & Phelan, 2004). The National Weight Control Registry (NWCR) collects data from individuals who have maintained their weight after losing pounds. Members have lost an average of 33 kg and kept their weight off for two to five years. The longer one keeps the weight off the better chance at keeping the weight off in the future. Ultimately, mental health is shown to improve as weight is taken off. Contrary to the negative research that weight is hard to keep off once lost, this information is hopeful for those trying to fight the battle of obesity (Wing & Phelan, 2004).

Successful weight loss maintenance is defined by the NWCR as having lost 10% of one's body weight and keeping that weight off for at least one year. The explanation for 10% being successful is because medically positive changes result in this amount of weight loss.

This registry is comprised of mostly white individuals with 77% being women and most are college educated. The NWCR, created in 1994, demonstrated some individuals are successful at weight loss in comparison to the general thought that most are not. The median weight loss is 33 kg with weight kept off for an average of five years. Thirteen percent of those registered have maintained their weight loss for 10 years. Roughly half of the 4,000 individuals registered have lost weight through the help of a doctor, a weight loss program, or specialist in the field. Forty-four percent report losing weight independently. Most respondents used a combination of exercise and eating properly on their weight loss journey.

Changing behavior was one of the strategies used to lose weight. Members stressed they watched what they ate, exercised, checked the scale, and started the day with a healthy meal. On the physical level, participants who were most successful exercised for one hour a day, with the
most utilized exercise being walking briskly. Weighing themselves frequently, members maintained they were able to see if they had gained weight and quickly try to reverse the scale within a short time. Maintaining weight is challenging and the biggest predictor of success per the NWCR is the length of time weight has been off. The longer maintained the more likely the extra weight will not return (Wing & Phelan, 2004).

**Guide for Weightloss**

**Weight Loss Assistance**

Reviewing a meta-analysis of weight loss demonstrates the effectiveness of overweight clients seeking assistance. Overall, seeking assistance in weight loss manifested in better overall mental health (Blaine, Rodman, & Newman, 2007). Although much research exists regarding the unsuccessful number of people that can maintain weight loss, this is contrary to what most weight loss systems purport (Rothblum, 1999). Research demonstrates that people with obesity often have other psychological problems in comparison to individuals that are overweight (Blaine et al., 2007).

Blaine et al. reviewed present work and looked at the overall mental health aspect from outside help at assisting in weight loss. First, they look at the newly lost weight and how to keep it off for a greater amount of time. Reviewing the treatment plan for weight loss, depression, and self-esteem is warranted.

Conclusions drawn from this meta-analysis of over 100 batteries and 4500 subjects determined the average sample was female with a BMI of 36 and lost 7% of body weight (Blaine et al., 2007). This amount, which concurs with other studies that stipulate management for losing weight, does not manifest in a large amount of weight lost (Rothblum, 1999). Contrary to a small amount of weight lost with psychotherapy, subjects that used medication or had surgery
had more weight lost and kept it off both short and long-term in comparison to those in a weight loss program. This analysis of numerous studies also demonstrated the small amount of weight lost and kept off using psychotherapy-based weight loss treatment (Blaine et al., 2007).

Although the treatment for weight loss was minimal, the effects on mental health were greater. In comparison to baseline there was movement to a lesser degree of depression for subjects when weight loss occurred. Self-esteem increased, although not as significant as depression decreased when weight was lost. Blaine et al. noted looking basically at greater weight loss with surgery or medication lowered depression, but did not elevate self-esteem. While psychotherapy did not produce as much weight loss and alleviation of depression, self-esteem was enhanced (Blaine et al., 2007). The effects of obesity affect physical health and psychological well-being, but also have monetary consequences (Sturm, 2002).

**Monetary Consequences from Obesity**

Continual health problems can occur with obesity increasing health care costs across the life-span (Rothblum, 1999). According to Sturm (2002) the financial burden of obesity has risen in medical expenses the past twenty-five years as the cost for smoking and alcohol related health problems has gone down in cost. Questioning whether obesity should be classified as a disease continues to transpire, as this could create fair laws for individuals dealing with obesity. Some caution that this could be selfish without scientific reasoning. In comparison to being at a healthy weight, obese patients cost the health care system 36% more in medical costs and 77% more in medication costs. Ultimately, obesity is costing more for insurance companies each year in the medical field (Sturm, 2002).

Concurring with Sturm's findings, Finkelstein, Strombotne, and Popkin (2010) also discuss the medical costs incurred by government and employers. Finkelstein and colleagues
note that the BMI is escalating faster than ever before and continues to rise. The health problems stemming from obesity are numerous and are having an affect on health care costs. Alarming is the fact that more children are considered obese than ever before. Healthcare costs are greatly affected by this epidemic. Employers are seeing employees with obesity taking more time off than normal weight individuals. Also this population of individuals who are obese uses more worker's compensation than normal weight individuals. This was evaluated through the Work Productiviey and Activity Impairment (WPAI) instrument (Finkelstein, Strombotne, & Popkin, 2010). Argued is that people with obesity do not incur more costs on healthcare because their life expectancy is less (Pimenta, et al. 2009).

Theories

Adlerian Theory

When considering the Adlerian view of the desire to belong demonstrates the distress many people who are overweight or obese may feel when they are perceived undesirable in society. Carlson, Watts, and Maniaci, (2006) noted that Adler stressed psychological health is calculated by Social Interest. This need to belong starts from the minute a person comes into the world (Carlson, Watts, & Maniaci, 2006). This could be a good argument that individuals who are overweight may have success working with other people, such as, a friend to talk with, joining a fitness club, or belonging to a weight loss organization or support group.

Adler taught our Lifestyle or the way in which we deal each day is a major part of how we move through life. Adler believed people are always moving either productively toward the useful side of life, or unproductively toward the useless side of life. People who are overweight or obese may deal with overeating to supposedly alleviate stress or problems. This is where choice comes into play. One can decide to remain in a minus state or move to plus side by
changing their unhealthy way of dealing in life. It is a choice whether to overeat or eat healthy and being physically active or having a sedentary Lifestyle (Carlson et al. 2006).

Another Adlerian principle is Private Logic or what one believes and comes into view at childhood; this moves into one's adult life. The saying you are what you think is embedded in one's mind which can leave one unable to make changes (Carlson et al., 2006). If this is a negative view or belief, one needs to change for positive outcomes to occur. For example, if a person believes they can never lose weight, one's faulty thinking would need to change. Adler maintained one always has a goal even if unconsciously. People look and try to do what is significant. Counselors can help one achieve or change goals to help in weight loss.

Adler discussed Inferiority Complex or moving from a place of despair to a more positive place in one's life (Carlson et al., 2006). This can be noted in the movement of losing weight and becoming more physically active. When one is not living up to expectations of self-actualization feelings of inferiority may result. If one does not feel in line with others, one may develop a feeling of inferiority. The person who is overweight may feel judged by society for not being of normal weight and could possibly develop feelings of inferiority. To help one in dealing with feelings of inferiority a therapist could use encouragement in counseling a person dealing with weight issues.

A common thread in Adlerian practice is Encouragement. If one is going through life feeling discouraged it is hard to make changes. Adler stressed one needs to be in charge of their actions (Carlson et al., 2006). One may need to be in charge of one's actions, but seeking counseling from a therapist who is encouraging could have advantageous results on losing weight. Some therapists may delve into the past to help a client discover one’s goals.
Looking into the past could reveal insightfullness into Early Recollections. Reviewing an article on the relation between obesity and Early Recollections deemed some information with regards to the link between early-childhood and how one strives in adulthood (Laser, 1984). Laser’s article over 30 years ago was timely in the 80s and is relative today. Laser noted that little has been studied as to the relationship during childhood, with relation to adult obesity, even though Adlerian Psychology stresses the importance of the first years of one’s life. Stemming from Adlerian Psychology, Laser researched this relationship of childhood obesity and obesity in adulthood (Laser, 1984).

Laser hypothesized that overweight people and people with obesity will be categorized either as a getter or a controller in terms of Lifestyle. Getters feel life is not giving what one wants and may feel denied about what life is not providing. Lacking self-confidence and control of one’s life is a feeling a getter may develop. Laser notes this manifests turning to food for comfort (Jones & Sicigano 1979, as cited in Laser, 1984). Laser hypothesizes that the getter wants to receive and this is demonstrated with food consumption. The controllers could get attention by being noticed or ignored by being overweight. Either way will serve a purpose to control. The thought of this study was that the getter and controller Lifestyles could manifest in obesity and be incorporated into one’s Early Recollections.

Laser's design of this study consisted of a total of two groups of 65 women, one group clinically obese and the other of "normal" weight. After Early Recollections were obtained, eight participants were discounted because they did not meet the criteria of an Early Recollection, such as, a report versus an Early Recollection was given. Adlerian therapists trained in Early Recollections deciphered the memories before age eight and found that results
demonstrated a significant amount of people with obesity were controllers and getters. Adlerian view that early memories will affect adulthood were demonstrated in this study.

Laser maintained controllers may use food and being overweight as a way to get noticed in an unconstructive way. Low self-esteem may be internalized by showing the world I am not worthy. Laser notes that much more is needed to determine the relationship of different lifestyle types and the relation to weight (Laser, 1984). Using Adlerian Theory to detect one's goal could be beneficial to assisting a person with weight loss.

An article in the The Journal of Individual Psychology, unfortunately, did not relay enough information into individuals who are overweight, but used generalized eating disorders to explain Adlerian theory of humans being goal-directed (Belangee, 2006). Belangee noted many theorists suggest eating problems stem from childhood problems. Individual Psychology suggests that all behavior is Holistic, meaning when one has an eating problem it is based on physiology, psychology, and socially as a whole. This thinking is goal oriented as Adler maintained that one is always trying to find a real or unreal goal. Adler also felt all behavior was socially motivated or in that context. Inferiorior thoughts are those that one strives to overcome oftentimes to find acceptance. One often strives for but and does not meet expectations, resulting in an inferiority complex. Eating disorders can occur if one chooses to cope with inferiority in the form of controlling what one does or does not eat. This fixation on food can detour one from feelings of Inferiority.

Adler referenced the useless side of life as striving for superioity or being self-centered. Or one may strive for perfectionism which is considered positive as one is trying to enhance themself. Adler used the example of striving for superiority in only caring about self, focusing on self, and losing weight or becoming anorexic (Belangee, 2006). Unfortunately, no
information was given on persons with obesity or who are overweight. Being on the useless side of life a person’s objective is to gain self-worth (Belangee, 2006).

When one is on the useless side of life behavior is considered abnormal and the objective is to protect one’s self-esteem. In relation to eating one could Safeguard, meaning to protect one from getting hurt and from fully participating in life. One may be consumed about weight and in actuality kept from fully engaging and possibly failing. People who were unsatisfied with their body reported more anxiety in social settings. Safeguarding protects one from inferior feelings. In unhealthy families one can learn to cope by developing an eating disorder (Belangee, 2006).

Belangee emphasized how to feel as if one belongs in society, a person may strive for a certain look that is expected. Anxiety can develop when one does not look like the images presented through television and magazine ads. Adler emphasized that psychological distress stemmed from non-interest in socializing. One with eating disorders is consumed with thoughts of weight and appearance more than likely having less social opportunities because of feelings of inferiority. Adler proposes that one with eating disorders has little regard for Social Interest as one is preoccupied with thoughts of body flaws. Socially the home is a factor where one learns food habits (Belangee, 2006).

Family Constellation or finding what is important in one’s home is related to either healthy or unhealthy eating habits. Studies show that girls who have mothers who display obsession about weight also learn these behaviors. If there are problems within the home, one may deal with coping in turns of eating. Belangee noted Birth Order and where one fits in the family could result in striving to look a certain way which could result in eating disorders to obtain this desired look. For example, in order for one to feel accepted in appearance they may
strive to be extra thin. Feeling different from societal expectations could lead to using food for comfort (Belangee, 2006).

Again little information was given on those who are heavy, but Belangee explained that if a person is teased as a child because of obesity, excessive dieting or eating disorders to be thin could develop in adulthood. As a child, these inferior feelings bring about striving to overcome such feelings. Lifestyle is learned in childhood and messages about nutrition and exercise taught at an early age may affect one’s adult behavior (Belangee, 2006).

A non-Adlerian article addressing the need to avoid inferiority and to compete with society was based on findings of young female college students (Bellew, Gilbert, Mills, McEwan, & Gale, 2006). Bellew and colleagues maintain that because individuals compare themselves to others, especially women, anxiety may manifest in regards to how one looks on the outside. This study found that one was psychologically more healthy when less inferiority was noted (Bellew et al., 2006). In societies, such as Western culture, one can become competitive on appearance to avoid insecurities and feelings of inferiority (Burckle & Ryckman, 1999).

Limitations of this study include the age and sex of the subjects may determine more competition in looks than in other demographics (Bellew et al., 2006). This article seemed limited in informing the reader about eating disorders, but offered the advice that this could preclude eating disorder because of the fierce competition to have a certain body image.

**Choice Theory**

Also concurring with Adlerian view that one makes choices is the view of William Glasser, M.D. (Glasser, 1998). Succinctly put, this is making decisions in everything one does, including any distress put upon one's self. Knowing this, one can determine the direction of
one's life. Chosing to eat healthy and exercise, will take care of one's physical health which, described previously, balances one's mental health. Glasser maintains living with free choice can direct one's life into a positive direction. Changing behavior that is ineffective is possible with choice according to Glasser (Glasser, 1998).

Glasser uses the example if a patient's doctor advises of clogged arteries and this can be altered with a healthy lifestyle, one now has the choice to take the doctor's advice and change that lifestyle with exercise and healthy eating, or live with knowing life can be shortened because of this condition. Living ineffectively can change the course of one's life, but chosing to change to a more effective way of living can modify life in a more positive way. Glasser maintains all is connected to how one thinks and believes. Glasser warns the unhealthy heart is one's lifestyle choice and unlikely by chance. A doctor could mention surgery or medications to help prevent heart disease, but ultimately the patient has the choice which direction to select. One can continue a sedentary life with fatty foods or choose to be more active and eat healthy. Looking into mental health assistance may help one to make more effective choices. Glasser notes one can ignore the health problem, but this will not change the fact that one is unhealthy (Glasser, 1998).

**Conclusion**

The concern in trying to lose weight is the alarming fact that if one does lose weight, the chances of keeping that weight off is 5% according to statistics (Matz, 2011). Because of this alarming statistic, new ways need to be developed in helping one lose weight when one desires to do so. According to Matz, when one seeks counseling for an eating disorder often there is underlying issues to the weight. Matz contends there is evidence that dieting is ineffective (Matz, 2011).
Not discussed in this paper is the effect genetics plays in one's size. More research is being conducted in this highly controversial topic. Matz maintains when one is unsuccessful when dieting, and if 95% of those dieting fail to keep weight off, it can lead to shame (Matz, 2011). Similar to shame I think of the word embarrassed. When researching people struggling with overweight and obesity I was astounded I did not find more information on shame or view the word embarrassed in the journal articles I reviewed. Many people, especially women, are likely embarrassed about the lack of success when weight loss is not achieved.

With this unfortunate outlook to the success in dieting, another idea needs to be brought into the weight loss solution. Matz suggests one eats when they are hungry and listen for cues to know when to eat and not eat. Research was done in the 1980s to bring about the thought to eat only when hungry, and discover physical cues to access hunger. Recent research of a controlled study validated intuitive thinking. Consisting of a diet encouraging participants to eat only when hungry, looking for physical cues before eating, confirmed the effectiveness of eating when hungry. The non-dieting, or intuitive eating group had a drop-out rate of 41% in comparison to the non-dieting drop-out rate of 8%. Improvement was noted in both groups after a one year follow-up including weight loss and more self-worth. After the two year check the non-dieters had kept the weight off, and the diet group had gained weight back (Matz, 2011). This stresses the importance of finding effective solutions in combating obesity as world-wide BMI is increasing. It appears a new way of looking at losing weight needs to be devised.

Matz asserted that the conflicting facts in research regarding how many people die from obesity is staggering. Matz notes it is too difficult to decipher how many deaths are caused each year due to obesity because the causes and connection often are misrepresented in methodical study (Matz, 2011).
In lieu of diets being ineffective, suggesting a new way of thinking is timely Matz asserts. One suggestion is that if overweight and people with obesity lose five to ten percent of total body weight, studies conclude it is beneficial to overall health (Matz, 2011).

The consequences of being overweight or obese can affect one's life in numerous areas. Those who are overweight are stigmatized by societal expectations to be thin. The serious health consequences are numerous, and the effects of obesity can manifest physically. People who are overweight likely have self-esteem issues. Research is mixed to the relationship if obesity is causal to depression or if depression is causal to obesity. This bi-directional hypothesis is debated and more research is needed in this area. Highly debatable is to what extent certain foods may be addictive, and questioning a diagnosis as food addiction. The soon to be published DSM-V may diagnosis obesity as a brain disorder. Consistent research demonstrates that dieting is not effective. The statistics for maintaining weight loss could be discouraging for individuals who are overweight. More research is needed in this area to assist clients with obesity to lose weight, but also maintain a weight loss. Adlerian view could be helpful to a clinician to uncover what the goal of overeating is stemming from. The encouragement component in therapy would be vital when assisting one in losing weight.
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