Obesity and Psychotherapeutic Intervention

A Research Paper

Presented to

The Faculty of the Adler Graduate School

In Partial Fulfillment of the Requirements for

The Degree of Master of Arts in

Adlerian Counseling and Psychotherapy

By:

Kathryn Szostek

October 2014
Obesity is a global health epidemic that has serious somatic, social, and psychological repercussions. The following literature review examines research relating to traditional and psychotherapeutic treatment methods for obesity. The discussion includes an overview of the current obesity crisis, including diagnostic criteria, psychophysical pain, financial costs, and contributing factors. This paper examines the efficacy of talk therapy as a treatment of obesity, highlighting current research on four approaches: behavioral therapy, cognitive-behavioral therapy, mindfulness, and motivational interviewing. This paper also discusses the usefulness of group therapy as a format for obesity treatment and Adlerian psychology as a theoretical foundation on which to build a more comprehensible treatment modality. Research indicated that psychotherapeutic interventions work best in conjunction with traditional treatments and that group therapy is an ideal format for the distribution of psychological interventions for obesity treatment. Research indicated that Adlerian psychology is one of the oldest established psychosocial theories and thus the tenets of social interest and lifestyle may offer a promising framework to address the complex social and interpersonal dynamics of obesity treatment.

**Keywords:** Obesity, Weight loss, Treatment of obesity, Psychotherapy, Interventions, Group psychotherapy, Adlerian psychology
Acknowledgements

I extend my sincerest gratitude to Dr. Susan Belangee for her wisdom, editing prowess, and encouragement. Dr. Belangee had several conversations with me over the course of a year and yet stuck by me when I decided to wait until, well, pretty late, to finally finish writing this work. I am so grateful she helped me to reach my graduation deadline. What a gift. Thank you to Lisa Venable for her proficient work as reader and editor – and even more for creating a group therapy class that was so profound and engaging I scrapped 15 pages of writing and changed my Master’s Project topic. I would also like to extend many thanks to Marina Bluvshtein for her reassurance and telling me “I could do this!” even when I was pretty sure that it was completely impossible. Apparently it wasn’t!

I’d like to thank my husband, Jay, for his endless hugs, emotional support, and assertion that I’m “the most emotionally intelligent person” he knows. He is one of the best people I have ever known. Thank you to my mom (Mom-o), Janeva, who helped me learn that writing is a process and that my drama serves a purpose. Kudos to my dad and sister, Donavon and Meredith, for putting up with countless (and no doubt boring) pontifications on the topics of writing and obesity. Feel like perusing a chunky 50-page read? Thank you to my hilarious and lovely friends, Darby, Allie, and Sarah, for their heartfelt encouragement and telling me, almost four years ago, that my being a therapist “makes sense.”

This paper is dedicated to every person who has struggled with weight and been told the lie that they are just “lazy.” It is for every person who has believed that they should “just do it” and then suffered bitter disappointment and self-doubt. You are not lazy. You are not worthless. And you are not alone.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>2</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>3</td>
</tr>
<tr>
<td>Introduction</td>
<td>6</td>
</tr>
<tr>
<td>Diagnosis of Obesity</td>
<td>7</td>
</tr>
<tr>
<td>Costs of the Obesity Epidemic</td>
<td>8</td>
</tr>
<tr>
<td>Definition of an Epidemic</td>
<td>8</td>
</tr>
<tr>
<td>Physical and Psychological Pain as Costs of Obesity</td>
<td>9</td>
</tr>
<tr>
<td>Financial Costs of Obesity</td>
<td>12</td>
</tr>
<tr>
<td>Contributin Factors to Obesity</td>
<td>13</td>
</tr>
<tr>
<td>Age</td>
<td>13</td>
</tr>
<tr>
<td>Genetic Influence</td>
<td>14</td>
</tr>
<tr>
<td>Environmental Factors</td>
<td>14</td>
</tr>
<tr>
<td>Conventional Treatments for Obesity</td>
<td>15</td>
</tr>
<tr>
<td>Diet Programs</td>
<td>16</td>
</tr>
<tr>
<td>Physician Advice</td>
<td>17</td>
</tr>
<tr>
<td>Surgery</td>
<td>18</td>
</tr>
<tr>
<td>Behavioral Change Through Force of Will</td>
<td>19</td>
</tr>
<tr>
<td>The Role of Talk Therapy in Obesity Treatment</td>
<td>20</td>
</tr>
<tr>
<td>Effective Psychotherapeutic Interventions</td>
<td>21</td>
</tr>
<tr>
<td>Behavioral Therapy</td>
<td>22</td>
</tr>
<tr>
<td>Cognitive-Behavioral Therapy</td>
<td>23</td>
</tr>
<tr>
<td>Mindfulness</td>
<td>25</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
</tr>
<tr>
<td>--------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Motivational Interviewing</td>
<td>27</td>
</tr>
<tr>
<td><strong>Group Format for the Psychotherapeutic Treatment of Obesity</strong></td>
<td>28</td>
</tr>
<tr>
<td>Research on Group Therapy for Obesity Treatment</td>
<td>30</td>
</tr>
<tr>
<td>History</td>
<td>30</td>
</tr>
<tr>
<td>Group Versus Individual Therapy Research</td>
<td>30</td>
</tr>
<tr>
<td>Long-term Psychotherapy in the Group Format</td>
<td>32</td>
</tr>
<tr>
<td><strong>Adlerian Application</strong></td>
<td>34</td>
</tr>
<tr>
<td>Social Interest</td>
<td>35</td>
</tr>
<tr>
<td>Lifestyle</td>
<td>36</td>
</tr>
<tr>
<td>Conclusions and Future Study</td>
<td>40</td>
</tr>
<tr>
<td>References</td>
<td>42</td>
</tr>
</tbody>
</table>
Worldwide, obesity is a global health epidemic. According to the World Health Organization (WHO, 2014), “around 3.4 million adults die each year as a result of being overweight or obese” (para. 6). In medical terminology, obesity refers to the unhealthy accumulation of body fat with a body mass index (BMI) of >30 kg/m$^2$ (Obesity, 2014). Overweight is defined as a BMI of 25.0 to 29.9 kg/m$^2$ (Center for Disease Control [CDC], 2012). Obese and overweight individuals are at risk for developing numerous detrimental health conditions including Type 2 diabetes, hypertension, heart failure, stroke, sleep apnea, reproductive problems, gallstones and gallbladder disease, dyslipidemia, osteoarthritis, gynecological problems, and heart disease (National Institutes of Health [NIH]: National, Heart, Lung and Blood Institute [NHLBI], 2013). The most current data from the CDC reports that heart disease is the leading cause of death in the United States (Murphy, Xu, & Kochanek, 2013). Obesity not only has serious and harmful effects, it is also prevalent and widespread; more than one-third of U.S. adults (35.7%) are obese (Ogden, Carroll, Kit, & Flegel, 2012). Clearly there is need to treat this public health crisis; however, in primary care settings, obesity often remains unidentified and undertreated (Kushner & Ryan, 2014).

Research shows that the effective treatment of obesity must include behavioral change in the form of increased physical activity and decreased caloric intake (Ladabaum, Mannalithara, Myer, & Singh, 2014; NIH: NHLBI, 2013; Ryan & Heaner, 2014; WHO, 2014). Behavioral change to achieve weight loss is nevertheless a difficult challenge (Stubbs & Lavin, 2013). Sometimes individuals can suffer from a resistance to change and are incapable of making behavioral changes without first addressing their conscious or unconscious obstacles. In other words, there is often a discrepancy between intent and behavior because individuals
underestimate barriers to diet and exercise (Dibonaventura & Chapman, 2008). Thus, it is of vital importance to create a comprehensive treatment plan that addresses all barriers to weight loss, including known and unknown physical and psychological barriers.

This literature review calls attention to the seriousness and costs of the global obesity epidemic and explores research related to the efficacy and inadequacy of current non-psychotherapeutic treatments. There are multiple studies to support the efficacy of treating individuals who desire to lose weight with psychotherapy (Brown et al., 2009; Shaw, O’Rourke, Del Mar, & Kenardy, 2005; Wiltink et al., 2007). This paper will investigate four psychotherapy-based interventions: Behavioral, Cognitive-Behavioral, Mindfulness, and Motivational Interviewing, followed by a discussion of the usefulness of adding Adlerian theory-based group psychotherapeutic treatment to established treatment methods.

**Diagnosis of Obesity**

In order to effectively treat obesity and alleviate the myriad associated somatic and psychological afflictions, it is critical to understand how obesity is determined and what factors contribute to its development. Obesity is most commonly identified through calculating an individual’s Body Mass Index (BMI). The BMI is a number that aims to represent the amount of body fat individuals have in relation to their height and weight (NIH: NHLBI, 2012). It is then used as a screening tool to determine those adults who are at risk for detrimental weight-related conditions. The method is efficient, cost-effective, and gives individuals the ability to compare their weight to the general population averages.

Although common and fairly reliable, BMI does have some limitations. Strictly speaking, BMI measures excess weight, not excess fat. The calculation does not take into account a person’s individual muscular build, bone mass, age, sex, ethnicity or any of the other variables
that affect fat levels and weight (CDC, 2014). For example, athletes that develop high amounts of muscle mass may report BMI’s that categorize them as obese, when in truth their weight may be entirely appropriate for their level of physical fitness. Given these variances, the NHLBI (2013) recommends that additional factors be assessed when determining obesity. These considerations include risk factors such as excessive abdominal fat (measured through waist circumference) and high blood pressure. Once the guidelines for determining obesity have been met, it is vital to understand the toll it takes on the individual and society.

**Costs of the Obesity Epidemic**

The condition of obesity causes countless physical and psychological ailments, resulting in intense somatic and emotional pain. In addition to health complications like heart disease, stroke, and sleep apnea, the issue of obesity has reached a crisis level. Not only are there physical and psychological costs, but it also presents an enormous financial cost.

**Definition of an Epidemic**

The CDC has referred to obesity as an epidemic on multiple occasions (CDC, 2011; CDC, 2013b). Although the term epidemic has sometimes been applied loosely in the press and social media, it can be employed accurately when discussing obesity. An epidemic is defined as “affecting or tending to affect a disproportionately large number of individuals within a population, community, or region at the same time” and is characterized by “very widespread growth” (Epidemic, 2014). The number of individuals affected by obesity is indeed extensive and growing. According to the most recent data from the National Health and Nutrition Examination Survey (NHNES), more than over 78 million Americans are obese and the prevalence of obesity among adults has nearly doubled since the 1960’s (Ogden, Carroll, Kit, & Flegel, 2012).
Physical and Psychological Pain as Costs of Obesity

Research confirms that severely obese and obese adults have a lower health-related quality of life than their normal-weight counterparts (Cameron, Magliano, Dunstan, Zimmet, Hesketh, Peeters, & Shaw, 2012; Muennig, Hassan, Joshi, Madhavan, & Amonkar, 2003). As a person’s weight increases, there is a corresponding increase for the risk of countless conditions, ranging from heart disease to mortality. The current trend is toward an ever-increasing amount of health problems related to obesity. A report by Wang, McPherson, Marsh, Gortmaker, and Brown (2011) confirms the seriousness of the health repercussions stemming from obesity.

These trends project 65 million more obese adults in the USA and 11 million more obese adults in the UK by 2030, consequently accruing an additional 6–8.5 million cases of diabetes, 5.7–7.3 million cases of heart disease and stroke, 49,000–669,000 additional cases of cancer, and 26–55 million quality-adjusted life years forgone for the USA and UK combined. (p. 815)

The numbers are of great concern and confirm the urgent need for care that goes beyond traditional approaches.

Recent research discovered that adults with obesity are at an increased risk for even more illnesses in addition to the myriad well-established conditions; some of these include meningioma, sciatica, and pneumonia (Shao, Bai, Qi, Hui, & Wang, 2014; Shiri, Lallukka, Karppinen, & Viikari-Juntura, 2014; Wei et al., 2014). Interestingly, adults with obesity are at a decreased risk for heart failure mortality, pneumonia mortality and developing hip injury (Fonarow, Srikanthan, Costanzo, Cintron, & Lopatin, 2007; Tang et al., 2013; Wei et al., 2014). Thus, in some cases, obesity may actually be a protective factor.
The idea that obesity has benefits in addition to risks has been termed the *Obesity Paradox*. This paradox is described as “the unexpected finding that obesity is often associated with increased survival time among people who have some serious injury or illness in spite of being associated with reduced survival time among the general population” (Childers & Allison, 2010, p. 1231). In 2002, Gruberg et al. conducted one of the first studies that established this paradox. Their surprising discovery was that patients with normal BMIs had significantly higher overall mortality rates than their overweight and obese counterparts. In addition, the obese patients started with “consistently worse baseline clinical characteristics” than normal-weight or overweight patients, and had a “higher incidence of hypertension, diabetes, hypercholesterolemia, and smoking history” (p. 578). In other words, the obese patients had developed many of the conditions known to be associated risk factors with obesity and yet still had better results after their coronary surgical procedure.

Researchers have posited many explanations for the obesity paradox. One explanation is the level of cardiorespiratory fitness of participants. “Cardiorespiratory fitness altered the obesity paradox such that mortality risk was lower for both obese and non-obese men who were fit” (McAuley, Smith, Emerson, & Myers, 2012, p. 1). In other words, a person may have a BMI in the obese range, but still be more physically fit than a non-obese individual. Thus far the evidence is inconclusive as there are no clinical trials examining the direct cause-and-effect relationship.

Even with the growing body of evidence supporting obesity benefits, the health risks of obesity are still indisputable. It is important to note that somatic repercussions are not the only consequences. There are also emotional and psychological concerns for adults with obesity. There is a great deal of research to support the assertion that individuals with poor body images
or high BMI’s suffer emotionally as a direct consequence of those conditions. Obesity is associated with anxiety, depression, and many other common mental disorders (Kivimäki et al., 2011).

The results of a 2014 study by Jackson et al., suggest that women with “poor body image may be more likely to have clinically significant levels of depressive symptoms” (p. 177). In Western culture, the ideal body size has become increasingly smaller over the last few decades. Given the psychosocial nature of human beings, the need to belong is a pervasive and powerful motivator (Baumeister & Leary, 1995). Simply put, humans will take the action they feel is necessary to belong, which is influenced by biased personal perceptions, environmental factors and psychological disposition. Thus, body image and body dissatisfaction are key factors in the development of disordered eating (Keery, van den Berg, & Thompson, 2004; Stice & Shaw, 2002).

In a 2013 study of 414 undergraduate students, researchers found that a higher BMI number was associated with poorer mental health-related quality of life and body image dissatisfaction (Wilson, Latner, & Hayashi, 2013). Losing weight or lowering one’s BMI, however, does not always increase psychological health or alleviate distressing symptoms (Weiss, 2004). Underlying feelings of sadness or loneliness may still be at work.

In her 2013 qualitative study on the effects of massive weight loss, Gilmartin found that body image issues caused feelings of psychological distress, social marginalization, isolation, and intimacy difficulties, even in individuals who had massive weight loss. Gilmartin recommended greater sensitivity while assisting patients to work through the emotional isolation that many still carry from childhood. In addition to these emotional repercussions, and all the
aforementioned physical consequences, the obesity epidemic also takes a heavy financial toll on individuals and societies.

Financial Costs of Obesity

In *Global Conference on Business & Financial Proceedings*, Hojja (2013) wrote that the economic and health care costs of obesity make it “perhaps the largest medical problem in America” (p. 455). Individuals and societies with high levels of obesity pay a heavy economic price. According to a systematic review of original studies on the direct medical cost of overweight and obesity, Tsai, Williamson, and Glick (2011) found that in the United States alone, the aggregate national cost was a combined $113.9 billion. More recent data suggests that previous research has underestimated the medical costs of obesity. According to Cawley and Meyerhoefer (2012), the estimated obesity-related health care costs in the U.S. are closer to $190 billion.

Financial costs are both *direct* and *indirect*. Direct costs related to obesity include expenses like hospital and clinic visits, personal health care, insurance claims, and medication; indirect costs refer to loss of productivity or income due to occurrences like lost work days, restricted activity, excess physician visits, and premature mortality (Dee et al., 2014). In a systematic review examining direct and indirect costs of both overweight and obesity, Dee et al., found that indirect costs were higher than direct, accounting for between “54 and 59% of the estimated total costs” (p. 2). These costs have an extensive economic impact on employers. In 2011, normal-weight workers cost an average of $3830 per year in covered medical care, such as short-term disability and workers’ compensation, whereas morbidly obese employees cost $8067 on average (Van Nuys et al., 2014).
Undoubtedly, the health and financial costs of the obesity epidemic are steep and will only continue to grow if not treated properly. By the year 2030, total health-care costs attributed to obesity and overweight are projected to reach 16–18% of total US health-care expenditure (Wang, Beydoun, Liang, Caballero, & Kumanyika, 2008). The health and financial costs of this crisis cannot be comprehensively addressed without a consideration of the factors that contribute to its formation and progression.

**Contributing Factors to Obesity**

Many variables contribute to this multifactorial disease, including age, genetic disposition, the culture of modern society, and healthy food availability. It is imperative to consider these dynamics when addressing obesity treatment.

**Age**

According to Low, Chin, and Deurenberg-Yap (2009), there is an increasing prevalence in adult obesity with age: ‘The peak prevalence is reached at around 50 to 60 years old in most developed countries and earlier at around 40 to 50 years old in many developing countries’ (p. 57). There are many explanations for these numbers. For example, older adults often have difficulty maintaining regular physical exercise, frequently citing poor health, physical pain, reduced mobility and low endurance as main constraints (Booth, Owen, Bauman, Clavisi, & Leslie, 2000). Understandably, these issues may contribute to lower energy expenditure. Without expending the necessary amount of physical activity, weight gain in older persons remains a potential, natural consequence (Howarth, Huang, Roberts, Lin, & McCrory, 2007).

And yet, maintaining a healthy weight is not impossible for older adults. Findings from a 2013 study published in *The Journal of Nutrition, Health & Aging* suggest that long-term maintenance of weight loss is possible in obese older adults. Adults in this study maintained
their weight loss through lifestyle intervention and subsequent caloric restriction (Waters et al., 2013).

**Genetic Influence**

According to the CDC (2013a), genetic changes occur too slowly in humans to be exclusively liable for the obesity epidemic; however, they do play a role in its development. Some studies identify variants in genes that may influence behavior or metabolism. Current evidence suggests that obesity may be a combination of interactions among multiple genes and environment factors, although inherited obesity cannot be narrowed down to a specific gene. In 2011, Choquet and Meyre conducted a summary analysis of 15 years of genetic research. The authors describe how genes are involved in the “central regulation of food intake and genetic predisposition to obesity” (p. 169). They posit that the interaction between obesity predisposing genes and an individual’s unique environment can impact obesity prevention.

While promising, the research on genetics and obesity is still in its infant stages. Because of the limited contribution to treatment, the CDC does not recommend genetic testing as a method to inform individual weight loss plans.

**Environmental Factors**

The modern Western culture has features that hinder maintaining a healthy weight. These environments have been dubbed *obesogenic*. Obesogenic environments are settings in which it is easier to make unhealthy choices than healthy ones (Swinburn, & Egger, 2004; Swinburn et al., 2011). For example, in countries like England and the United States, the abundance of accessible, high-caloric food, combined with the profusion of automobiles perpetuates excess energy intake and low energy expenditure levels. Many communities are built in such a way that requires driving to work or school instead of walking or biking. Modern technology also allows
for individuals to connect professionally and socially with negligible physical exertion. While significant influences, these factors do not affect all populations equally.

Barriers to healthy eating most often affect the financially disadvantaged and minority groups. According to the American Heart Association (AHA), some of these barriers include “poor dental health, lack of access to quality produce at affordable prices… transportation problems, family customs/habits… and low price and easy access to snack foods” (Artinian et al., 2010, p. 430). Residents in rural communities also face disproportionately higher risk for chronic diseases like obesity than their urban counterparts; fewer healthy options and long distances to food stores contribute to this disparity (Jilcott, Moore, Wall-Bassett, Liu, & Saelens, 2011; Smith & Morton, 2009; Ver Ploeg et al., 2009).

The enormity of variables contributing to obesity makes it an extremely complex health issue. Traditional treatments for obesity have targeted behavioral modification via conventional means, such as diet programs, recommendations from primary care physicians, and surgery.

**Conventional Treatments for Obesity**

Obesity is a chronic disease (Kushner & Ryan, 2014). Chronicity implies a condition that persists for a long period of time or is constantly recurring: both circumstances can be true of obesity. An individual could attain an obese state in childhood and live with it constantly for years into adulthood and older adulthood. Conversely, a person may move back and forth between healthy and unhealthy BMI’s. This occurs quite frequently with the syndrome popularly dubbed the “Yo-yo Effect” (Amigo & Fernandez, 2007, p. 321). Consequently, there are many difficulties when treating these individuals. Examining the efficacy of diet programs, physician advice, and weight loss surgery can shed light on these challenges.
Diet Programs

There are countless weight loss diet programs on the worldwide market. A program is defined as a “plan of things that are done in order to achieve a specific result” (Program, 2014, para 1). The implication is that once the desired result is achieved, the program is complete. A natural consequence then with diet programs is that individuals can assume that the required dietary change is only necessary for a finite period of time. Thus, instead of changing their diets permanently, individuals go on diets, planning only for a temporary change in their behavior. The dieters attain their desired weight and then lessen the caloric restrictions or physical activity level that was required to reach the goal. Consequently, the excess weight returns over time.

In a 2007 study, Amigo and Fernandez examined the secondary effects of hypocaloric diets. They found that patients who had a large number of failed diets were more likely to be unsuccessful at future calorie-restricting diets. Additionally, most individuals successful in attaining short-term effects still could not maintain the weight loss long term. It is crucial, then, to change the whole of the lifestyle indefinitely and not simply restrict calories for a limited time. “Any attempt to lose weight should revolve around a modification of the lifestyle of the patient, paying particular attention to type of food eaten and physical exercise” (p. 325). The authors added that diets could have many undesired psychological or metabolic effects, making it even more critical to have a multifaceted treatment plan for people with obesity.

A recent meta-analysis by Johnston et al. (2014) found that individuals achieved significant weight loss with low-fat or low-carbohydrate diets. The researchers discovered that no particular diet was more effective than any other, but that patient adherence was crucial. Effective treatment through dietary change is possible, then, but limited by an individual’s ability to implement and maintain behavioral changes.
Physician Advice

Another critical component in the successful treatment of obesity is primary care physician recommendations. Obesity affects many areas of physical health and is consequently a necessary topic of discussion for primary care doctors and their patients. Physician advice regarding weight loss has a significant impact on patients’ attempts to change their behavior and increases the likelihood of successful weight loss (Kirk, Penney, McHugh, & Sharma, 2012; Rose, Poynter, Anderson, Noar, & Conigliaro, 2013). Physician advice may appear to be a simple addition to obesity treatment, however, there are several factors that prevent physicians from effectively relaying the necessary advice; two of these include physician attitude and confidence in addressing obesity issues and patient perception of physician’s overweight.

Not all physicians feel comfortable or competent addressing weight issues with their patients (Davis, Shishodia, Taqui, Dumfeh, & Wylie-Rosett, 2008; Hayden, Dixon, Piterman, & O’Brien, 2008; Warner et al., 2008; van Gerwen, Franc, Rosman, Le Vaillant, & Pelletier-Fleury, 2009). Although most physicians understand the importance of discussing obesity, many still lack the ability to create effective dialogue. They may not have any training on addressing the issue and can fear that patients will find them insensitive or intrusive. The terms that a physician uses to discuss weight issues do have an impact on patients’ perceptions of doctor-patient conversations (Gray et al., 2011). Conversations can be less effective if physicians choose words that are offensive to their patients.

Even for those practitioners who are familiar with the proper language and word choice, there are other limitations that come into play. During a general medical exam there is often very little time for one-on-one discussions about obesity issues. And when there is sufficient time, many physicians perceive that weight management treatment will not be successful anyway.
The weight of the physician affects this perception as well. “The probability of a physician recording an obesity diagnosis or initiating a weight loss conversation with their obese patients was higher when the physicians' perception of the patients' body weight met or exceeded their own personal body weight” (Bleich, Bennett, Gudzune, & Cooper, 2012, p. 999). These obstacles naturally lead to a scarcity of weight discussions in the primary care setting.

Furthermore, patients’ perceptions of their physician have an impact on obesity treatment. “Providers perceived to be overweight or obese may be vulnerable to biased attitudes from patients, and that providers' excess weight may negatively affect patients' perceptions of their credibility, level of trust and inclination to follow medical advice” (Puhl, Gold, Luedicke, & DePierre, 2013, p. 1415). Whether the patients are projecting hypocrisy or simply playing out their own biases, the effect is a lack of trust on the part of the patient. And yet, when the patient feels confident in the physician’s ability to help them implement behavior change, they have a greater chance of succeeding in making the desired improvements (Barry, Flynn, Seiders, Haws, & Quach, 2014). In any circumstance, it is clear that the physician-patient relationship has a significant impact on the frequency and quality of conversations about obesity issues and healthy BMIs. This has expected consequences on physicians’ ability to treat overweight and obesity in their patients. When the conversations are successful, many patients opt for surgery as a treatment for their obesity.

**Surgery**

Bariatric surgery is a proven method for effective treatment of morbid obesity (BMI >40) and significantly decreases the development of health-related conditions (Christou et al., 2004). This surgery, however, is associated with many risks. According to the Mayo Clinic (2014b),
some of these risks include, but are not limited to: excessive bleeding, infection, blood clots, lung or breathing problems, malnutrition, gallstones, ulcers, and in rare cases, death. Summarily put, “obesity surgery is an efficient but invasive procedure” (Choquet & Meyre, 2011, p. 173).

There are many potential benefits and costs of weight loss surgery. It is important to consider, however, whether it is the most effective long-term means of treating obesity. Even with surgery, subsequent long-term weight loss depends on the “patient's ability to implement permanent lifestyle changes” (Sierra-Murguia et al., 2012, p. 405). In other words, surgery can get results, but patients must maintain those results. Again, there is a connection between effective obesity treatments and an individual’s ability to make behavioral change. If an individual has not developed the ability to implement behavioral changes, then the weight loss is most often temporary.

Another risk associated with weight loss surgery is the possibility of postoperative addiction development or addiction transfer (Conason et al., 2013; Fowler, Ivezaj, & Saules, 2014; Reslan, Saules, Greenwald, & Schuh, 2014). For example, a bariatric surgery patient could replace a prior food addiction with an alcohol addiction. Thus, even if surgery is successful, additional postoperative treatment may be necessary to prevent addictions from forming in some individuals (Fogger & McGuinness, 2012).

**Behavioral Change Through Force of Will**

The “Just Do It!” attitude and slogan of the 1990’s is fast-becoming passé. For many struggling with obesity, it is impossible to “just do it” and make the necessary behavioral change. As a result of recent genetic research, “it is clear that obesity cannot be considered as a consequence only of indolence or lack of will, as often thought in our societies” (Choquet & Mayre, 2011, p. 169). Traditional approaches for the treatment of obesity are often limited in
scope and do not last long term. Naturally, the question arises, “Why are attempts to lose weight often unsuccessful?” It is possible that there is a missing piece to the puzzle; that humans require more than force of will to overcome the challenge of obesity.

While traditional approaches to obesity treatment have their limitations, physicians recognize that long-term weight loss maintenance requires permanent lifestyle changes and not just temporary diet and exercise adjustments (Warner et al., 2008). It is important to consider how individuals’ best implement long-term changes. Elder, Ayala, and Harris (1999) assert, “Integration of behavioral counseling interventions with primary care delivery increases the reach of effective prevention strategies” (as cited by Curry, Grossman, Whitlock, & Cantu, 2014, p. 407). It is crucial to have a multifaceted approach when treating obesity. The addition of talk therapy can aid this endeavor.

The Role of Talk Therapy in Obesity Treatment

Certain physical health problems are treatable with talk psychotherapy. According to the National Institute for Health and Clinical Excellence (NICE) (2014) some physical conditions, such as obesity, diabetes, and eating disorders, can be treated with talk therapies like psychodynamic and behavioral. Research shows there is a positive relationship between obesity and many mental health complications, including depression and anxiety (De Wit et al., 2010; Fabricatore et al., 2011; Kivimäki et al., 2011; Svenningsson, Björkelund, Marklund, & Gedda, 2012). Depression is also a predictive factor as it can predict the onset of weight gain and obesity (Grundy, Cotterchio, Kirsh, & Kreiger, 2014; Marmorstein, Iacono, & Legrand, 2014). Depressed individuals are also more likely to gain weight than their non-depressed counterparts (Zhao et al., 2009). There is undoubtedly a correlation between certain mental health conditions and weight gain. Thus, it is possible that treating the underlying psychological conditions can
help treat obesity or prevent weight gain. Clearly there is a need for obesity treatment to include a component of mental health care.

Psychotherapy can offer symptom relief to conditions in addition to depression. The most recent NICE (2014) guidelines recommend referring patients with long-term physical illnesses, like obesity, to mental health services and registered psychologists. Talk therapy can help these patients manage the emotional repercussions of their condition and ease the burden on them and their families. Psychotherapy helps reduce the burden of painful feelings and experiences, but also assists behavioral change (Wiltink et al., 2007). As previously established, behavioral change is what ultimately helps individuals achieve weight loss.

Because obesity is associated with social stigma and numerous mental health disorders, it is crucial to have interventions that address the psychological components of weight loss (Kivimäki et al., 2011; Svenningsson et al., 2012). For example, individuals with obesity often have increased feelings of body image-related stress but may be uninformed as to effective coping methods. Replacing ineffectual coping styles with more effective ones could result in a more positive body image outcome (Choma, Shove, Busseri, Sadava, & Hosker, 2009). This is just one of the ways psychotherapy can help to address the gaps in obesity treatment.

**Effective Psychotherapeutic Interventions**

There is an undeniable correlation between weight loss and psychological health. This academic investigation has elucidated many of the difficulties in effectively implementing long-term behavioral changes for the treatment of obesity. Research presented here has also shown that certain physical conditions and their symptoms can be effectively treated in talk therapy. After a multidisciplinary treatment of uncomplicated obesity, researchers discovered that “…Psychological quality of life is associated even with modest amounts of weight loss in
the long run” (Buscemi et al., 2013, p. 351). Therefore, it is vital to examine effective psychotherapeutic treatments for obesity. Four theories will be discussed in this section: behavioral, cognitive-behavioral, mindfulness, and motivational interviewing. Research provided will confirm that implementation of these therapeutic techniques enhances the efficacy of traditional methods of obesity treatment.

**Behavioral Therapy**

The U.S. Preventive Services Task Force (USPSTF) recommends that primary care physicians offer or refer individuals with obesity to intensive, multicomponent behavioral counseling (Curry, Grossman, Whitlock, & Cantu, 2014). This type of counseling is crucial as it targets the primary goal of obesity treatment: behavior modification.

Behavioral therapy techniques, in combination with diet and exercise, increase the chance of successful weight loss success and healthy weight maintenance as opposed to diet/exercise alone (Brown et al., 2009; Shaw, O’Rourke, Del Mar, & Kenardy, 2005). The purpose of this goal-oriented approach is to decrease unwanted symptoms through behavior modification. For people with obesity, there are many unwanted symptoms to reduce: excess weight, excess fat, hypertension, arthritis, and diabetes symptoms are just a few. The unwanted symptoms may also be of a psychological nature, including depression and anxiety symptoms. Since the foundation for treating obesity is lifestyle change, primarily through increased physical activity and decreased caloric intake (WHO, 2014), behavioral therapy can assist individuals to reduce detrimental behaviors and increase healthy ones.

Behavioral approaches include developing healthy self-monitoring behaviors and coping strategies proven to increase the chances of successful weight loss (Elfhag & Rossner, 2005). There are many intervention strategies implemented by behavioral counselors. Some of the
techniques introduced include stimulus control, slower eating, goal setting, behavioral contracting, education, and social support (Jacob & Isaac, 2012). Even though the method of weight loss sounds simple: “Exercise more, consume fewer calories,” people often have a difficult time with consistency and behavioral techniques can address this lack of follow-through. For example, an intervention like social support offers inspiration and motivation when individuals feel discouraged; an action like food journaling helps reveal the amount of calories an individual is consuming on a daily basis. These strategies address many of the most common roadblocks to successful weight loss.

Countless people have had success simply by applying behavioral techniques, however, it is important to note that they don’t always work for everyone. For instance, a 2007 study by Martin et al., found that some behavioral weight control, such as slower eating, was supported for men, but not for women. Fortunately, researchers and clinicians have successfully adapted additional psychotherapeutic theories for the treatment of obesity.

**Cognitive-Behavioral Therapy**

The addition of cognitive-behavioral therapy (CBT) to traditional methods of obesity treatment can help to lower BMI and improve feelings of depression and low self-esteem (Ames et al., 2005; Shaw et al., 2005; Vanderlinden et al., 2012; Werrij et al., 2009). The efficacy of any obesity treatment can be measured by calculating BMI. Likewise, self-esteem and self-efficacy are crucial for changing behaviors in individuals with chronic conditions like obesity (Bonsaksen, Fagermoen, & Lerdal, 2014).

The National Alliance on Mental Health (NAMI) defines CBT as a “treatment that focuses on examining the relationships between thoughts, feelings, and behaviors” (Duckworth & Freedman, 2012, p. 1). This theory investigates learned behaviors and faulty thinking with the
goal of correcting those thought patterns and reducing distressing emotions and unhelpful coping methods. CBT helps individuals reduce anxiety and replace ineffective coping habits with healthier alternatives. It is important for adults struggling with obesity to believe in their capacity to cope, as this is an essential element of healthy self-esteem (Bonsaksen et al., 2014).

CBT, like behavioral therapy, is goal-oriented, focusing on an alleviation of unwanted symptoms. American Heart Association (Artinian et al., 2010) recommends CBT therapy for behavioral change:

…Use cognitive-behavioral strategies to assist adults to adopt and maintain healthy dietary and [physical activity] targets; to make decisions about behavior change intervention processes and delivery strategies; and to modify interventions for addressing cultural and social context variables that influence behavioral change. (p. 431)

The results of a 2012 study investigating the efficacy of a manualized CBT approach for adults with obesity and binge-eating disorder (BED), “indicate that a CBT approach offered 1 day a week during an average of 7 months produces benefits on eating behaviors, weight, and psychological parameters that are durable up to 3.5 years post treatment” (Vanderlinden et al., 2012, p. 670).

Additional studies have found that CBT is more effective than anti-depressant medication when treating obesity-related conditions, such as BED. In 2012, Grilo, Crosby, Wilson and Masheb published the results of a randomized control trial examining the long-term efficacy of fluoxetine + CBT and placebo + CBT against a fluoxetine-only treatment. The study included a 12-month follow-up after treatments were completed. Results revealed that implementation of CBT, with fluoxetine or with the placebo, had superior results to the medication-only treatment. The findings demonstrate the long-term effectiveness of CBT in treating BED. The effectiveness
of CBT is only enhanced with the addition of other psychotherapeutic interventions, such as mindfulness (Hilbert et al., 2012; Leahey, Crowther, & Irwin, 2008).

Mindfulness

The acquisition of mindfulness and acceptance skills increases well-being and weight loss (Baime, & Wolever, 2012; Forman, Butryn, Hoffman, & Herbert, 2009). Mindfulness is the practice of intentionally focusing one’s attention to the present moment and, observing one’s self and environment, without judgment. This approach emphasizes noticing internal signals, sensations, and emotions, with the goal of improving self-awareness and self-regulation. These techniques can be used to target feelings of depression or low self-esteem, physical activity levels, and eating behaviors. Current mindfulness techniques are derived from Buddhist meditation practices that can be traced back thousands of years. There are many similarities between the two forms, although critics have pointed out that the contemporary intervention lacks the original emphasis on ethical reflection (Stanley, 2013). Nevertheless, the majority of current literature employs the modern-day understanding of mindfulness and this discussion will follow accordingly.

Much of the research on mindfulness for obesity treatment concentrates on addressing eating behaviors. In 2014, a comprehensive literature review was conducted on the effectiveness of mindfulness-based interventions (MBIs) for treating obesity-related eating behaviors (O’Reilly, Cook, Spruijt-Metz, & Black, 2014). Interventions in the included studies used a variety of approaches including, but not limited to, mindfulness in combination with CBT, mindful eating programs, and mindfulness-based stress reduction. The authors found evidence to support the efficacy of MBIs “for changing obesity-related eating behaviours…” (p. 453).
Adults able to learn the flexibility and acceptance that arise from a mindfulness practice show improvement in several areas: obesity-related stigma, body mass, quality of life and tolerance to psychological distress (Lillis, Hayes, Bunting, & Masuda, 2009). These improvements are crucial for individuals wanting to lose weight and maintain that loss long-term.

In addition to lowering BMI, evidence for mindfulness reveals that it also aids in preventing weight regain. Caldwell, Baime, and Wolever (2012) tested the efficacy of mindfulness for preventing weight regain through the EMPOWER program (Enhancing Mindfulness for the Prevention of Weight Gain). This program was composed of two interventions: group mindfulness-based psychoeducation and one-on-one telephone coaching. Through the psychoeducation sessions, participants learned mindfulness skills and were instructed to practice them for 30 minutes per day. The coaching consisted of goal setting and action planning designed to help participants apply the new MBI skills. Results at the end of the 24-week program revealed numerous improvements for participants. Progress included "changes in eating behavior, thinking patterns, emotional reactions, and physical activity and increased acceptance of personal responsibility for making choices, planning, asserting needs, and accomplishing personal goals" (p. 269). Based on their research and the findings of this study, Caldwell et al. highly encourage clinicians who want to employ MBI to consider practicing it themselves.

MBIs, in combination with traditional behavioral weight loss strategies, are a promising solution for effective, long-term obesity treatment. It is important to consider, though, that although these interventions provide numerous benefits, individuals must have the motivation to start and continue using the techniques in order to achieve results.
Motivational Interviewing

Ongoing weight maintenance is associated with an internal motivation to lose weight (Elfhag et al., 2005, p. 67). Without motivation, individuals do not have the drive and energy they need to begin the aforementioned strategies, let alone employ them over the long-term.

In 2006, Teixeira et al. conducted a study where 136 participants completed a 4-month lifestyle weight reduction program based on small, behavioral changes. Researchers found that reductions in perceived barriers to exercise significantly predicted short-term weight loss and highlighted the “importance of cognitive processes during weight control” (p. 179). Furthermore, increase in exercise motivation, with special emphasis on intrinsic motivation (e.g., interest and enjoyment in exercise), predicted long-term (16 months) weight loss. Although the changes were behavioral, the most indicative factor of long-term weight loss was internal motivation. In other words, feelings stimulate action and inspiration. Therefore, the ability to find or reveal motivation is an integral component to successful weight loss.

Many health practitioners have found motivational interviewing (MI) to be an efficient solution to this challenge. MI is “associated with a greater reduction in body mass compared to controls” (Armstrong et al., 2011, p. 709). This method is designed to facilitate change through reducing ambivalence. The goal is achieved by enhancing underlying motivation. Where obesity is concerned, this strategy helps individuals gain awareness of unconscious motivation for permanent weight loss. Research showed that obese patients treated with low-intensity MI-based interventions exhibited significant improvements in body mass index (Hardcastle, Taylor, Bailey, Harley, & Hagger, 2013). MI is a person-centered, collaborative process that involves asking questions and conversing about an individual’s ambivalence to change. Similar to behavioral and CBT interventions, MI is goal-oriented in approach, but uses the patient’s own
motivation and skills to elicit change. The process can be employed by a wide variety of health practitioners, as it does not include giving directives or recommendations. Patients whose physician employed motivational interviewing behaviors in weight-related discussions lost more weight than their counterparts whose physicians did not (Pollak et al., 2010).

A 2007 study published in Health Psychology demonstrated that motivational interviewing had a significant impact on weight, physical fitness and diet: “Participants significantly decreased their weight, increased physical activity/fitness, and improved dietary intake…. [They] lost more weight and engaged in greater weekly exercise than… participants who did not receive MI” (Carels et al., 2007, p. 369). MI is an effective intervention worthy of consideration for health practitioners treating obesity issues.

In conjunction with traditional treatment methods, behavioral therapy, CBT, mindfulness, and MI are all promising solutions to the obesity crisis. In order to successfully implement these approaches, a mental health practitioner must determine what format or delivery method is most effective in disseminating the information and strategies. The following section discusses the efficacy of group psychotherapy in treating obese adults.

**Group Format for the Psychotherapeutic Treatment of Obesity**

Group therapy has long been recognized as an effective means to help individuals achieve behavioral change (Blackmore, Tantam, Parry, & Chambers, 2012; Burlingame, Fuhriman, & Mosier, 2003; Yalom & Lesczc, 2005). Research also supports that group psychotherapy helps to relieve psychological pain, such as depressive and anxious symptoms (Heatherington et al., 2014; Krishna et al., 2013; Wersebe, Sijbrandij, & Cuijpers, 2013). The group format offers social support, accountability, empathy, observational learning, and access to
new ideas and resources. It can also be a cost-effective delivery mode as individuals share the expense of a mental health practitioner.

It is a well-recognized fact that humans are interdependent, social creatures who need a group to survive (Adler, 1926; Aristotle, trans. 1984; Crain, 2005; John, 2011). Infants cannot endure without another person to care for them. Naturally, as they age, people continue to strive for social belonging and emotional support (Baumeister & Leary, 1995; Carlson, Watts, & Maniacci, 2006; Ferguson, 2010). The group format allows for individuals to acknowledge this basic human need and use the interdependence to their benefit (Yalom & Lesczc, 2005). Individuals can also obtain more accurate self-perceptions through the feedback they receive from other group members (Gallagher, 2013). This component aids in increasing self-esteem within group members. These increased feelings of self-worth also support self-efficacy. The social-supportive aspect of group psychotherapy allows the group as a whole to help members help themselves. “Through identification resonance, the central problem takes on a previously undiscerned or completely different meaning for each group member” (Van der Avort & Van Harberden, 1985, p. 269). Identification resonance is a process that heightens individual learning and growth.

A psychotherapeutic group offers the benefits of social interaction – validation, encouragement, enhanced self-esteem, motivation and accountability – while still keeping therapeutic focus and goals. When considering the benefits of group psychotherapy and the needs of an obese client, it is reasonable to examine the group format as a treatment for obesity. Research supports that emotional support from social relationships increases the likelihood of permanent weight loss. Simply by participating in the group, members have an increased chance
of successful weight loss (Shaw et al., 2005; Strine, Chapman, Balluz, & Mokdad, 2008; Yarcheski, Mahon, Yarcheski, & Cannella, 2004).

**Research on Group Therapy for Obesity Treatment**

**History.** Employing the group format to treat obesity is not a new concept; in fact, the Take Off Pounds Sensibly (TOPS) program was founded in 1948 as one of the first programs to address weight loss within a group format (TOPS Club, Inc., 2014). A few years’ later physicians began publishing studies on the efficacy of the group format for obesity treatment. These groups were thus introduced long before obesity was dubbed an epidemic. Studies published in Europe and the United States can be found as early as the 1960’s (Blondheim, Kaufmann, & Poznanski, 1963; Kotilainen, 1963; Linder, 1963).

As the obesity issue grew over the years, so did the amount of research studying this format. Heshka et al. (2003) found that commercial programs using a group and self-monitoring combination to regulate caloric intake appeared to be more effective than self-help approaches. Group-based interventions are now employed frequently in clinical trials using behavioral interventions for weight loss (Artinian et al., 2010). In more recent years, researchers have further refined their exploration, moving from commercial-behavioral and medical models to psychotherapeutic models. There is now a great deal of research studying the effects of group psychotherapy-based interventions.

**Group versus individual therapy research.** Research supports that group psychotherapy is an effective format for the provision of psychotherapeutic services to obese adults (Leahey, Crowther, & Irwin, 2008; Renjilian et al., 2001; Weiss, 2006). This conclusion is confirmed even when the group format is compared to a one-on-one format. “...Group therapy produced significantly greater reductions in weight and body mass than individual therapy....
These findings suggest that group therapy produces greater weight loss than individual therapy, even among those clients who express a preference for individual treatment” (Renjillian et al., 2001). Clearly, for some individuals, the group format offers advantages that individuals could not attain on their own.

In a 2007 study conducted by Cresci et al., researchers compared individual versus group CBT for the treatment of obesity. Within the first six months, participants in the group program had superior weight loss to those in individual treatment. While all participants reached similar levels of weight loss at 36 months, the authors conclude that the group program was as effective as the individual program in the long-term and more effective in the short-term. This is significant considering that more recent research by Karlsen, Sohagen, and Hjelmesæth (2013) showed that larger 12-week weight loss did predict larger 12-month weight loss. It is possible, then, that early positive results may increase the likelihood of program adherence. Although future research in this area would be beneficial it is nevertheless important to consider that group psychotherapy may be a preferable treatment modality to individual, or one-on-one therapy.

The type of intervention techniques employed in group psychotherapy for obesity have a significant impact on the outcome. In 2006, the British Journal of Guidance & Counseling published two preliminary studies, testing the hypothesis that women who eat compulsively do so as a way of handling their emotions and, that improvements in emotional management, will result in weight loss (Buckroyd, Rother, & Stott, 2006). The intervention strategy of the first study focused solely on the emotional states of the clients: feeling badly about eating behavior, feeling out of control, and obsessing about food and eating. The researchers admit that the first study was probably too short in length to yield significant weight loss results, however, it did seem to elicit a change in attitudes that tend to affect eating behavior. A second study was then
conducted that took place over the course of 12 months, six months longer than the first study. Results of the second study confirmed the same attitude changes as in the first, but also demonstrated weight loss of 5% or more of initial body weight. This weight loss was maintained through 18 months of follow-up. Due to the small sample size and other limiting factors, the results of these studies are only suggestive; the researchers recommend further studies to include behavioral interventions in the form of food choice and physical activity, in addition to the emotionally focused psychotherapy.

Group therapy is an effective format for the delivery of psychotherapeutic services to adults with obesity. The findings presented in this review suggest that the best intervention strategy is a comprehensive one; traditional approaches combined with group therapy that implements behavioral change and other therapeutic approaches addressing thoughts and emotions. Another critical component to group therapy is long-term follow-up.

**Long-term Psychotherapy in the Group Format**

The common result of many obesity treatments is that most participants steadily regain any lost weight within subsequent years (Cooper et al., 2010; Wilson & Brownell, 2002). This outcome may be due to many factors. Some of these factors are behavioral in nature and include cessations like failure to keep to dietary restrictions or inability to maintain the increase in physical activity.

Sometimes weight regain has a psychological explanation. The results of a study by Byrne, Cooper, & Fairburn (2004), indicated that a significant predictor of weight regain is an individual’s current cognitive dynamics, or more specifically, the presence of dichotomous thinking. Dichotomous thinking, also known as black-and-white thinking, is when a person “is only able to see the “extremes of a situation” and unable to see a balanced viewpoint (Salters-
Pedneault, 2014, para. 2). Participants in the study who showed a high dichotomous thinking style were more likely to relapse post-treatment. In a subsequent study, Dove, Byrne, and Bruce (2009), tested whether dichotomous thinking moderated the association of depression with body mass. Their study revealed that depression, not dichotomous thinking, was likely to interfere with adherence to short-term weight loss interventions. There is clearly a need for further research, however, it is reasonable to assert that psychological factors affect adherence to weight loss goals and may impact long-term weight loss maintenance (Byrne, Cooper, & Fairburn (2003).

Long-term follow-up that addresses behavioral and psychological barriers is essential for sustained weight loss and obesity management (Buclin-Thiebaud, Pataky, Bruchez, & Golay, 2010). And yet, consistent follow-up over the course of months and years can be a time-consuming and costly endeavor when implemented through individual counseling. In addition, adults recovering from obesity may require more social support and encouragement than what one therapist or behavioral specialist can provide. Attending a long-term psychotherapeutic group for weight loss and maintenance is a possible solution to both of these concerns. Several of the effective psychotherapeutic techniques mentioned in this literature review can be adapted to the group setting.

While some of the research conducted on the treatment of obesity using psychotherapy occurred in the individual therapy setting, many of the interventions have already been modified for use in groups. In fact, much of the research was piloted in the group settings of hospitals and treatment follow-up. For example, behavioral and CBT techniques are effective in uncovering core beliefs about self-worth and lovability. Once uncovered, such beliefs can then be utilized for therapeutic advantage in a group format (Yalom & Lescze, 2005). Motivational interviewing is
adapted through questions and inquiries brought by the therapist. Other members of the group can learn through observation and participation. Furthermore, as much of the research in this discussion has already confirmed, behavioral strategies are most effective when used in the group setting, as group members provide accountability, motivation, and fresh perspectives.

*Behaviour Research and Therapy* recently published the results of a study observing the effects of a community-based behavioral weight-loss treatment (Latner, Ciao, Wendicke, Murakami, & Durso, 2013). The program began with a 20-session group treatment, with some participants randomized to continuing care and instructed to meet as groups on their own for 18 months following treatment. Participants in the study achieved significant weight loss after the initial 20 sessions and sustained it at six and 18-month follow-ups. The behavioral group treatment intervention also resulted in changes in waist circumference, body image, eating patterns, physical activity and quality of life.

Participation in a group can help individuals develop the confidence and awareness they need to lose weight. According to Yalom and Lescze, “A sense of life meaning ensues but cannot be deliberately pursued: [It] materializes when we have transcended ourselves, when we have forgotten ourselves and become absorbed in someone (or something) outside ourselves” (2005, p. 15). This description of selflessness bears much in common with Alfred Adler’s theory of *community feeling*, or as it is more commonly referred, *social interest* (Ansbacher & Ansbacher, 1956).

**Adlerian Application**

According to researcher and professor Eva Dreikurs Ferguson (2010), Alfred Adler was a “pioneer in community psychiatry, in group counseling and group psychotherapy” (p. 1). Adler saw the group as a powerful force for change and was arguably one of the first clinicians to
implement therapeutic techniques in the group setting. Undoubtedly, the psychotherapeutic focus for group treatment of obesity can be further enhanced with the addition of Adlerian theory. This researcher chose to refine this investigation with Adlerian concepts because of Adler’s contributions to group theory and her own education and guidance at the Adler Graduate School. Adlerian theory, through the tenets of social interest and lifestyle, helps to explain why group psychotherapy is an integral component for comprehensive obesity treatment.

**Social Interest**

The influence of Adlerian theory is most evident in the fostering of social interest that occurs naturally in the group setting. Social interest, also called social feeling and community feeling, are translations of the German term, Gemeinschaftsgefühl (Griffith & Powers, 2007). According to Griffith and Powers, the phrase “encompasses the individual’s awareness of belonging in the human community…. It is a fundamental sense of being one amongst the others as a fellow being” (p. 11). Social interest also includes a component of personal responsibility. This responsibility implies that each person’s actions have an effect on the community of which they are a part.

Adler knew that the group setting was an ideal format in which to use this interrelatedness and accountability to its greatest benefit. It is the job of the mental health clinician to cultivate and encourage social interest within group members. The more connected group members feel, the less they will suffer from feelings of loneliness and isolation. Yalom and Lesczc (2005) make note that individuals can learn much about themselves by hearing feedback from the other group members and consequently will change in order to increase community feeling.
Research also confirms the significant influence that a social community has on its members’ behavior. A person’s ability to change is affected by the level of social support he or she receives. In Wing and Jeffery’s (1999) study, participants with social support had higher rates of treatment completion and weight-loss maintenance. “Among those recruited… and given [Standard Behavioral Treatment] SBT plus social support, 95% completed treatment and 66% maintained their weight loss in full” (p. 132). An Adlerian group is characterized by “acceptance, interest, and caring” (Sonstegard, 1998, p. 238). These principles are foundational for effective group work.

**Lifestyle**

Adler theorized that an individual lifestyle is formed by age five or six (Ansbacher & Ansbacher, 1956). Each person’s unique style of life influences how he or she endeavors to achieve life goals. A lifestyle is similar to the term *personality* that is found in other psychological theories. The lifestyle differs from personality, though, in that it stresses the importance of a person’s unique way of *moving* through life. This difference is an important distinction when treating adults with obesity. As evidenced by research presented in this literature review, a complete obesity treatment plan must include a component of behavioral change. Thus, understanding a person’s movement, both literally and metaphorically, is an essential step on the path to physical and emotional healing and change. An Adlerian framework offers a comprehensive foundation with which to address the behavioral and psychological needs of adults with obesity.

The Adlerian theory of lifestyle lends perspective to the process of behavior modification. The results of a 2009 study by Stoltz, Reysen, Wolff, and Kern revealed that “by understanding the relationships of [Adlerian] lifestyle attributes to the process of change…”
OBESITY AND PSYCHOTHERAPEUTIC INTERVENTION

practitioners can help clients understand how lifestyle may either inhibit or encourage a person’s advancement toward expressed goals” (p. 82). Similar to the exploration that occurs with CBT and motivational interviewing, when clients seek to understand the mistaken beliefs and learned behaviors that inhibit their goals, they gain further clarity on how to achieve them. For example, Adler stated, “Both the feelings and the attitude, in their turn, obey the individual’s law of movement” (Ansbacher & Ansbacher, 1956, p. 214). This means that beliefs formed long ago in childhood (about self, others and life) drive movement (choices and actions) and result in present-day feelings and physical state (psychological symptoms and obesity). In other words, all individuals have their own private and logical explanations for why they cannot make the lifestyle changes necessary to treat their obesity. The process of observing the lifestyle of each individual in the group helps to reveal any unconscious resistance to behavior change.

**Application of Adlerian technique.** Much headway has already been made on the use of Adlerian theory in the group counseling setting. “The heart of Adlerian psychological interventions involves guessing, suggesting possible motivations or patterns that make sense out of the behaviors and experiences of individuals in the group” (Sonstegard, Bitter, & Pelonis, 2004, p. 120). The following discussion elucidates how some Adlerian principles look when adapted to the group setting.

Alfred Adler stated, “If an individual cannot decide whether he should do this or do that, one thing is certain, namely, that he does not move” (as cited by Griffith & Powers, 2007, p. 52). By applying an Adlerian concept, such as hesitating attitude, one can help the growth process. A hesitating attitude may present itself in many forms but, at its root, this attitude signifies discouragement – a lack of courage to do what a situation requires (Griffith & Powers, 2007). This behavior is recognizable in adults with obesity as individuals cite many reasons why they
do not implement healthy eating and exercise behaviors: lack of time, physical limitations, cost of gym memberships, insufficient family support, lack of energy, etc. (Booth et al., 2000; Hodgkin, 2012; Mayo Clinic Staff, 2014a). Many explanations are valid and unavoidable, however, some individuals do not take the necessary and healthy action required to reduce BMI because they have conscious or unconscious fears and anxieties. These worries may be frightening enough to cause a person to avoid the activity that may elicit the feelings. “Avoidance functions to minimize distress and hence, is its own reward” (Craighead, Miklowitz, & Craighead, 2008, p. 286). For example, adults with obesity may avoid increased physical activity because of the physical strain, social nervousness, or discouragement they might feel if they do exercise. An anxiety-provoking situation (such as going to the gym) is evaded and the anxiety is lessened, but only temporarily. The original problem still remains and the avoidance transforms into a negative coping cycle.

Adler believed that all behavior is goal-directed and serves a purpose (Ansbacher & Ansbacher, 1956). This behavior can be proactive or inactive. The concept of purpose-driven behavior can shed light on the underlying reasons those struggling with obesity cannot “just do it” and implement the required behavioral change.

According to Adlerian training analyst and author, Henry Stein (1997), a symptom such as overeating may have an underlying symbolic meaning. Stein relayed a case where his client discovered that he/she was consuming an overabundance of sweets to compensate for the “bitterness” of life. While some practitioners may shy away from the metaphorical way of speaking Stein employs, the purpose behind the behavior is still discernable. The symptom of obesity can serve a purpose, yet unconscious to the individual. Another example of this would be the idea of self-handicapping. This term was introduced to describe the strategy where an
individual uses his or her obesity as an excuse for predicted failures. In their study, Baumeister, Kahn, and Tive (1990) found that “self-handicapping did predict tendencies to blame personality shortcomings and problems on obesity” (p. 121). Thus, for participants in this study, obesity served a protective purpose – it safeguarded individuals’ from facing their feelings of inferiority.

Additionally, Adler’s theory of *usefulness* connects well with his other concepts and enhances social interest in the group setting. Every human being wants to belong and feel useful (Adler, 1930). Group members can be useful to others by providing their feedback, challenges, and unconditional support. They directly help to facilitate healing and change in the other members. Additionally, an Adlerian framework offers the simple strategies of encouragement and behavioral change through education. According to Laser (1985),

> The overweight frequently operate from a base of mistaken lifestyle perceptions. They have incorrect information about nutrition, weight gain and loss, and the impossibility of rescripting from “fat” to “thin.” Chipping away at these and other discouragements through education, group reinforcement, and behavioral techniques permitted some individuals to begin to develop new decisions about themselves and their bodies. (p. 127)

Many adults with obesity struggle with mistaken beliefs formed through childhood experiences. The meaning they make from these experiences often results in feelings of inferiority (low self-esteem), which can lead to safeguarding and overcompensation (negative coping).

A group founded in Adlerian theory offers a complete framework with which to assess early recollections, identify mistaken beliefs, and apply the subsequent learning in an encouraging, social context. Obesity is associated with social stigma. Thus, the ideal theoretical intervention in the group setting addresses the psychosocial needs of group members (Kivimäki et al., 2011; Svenningsson et al., 2012). Adlerian theory recognizes theses needs and
acknowledges the significant impact that a community has on individual behavior and choices. Alfred Adler was a forerunner in this area; his theories on community feeling, belonging, and individual responsibility laid the groundwork for our modern-day understanding of psychosocial relationships. “This sense of belonging cannot be denied anyone, against which there are no arguments, can only be won by being involved, by cooperating, and experiencing, and by being useful to others. Out of this emerges a lasting, genuine feeling of worthiness” (Alfred Adler, 1926, p. 167). Participation in a group enhances feelings of usefulness and belonging, which in turn increase a person’s feelings of self-worth and self-esteem – vital ingredients for successful obesity treatment.

**Conclusions and Future Study**

The obesity epidemic has reached global proportions (CDC, 2011; CDC, 2013b; WHO, 2014). There are numerous physical and psychological repercussions of this condition, affecting millions of people worldwide. The costs of the crisis are steep and the burdens on societies are heavy (Cawley & Meyerhoefer, 2012; Tsai et al., 2011). Effective treatment of obesity must be effective, accessible, and comprehensive.

There are many components necessary to successfully treat adults with obesity. Research relayed in this discussion confirmed that physician advice increases the chance of successful weight loss; therefore, it is ideal for all individuals wishing to address issues of obesity to seek counsel from their primary care physicians (Kirk, Penney, McHugh, & Sharma, 2012; Rose, Poynter, Anderson, Noar, & Conigliaro, 2013). Although necessary for reduction in BMI, not all individuals can adhere to strict dietary and behavioral changes. Talk therapy can help to address physical conditions like obesity through psychotherapeutic interventions (NICE, 2014). Some of the most effective therapies include behavioral, CBT, mindfulness, and motivational
interviewing. Accordingly, it is important that mental health practitioners consider the optimal format for implementing these talk therapy interventions. Research shows that the group setting is an ideal structure (Leahey, Crowther, & Irwin, 2008; Renjilian et al., 2001; Weiss, 2006), and that the addition of an Adlerian theory framework is a very promising option for the management of obesity (Laser, 1985; Stoltz et al., 2009).

Overall, outcomes of the research presented in this literature review suggests that the optimal intervention strategy for the treatment of adults with obesity is a comprehensive blend of primary care physician recommendations and a minimum of 6-months of face-to-face Adlerian theory-based group psychotherapeutic treatment. Preferably, interventions for the group would focus on attaining three goals, including

- creating behavioral change (in the form of increased physical activity and decreased caloric intake);
- correcting and reducing cognitive distortions (this may include correcting distorted body images or reducing dichotomous thinking); and
- relieving symptoms of depression and loneliness through increased social support.

Adlerian theory has great potential to enhance the effectiveness of psychotherapy for the treatment of obesity. Although there are a few studies on eating disorders, more research explicit to Adlerian theory would be efficacious. In order for the Adlerian practitioner to be truly evidence-based, it is necessary to conduct additional studies that strictly examine the impact of Adlerian principles on psychotherapeutic treatment for weight loss and obesity.
References


Sierra-Marguia, M., Vite-Sierra, A., Ramos-Barragan, V., Lopez-Hernandez, J. C., Rojano-


care physicians’ knowledge, attitudes, beliefs, and practices regarding childhood obesity: A systematic review. *Obesity Reviews, 10*(2), 227-236.


Clinical Psychology, 67(1), 132-138.


