CAT and Obesity: My Reflections

Laura Hill

In this paper I am sharing my reflections on my experience of using CAT to inform my thinking in a tier 3 NHS community weight management service (for those with a Body Mass index over 35 who may be eligible for bariatric surgery within the NHS). My role in the team was as Psychologist, working alongside Dietitians and Physiotherapists. The tier 3 service saw a diverse group of clients. My focus here is on themes that arose through my work with a number of individuals, and how these themes connected to the wider context.

There is now almost daily media coverage of obesity in one form or another. Yet the research shows that despite the stated goal of public health policy to address obesity as a social and environmental issue, there is a marked mismatch between this goal, and the unrealistic assessments of the problem and solutions as portrayed by the media: as the Foresight report (2007) states, 'popular views on the issues can draw on stereotypes, present simplified descriptions of the problems and do not always reflect the current state of the scientific evidence and understanding'. As highlighted by the Foresight report, the health inequalities in obesity are starkly laid out, particularly for women, demonstrating clearly that severe obesity occurs in a wider context of poverty and social adversity, and cannot be meaningfully addressed in isolation.

Currently there is a lack of evidence of efficacy for therapy models in severe obesity other than behavioural approaches recommended by NICE (2006). The NICE guidelines for binge eating disorder recommend CBT (NICE 2004). Crucially for research in this area, there has been a division at a conceptual level between obesity as predominantly the domain of nutrition, medicine and public health, whilst Eating Disorders have become predominantly the domain of mental health specialists, psychiatrists and psychologists (Hill 2007). I believe this conceptual division has meant that psychological models (such as CAT) have largely neglected, and been neglected in, this area. I have become even more aware of this conceptual division, and its implications, since I have commenced work in an Eating Disorder Service. There is an obvious overlap in terms of eating difficulties; a proportion of people classed as severely obese suffer from binge eating disorder, for example, and have experienced other eating disorders in the past, consistent with the trans-diagnostic model of Eating Disorders (Fairburn 2003). In addition, the interacting relational, cognitive, emotional and biological factors in obesity suggest that models incorporating these processes may help inform understanding and potential opportunities for change. There is a strong and bi-directional link between obesity and depression, shame, social isolation and many physical health conditions, such as diabetes for which a CAT trial already exists (Fosbury et al 1997) and research is ongoing.

As a model with relationships at its core, I believe CAT offers a potential framework for considering both social and individual factors in severe obesity, through a dialogic view of self as socially formed. The way in which social and cultural context is represented and addressed in CAT practice has been a topic of discussion (for example see Howe 2013; Brown 2010), and arguably there is further potential for this to be developed in CAT in general. However I believe that through the process of actively and collaboratively mapping internalised relationships (Reciprocal Roles) with people who have sought help for severe obesity, there is scope for the wider social, as well as immediate historical and current family context, to be sited on the map' on the same piece of paper . The process of CAT mapping, serving to show how these roles become internalised, allows the different levels of context to be kept in mind and addressed. From my experience, the chance for people to think about their difficulties in this kind of way could itself facilitate change.

From my work, I found examples of some common themes and key reciprocal roles which had been internalised both from individuals' direct experiences and from those within society more widely:

i. Neglect

'Neglecting to neglected' was a central experience. (See diagram). I believe those who were classed as 'morbidly obese' formed a 'neglected'

group within society, despite often dealing daily with adversity, pain, disability and stigma. Individually they also described experiences of neglect which could be tracked throughout their lives. I found people had often learnt early in their lives that their own needs were secondary to those of others, such as by living in deprived circumstances or being child carers for disabled or ill parents. In adult life this often continued through working as unpaid carers for relatives, or in low paid caring jobs, with their own needs unmet and their own emotional struggles silent. It is not surprising, given this context, that individuals themselves had sometimes internalised this position of neglect towards their own emotional wellbeing, and difficulties with weight and health. As a result they tended to negate or minimise the problems in their immediate environment which made sustained focus on wellbeing, health and weight loss very hard, such as few other sources of comfort or fulfilment, lack of time to focus on their own health or engage in activity, physical disabilities limiting mobility, lack of financial resources, and controlling behaviour from others. Repeated experiences of 'failure' (many people in this category had lost a considerable amount of weight at times in the past and then regained it) added to poor self-efficacy and shame, fuelling more self- neglect. I believe such neglect was also paralleled in the relative lack of therapeutic resources available to help this group in the NHS.

ii. Power

Linking with neglect, and social adversity, lack of access to power was a prevalent theme; social power, economic power, power through status and power through physical capabilities. This was most often articulated by the men I saw, such as not feeling able to run or protect themselves or their children when out on the street, because of mobility and health problems. Another way in which I think these individuals lacked access to power was in the power to elicit care, contrasted for example, with some people diagnosed with Anorexia. Others do not tend to view those who are severely obese as vulnerable and in need of protection. I found that people had often turned to food to cope precisely because they had become used to internalising their distress and coping with feelings alone, rather than through showing neediness or vulnerability.

iii. Blame/Bullying

Another core experience, of being blamed, bullied, and in some cases abused could also be traced through individuals' lives. Some peoples' difficulties with food began through attempts to regulate emotions, or change physical appearance, due to trauma, abuse or bullying (there is a high prevalence of child sexual abuse history in severe obesity; BPS report 2011). Many people also described always having felt physically out of place, such as earliest memories of being the biggest person in their school class, and mocked about this from an early age. This experience contributed to a template which had been strengthened by repeated experiences of bullying and stigma, sometimes prompting coping through use of food so perpetuating the problems. Individuals often expressed intense self- disgust, blame and shame about their body weight and shape, thereby internalising the bullying stance towards their own difficulties. People also described feeling blamed and judged when seeking help. For example, one woman told me that wherever she went, even when seeking help for her health difficulties, the 'pointing finger of blame' would follow her, and she would be told to go away and lose weight, as if this thought had not already occurred to her. Her experience, and those of many others I spoke to, fitted with the findings of an analysis of UK Newspaper coverage of obesity, which showed that there was a prevalent association with negative stereotypes such as greed, sloth, lack of discipline, and that blame for obesity was attributed to individuals (Patterson and Hilton 2013).

I found mapping these different roles out explicitly with people could facilitate a conversation about use of food as a way of coping with historical as well as current sources of distress, including the role of the internalised 'bully' in maintaining the problems.

I found there were 3 main ways in which eating was used in procedural sequences: comfort, numbing or self-punishment. These could vary