Our relationship with our bodies: Reflections from bariatric surgery and the wider cultural context

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Introduction

Our dialogue with our bodies is ever changing. Throughout childhood, adolescence, adulthood and older age, the way we understand our physical selves is affected by our physicality, experiences, culture and relationships. This article will reflect on having established a psychological service with patients who are perusing bariatric (weight loss) surgery and using CAT to understand the emerging dialogue with the self. We will discuss a number of themes, patterns and procedures that emerged in our work with clients and will explore the role of the CAT therapist in the therapeutic space. By considering Vygotsky's (1978) thesis that the self is developed through the social world, this article will consider how society, cultural norms and values can affect the dialogue we have with our bodies and the relationship we have with obesity.

Context:

Bariatric surgery

With more than half the adult population in the United Kingdom being overweight or obese, according to the National Institute for Health and Clinical Excellence (NICE, 2006), the management of obesity is seen as a complex problem requiring both prevention and treatment strategies. In this context, there is a powerful pressure to improve services. Public health bodies have called for cost-effective, evidenced based interventions relating to obesity and, responding to the evidence, bariatric surgery remains an important option for the management of morbid obesity and its comorbidities (NICE, 2006).

Bariatric surgery involves a variety of procedures that change the body to achieve weight loss. Currently, the most frequently performed procedure is the gastric bypass where the stomach is divided into a small upper pouch and a larger lower pouch and the intestine is rearranged to connect them both. Other types of surgery include the gastric sleeve where a section of the stomach is removed and the gastric band procedure, which is effective by reducing the size of the stomach.

Service

Developing psychological services into an existing bariatric pathway involved integrating mental health NHS services, physical health NHS services and a surgical team from the private sector. The psychology element of the service started in April 2013 with clinicians from an Eating Disorder Service. This was developed with a consultant psychotherapist (CAT practitioner), clinical psychologists (CAT practitioners) and a Cognitive Behavioural Psychotherapist. Through clinical experience we understood that this time of physical change to the body and eating patterns presented an opportunity to develop new ways to relate to the self. It is documented that disease and illness can contribute to a change in self-identity (Karnilowicz, 2011). We observed bariatric surgery as a time of hope for clients that presented an opportunity for psychological growth.

Relational processes and reciprocal roles in bariatric surgery:

Processes pre and post operatively

Themes emerging from clients' accounts of their life before surgery included 'being criticised, bullied and victimised'. CAT theory would understand how repeated experiences of powerlessness can lead people into a helpless, 'fix me' place, looking for an external person (or power) to save them. Clients often presented with an adoring relationship with the surgery early in the process, which was often followed by a post-surgery period of elation (the 'elated self'). At these times, we noticed a post-surgery emotional high and in some, a narcissistic enactment. We observed clients, in becoming 'a thin person' assuming a superior role, looking down upon and criticising those who could not use the surgery effectively. We experienced these clients as cutting off or rejecting of therapy services during the initial post-procedure 'high'. Therefore, we needed to be mindful that we did not enact a rejected and withholding/cut off reciprocal role procedure in response.

Initially, surgery would fulfil the role of rescuing. Subsequently we observed some clients moving to a place

where they felt let down and were contemptuous of surgery, describing their disappointment that 'you didn't fix me, you did not make my life wonderful'. This could lead to a strong sense of deflation (the 'deflated self') and we observed an enactment of the contemptuous – contemptible reciprocal role in relation to the client's perception of self, as well as the service. This was a risk for the client developing low personal responsibility in relation to the changes necessary for long term adherence to life after surgery.

Considering the wider CAT literature, Brown and Msebele (2001) described a process occurring in people who had been subjected to racial abuse. They described the racially abused person as potentially becoming hyper vigilant to threat and fearful of abuse in new situations, at times to the extent where they adopted this position with themselves.

In working with people with obesity the team observed that there were themes amongst clients who developed a 'fat mask' where they openly directed jokes/abuse at themselves in a pre-emptive move to be critical before others could criticise them. In doing so they may also switch roles to establish protective hierarchies of their own, thus positioning themselves in an abusive or contemptuous place towards others.

Prior to surgery and in weight management services we often heard experiences of clients feeling unimportant and unattended to, describing an overlooking to overlooked reciprocal role procedure. This could potentially invite a neglecting self-to-self and self-others role. We noticed this happening post-surgery with themes of overeating, eating unhelpful foods or inactivity, with the consequence of clients then disengaging from helpful caring relationships. A striking pattern whilst working in bariatric care was the observed externalisation of control, which can lead to what looks like apathy and giving up. This could be hard to work on in therapy as the belief that 'you/the NHS should fix me' may confirm the action of 'doing nothing' and clients could present with a sense of entitlement. Mapping this out in session was a good way to aid recognition, whilst understanding the origins.

Reciprocal roles

Considering Object Relations Theories developed by Melanie Klein (1946) and its description regarding enactments in CAT, it was evident over time that I was being pulled into unhelpful reciprocal roles. When I began working as a clinical psychologist with this client group I was empathic, interested and understanding, however, I could notice myself being pulled into a contemptuous and critical place. This was named in supervision, and we wondered whether clients and myself were moving between the 'top and bottom' of the reciprocal roles. Whilst the clients were grappling with disgust, even though I am aware how powerful and pervasive enactments can be, I could be drawn into this role.

Thinking of the dialogic view of the self, and this evolving through life, I began to consider CAT literature and the debate of the "neutral therapist" (Ryle and Kerr, 2002). This questioned whether in therapy we can ever be neutral, or whether we are always identifying with, challenging a social power or caught in an enactment.

Understanding the influence that cultural values were having upon me could be traced to procedures identified in my own personal therapy, having a vulnerability to listening to dominant voices and following strong, powerful others. Further, it may be related to social class and my own socially derived assumptions regarding weight and appearance.

Current service: CAT and bariatric surgery

The above discussions have informed the current service development. Over the past two years, the team has a better understanding of the relational dynamics people present with. As a consequence of our learning that has been informed by reciprocal role enactments observed by the team we now routinely wait until four months post-surgery whilst the 'elated self' is adjusting to normal life. We have moved to a service that involves offering:

- A screening assessment in a multi-disciplinary team (MDT) New Patient Clinic. This involves a psychologist or psychotherapist meeting with a client for thirty minutes, six weeks before their surgery. Within clinic the client also meets a surgeon, anaesthetist and dietician. The aim of this session is to help them to think about the emotional impact of surgery and the associated changes. The therapist aims to provide a new perspective of psychological therapies within the team and an opportunity to recognise and revise previous critical relationships with the self, others and services.

- A psychological review four months post-surgery to those who are identified in the New Patient Clinic as potentially benefiting from input. This considers whether the client would benefit from individual or group therapy from a CAT, Cognitive Behavioural Therapy (CBT) or integrative model.

- A post-surgery CAT group; an open relational group aimed to help the cohort of people who are physically coping with weight loss but struggling with/ wanting to learn about their new sense of self. Clients can attend the group for up to nine

months following post-surgery review. Within the group themes are discussed, including clients' relating to themselves as a thinner person, understanding changes in how others relate to them and how they relate to others. In this group a collective dialogue develops on the changing self.

- Post-surgery individual therapy from a CAT, CBT or integrative model.

The role of society and culture

What struck me on hearing clients' histories is the acceptability in society within the United Kingdom (UK) to be in a bullying and contemptuous position towards people with obesity. There appears to be a seductiveness to this, that thinner people are in the superior and critical position, leaving others feeling inferior and criticised. On discussion with a colleague, we reflected on the similar feel this had to racism in the 1970s when television programmes such as Mind Your Language or Rising Damp were broadcast that depicted racist stereotyping and offensive language that would be unacceptable for television screening today. From a CAT perspective, this would fit with Vygotksy's Social Constructivism Theory (1978) in that language is developed where groups construct meaning for one another. The dominant discourse within the UK appears to be that being bullying, critical and superior towards people with weight problems is currently acceptable, whether spoken or unspoken. Within other cultures this discourse is different (Davidson and Knafl, 2006).

In considering literature on racism, social status and 'otherness' it appears there is a common reciprocal role procedure between society and others of 'normal – different, denigrated'. Social class also plays a role; this has been noted in early studies showing the association between obesity and socioeconomic status of origin. The results from studies are striking, with the prevalence of obesity seven times greater in women born into the lowest ranking social class when compared with those born into the highest ranking (Moore, Stunkard and Srole, 1962). The data is consistent with recent studies; Moore and Cunningham (2012) conducted a systematic review of the literature and across fourteen studies found higher social status positions were related to healthier eating patterns and lower body weight.

Conclusion

Our experiences in the service have allowed us to hear about a generation of children where the dominant voices are that obesity is shaming and degrading. Clinical work has led to us noticing this internalised view of the self and others (Vygotsky, 1978). If social groups accept these judgements, assumptions and expectations of obese people, then we are accepting this internalised victimisation of this group, in a similar way to previous acceptability of racial abuse. Therapy within the service seeks to provide a new opportunity for relationships and discuss this with clients in a way they may not have previously experienced. We suspect the privileged (thin) group may be unaware of how their position may have developed from social advantage and this is rarely acknowledged. This can be difficult to accept, but naming such processes can often be one of the liberating features of therapy. Not to do so, may seem polite or safe, but there is danger of colluding with, and not challenging some tacit social assumptions that we and others may have internalised. This liberation may lead to better outcomes for clients if they can develop a new relationship with themselves and their bodies at this time of great change.

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