Private Social Work Practice for Obese Adult Clients

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ABSTRACT. More and more, private-practice social work practitioners are seeing patients with eating disorders and problems in weight control. This paper will focus on the nature and treatment of such patients. Because of their psychodynamic training, independent social work psychotherapists have a special advantage over other professionals who treat this problem. Not only do clinicians have training in psychodynamic areas, but also in psycho-social environmental issues. This paper will discuss what private practitioners need to know from a psychological point of view when new patients arrive.

INTRODUCTION

More and more nowadays, private practice social work psychotherapists are seeing patients with eating disorders and difficulties with weight control. The problems manifested here are usually multidimensional and complicated. Yet some professionals believe such patients require only a simple review of basic behavioral techniques. Once people come to see how they have thrown caution to the winds and disregarded the nature of their intake and exercise, once people understand how both the ageing process and our civi-

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lized, sedentary life have contributed to this disregard, they improve. And it is true that gaining this awareness alone will help some people. For others, however, especially those seeking the assistance of a private practitioner, the issue grows thornier, for the answer to their roadblocks generally lies in the provinces of fantasy, family, and the unconscious. These are the areas which need addressing before patients can be freed to do what they choose to, not what they feel they should do, i.e., what society or others want them to do. Thus it becomes increasingly clear that the wish to lose or control weight is not merely about losing fat.

Missing this point can be the downfall of even the best clinician.

OVERVIEW

Obesity, the most common symptom of eating disorders, is poorly defined as "an excess in body fat with related health hazards" (Guy-Grand, 1987, pp. 313-317). But the symptom itself, as professionals now recognize, is complex: heterogeneous, multifactorial in origin, and elicited by various etiologies. Appropriately, clinicians would be expected to consider a variety of treatments for the different kinds of obesity.

To further define obesity, the bio-medical community has attempted to classify it in terms of "Age of Onset": "Childhood Onset," "Juvenile Onset," and "Adult Onset." Since no standardized parameter exists for "Age of Onset," this may not be an accurate way to define obesity. It might be preferable to ask at which age obesity presented a problem subjectively to the patient and medically, as measured by Body Mass Index, and/or the percentage above the desireable weights on the Metropolitan Life Insurance Index (Aronson, 1986, p. 222). Evidently, the bio-medical issues are complex and certainly beyond the scope of this paper, but these remain important points to seriously consider when patients come to you saying they want to lose weight.

In the United States today, weight loss has reached the proportion of a major industry, with annual expenditures of over five billion dollars (Brown and Konner, 1987, pp. 29-46). It offers "quick fixes" (none FDA-approved) and non-prescription fads, which consumers buy at astronomical rates. In addition, the number of diverse

weight control programs proliferates. Choosing the right one is no mean feat.

Moreover, the lay public tends to want magical solutions, requiring little insight or work. But magical solutions and "quick fixes" are dangerous. And not only are amphetamine-based diet pills, formula-based diet products, and liquid protein diets hazardous to health, they are essentially unproductive, where long-term weight goals are concerned. Liposuction, the latest vogue, presents a higher risk of serious complications than any other form of cosmetic surgery (Henig, 1988, pp. 41-42).

PSYCHOLOGICAL CONSIDERATIONS

> Ascribing overweight to overeating is hardly more illuminating than ascribing alcoholism to overdrinking.
>
> *Jean Mayer* (Jordan, 1980, p. 16)

From a clinical-psychological point of view, it helps, to begin with, to know the age at which weight became a predicament to the patient or to the patient's family. Age may indicate potential developmental problems and give an entry point for psychotherapeutic treatment. Childhood onset, for instance, reveals different problems and reasons of origin from those of adult onset. The next question is how does the knowledge of the bio-medical aspects of obesity help the practitioner treat the patient who is, at best, ambivalent and potentially unmotivated to lose weight and, at worst, wants the magic of weight loss without effort—while at the same time perceiving weight loss as the solution to all his/her problems? Although the practitioner might supply the answers to pertinent questions—how much weight can this patient lose, given his/her specific bio-medical make-up? Is he/she in biological danger? And more—this information at first might well elude patients. It may fail to reach them on an emotional level, until they are more ready to grapple actively with their weight problem, to let it go.

Yet, in turning the focus to the psychological community's point of view, it should be noted that psychological testing of the obese population brings conflicting results. In fact, current psychological testing contradicts the popular belief that all obese persons have

emotional problems. To the contrary, no distinct personality type seems to be found in obesity; indeed, only one-third of the obese population show signs of psychological disturbance (Powers, 1980, p. 18; Moore, Stunkard and Strole, 1962, pp. 962-966; Crisp and McGuiness, 1962, pp. 7-9). One reference even suggests that for obese people the statistics are no higher for psychological problems than they are for normal weight individuals in the general population. Nonetheless, as Brownell points out, "Obese persons may or may not be fat for psychological reasons, but their obesity can be the cause of severe distress" (Brownell, 1984, pp. 406-412).

CLASSIFICATION

Of the numerous classification schemes for obesity, Bruch's may be particularly useful to the clinician. Bruch separates obesity into three major types: constitutional, reactive, and developmental.

> Constitutional obesity is presumably due to genetic or physiological causes and is usually associated with normal personality development. Reactive and developmental obesities are associated with emotional maladjustment. In reactive obesity it is postulated that the person overeats in response to tension or anxiety. Eating is thought to somehow compensate for, and relieve, emotional conflict. Bruch believes that this type of obesity is more common in adulthood than in childhood. If it does occur in childhood, clear precipitating factors can usually be identified.
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> Developmental obesity, like reactive obesity, is associated with emotional problems but begins in childhood and has a more ominous psychological import. Bruch believes that these youngsters grow up in a family setting where they are used by one or both parents as an object to fulfill the needs of the parent and to compensate for failure and frustration in the parent's own life. She goes on to say that from birth there are two types of behavior, behavior that originates in the infant and behavior in the infant in response to stimuli. The family producing the disturbed patient does not respond appropriately to cues from the child and overprotects and overfeeds the child in

> order to meet its own needs. Generally, the mother plays the dominant role in such families and keeps the obese child close to her by constant and excessive demands. Overfeeding the child comes not from love and caring but from the parent's need for continuing symbiotic bonds with the child. Since feeding is often a response to the parent's emotional needs rather than the child's hunger, these obese patients grow up confused about their own body urges, and may be unable to distinguish hunger from anxiety or other emotional states. The pathological bond between mother and child is postulated to result in a deficient sense of separateness in these obese patients, thus promoting feelings of helplessness and inadequacy. (Hilda Bruch in Powers, 1980, pp. 18-19)

ASSESSMENT

From a psychodynamic vantage point, Bruch's classification offers a conceptual framework for obesity, giving the clinician an entry point at which to begin a comprehensive assessment of the patient. (Each level of classification may require a different point of entry for treatment. The scope of the problem is tremendous. The DSM IIIR currently is not fully equipped to evaluate eating disorders (Charles, 1987, pp. 415-432). Clinicians working in those areas have had to carve the way for fuller, more exacting and more comprehensive evaluations. Since eating disorders are multidetermined, each patient must have a dual diagnosis, bio-medical and psychiatric DSM IIIR. Subdivisions of this diagnosis are: (a) evaluation of the factors in the eating environment, how, what, when, where, (b) the experience of eating, as the patient feels it. What does eating do for him/her? Is eating a substitute for denial of his/her needs? In addition, locus of control also needs evaluation: is it internal or external? Those who feel they have control over their lives, not that life happens to them, have a better chance to implement the knowledge they acquire to lose weight (Stevenson, 1978, pp. 165-178). Further, behavioral research has shown that obese patients seem to respond more highly to external cues in the environment than their normal weight counterparts do. Finally, as part of every assessment, close attention must be given to motivation, a

critical factor. Why does the patient want to tackle the problem *now*? What are his/her fantasies connected with weight loss? What function has this symptom (weight or eating disorder) played in the patient's life? This can be determined by evaluating the patient's "Weight Zone" and "How Does My Fat Serve Me?" (Weiss, 1986, pp. 521-542). Thus a weight graph can be interpreted as an emotional barometer rather than an instrument for weighing and measuring poundage. Once the clinician understands the fantasies attached to weight loss, he/she can anticipate how to prepare a patient for outcome. The danger, of course, is the achievement of drastic weight loss quickly, only to have the patient find that life is the same, that the only accomplishment is, as Ingram calls it, "a hollow victory." Meanwhile, defenses are stripped. For the more pathological, fat may be the glue that holds their defenses and personalities together; quick weight loss may lead potentially to psychotic episodes. So programs like formula diet, stressing rapid change, may bring not only medical but psychological disaster.

TECHNIQUES OF ASSESSING AND DIAGNOSING

Current trends in psychodynamic psychotherapy have further developed the techniques of assessing and diagnosing eating disorders. Ron Davis has worked out an invaluable comprehensive assessment framework, using five core areas. Each area is essential. Evaluating any one of them incompletely can lead to misdiagnosis and thus an inappropriate treatment plan. (The writer has found it helpful to modify his format for her own use.) In summary, these areas are:

1. *Predisposing Factors*. Examination of the circumstances surrounding the onset of the disturbed eating pathology. Focusing on weight history during adolescence may clarify how the patient deals with autonomy and control issues.
2. *Abnormal attitudes toward weight and shape*. The accepted definition of body-image disturbance in the obesity literature is an overestimation of actual size and shape, coupled with derogatory attitudes towards the misperception (Powers, 1980, pp. 158-196).

Yet not all obese people suffer body image disturbance. Stunkard notes that 40 to 50 percent of obese individuals have no disturbance in either the perceptual or attitudinal aspect of body image (Stunkard, 1975, pp. 355-367). While body image distortion is not unique to eating disorder patients, it has vital clinical relevance for assessment and treatment purposes. In addition, for adult onset of obesity there is also the question of the internalization of a thin memory (Weiss, 1986, p. 521-542).

A consistent finding in the literature reveals that patients who have body size distortion have a poorer outcome. Body image distortion is also associated with a more serious eating disorder, bulimia or anorexia, and greater psychopathology. A fuller evaluation of body image through a series of drawings can be found in Weiss, but patients can fool any competent clinician unless the full range of drawings is obtained.

3. *Dieting and Extreme Weight Control.* While most people at some time in their lives have to regulate their intake, the weight-conscious person and occasional dieter are different from the few who "feel too fat" subjectively or realistically and go to extremes to lose or maintain weight. Their methods are self-induced vomiting, laxative or diuretic abuse, and fasting, along with frequent bouts of strenuous exercise: the prototype of a bulimianorexic personality.
4. *Bingeing and Vomiting* DSM III "the rapid consumption of a large amount of food in a discrete period of time." Davis points out that it is less important to focus on rate of time than on the experience for the patient. "Many patients construe themselves as emotional eaters and conceptualize their binges as temporary lapses in rigid self-control for the purposes of ameliorating negative mood states. The patient comes to construe her bingeing as a method of coping with distressing thoughts and feelings. It is vitally important for the clinician to understand that negative moods trigger a binge only if the individual is dieting."
5. *Physiological and psychological sequelae.* Dieting, vomiting, and laxative abuse all have important psychological and physical implications. "Starvation produces such depressive symp-

toms as mental confusion, lability of mood, lethargy, social and sexual anhedonia, and sleep disturbance." Suicidal ideation must be monitored along with depression. Some of these symptoms are the consequences of semistarvation rather than an underlying affective or personality disorder; the symptoms reliably improve with feeding. Starvation, self-induced vomiting, and laxative abuse seriously threaten patients' health, leaving them open to risk of cardiac problems and electrolyte imbalance (Van Itallie, 1984, pp. 695-702; Davis, 1986, pp. 33,36).

CLINICAL INTERVIEWING TECHNIQUES

It is best to do the initial clinical interview in two or, if necessary, three separate sessions. Until an alliance and rapport are established with the patient and his/her agenda is determined, the therapist would do well to stick to history and the more easily reportable issues of eating pathology and physical problems. Concurrently, assessment of the patient's capacity to undergo an invasive evaluation procedure must be decided upon, as well as his/her motivation for treatment. According to Davis, "Shame, ego syntonicity of symptoms with these particular patients may make trust in the first interview difficult" (Davis, 1980, pp. 33-36). What some professionals call "ego syntonicity" means that patients regard their fat as existing outside themselves. Consequently, the evaluation of obesity as "ego syntonic" or "ego alien" forms an important part of the initial interview. The more a patient views his/her obesity as "ego syntonic," the harder it is to deal with in treatment. Ego syntonicity may be reflected in the perception that the body functions entirely in accordance with its own rules, having no physiological basis, and that its functioning is altogether unconnected to any activity of the self, notably eating and exercising. For some patients, this belief can be unshakable. In essence, they think that their mouth and stomach are unrelated. They don't understand the causal relationship that makes them heavy. The externalized body image is then perceived as inimical and an adversarial relationship is developed by the self against it" (Altshul, 1981, p. 543). Such patients believe they should have a beautiful body with no effort. They

should be able to do anything they want to do, but also look the way they want to. Briefly stated, some measure of how compatible or incompatible their obesity is to a patient's value system or self-concept is another important dimension of treatment.

The second interview should deal with continued history and themes of self-concept deficiencies and associated personality dysfunction. At this time, the therapist should determine where the symptom fits into the patient's life. Some clinicians prefer using psychodiagnostic evaluation of the patient as an integral part of the examination. This, however, should be used only as an adjunct, not as the sole means of diagnosing, not as a replacement of the clinician's judgments. Along with psychodiagnostic testing, the patient should be evaluated by an endocrinologist, or a physician familiar with eating disorders. This is especially important for patients who are bulimic, anorexic, or who want a below-800 calorie diet. Both psychodiagnostic testing and physical work-up can be done between the second or third evaluation session.

CONTRACTING, TREATMENT TECHNIQUES AND ISSUES

During the evaluation and ensuing treatment, the clinician should be sure to take a neutral stance regarding weight and body image. These patients, in particular, will try to entangle the inexperienced practitioner in moral stances about their symptom and force the focus of treatment on the symptom, the "how to lose weight" rather than on the meaning of the underlying material. Care must be taken to avoid engaging in this transferential issue. Of course, with the more pathological patients, their projection will manifest themselves, no matter what. Some specific issues need to be addressed in contracting with these patients: The therapist is not invested in the patient losing weight, but in helping the patient to understand his/her own motivations and needs with reference to eating, weight control, and body image. Included here is decoding the patient's personal meaning of his/her fat, what purpose it serves and where his/her hunger is coming from, e.g., emotional or physical places. When patients' hunger comes from an emotional place, the task is to help them find another way to "feed their need," a way neither

self-destructive nor food-related. The aim in weight control is helping patients make a conscious choice of what they want to do rather than describing what it, the food and weight, is doing to them. Giving oneself permission to gain, lose, or maintain weight in response to a known emotional need is often a welcome relief for patients who are bound up with "right and wrong."

What about using a combined approach, along with your primary therapy? The efficacy of referring a patient to a program that pragmatically deals with weight must be evaluated carefully, but there are obvious advantages. It is difficult to take a neutral stance about weight while one is also counseling a patient about the "how to's" of weight control. Wearing two hats in treatment can lead to sabotage of treatment while the therapist is trying to sort out the countertransferential issues. Thus, in some instances, it may be best to refer a patient to a program which treats the symptom, while the therapist works on the patient's resistance, weight control or symptom control and relief. Of course, in making this treatment decision, one should evaluate the possibility of negative transference or splitting of transference.

TRANSFERENTIAL ISSUES

Trust may also waver if patients sense that the clinician disapproves of their symptom or that the clinician wants to take the symptom away or to send the patient away, i.e., referral. Clearly those who work in the field of eating disorders must be continually aware of their own feelings about patient peculiarities of eating and patient appearance. Since people with eating disorders fall into a minority group, and since obesity, unlike bulimia, is so visible, clinicians may find it difficult to avoid the commonly held stereotypes about this population. Not even the most skilled therapist escapes these prejudices. Therapists must know how they feel when faced with a patient who is vomiting all the time or at the sight of a 400+ lb. person. (For further reading on issues of countertransference see Charles, 1987, pp. 415-432.)

For practitioners, care must be taken not to link up their success in treating patients with the evidence of their weight, increase or decrease. Too many practitioners are trapped in these ways. The

issue of success with these patients has to be individually evaluated. Since they tend to be demanding and primal in their needs, often believing that all of their failings in life are bound up with their weight, therapists in private practice are advised to treat a varied population. Keeping perspective is critical; practitioner "burn out" is high in the eating disorders field.

TREATMENT SETTINGS AND MODALITIES

Although a patient may be seeing you as a private practitioner, you should make sure you know the treatment parameters of the eating disorder field, especially when it may be necessary to understand the program your patient is involved with, or where you may wish to refer him/her to.

A range of treatment settings deal specifically with weight control: self-help non-profit groups—Overeaters Anonymous/Think Thin; commercial programs—Weight Watchers, formula diets; obesity clinics which are generally connected with a hospital and are physician-directed; in-patient metabolic units. Some patients prefer to get away from it all and immerse themselves in the process. Aside from health spas, the most popular of these live-in settings are Duke University and Pritikin. The problem, of course, is what happens when patients re-enter their everyday lives.

Treatment modalities include: traditional medical approaches—diet and exercise with nutritional evaluation; behavior modification; partial fasting; controlled environments; drugs; surgery. Psychotherapy is separated into psychoanalytic psychotherapy, psychoanalysis, and family therapy. Some of the feminist groups out of women's treatment centers have also made an impact on this field. Eating disorders and family therapy systems approaches are an exciting area now, especially with adolescents (For further reading in this area see Root, Fallon and Friedrich, 1986; Hansen and Harkaway, 1987). Psychotherapy is also on the list. Groups have proven to be an effective treatment modality. There is controversy about psychotherapy alone, which may result in an emotionally healthier patient, but does not necessarily result in successful weight control. As Stunkard says, "Insight therapy, with its focus on inner drives,

motives and conflicts, all too often ignores environmental factors in control of good intake."

MINIMUM STANDARDS

Since no professional group has a corner on the market in the area of weight control, and since there is such a high recidivism rate, it is essential to review minimal standards and guidelines for professional weight control programs (Weinsier et al., 1984, pp. 865-872). The following may be helpful:

- —Strongly discourage the use of very low calorie diets by mildly overweight persons (40% or less overweight), citing the unacceptable risk-benefit ratio, and the availability of safe and probably more effective alternatives, such as behavior modification.
- —Refer moderately and severely overweight persons to physicians, hospitals, or clinics actively engaged in the study and use of very low calorie diets. (Because of current research, low calorie diets administered today are 800 calories as opposed to very low, 300-400 calories.)
- —Become familiar with the most current medical literature on the nature, benefits, and hazards of very low calorie diets.
- —Because diet-induced weight loss usually is followed by relapse, encourage patients to find a program that includes behavior modification, nutrition counseling, and exercise instruction. (Wadden, Stunkard, Brownell and Van Itallie, 1983, pp. 2833-2844).

(For further reading on the subject see Weinsier et al., 1984; Ravussin et al., 1982; Leibel and Hirsch, 1984; Fisher and Lachance, 1985; James et al., 1987).

BIO-MEDICAL

Knowing whether a patient has a bio-medical problem in losing weight is essential to successful treatment. A good bio-medical work-up can determine whether patients are injuring themselves by

very low-calorie diets, using laxatives or throwing up. This evaluation can also discover other bio-medical problems: hypothyroidism, joint problems, hyperlipidemia, high levels of cholesterol, high blood pressure, high levels of testosterone, diabetes, sleep apnea—to mention only a few possibilities. It is important, too, to see if those dieting on very low calories are hypometabolic. Furthermore, knowing the parameters of Basal Metabolic Rate and energy output can give realistic checks to both patient and clinician as to expectation: how much weight can this patient lose, given his/her individual bio-medical make-up? Is he/she in biological danger?

CONFLICT AND CONCLUSION

For years, the bio-medical and the psychological communities in the treatment approach of obese patients have been in conflict—in part because some members of the former say that fat is only a biological-nutritional problem, while some members of the latter say that the issue is only emotional, resulting from non-resolution of unconscious conflict. Yet, as stated earlier, some people do find knowledge of nutrition and brushing-up on aerobics and behavior adequate enough. They are able to follow the "how to" instructions of the physician or nutritionist successfully. Still, for a large part of the population, this information has no impact except to make them feel guilty that they cannot do what they are advised to. To work out why they are unable to do what they say they want to do but can't, those who are psychologically minded may go to psychotherapy and others to quick weight-loss centers, sometimes putting themselves at risk. The bio-medical community's focusing only on the pragmatic, how to get weight off efficiently, without giving adequate credence to the complicated nature that emotions, unrealistic expectations and fantasy play on compliance and motivational issues, may thus miss the point entirely for some of these patients. Perhaps this is one reason that medically directed programs ultimately fail. What has not been accepted, or seen as valid, in these circles is that some people need their weight, and need to eat, to stifle underlying emotional needs, needs which may be unconscious but which nonetheless, run their lives. Before these patients can properly make use of pragmatic medical knowledge, other signifi-

cant emotional issues must be identified, explored, and resolved. Of course, some patients are not open to psychotherapy. They want something done to *them* and, in the final analysis, this must also be respected.

Both the bio-medical and psychological communities have much to offer these patients and each other. Yet a large part of the problem between these professionals seems intransigent. It would certainly be more beneficial to make use of each other's knowledge.

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