



Key Points in the Psychotherapeutic Treatment of Obesity

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Abstract

One of the essential points in the treatment with obesity is psychotherapy. However, in many occasions, this is the most absent part. Clinical experience shows that the relationship between food and adverse life experiences is strongly connected. If patients do not work with these experiences, they will feel unable to regulate the emotional side; they will act according to what they are used to: through food.

In professional practice, we observe that some of the associated diagnoses that are most frequently at the base of the problem are food related. Identifying them and developing a treatment plan appropriate to each case will facilitate the treatment.

The often negative experiences with food from an early age onwards that define the relationship with the body, the social rejection to which these patients are often subjected, and the failed attempts of constant weight loss that leave their mark on these patients, are issues to be addressed to restore to these patients a real quality of internal life.

The key points for psychotherapeutic treatment are described throughout this article which may be of help to those professionals who need solutions to reach their goal with these patients.

Introduction

Overweight and obesity are the fifth leading risk factor for death worldwide, killing at least 2.8 million adults each year. The majority of obesity cases are of multifactorial origin and include genetic, metabolic, endocrinological, and environmental factors.

We Can Distinguish Two Types of Obesity

Endogenous Obesity: Endogenous obesity has internal causes and is generated, among others, by problems such as hypothyroidism, diabetes, polycystic ovary or hypogonadism. When we speak of endogenous causes, we usually refer to endocrine obesity. This type of obesity is caused by the dysfunction of an endocrine gland, such as the thyroid. It usually accounts for a minimum percentage (2-3%) of people who suffer from obesity.

Exogenous Obesity: Exogenous obesity has a psychological or emotional origin. Nowadays, it is the most common form of obesity and mainly occurs due to excessive consumption of food, certain eating habits, and/or undiagnosed eating disorders such as hyperphagia or binge-eating disorder. It is also associated with affective disorders such as depression and anxiety. This type of

obesity represents 90-95% of obesity cases.

One of the difficulties that many therapists encounter is organizing the treatment with these patients. First, because it was believed for a long time that it was a disease that had no place in psychology centers, which was due to the view that the origin was either genetic or organic. Second, because people who requested psychotherapy for this problem did not receive specific treatment due to a lack of knowledge on the part of the professional. Although the work with people suffering from endogenous obesity will be briefly described, this article will emphasize the approach for exogenous obesity, with a psychogenic basis.

Our goal is to help clarify the questions that arise regarding the treatment of these people and the difficulties that may ensue. We insist on the importance of learning to conceptualize the case and develop an adequate treatment plan for the person with obesity. The treatment plan includes the phase of collecting the patient's history, as well as phases in which the work focuses on softening the patient's defense system. This is a specific procedure that allows access to the processing and integration of memories of certain life experiences, which sustain the disease.

Eating Disorders and Obesity

When talking about exogenous obesity, it is necessary to refer to the Eating Disorders (ED) that are usually associated with people with obesity. In most cases, there are serious problems in the relationship between patient and food. Among the most common ED, we can mention the following:

Binge Eating Disorder

Characterized by binge eating -sometimes several times a day- in which the person can ingest large quantities of food in a short period of time. The calories ingested are not compensated with any other activity. The binges are related to external triggers that activate parts in the internal world of the person, which leads them to eat to calm down and regulate themselves emotionally.

Hyperphagia

This diagnosis refers to someone who only concentrates on eating. The desire to eat is enhanced or uncontrolled since they eat at any time and even after having eaten properly. There is an excessive intake as a reaction to stressful situations which often leads to obesity, especially in people predisposed to gaining weight.

Nocturnal Eating Syndrome

It consists of food intake at night, which is manifested either by eating when waking from sleep in the middle of the night or by excessive consumption of food after dinner. There is awareness and memory of the intake.

Therapeutic Objectives of Working with Obesity

Therapy for obesity focuses on those experiences of attachment or of traumatic events where the person learned to manage their discomfort through food. The goal is to understand the effect of these adverse life experiences, in order to treat a disease classified as chronic and with few possibilities for improvement.

According to the type of obesity, the objectives -which will be of main importance in the work with these patients- differ. The main objectives in working with endogenous obesity are:

- Regain motivation to foster self-care.
- Work with the defense of the “lack of disease awareness,” Which means that the person does not recognize that they are sick and, thus, avoid self-care.
- Improve and encourage self-concept, which can be so damaged in these people.
- Process events that may be associated with the disease.

- Work with the body and the perception of it.

In order to work with exogenous obesity, an approach that integrates issues of attachment, trauma, and dissociation is proposed. These are the pillars which support the disease when the basis is not organic. In this case, the proposed objectives include:

- Outline a treatment plan to get access to those life events that have resulted in the disease.
- Identify urge regarding food (the urge to eat).
- Identify those triggers that activate compensation for food intake.
- Identify the defenses that block access to the internal world of the person and, therefore, to the development of therapy.
- Identify the exceptions, those moments in which the person was able to regulate the food intake.
- Identify resources that help the person to stabilize.

An Obesity Approach from the Work with Attachment, Trauma and Dissociation

The proposed approach combines working with attachment, trauma, and dissociation. These three pillars are essential to develop the therapeutic treatment for obesity. When treating attachment, trauma, and dissociation, we cover all those aspects that influence both the appearance of the disease and its development. Many of the cases of obesity find their origin in an attachment disorder since food ends up associated with adverse life experience. In other cases, food becomes the way in which the person learns to survive traumatic experiences and, in others, food is the means through which the person connects with the dissociative experience to regulate themselves or disconnect.

Attachment

Attachment in exogenous obesity is key, since it is one of the three pillars by which the disease is supported and which determines its origin. Bowlby [1] proposed that attachment is a specific aspect of the relationship between the child and the attachment figure (usually the mother). This relationship is asymmetric: the mother provides care and the child depends on her. Attachment is the product of the activity of numerous behavioral systems, composed of behaviors such as crying, smiling, following, etc. The common goal of these behaviors is to achieve the proximity, safety, and protection of the attachment figure, which are the three characteristics and functions that define attachment.

Searching for Proximity

Searching for Proximity is defined as any behavior of the child aimed at seeking and maintaining closeness with the figure of attachment.

Safety

Safety refers to the child's ability to use the figure of attachment as a source of comfort in situations in which it is required.

Protection

Protection refers to the child's ability to use the figure of attachment as a source of safety (a secure base) [1].

According to Bowlby [1], the repetition of these behaviors reveals the predominant attachment pattern the child has with the mother, which can be different with other people, such as the father or grandparents. The type of attachment can be constant over time and can influence the way people relate to others throughout their life. It is known that when a person has a secure attachment pattern in childhood, their social interactions are adequate and their levels of stress and anxiety low. In contrast, when they have an insecure attachment pattern, they tend to have problems relating to others, and high levels of stress and anxiety.

Attachment styles are also present in adulthood. Insecure (anxious and avoidant) attachment styles in adults have been related to family adversity, psychological development, and self-regulation of the child's behavior [2]. Since the mother is usually the primary caregiver, it becomes relevant to address the relationship between the child's attachment pattern and the maternal one. Parents, especially the mother, create the environment in which the child grows up. This influences the child's eating patterns. Of particular relevance to this article is the fact that the parents' insecure attachment styles have been linked to obesity in their children [2].

In people who suffer from obesity, there is a direct causal relationship between childhood experiences and their regulation strategies through food. In clinical field work -and associated with the regulation factor in the relationship with the main attachment figure- it is frequently observed that food is an activating element of the secure base. There are several characteristics of attachment in obesity, which are described below:

- When the attachment figure is overfeeding the child [3] and feeds to regulate themselves and the child. In these cases, the attachment figure overfeeds the child as a way of offering security, affection, or stability. This figure is, in turn, a person who has problems with food and these problems are transferred to the relationship with the child, not only in childhood but also in adolescence and into adulthood. People who have had these overfeeding attachment figures reach adulthood associating food with situations that are not necessarily related to eating. These associations come from the highly inadequate relationships that this particular attachment figure has established with food.

For example, when a patient is at work and hungry, she may feel the urge to look for food desperately because she is scared. It is quite interesting to be scared when one is hungry, because fear is not organically connected with food; in fact, they are opposites. Fear activates the defense system, while food is connected to the attachment system. It is interesting that both are activated at the same time by a harmless signal such as hunger.

When asked how familiar it was for the person to feel hunger and fear at the same time, she responds that it is a very familiar feeling for her. She points to her grandmother as her main attachment figure; an overfeeding grandmother who she describes as obsessed with feeding everyone at all times. Thus, the patient connects hunger with fear. She explains that she was never allowed to go hungry. The overfeeding grandmother always anticipated her natural sense of hunger, so the few times the patient said she was hungry, the grandmother would get upset and show exaggerated concern. She would search for food quickly and overfeed her so that she would stop being hungry, while insistently asking her if she wanted more food. Over time, and because of her grandmother's reactions, facial expressions, and overeating behaviors, the patient ended up concluding that being hungry is dangerous.

The patient tells us that her grandmother was from a deprived family and had suffered hunger in her childhood. These adverse life experiences had determined the relationship that her grandmother had with food and the problems derived from it. The patient describes her grandmother as a woman with difficulties expressing emotions, with a tendency to worry, and who had learned to show affection and take care of the family through food, especially with the patient, who developed obesity at a very young age. Since she was a baby, she has been eating with the grandmother because the mother needed help to go to work.

- The relationship between food and attachment experiences. In the case of people with obesity who are nocturnal eaters, the second helping (eating a large amount of food just after dinner) or getting up to eat at night may be associated with an unresolved attachment experience. For example, a patient used to eat cupcakes at night after dinner, when everyone in her house went to bed. In therapy, the patient associated the search for tranquility and comfort with eating cupcakes at night. As she delved deeper, she began to remember that her secure basis was a young aunt with whom she lived, and who died at an early age. Her aunt secretly brought her cupcakes after the beatings that her mother gave her. When we process the memories associated with the trauma in therapy, and the patient has recovered her secure basis, she stops eating cupcakes at night because, in her own words: "I do not need to eat cupcakes at night to remember that I was loved, because now I know I am."

- When food covers unmet attachment needs, and food is used as an element that activates an internal haven of calm and tranquility. An example is the patient who describes how she has been eating to calm down ever since she was a young girl. She explains that when everything was chaotic at home -whenever she heard her parents arguing, she was afraid because the fights were very violent-, she secretly went to the kitchen and climbed up on a chair to get food. She opened the cupboards, took what she liked -usually something sweet-, went back to her bedroom, closed the door, and sat down on the bed. She would put the food next to her and start talking to it. She would eat until she could not eat anymore and fell asleep. When she woke up, and since the fight was over, she could leave the room to check if everything was alright. She repeated this behavior as a ritual every time there was a fight at home. Over time, there were many fights, so this ritual became a way to survive, yet also a health problem because of the way her body changed over time, without any adult around her noticing what was happening to her.
- When the mother has a problem with food and her body and projects it on her child. They are usually put on a diet from an early age onward. The child ends up making the wrong associations about food, and the desire to eat is distorted. For example, a patient's mother suffered from a body image disorder and had an obsession with being thin. She put the patient on restrictive diets by taking her to endocrinologists who recommended adult diets that did not include sugar or food that children typically like. As a result, the daughter learned to binge sneak around on those foods that were banned from diets. Over time, this situation turned into a serious overeating problem, leading to morbid obesity. On the one hand, food provided her with emotional compensation for the frustration and sadness she could not show and, on the other, with the only way to rebel against her mother. In the words of the patient herself, "My mother could never bear that I was a fat woman, but she has not won. I have won; I am not who she wants me to be."

Trauma

The definition of trauma does not mention any types of trauma or traumatic events. Instead, it describes the experience of trauma and highlights the factors that influence the perception of trauma. Saakvitne and his collaborators [4] write:

Psychological trauma is the individual's unique experience of an incident, a series of incidents or a set of conditions lasting over time in which the individual's ability to integrate his or her emotional experience, i.e., his or her ability to remain present, understand what is happening, integrate his or her feelings and give meaning to the experience, is exceeded. Trauma can occur

by excess or by default. Trauma by excess comes from the impact of the situation. Trauma from physical assault or sexual abuse are examples of the most visible forms of excessive trauma. So is excessive behavior, such as overprotection.

However, other traumas are not as visible but can be equally damaging: trauma by default. In these cases, the damage does not so much come from the impact generated in the system of the person who suffers it, but from that which is not obvious or visible. A clear example of this would be the absence of physical contact that meets a person's emotional needs from an early age onward. This absence generates an inconspicuous trauma in which the person feels unseen and ignored.

In people with obesity, we can find both types of trauma: both by excess and by default. Within the working model proposed in this article, certain type of traumas must be taken into account to achieve system integration. Through integration, all the symptoms associated with distress, emptiness, sadness, and anxiety -which in most cases are the triggers or precursors of binge eating and all food-related behaviors used to calm down or disconnect from the emotional- are reduced.

The traumas to be taken into account when conceptualizing the cases are described below:

Attachment Trauma

Renn [5] indicates that the theory of attachment can be considered a theory of emotional regulation, given that the quality of care generates an attachment organization that includes a characteristic style of emotion regulation. The effects of early trauma on the child's relationship with the attachment figures can lead both to a poor ability to process the information transmitted by others, as well as to varying degrees of difficulty in regulating bodily states. If parental figures are unable to help their children when they feel frightened, they develop an excessive sensitivity to any stress factor during childhood, which will be expressed in adult life as an inability to cope with any conflictive situation. For people who are obese, attachment trauma is one of the most influential factors in the disease. It is intimately related to the food and the triggers that drive the person to eat.

Critical Incident Trauma

It refers to traumatic experiences or incidents that have a strong impact on the person, as described in the definition of trauma. These incidents in a patient's history also influence the origin or development of obesity (e.g., sexual abuse, violence).

Diet Trauma

People suffering from obesity spend much of their lives on diets. In many cases, from early ages onward and forced by attachment figures. These diets leave their mark because of the

effort they require, and the suffering patients describe it by, remembering what it was like not to be able to eat because of the diet when everyone else around them ate normally. These repeated restrictions profoundly affect the beliefs of people who suffer from them; beliefs such as, “I am not capable,” “I am useless,” “I am a fraud,” “I am fat,” “I am flawed,” etc. These beliefs prevent the person from losing weight because of the learned helplessness, as a result of which they continue to feel the inability to lose weight. Just thinking about dieting generates rejection because of all the sensations and emotions related to it.

Humiliation Trauma

This includes all those experiences that made the obese person feel disrespected, judged, or abused. This type of trauma often occurs in the realm of social relationships. For example, an obese patient working in a coffee shop receives a client first thing in the morning who orders a coffee and a donut. The patient gives her the coffee but says she is sorry she cannot give her the doughnut because the delivery boy has not arrived yet. And the customer says, “I’m sure it’s a lie, you must have eaten all of them.”

The Feeling of Emptiness in Obesity

It is essential to refer to the feeling of emptiness, described by many patients, as a result of adverse experiences or trauma. This feeling of emptiness is often described, but in people who are obese, it is important to point it out, as it is one of the reasons why they eat and one of the main triggers of binge eating. Usually, the person is unaware of this feeling of emptiness, as it is highly integrated and associated with eating immediately. At other times, you may find a phobia of emptiness, in which simply a vague feeling of emptiness causes the person to start eating and not stop until the sensation disappears. So, depending on the intensity of the feeling of emptiness, filling oneself up with food can be more or less intense.

Emptiness is part of the natural process of grief. It is composed of a general feeling of apathy, often accompanied by dysthymia, hopelessness, and an acute feeling of loneliness and anguish. In the emptiness are also collected all those frustrations and shameful and painful experiences of a person’s life. To go deeper into the emptiness is to go deeper into that which the person does not accept and with which it is difficult to get in touch.

In people with obesity, emptiness usually has two common manifestations: feelings of emptiness (emotional emptiness) with anxiety and/or anguish, and emptiness of hunger (the defense of hunger) [6]. In the first part of the treatment, the practitioner helps the person to identify this emptiness, naming the emotion or emotions that make it up. This emotional emptiness is usually located in the center of the chest and generates anguish and anxiety.

They use food to calm these feelings because they have learned that food makes them go away. It is like filling the void by eating.

The hunger emptiness or hunger defense [7] may appear through different feelings or emotions, including unexpressed anger or rage. This emptiness is usually located in the stomach and is called hunger defense because the person avoids feeling through the emptiness, which, in turn, also leads to eating. It is a false sense of hunger, because it is not real hunger. For example, a patient who habitually felt the emptiness of hunger blocked the expression of her anger for fear of being out of control, so she “Swallowed” it. Somaticizing it in the stomach, she felt the emptiness when she got angry. This generated an unstoppable sensation of hunger that forced her to eat until she felt relieved and in control. Working with emptiness, therefore, is a job that leads back to attachment and trauma. When the emptiness is integrated correctly, it has a transforming effect, and it becomes a full emptiness, resulting in a change in experience.

Dissociation

Dissociation may be present at different levels in people who are obese. It is essential to know how to identify and diagnose it in order to carry out a proper case conceptualization and a treatment plan. To understand the patient’s inner world -where the different aspects, states or parts of the personality will be shown-, the therapist can do a simple exercise that consists of drawing a circle on a blank sheet of paper and asking the patient to draw the different parts or aspects that represent her. There are also other techniques through which the internal world can be represented, and all of them are valid, as long as they allow us to talk about those internal parts, since through them we can enter into the person’s inner world.

The parts or aspects of the personality that we usually find in the inner world of these patients and to which we must pay special attention are:

The Fat Self

It is the part that is related to the rejection of the body and is the most resistant to change during treatment. The therapist has to understand the meaning of this part in order to see how the whole dissociative structure that influences the disease has been generated.

The Child Who Could Not Grow Up

This is the part that did not have an adequate maturative development and shows behaviors that do not fit with the biological age of the person. It is an aspect of the personality that leads the person to defend themselves by being complacent and that, instead of expressing what they feel, they eat.

The Hidden Self

It is the part that protects the internal system by hiding. It tends not to expose itself, not to show itself, because in the past it could have been threatening or dangerous to do so. Staying in the shadows is the safest thing to do. It is closely associated with the body, and it is the part of the person that somaticizes what cannot be expressed in any other way. We can understand this part with examples of some patient comments. "I think my fatness has helped me to hide inside myself. It's like I put on layers and layers of fat to protect myself. So, no man can be attracted to me and do to me what he did to me that left me so damaged," said one patient when she became aware of her father's childhood sexual abuse during a session. Another version of the hidden self is evident in another patient's comments: "My needs were never met, and I always had the belief that there was no place for me in the world. By being obese, I would be seen, even if it was at my own expense."

In this type of patient with obesity, we usually find the following types of dissociation:

Somatic Dissociation

The body itself is felt as alien, as something external, even sometimes felt as "The enemy." Examples of this type of disassociation could be expressed as: "This (pointing to the body) is what does not let me live" or "this body is what I got, and I live trapped in it."

Somatoform Dissociation

This type of dissociation differs from somatic dissociation in that there is no distorted perception of the body. The person projects her discomfort on a physical level.

Depersonalization

Persistent or recurrent experiences of detachment, as if one were an external observer of one's own mental and physical process, as if the person were dreaming. There is a sense of unreality of oneself or one's body. Suzette Boon classifies as mild or more common symptoms feeling strange, unreal or disconnected from oneself; feeling or behaving like "On autopilot" or like a robot, and feeling disconnected from emotions or dull. Severe symptoms of depersonalization include somatoform depersonalization (sensation of disconnection from the body, to the point of not being able to feel the body or parts of it) and psychoform depersonalization (experience of being outside the body).

Dissociative Fantasy

It usually goes unnoticed unless the clinician can identify it. It has a protective function and emerges at very early ages as a refuge or safe place to avoid suffering. It is the favorite refuge of the hidden self, who learned to protect herself by hiding.

Another Key Point in Working with Obesity: The Body

The body is associated with negative life experiences, and that is where the disease is somaticized. This can be seen very clearly in the beliefs mentioned above of the "May Be-I-fatten-up-to-hide" style.

The work with the body, the rejection and shame towards it, becomes indispensable. In people who are obese, the body expresses life experiences through weight. For these people, the body is the enemy, as it is the cause of social mockery and humiliation. Being obese generates enormous social pressure, as well as a series of important handicaps such as clothes or seats in public places, such as airplanes. It may also just be that the first insult that an obese person receives in any conflictive situation is, unfortunately, related to the body.

With obesity, the body is one of the most damaged parts. Physically, the weight changes caused by the extreme diets they underwent throughout their lives cause scars that are sometimes rather intense and difficult to disguise, such as stretch marks or tissue sagging. All this is damaging to a person's self-esteem and social life. They need help to repair them by working with compassion, acceptance, and coping skills. The objective is always to promote self-care, helping the person to stop associating with food what it is not naturally associated with, such as the compensation of the emotional states as described earlier. In this way, a healthy integration of food can be achieved.

Summary

This article describes the key points that must be taken into account in the treatment of obesity in order to obtain good therapeutic results. Unfortunately, psychotherapeutic treatments with obesity lack these fundamental principles that meet the needs of patients. Meeting these needs becomes the foundation for good work and a successful treatment plan. Without it, many patients, with their sense of learned helplessness, begin unsuccessful diets and treatments that lead to drops-outs, time and time again.

References

1. Bowlby J (1969) Attachment and Loss: Separation: anxiety and Loss Ed Basic Books.
2. Fröhlich G, Wilfried P, Albayrak Ö, Hebebrand J, Pauli-Pott U (2011) Conditions of Long Term Success in a Lifestyle Intervention for Overweight and Obese Youths. *Pediatrics* 128: e779-e785.
3. Seijo N (2015) Treating Obesity with EMDR Therapy. Conference presented at the EMDR National Conference of EMDR in Madrid, Spain.
4. Saakvitne, K. (2000) Centre for Early Childhood Mental Health Consultation.
5. Renn P (2006) Aggression and Destructiveness: Psychoanalytic Per-

- spectives. New York: Routledge. In: C. Harding.
6. Seijo N (2015) Eating Disorders and Dissociation. ESTD Newsletter 4.
 7. Seijo N (2015) Treating Eating Disorders with EMDR therapy. EMDR International Association Conference. Philadelphia.