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Counselling Psychology in a Changing National Health Service

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Professional Doctorate in Counselling
Psychology (DPsych) Portfolio

City University, London

Department of Psychology

March 2014

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Chapter A: Prologue

Counselling psychology in a
changing National Health
Service

PROLOGUE

Counselling psychology in a changing National Health Service

The decision to focus on counselling psychology in a changing National Health Service (NHS) as the theme for this thesis Portfolio was the result of an evolving process throughout my training.

I began my training having completed a foundation year in psychotherapy and I was convinced that I would ultimately become specialised in the psychodynamic approach. What had drawn me away from psychotherapy and towards counselling psychology was the desire to undergo a training that allowed me to contribute to evidence-based practice and also one which enabled me to work in the NHS. Having started my training with a Cognitive Behaviour Therapy (CBT) placement in an Improving Access to Psychological Therapies (IAPT) service, I became fascinated by this initiative, which was becoming a revolution within the world of talking therapies. Never before were so many people able to access psychological help and services were supposedly becoming more and more effective. However, I was concerned that people were being labelled as ‘recovered’ without their own say-so and although I could see the benefits of focusing on symptom reduction in a goal-directed therapy, I had my doubts about this being the only approved method to prove effectiveness.

The ‘Literature Review’ (Chapter B) outlines the evolution of the IAPT programme and provides a critical evaluation of it. Part of the critique comprises the concern that treatment focuses on symptom reduction (Elkins, 2009; Pilgrim, Rogers, & Bentall, 2009; Guy, Thomas, Stephenson, & Loewenthal, 2011) and that a biomedical view of mental health problems is inaccurate, even by the admission of the organisation responsible for recommending treatment (the National Institute for Health and Care

Excellence: NICE), which relies on evidence that is based on a biomedical model.

Related to this point, the review highlights the concern shared by some researchers and practitioners that NICE does not consider research unless it is produced from Randomised Controlled Trials (RCTs), which give a false impression of the realities of therapy (Rawlins, 2008; Marzillier, 2009). Some professionals hope that NICE will soon consider evidence from non-RCT methodologies in an inclusive paradigm (e.g. Bohart, & House, 2008). Those opposed to the current measurement of effective treatment believe that CBT is over-prescribed (Samuels, 2009) and that more emphasis should be placed on the interpersonal aspects of the therapeutic relationship rather than symptom reduction, given that a large body of evidence proves this to be the mechanism of psychological change (Pilgrim, *et al.*, 2009).

The review goes on to discuss how the economic and political drive behind IAPT results in increased pressure on IAPT workers to achieve targets in order to receive funding (Rizq, 2011), and possibly also results in a treatment being delivered that is more about servicing a quantity than delivering on quality (e.g. Fitzpatrick, 2006).

Following the completion of the Literature Review, I began a placement providing one-to-one and group therapy to help with weight loss for people with obesity, which paved the way for the development of my research project (Chapter C). I was intrigued that CBT seemed to be the only form of therapy available (which does not emphasise past experience), despite clients having traumatic and abusive histories. I became interested in the link between emotional eating and attachment theory and began researching it.

A review of the literature informed me that weight loss treatments may be successful initially but that weight loss is generally not maintained (e.g. Curioni, & Lourenco, 2005; Barte, Bogt, Bogers, Teixeira, Blissmer, Mori, *et al.*, 2010). This led me to

question what it is that current treatments are missing if successful outcome in the short term is generally not maintained. I understood that emotional eating is common in people with obesity (e.g. Telch, & Agras, 1996; Chua, Touyz, & Hill, 2004) and that attachment theory has become one of the main models to aid our understanding of emotion regulation and interpersonal relationships (Mikulincer, & Shaver, 2007). Despite this, I could see no evidence that treatment was attending to concepts of attachment theory, such as affect regulation, interpersonal difficulties, and low self-esteem (Fairburn, Cooper, & Shafran, 2003). I believed that increasing our understanding of the relationship between attachment style and obesity might inform better treatments.

Existing literature on attachment style and outcome demonstrated that people with different attachment styles have varying success in treatment outcome. Individuals with higher attachment avoidance have been found to be more likely to avoid closeness with others and will not seek social support from other group members (e.g. Dozier, & Tyrrell, 1998; Smith, Murphy, & Coats, 1999; Rom, & Mikulincer, 2003). Individuals with higher attachment anxiety have been found to report less satisfying social support within a group due to their preoccupation with concern over whether they will be accepted or rejected by other group members (Smith, *et al.*, 1999; Rom, & Mikulincer, 2003). Furthermore, it has been found that women diagnosed with Binge Eating Disorder (BED) who have higher attachment anxiety responded better to group psychotherapy, whereas those with lower attachment anxiety improved with group CBT.

Following a literature review, two specific areas were identified for future investigations: (i) to investigate whether attachment style predicts change in BMI in a group treatment for obesity and (ii) to explore the experience of that treatment. These

became my research questions, and it was hoped that findings could provide information on whether alternative treatments may be more appropriate for certain individuals, based on observable scores of their weight and on their verbal accounts if the theme of attachment arose.

A quantitative methodology was employed to answer the first area of investigation and a qualitative methodology to answer the second.

At the same time of undertaking the research project, I was learning as much as I could about the psychodynamic approach on a third-year placement. I felt ambivalent towards this approach because I was finding it extremely interesting in theory but in many ways challenging in practice.

The last section in this thesis includes a Professional Case Study (Chapter D), in which I worked with a client with depression, following the psychodynamic approach. For me, this links with the title of the prologue because of how scarce psychodynamic therapy is becoming in the NHS due to its inability to produce evidence which NICE will give serious consideration to. I was struck by how many psychodynamic therapists had lost their jobs whilst at this placement. Furthermore, it is a long-term therapy which is apparently not cost-effective in these times when there is pressure to keep costs down. The Professional Case Study also links to the research project as the latter tries to bridge a gap between CBT and psychodynamic therapy (specifically attachment theory).

Writing about this client allowed me to employ theory from different psychoanalytic schools in the case conceptualisation. Freud's (1900; 1923; 1939) idea of unconscious intrapsychic dynamics and the associated defences is relevant to the case, but the main focus is on object-relations theory, particularly the work of Klein (1957; 1959) and

Winnicott (1975). The contribution of Bowlby's attachment theory (1969; 1977) is also considered in relation to the client.

It is hoped that this Portfolio can provide the reader with a sense of the professional development that took place over the last three years. In summary, the Literature Review (Chapter B) is about the start of this journey which led to a growing interest in what the NHS recommends as a treatment and why; Chapter C illustrates how research sought to develop a deeper understanding of the influence of attachment on outcome in therapy for people with obesity and people's experience of that therapy; and lastly Chapter D puts forward the case for an interest and value for the psychodynamic approach at a time when its long-term provision is being undermined by the NHS due to pressures associated with cost-effectiveness.

Although the journey began with a fervent certainty that psychodynamic therapy is the best approach, I have come to see the value in CBT and the psychodynamic approach (as well as the person-centred approach) during my training. I am now training as a CBT therapist in an IAPT job and I feel very strongly about the merits of the IAPT programme, but I still remain inquisitive as to what effective therapy really is and how we should be proving it.

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Chapter B: Literature Review

A critical evaluation of the IAPT
initiative

A critical evaluation of the IAPT initiative

INTRODUCTION

The National Health Service (NHS) has provided talking therapies for at least 30 years. It was recognized that the delivery of these services could be improved when the Labour Government's General Election Manifesto (2005, p.64) recommended increased funding to improve mental health services in the UK. This was the result of lobbying of the government by service users, NHS professionals and policy makers. An influential report was later published by Economist Lord Richard Layard (The Centre for Economic Performance: CEP, 2006) which highlighted the need to make evidence-based psychological therapies more available to the 16% of the population suffering from depression and anxiety disorders (Office for National Statistics, 2002). The report outlines a seven year plan for a programme which has come to be known as Improving Access to Psychological Therapies (IAPT). Apart from alleviating the suffering of millions of people, the report claimed that the programme could pay for itself by reducing incapacity costs and boosting financial output by enabling people's return to work. £300 million of funding was plunged into the first stage of the IAPT programme (Department of Health: DoH, 2012).

The aim of the IAPT programme has been to help Primary Care Trusts (PCTs) and now Clinical Commissioning Groups (CCGs) implement guidelines from the National Institute for Health and Care Excellence (NICE) to deliver evidence-based psychological therapies to people suffering from depression and anxiety disorders to enhance health and well-being, endorse social inclusion and increase economic productivity (DoH, 2008b). Seven years after the release of Layard's leading report, at

a time when IAPT is not far from full roll-out, this paper aims to address how effective the services really are in a critical evaluation of the IAPT initiative.

Much controversy surrounds IAPT (Asare & O'Sullivan, 2010). As yet, there is no systematic analysis of IAPT's empirical findings, and as a result, the critical appraisal of the programme in this paper is comprised of a selection of opinions on the IAPT initiative that were found in a literature search – opinions from senior staff at mental health consultancies, mental health charities, health policy workers, and renowned psychologists. Some of the critique is based on efficacy studies in psychological therapy to ascertain whether IAPT is biased towards CBT, and the findings that have been produced on the IAPT services themselves will also be appraised.

This topic is extremely relevant to counselling psychologists as many in the profession are delivering psychological therapies within IAPT services. Having undertaken two IAPT placements whilst training as a counselling psychologist and having begun training as a CBT therapist in IAPT, the author is interested in considering the strengths and weaknesses of the initiative in the hope of identifying how the programme could best be developed in the future.

The original vision for IAPT

Layard (CEP, 2006) proposed that 10,000 therapists (many of whom would already be employed in the health system) should be trained to deliver therapy in accordance with the NICE guidelines. He reported that the evidence base of randomised controlled trials (RCTs) in CBT demonstrates that 16 sessions of CBT produces a success rate of approximately 50% after four months, with those treated for anxiety being unlikely to relapse and those treated for depression being less likely to relapse than those in receipt

of medication only (Paykel Scott, Teasdale, Johnson, Garland, Moore, *et al.*, 1999). This target of 50% recovery rate is the aim for outcomes in IAPT (DoH, 2008c). The vision for increasing access to psychological therapies included: the ability for GPs, employment centres, other health services, and people themselves to refer to services; for people to access the service near their homes; for services to be organised into teams, with universal measurement of outcomes; and for teams to include advisers for employment, benefits, and housing. The aim was to develop 250 teams nationally, consisting of about 40 therapists (to cover approximately 200,000 people) by 2013. After this point, the aim was for the service to be sustained by decentralised methods, where GPs can choose their supplier based on results produced by services, in order to develop a system that is more sensitive to the needs of patients. This aim has been achieved, as CCGs (which are clinically led groups) have been responsible for decision-making in commissioning since April 2013, following the announcement in the Government White Paper 'Equity and Excellence: Liberating the NHS' (DoH, 2010b).

The notion behind the IAPT programme is the provision of a stepped care approach, and thus a more tailored provision of psychological therapies. For an illustration of the 'stepped care model', see Needham (2006). The evidence for stepped care was provided by findings into the efficacy of low- and high-intensity versions of CBT, and the benefits of collaborative care and stepped care (Turpin, Richards, Hope, & Duffy, 2008). The intention behind the split into low- and high-intensity levels of CBT is to help those that may not require the intensity of the more traditional delivery of CBT by providing interventions focussed on self-management, through guided self-help, for example.

The IAPT programme includes routine collection of outcome measures at every session (DoH, 2008/9). The use of a ‘minimum data set’, which is standardised across the services, enables the measurement of whether sites can meet their aim in clinical outcomes and patient experience. The main measures collected include the Public Health Questionnaire (PHQ-9: Kroenke, Spitzer, & Williams, 2001), Generalised Anxiety Disorder questionnaire (GAD-7: Spitzer, Kroenke, Williams, & Lowe, 2006), the Work and Social Adjustment Scale (WSAS: Mundt, Marks, Shear & Greist, 2002), the employment status and patient experience questionnaires. The measures for anxiety and depression are targeted at symptomatology, and define cut-off points to determine categories of severity. The scores on assessment determine whether a person is of clinical ‘caseness’ if they score above a certain point and this allows for IAPT to assume it is reaching its target of ‘moving to recovery’ if the score moves from ‘caseness’ at pre- treatment to below ‘caseness’ at post- treatment.

CRITIQUE

Evaluation of IAPT’s progress

Evaluation of Demonstration Sites: Doncaster and Newham (2006/07)

Layard’s hypothesis was tested with the funding of two demonstration sites, Doncaster and Newham, to deliver cognitive behaviour therapy (CBT) services to their respective communities. The main findings from the first thirteen months’ service of the demonstration sites were considered to be promising, with recovery rates of 56% (exceeding the IAPT national target) and a 5% return to employment (Clark, Layard, Smithies, Richards, Suckling, & Wright, 2009). Generally, the findings from the

demonstration sites showed that people were accessing psychological therapies who would not previously have had access.

Although results from the demonstration sites were encouraging, Cooper (2009) points out that over 40% of patients were either considered not to be suitable for treatment, refused therapy, or terminated therapy after only one session. Nevertheless, the results of the demonstration sites were persuasive enough for the government to expand the provision of psychological therapy services.

Evaluation of Pathfinder sites (2007/08)

The achievements of these demonstration sites led to 11 IAPT Pathfinder sites in 2007/08 which were supported by Special Interest Groups (SIGs) to ascertain how their communities' needs could best be met (DoH, 2008a). The aim of the Pathfinder programme was to explore how IAPT services could meet the needs of the whole population in future, including such groups as older people, young people, offenders, black and minority ethnic communities, new mothers, and people with long term conditions (DoH, 2008c).

Results showed that procedures for referral needed to be improved and that the monitoring of ethnicity, sexuality and disability was not rigorous enough (DoH, 2008c). At the end of treatment, recovery rates were reported as 49%, which was considered to meet NICE objectives (DoH, 2008d). Therefore significant gains in health and well-being were reached and the rate for return to work was reported as 16%.

Evaluation of the first roll-out year (2008/09)

The encouraging results from the demonstration and pathfinder sites incentivised the rollout of IAPT services across the UK in 2008. In 2009, the first wave of IAPT sites underwent evaluation, with specific attention paid to equity of services in their delivery on demographics of gender, age, ethnicity, diagnosis, language and disability (Glover, Webb, & Evison, 2010) and also to the interventions provided and outcomes obtained. Data was collected from 32 sites.

Although the results from the first year roll-out did not meet the successes of the pilot sites, this was to be expected as success rates rarely match that of pilot programmes when they become more widespread (DoH, 2010a). Nevertheless, there was a fall of approximately 30% in the rate of ‘caseness’ between initial assessment and final contact for the PHQ-9 and GAD-7 (Glover, *et al.*, 2010). The data was poorly completed for ratings of disability, ethnicity and diagnoses, and older people and men seemed to be under-represented. Overall, although findings were considered to be successful, more needed to be done to ensure services were being provided equitably (Glover, *et al.*, 2010).

Evaluation of where IAPT is now and moving forwards

In 2010, the coalition government committed an additional £400 million to last until 2014/15 and proved its commitment to improving mental health in England through the strategy ‘No health without mental health’ (HM Government, 2011). After the first three financial years of the IAPT programme (March 2012), it was reported that over one million people had used the services, recovery rates were in excess of 45% and 45,000 people had moved off benefits (DoH, 2012). This suggests that the programme is achieving its original aims of economic savings to the NHS and welfare system,

enabling increased tax contributions, and improving individuals' quality of life. The programme has also achieved increasing access to children and adolescents and has improved access rates overall as more services have been set up and existing services have increased their visibility in local health communities, with IAPT services treating an average of 9.68% of the prevalence of common mental health problems in their local communities (DoH, 2012).

By March 2015, the aim is to have increased access to a further 15% of the adult population, achieving recovery rates of at least 50% (DoH, 2012), and to have generated net savings of £300 million, due to reductions in NHS healthcare usage, welfare benefits savings and reduced sickness absences. The focus includes meeting the needs of specific groups at risk (such as children and young people, people with severe mental illness, and people with long-term physical conditions), monitoring patient satisfaction and evaluating services to determine how evidence-based services are best delivered. Another aim is for services to achieve representative access from their local communities with regard to age, ethnicity and other factors.

IAPT has met most of its targets so far (DoH, 2012) but the success of IAPT has created challenges for the future. A rise in the number of referrals has caused waiting lists to increase as service providers struggle to meet the demand. Also, there are high expectations regarding service delivery to under-represented communities.

Furthermore, recent changes in the commissioning of the healthcare system might mean that IAPT services need to compete with other services that offer similar healthcare.

The percentage of people completing a course of treatment is 60% (DoH, 2012) and recovery rates are at 45%. Although recovery rates have increased each year, it could

be argued that 45% is in fact low and begs the question of how the other 55% of people being treated can be best helped. Furthermore, if there is 60% of treatment completers, over one third of people being treated in IAPT services are dropping out, which is a large number of people. It has been argued that many patients who do not ‘move to recovery’ during treatment still develop strategies to manage their symptoms and do make some worthwhile changes (DoH, 2012). However, although IAPT has clearly allowed for more people to access talking therapies than ever before, there is room for improvement in the services being delivered if over half of the people being treated do not move to recovery and more than one third of patients drop out of treatment.

The IAPT programme has clearly made cost savings. The idea behind the original proposal was that the programme would pay for itself and would also make net gains. It has been estimated that savings from reduced healthcare usage by those who recover will be £272 million by 2016/17 (DoH, 2011). Savings will also be made due to fewer long-term prescriptions of antidepressants as a result of effective talking therapy, fewer GP appointments, outpatient appointments and inpatient stays. Further gains are anticipated from people moving off welfare benefits or gaining employment and reduction in sick days for talking therapy patients.

It appears that IAPT has improved access to talking therapies and has made savings to the country’s economy. However, it is also clear that there is still room for improvement in these services.

Widening the debate: for and against IAPT

The theoretical basis of IAPT

Within IAPT, service structures vary according to their location. Cooper (2009) claims this to be of benefit because the services develop in response to their communities' needs. A further advantage of the programme is that the majority of referrals come from GPs, which is where most people in the UK go to get help (Goldberg, 2003), and another benefit is that the provision of psychological therapy supposedly meets patient choice (DoH, 2004). However, Cooper (2009) is doubtful about the theoretical basis behind Lord Layard's proposal (CEP, 2006) and the implementation of the IAPT initiative. He argues that mental health, happiness and economic consequences of unemployment should not be considered as part of the same issue, as clinicians, psychologists and economists are not all striving towards the same goal. He proposes that there is no evidence to prove that increase in access to psychological therapy will improve the nation's happiness, or lessen unemployment rates in a troubled economy.

Fraser (2006) claims that the emphasis on improving mental health to save money is unhelpful, because forcing people into receiving treatment on the basis that their benefits may be cut will not produce a positive experience in therapy. The pressure on both therapist and client to achieve the treatment target of returning to work may sabotage the development of a positive therapeutic alliance, in which both parties are equal partners. She suggests this drive to get people into work may put the public off talking therapies altogether.

Although increasing access to talking therapies is proving to be a success and is enabling people to get help for mental distress when they may not have previously been able to, there is a common opinion that the drive behind the development of empirically

supported treatment standards has been economic and political, rather than scientific (Beutler, 1998; Hubble, Duncan, & Miller, 1999; Bohart, & House, 2008). Indeed, the premise behind the original proposal was economically led and decisions are made by NICE with political agendas in mind. Nevertheless, in these times of economic strain, consideration has to be given to cost-effectiveness in order to provide the best possible services with whatever funding is available.

NICE's focus on symptomatology

NICE is responsible for providing guidance, setting quality standards, and managing a national database to improve people's health and to treat ill-health (NICE, 2010). It develops clinical practice guidelines based on the best available evidence for clinicians and patients to refer to (NICE, 2009). NICE has been criticised for deviating from its original aim of acknowledging the broad definition of mental health and the contested nature of the principles affecting mental health to adopting a research approach that is biomedical (Guy, Thomas, Stephenson, & Loewenthal, 2011). The biomedical model assumes that conditions underlie symptoms, and the symptoms are used to diagnose in order for treatment to be prescribed. Indeed the manualised protocols of treatments for different disorders in IAPT suggest support for a medical model of psychological distress (Rizq, 2011). Guy, *et al.* (2011) believe there is a problem with "acting as if experiences of mental distress are medical 'conditions' which can be 'diagnosed'" (p.6).

McPherson, Evans, & Richardson (2009) who disagree with the medical focus on symptom reduction believe that measures for Quality of Life (QoL) should be used instead and that for depression, NICE should recommend on the basis of recovery studies, so that the IAPT programme is consistent with the recovery evidence base.

Marzillier (2009) claims that focussing on diagnosis and symptom reduction is failing to treat the whole person. Clark, Fonagy, Turpin, Pilling, Adams, Burke, *et al.* (2009) defend this criticism by claiming that the person-centred assessment in CBT goes far beyond merely attending to diagnosis (See Commissioning Toolkit, chapter 5). Nevertheless, NICE presents depression as if it is a medical ‘condition’.

Elkins (2009) posits that the medical model has been “superimposed” on the practice of psychotherapy so that medical terms “are used to describe what is essentially an interpersonal process that has almost nothing to do with medicine” (p. 67–71). Pilgrim, Rogers, & Bentall (2009) highlight the importance of personal relationships in the creation and amelioration of mental health problems. They advocate the use of a biopsychosocial model to understand mental distress, of which biology is one part. Even NICE (2009, p.628) itself recognises: “Despite considerable work on the aetiology of depression including neurobiological, genetic and psychological studies, no reliable classificatory system has emerged that links either to the underlying aetiology or has proven strongly predictive of response to treatment”. Despite this admission, their focus is on diagnosis and symptom reduction.

Pilgrim, *et al.* (2009) summarise that “extensive and repeated research on the link between process and outcome has demonstrated that the quality of the relationship consistently predicts outcome, independent of the espoused model or condition being treated” (p.244). This supports the idea that therapy is first and foremost relational, rather than biologically symptom-based. Indeed DeRubeis, Brotman, & Gibbons (2005) stated that there is no significant difference in outcomes between different psychotherapies.

Bentall (2009) argues that psychiatric diagnoses do not indicate which patients will respond to which drugs and therefore diagnoses of mental health 'conditions' are not appropriate. Nevertheless, NICE will only consider the research evidence where participants have a firm 'diagnosis' of depression (e.g. NICE, 2009, p.262). If researchers and clinicians in the field do not concur with the use of diagnosis, then NICE must be discounting certain types of research evidence in favour of research that produces 'scores' that indicate whether someone is either 'recovered' or not. Indeed, Rizq (2011) argues that collecting objective outcome measures undermines what the patients themselves consider as important.

Within the NICE guideline for depression, it is acknowledged: "There was a strong feeling within the service user and carer topic group...that psychological treatment offered by the NHS...does not go far enough in addressing the trauma experienced in childhood" (NICE, 2009, p.90). The study by Ridge and Ziebland (2006) confirms the opinions of the topic group and the testimony from the personal accounts that people with "deep and complex problems felt the need for longer term therapy" (NICE, 2009, p.90). However, NICE explain in their report why they cannot recommend long-term psychodynamic therapy and that is because there is not sufficient evidence for this in the treatment of depression.

Carey and Pilgrim (2011) criticise IAPT for following a medicalised approach to care in that people who miss appointments are warned that they may be discharged from the service and people who do not engage in therapy are described as 'non-compliant'. This suggests it is an impersonal experience for those referred to IAPT services (Dowrick, 2008).

It seems from the literature that there is a difficulty in achieving a personalised approach to care with the possibility of long-term treatment due to the cost restraints that services face. This is exacerbated by the driving force behind IAPT being largely economical and political and the conditions of funding are based on the results that services attain. These cost pressures may perhaps account for NICE's reliance on symptom measurement to prove a therapy's efficacy as counting scores may appear to be an attractive and easy way to compare therapies. However, even by its own admittance, NICE undermines a medicalised view of depression. How success is measured in IAPT services therefore requires more attention.

RCTs as a methodology to prove efficacy

Randomised Controlled Trials (RCTs) are the primary method used for establishing efficacy (NICE, 2009), despite the fact that NICE recognises that there are problems with RCTs, particularly for psychological therapies because the treatment conditions are so different between experimental and real-life conditions (Rawlins, 2008).

Samuels (2009) argues that RCTs do not reflect a gold standard in psychological therapy. He believes that the methodology of some research into CBT's effectiveness is skewed so as to favour CBT, and that researchers are biased in CBT efficacy studies. He contends that attempting to measure psychotherapy as a science constitutes an attempt to influence opinion. Marzillier (2009) agrees that focussing on symptom reduction to prove CBT's efficacy is skewing the evidence to support the modality. He claims the Diagnostic and Statistical Manual of mental disorders (DSM) classifications of illness are overly rigid and allow for an easily quantifiable method of measuring symptom reduction, but that other ways to measure improved mental health, that take the whole person into account, may be preferable. Westen, Novotny, & Thompson-

Brenner (2004) found that RCTs appear to be valid for some disorders and treatments (notably exposure-based treatments of specific anxiety symptoms) but not for others.

Veale (2009), an advocate of CBT, contends that it is not only RCTs that prove the efficacy of CBT. He proposes that many experimental designs, case series studies, audits, routine monitoring, and cost-effectiveness studies prove that CBT is effective. Furthermore, he argues that NICE requires convincing evidence to support other modalities, and if this can be achieved, NICE will recommend them, which is now the case for interpersonal therapy (IPT), dynamic interpersonal therapy (DIT), couples therapy and counselling. As Salkovskis (2002) argues, all evidence is of value to develop clinical interventions with proven efficacy. Perhaps it is not fruitful to have such discord in opinions among psychologists as to whether CBT is effective or not, because CBT's large evidence base has helped raise the profile of psychological therapies *per se*.

Patient choice for therapy

Amongst psychologists, there has been concern that CBT is over-rated as a treatment method for common mental disorders (Cooper, 2009) and that this is reflected in the opinions of the people receiving therapy. Holmes (2002), for example, highlighted that CBT did not prove more effective than other approaches in a large trial for the treatment of depression. This type of research, and the concern that any benefits of CBT may not be lasting suggest that perhaps IAPT is over-reliant on CBT as the primary treatment of choice.

Marzillier (2009) claims that CBT does not have the psychotherapeutic value of the relationship between client and counsellor because it is short-term and focussed on

developing techniques. A plethora of evidence shows that the mechanism for psychological change is due to the therapeutic relationship (e.g. Lambert & Barley, 2001). Samuels (2009) claims that clients receiving CBT are approached in a mechanistic way and they are therefore passive in the receipt of therapy. Clark, Fonagy, *et al.* (2009) defend the claim that CBT does not pay attention to the therapeutic relationship. They point the reader towards the curriculum for high intensity therapists' training (IAPT, 2011) for evidence of the role of the therapeutic relationship. Many others have argued that the therapeutic relationship is not ignored in CBT (e.g. Gilbert & Leahy, 2007; Veale, 2009) as CBT requires collaboration and the client plays an active role in their psychological change.

The controversy around what therapy is most effective may convey a misrepresentation to the general public. If psychologists are arguing amongst themselves and damning various treatment modalities in favour of their own preferred method, the public may begin to doubt whether any psychological therapy is useful. Furthermore, such criticism of therapy chosen in the IAPT programme is belittling the good intentions behind the initiative, which is promoting the need to increase access to psychological therapies in this country. Fraser (2006) welcomes the training of more therapists to deliver IAPT treatments. People who use mental health services have said for a long time that they want talking treatments (DoH, 2006), and people who suffer from depression prefer psychological and psychosocial treatments to medication (Prins, Bosmans, Verhaak, van der Meer, van Tulder, & van Marwijk, *et al.*, 2011). So IAPT is undeniably a step in the right direction. Nevertheless, IAPT aims to offer patient choice over the type of therapy patients receive (Richards & Suckling, 2009) and if CBT is the prevailing therapy patients can choose, this leaves them with little 'choice'.

Before other modalities were introduced in IAPT, Fraser (2006) highlighted that CBT is effective for about 50% of cases, so for half the people treated CBT is not effective. However, with the introduction of IPT, DIT, couples therapy and counselling for depression, the recovery rate in IAPT is still no more than 50%. This means that over half the people treated are not being cured and this raises questions over what the mechanism of recovery is.

The standardisation of treatment and achieving targets

Hoggett (2010) has highlighted the emphasis on performance management, where practitioners are scrutinised on their targets and performance at work. IAPT workers are required to carry out strictly standardised assessment and treatment protocols, record large amounts of outcome measures each time they have contact with a client (which are under continuous review), and to demonstrate that they have made a large volume of clinical contacts each week (Rizq, 2011).

Rizq (2011) argues that the IAPT system prioritises targets, outcomes and protocols over the reality of the patient's emotional suffering. She maintains that the NHS is now increasingly driven by private sector notions of competition and 'managerialism' (Loewenthal, 2002) in order to make it more efficient and responsive to the customers' needs. As funding is dependent on service performance, the NHS is beholden to targets and indicators so that accountability and neo-bureaucracy (Harrison, & Smith, 2003) and economic rationalism are prioritised over basic trust in the health professionals (O'Neill, 2002).

Rizq (2011) contends that considering the scale of IAPT's therapeutic ambitions, it is not surprising that the programme invokes anxiety amongst its workers. She believes that this contributes to therapist burnout, in which the therapist can no longer provide

the necessary emotional care to every one of his/her clients when there are so many.

The desire to help the client is at odds with the reality that staffing, funding and clinical capacities are limited.

RCT methodology assumes that treatment is standardised so that different therapists can deliver exactly the same therapy (Rawlins, 2008). In IAPT, this has been done by manualising the approach taken (whether it is CBT, IPT, DIT or counselling), stating what the therapist should do and when. There is a major problem with this notion in psychological therapy because the dialogue between therapist and client is by nature unpredictable (Bohart, & House, 2008). Furthermore, the delivery of manualised treatment protocols means that the professional judgement of how to respond to each individual client in specific situations is over-ridden by a set of prescriptive instructions. Rizq (2011) argues that the highly standardised protocols that workers are required to follow in their work can thwart their instinctive empathic reactions to clients' emotional distress because they are too busy thinking about whether they have followed the protocol correctly.

Due to financial constraints and the search for cost-effectiveness in delivering healthcare services, Lemma, Target, & Fonagy (2010) have designed a manualised version of psychodynamic therapy for IAPT services (DIT). There are a growing number of researchers and clinicians forming Practice Research Networks which intend to offer "an alternative to traditional clinical studies" (Smith, Sexton, & Bradley, 2005, p.285) that are scientifically rigorous. The argument that psychological therapy research could embrace non-RCT relational methodologies in an inclusive paradigm (including a mixed-methods approach) is supported by many (e.g. McLeod, 2001, 2003; Schmitt Freire, 2006; Marshall, & Rossman, 2006; Bohart, & House, 2008; Guy, *et al.*, 2011). Qualitative researchers "tend to be concerned with the quality and texture

of experience, rather than the identification of cause-effect relationships” (Willig, 2008, p.8).

The training of clinical staff

Concerns have been raised over whether the training of clinical staff in the delivery of IAPT is adequate, contributing to the idea that the delivery of treatment may focus more on treating a quantity of people rather than delivering quality treatment. Samuels (2009) claims that IAPT’s training in CBT is relatively short. Byng and Gask (2009) argue that low-intensity practitioners often have little experience in mental health, yet are considered to be able to deliver a wide range of brief interventions in addition to having the expertise to notice when it is appropriate to signpost patients to other community services. The appropriate training and support of practitioners comprises a principal challenge in ensuring that the IAPT programme will improve the nation’s well-being (Turpin, *et al.*, 2008). Rizq (2011) highlights that the training is short and some of the complex psychological issues people are referred for are beyond the capabilities of less experienced IAPT workers.

In defence of IAPT, however, before the inception of the programme there was a considerable dearth of trained therapists to deliver treatment, which resulted in long waiting times and high levels of unmet need (McHugh & Barlow, 2010). At the time of Layard’s (CEP, 2006) report, as few as one in four people with depression or anxiety were accessing some form of treatment, primarily in the form of medication (Chilvers, Dewey, Fielding, Gretton, Miller, Palmer, *et al.*, 2001). Waiting lists for therapy exceeded nine months, and not all areas even had a service. More people are receiving psychological treatment now than ever before (DoH, 2012).

Loss of jobs and expertise for psychologists

Due to the IAPT programme delivering predominantly CBT thus far, many psychologists have either lost their jobs or have had to retrain as CBT therapists, even though they were already highly trained psychologists (Himsworth, 2009). In response to this, Perren (2009) contended that in its initial stages, IAPT delivered only CBT due to its robust evidence base. Furthermore, IAPT training now includes a range of evidence-based therapies, which NICE (2009) includes as IPT, DIT, counselling for depression, and couples therapy.

The effectiveness of IAPT treatment

IAPT's original concept was to deliver CBT to people suffering from anxiety and depression. However, the low-intensity therapy that the majority of patients from the Pathfinder sites received is very different from the CBT treatment that was delivered in the research studies that contributed to the NICE guidelines (Cooper, 2009). Low-intensity therapy intervention is mostly guided self-help with work-books, and many sessions are short 20-minute conversations over the telephone. Only 27.3% of patients referred to the Pathfinder sites were offered CBT, and this group received on average 6-7 therapy sessions, under half the number that NICE recommends (Cooper, 2009). On receipt of these interventions, which deviate somewhat from the original proposition put forth by Layard, half the patients were said to have recovered. Despite the delivery of interventions not appearing to reflect standard CBT, IAPT has provided an advance in the provision of psychological therapies, and this has been welcomed by psychologists (Cooper, 2009).

In support of the efficacy of self-help at low-intensity level, evidence from 34 randomised controlled trial studies demonstrated that the efficacy of self-help

interventions for depression had an effect size of 0.8 (Gellatly, Bower, Hennessey, Richards, Gilbody, & Lovell, 2007). Evidence for guided self-help has been shown to be effective in the treatment of mild to moderate depression (NICE, 2007).

Furthermore, there are more interventions available at low-intensity. Internet based computerised CBT (CCBT) and brief therapy (Roth & Pilling, 2008), including Behavioural Activation (BA), are available as well as self-help. CCBT for depression has achieved positive results (Kaltenthaler, Brazier, De Nigris, Tumor, Ferriter, Beverley, *et al.*, 2004), and the effectiveness of BA has been found in the treatment of depression (Ekers, Richards, & Gilbody, 2008; Jacobson, Martell, & Dimidjian, 2001).

It may be argued that giving people such a limited number of sessions in the IAPT programme is setting it up to fail in the way its critics predict, as the impersonalised method of delivering treatment in the manner of a ‘factory’ to deliver quick-fix interventions seems cold and uncaring. Clark, Fonagy, *et al.* (2009) believe that people do not receive less treatment than they require, as low intensity intervention offers 4-8 sessions with the flexibility to extend that contract. Overall, the idea is that stepped-care services are cost-effective.

CBT treatment has been criticised for its benefits not being lasting. Samuels (2009) argues that treatment benefits of CBT are only short-term, and that longer-term therapies have good results. Fitzpatrick (2006) suggests that “the notion that a few weeks of CBT will transform miserable people languishing in idleness and dependency into happy shiny productive workers is embarrassing in its absurdity” (p.729). Support for this comes from Westen, Novotny, & Thompson-Brenner (2004) who found that approximately 67% of patients treated for depression had relapsed two years post-treatment.

Veale (2009) admits that CBT has its limitations, and that it cannot offer a quick fix, but he argues that it has a strong research base and is more cost-effective than medication in the long-term. He also claims that the accessibility of clinical materials and education of skills for its delivery contribute to the rationale for the choice of CBT in IAPT.

GPs' limited specialist knowledge of mental illness

There is apprehension that GPs' lack of formal training in mental health will present a problem for IAPT services now that CCGs are responsible for commissioning services instead of PCTs. It is possible that GPs may prefer health services other than psychological therapies, which might mean that cheaper alternatives to quality psychological services will be preferred (Turgoose, 2011).

It may also be considered that GPs commissioning services is a positive notion, as psychological therapy services will need to strive to maintain quality outcomes so that GPs continue to refer to their service locality. This should cause services to continuously ensure that they deliver optimum treatment. It will increase the pressure on services however, to produce scores which prove effective service delivery and to prove that they are reaching targets. This may contribute to the culture of manualised protocols to standardise treatments and lessen the importance of the personal relationship between therapist and client in therapy.

SUMMARY

When there is a new development in mental health, it is often met with different reactions (Elliot & Popjay, 2000; Neale, Vincent, & Darzi, 2007; Smith, 2000). It is not surprising then, that the introduction of IAPT produced some polarized views. Despite the criticisms of IAPT, and its research evidence implementation (Bolsover, 2007), IAPT is here to stay (Yardley & Moss-Morris, 2009).

The concern that the economic and political drive behind IAPT has induced an obsession within services with standardised treatment protocols puts pressure on IAPT workers to meet their targets and ensure that they deliver manualised, standardised therapy. The ever-increasing targets and demands on services may cause therapist burnout and a lack of a personal approach of a therapist with his/her client. It could also be argued that the IAPT treatment is a quick fix and that a number of people may be receiving therapy but the quality and durability of the treatment is questionable. This is something IAPT may need to be aware of, as the pressure to keep costs down and to compete with other services for funding is likely to increase.

It has been raised in this review that there is a widespread view that RCTs are not the only research methodology NICE should take seriously when considering the effectiveness of therapies. Hopefully, with more researchers and clinicians drawing attention to this and gathering more data to prove effectiveness in different ways, NICE will become more flexible in the research it considers. Many hope this will include the rich data of experience that qualitative research produces. It is also commonly felt that treatment in IAPT should not focus on symptom reduction. Perhaps this will become less of a focus when NICE accepts more research that is not produced simply from

RCTs. This will also hopefully enable more varied therapy options in order to develop patient choice.

IAPT has already evolved from offering solely CBT to include IPT, couples therapy, DIT and counselling for depression. Although it is a concern that only 50% of patients move to recovery, it is important to note that IAPT is not yet fully developed, and in the future it will likely develop treatment approaches and service delivery methods. In the meantime, it would be logical for those who work in IAPT to continue to undertake research in an attempt to gather evidence to convince the government which therapies would be worth funding.

In considering increasing access, two important considerations exist. Firstly, although the programme may currently not reach all areas of society, endeavours are being made to ensure that the service is equitable. Secondly, if 50% of those who receive treatment are deemed to move to recovery, it is important that we find a way to help the other 50%. Overall though, IAPT has helped to identify psychotherapeutic need and at least people now have the option of talking therapy where previously they would not.

CONCLUSION

Many professionals who deliver psychological therapies are pleased that IAPT has helped to raise the profile of talking therapies. People with mental health problems had pleaded for a long time for talking therapy to be an available option for treatment before IAPT was introduced. However, there are still considerable criticisms of IAPT. It appears from the literature that NICE may need to reassess how they measure effective therapy if, by their own admittance, they focus on diagnosis and symptom reduction when there is not necessarily a classification system that links to aetiology or

response to treatment. Perhaps it is easier to prove therapy's effectiveness with numbers and percentages, but focussing on symptom reduction is flawed if, as research suggests, the effectiveness of therapy is about the relationship between therapist and client. If this is the case, some attention needs to be paid as to how to measure the relational outcomes of therapy because it is clear that the pressure will only increase on services to prove their effectiveness in order to receive funding in this time of economic strain. Perhaps if NICE begins to consider qualitative studies in proving efficacy, the way in which services can prove their effectiveness may change.

The pressure that the economic and political drive behind IAPT puts on the services to deliver to high standards means that IAPT services will need to try not to lose out on quality at the cost of quantity in achieving targets and outcomes.

IAPT has successfully increased access to psychological therapies, improved employment rates, and claims to have a 50% recovery rate. The programme is still not complete, and in the near future, it will need to meet its aim of achieving equality and diversity, and for services to become more integrated to ensure people receive a more holistic care with long-term benefits. IAPT services need to focus on gathering evidence to understand how to improve the well-being for the 50% who do not seem to benefit from treatment in IAPT.

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Chapter C: Research

An investigation on the
experience of group treatment
for obesity and attachment style
as a predictor of intervention
outcome: A mixed methodology
study

ABSTRACT

Aim

Within the field of obesity, evidence shows that weight regain following weight loss is extremely common, demonstrating that weight loss treatments are not effective. Considering that attachment history influences a person's capacity for emotional regulation and that some people use food to self-soothe, increasing our understanding of the relationship between attachment style and obesity might inform better treatments. This study is comprised of two parts: the first part investigates whether attachment style predicts outcome in a 12-session group treatment for obesity and the second part explores the experience of that treatment.

Design

The study utilises a mixed methods design with participants from a group treatment for obesity which comprises: the Attachment Style Questionnaire (ASQ), completed by 52 group members, along with their body mass index (BMI) measures at the start and end of the treatment, analysed using a backwards multiple regression to test whether the 5 dimensions of the ASQ can predict participants' change in BMI; and semi-structured interviews with 7 people from the same treatment analysed according to Interpretative Phenomenological Analysis (IPA) guidelines.

Method

Data was collected from 52 people attending group treatment for obesity with an NHS service in South East England, which included the ASQ and BMI measures at Week 1 and Week 12 of treatment. The change in BMI was entered as the dependent variable for the regression in SPSS and the five attachment dimensions were entered as predictors. 7 people who had taken part in Part I of this research participated in interviews about their group experience. Transcripts were subjected to IPA.

Results

Quantitative findings produced a model in which the ASQ dimension Confidence (in relationships) significantly predicted change in BMI in a negative direction (i.e. the participants who scored higher on Confidence lost less weight than those with lower scores). Confidence explained 8% of the variance ($R^2=0.08$, $F(1,50)=4.32$, $p<0.05$). Qualitative findings produced four super-ordinate themes which included: the sadness at the course ending; the support and comfort felt from others in the group experience; the positive aspects of the group treatment; and the negative aspects of the group treatment. Other group members appeared to have a substantial impact on participants, whether positive or negative. Some accounts reflected the importance of others in feeling accepted and supported. Other accounts conveyed less of an emphasis on feeling part of the group and more on feeling separate.

Conclusions

The quantitative results are inconclusive and possible reasons for this are discussed. The qualitative findings suggest that it is likely that group intervention for obesity could be improved by attention to attachment and by tailoring treatments more specifically to individuals.

INTRODUCTION

Argument for the current study

Research suggests that obesity might be linked to comfort eating in response to negative emotions relating to attachment insecurity (Gluck, Geliebter, & Lorence, 2004). If overeating is a means of managing insecure attachment due to a deficit in the capacity to self-soothe, it is possible that treatment programmes would do well to target this. Evidence shows that attachment style impacts on outcome in individual and group treatments and that some respond better to interpersonal treatments and others to CBT (e.g. Tasca, Ritchie, Conrad, Balfour, Gayton, Daigle, *et al.*, 2006). Increasing our understanding of whether attachment style affects outcome in group treatment for obesity might indicate a necessity to consider attachment style in treatment allocation (i.e. individual or group; interpersonal or CBT). Helping obese people who use food as a means of emotional management may include improving emotional regulation, by focusing on self-soothing and self-esteem. Existing treatments that prevail are CBT-based, which have proven effectiveness for many disorders but perhaps could be enhanced by incorporating a focus on theory and research in close relationships for the treatment of obesity.

The aim of the current research project is to contribute to our understanding of whether attachment style affects outcome in group treatment for obesity and to inform how people use the intervention. The findings will contribute to the evidence base of group CBT intervention for obesity and will provide a better descriptor of how people use the intervention. They might inform whether treatment approaches could be more specifically tailored to certain individuals by adopting a more interpersonal emphasis.

Clinical definition of obesity and BMI

Obesity has been defined as a disorder where excess body fat has accumulated to the extent that health may be compromised (Royal College of Physicians, 1998), usually indexed by the ratio of weight (in kilograms) to height (in metres) in Body Mass Index (BMI). Although BMI is not an exact measure of body fat (World Health Organisation: WHO, 2000) because it varies across age, gender and ethnicity, it correlates well with body fat mass (Gallagher, Visser, Sepulveda, Pierson, Harris, & Heymsfield, 1996) and the risks of diseases related to obesity (Haslam, & James, 2005). An individual is obese if their BMI is 30 kg/m^2 and over and morbidly obese if their BMI is 40 kg/m^2 and over (WHO, 2008).

Lambert Adolphe Quetelet, the Belgian mathematician, invented BMI in 1830 (Eknoyan, 2008). He was attempting to describe the average man by quantifying mean values of measured variables of weight and height that follow a normal distribution. In the 1970s when the obesity epidemic was beginning (2.7% of men and women were obese: WHO, 2000), the formula was used as a simple calculation to predict the prevalence of obesity-related conditions in various populations. BMI became a popular diagnostic tool for obesity due to its ease of use, and in 1985 the National Institute of Health Consensus Development Panel concluded that BMI was an appropriate measurement of obesity (NIH, 1985). BMI is still the official measurement of obesity to this day (Eknoyan, 2008).

Estimates of incidence, prevalence, and prognosis

In England one in four people are reported to be obese, affecting an equal number of women and men (National Institute for Health and Care Excellence: NICE, 2006). Numbers of incidence are continuing to grow (Wang, Colditz, & Kuntz, 2007). It has

been estimated that by 2050, 50% of the adult population will be obese (Department of Health: DoH, 2009). 3.5% of women and 1.5% of men in England are currently reported to be morbidly obese (Lobstein, & Jackson-Leach, 2007). Obesity poses serious threats to individuals' health as excess weight gain increases the instances of cardiovascular diseases, diabetes and cancers (Wang, McPherson, Marsh, Gortmaker, & Brown, 2011), as well as mortality rates (Haslam, & James, 2005). It is therefore becoming increasingly important to understand obesity in the hope that the cause can be unravelled and an evidence-based effective treatment developed.

Costs associated with obesity

Apart from improving the health of society, identifying effective treatment for obesity could make substantial savings to the country's economy. Overweight and obesity (and the associated health risks) costs the NHS more than £5 billion every year and it has a wider impact on economic development (DoH, 2011). Apart from direct medical costs, the economic impact of the obesity epidemic includes productivity costs. This involves employees being absent from work for obesity-related health problems, decreased productivity of employees while at work and higher rates of disability benefit payments (Hammond, & Levine, 2010).

The cost to the NHS is predicted to rise to £9.7 billion by 2050 and the wider cost to society is estimated to rise to £50 billion per year (DoH, 2009). The prevention of obesity is an important public health challenge and the government Public Health White Paper (HM Government, 2010) shows its commitment to tackling the high levels of overweight and obesity in England. Increasing our understanding of obesity and improving our treatments will hopefully help tackle this growing epidemic, and in this

difficult time of recession it is important that people will continue to have access to services within their health system.

Causes of obesity

In order to target the problem of obesity effectively, it is becoming increasingly important to determine the causes of weight gain and obesity, as this might provide more of an understanding as to how to lose weight and maintain weight loss. The condition of obesity is so multi-faceted that there is no single agreed aetiology. If energy intake exceeds energy expenditure, adiposity (body fat) rises and over time weight gain occurs. The cause of the population's excess weight therefore is due to increased energy intake, inactive lifestyle, or both (Canoy, & Buchan, 2007).

Humans have evolved to show a preference for energy rich, high fat foods (Blundell, & Gillett, 2001). This, along with traits of a high threshold for satiety and a low threshold for hunger leaves us susceptible to obesogenic environments (Cannon, & Buchan, 2007). The term 'obesogenic environment' refers to the accumulative environmental factors that promote obesity by impacting on the population's energy intake and expenditure (Egger & Swinburn, 1997). The obesity epidemic is a worldwide phenomenon across ethnic, geographical, gender and age groups, which suggests that the problem lies in environmental and/or behavioural and/or psychological changes, rather than biological changes.

Biological factors

Twin studies estimate heritability of BMI to be between 50–70%, and heritability for total body fat to be 80% (Andreasen, & Andreasen, 2009). These numbers, along with twin studies, have demonstrated that obesity is partially genetically regulated. Several

methods for finding genes that control obesity have been employed. Genetic studies have shown that obesity appears to be polygenic with no simple inheritance pattern and with a significant contribution from environmental factors (Walley, Asher, & Froguel, 2009). Studies which attempt to find genes responsible for obesity are complicated by the contribution of environmental factors like physical activity. Generally, studies on the inheritance of obesity have found that many different genes have only a small effect on weight (Ravussin, & Bouchard, 2000).

If obesity develops in childhood, there is an increased chance that it will continue into adulthood. Parental attitudes towards diet composition and overweight contribute to the development of a child's obesity and they also have an effect on the child's choices as an adult (Power, & Parsons, 2000). Furthermore, if a child gains weight, the irreversible increase in the number of fat cells means that they are more likely to be obese in adulthood (Brownell, 1986).

Environmental factors

The prevalence of obesity has risen too quickly in Western cultures for it to be due solely to biological factors (WHO, 2000). Environmental factors affect weight gain at the level of the whole population and at the level of the individual. Increasing urbanisation and industrialisation has caused humans to be less active in the process of obtaining food, farming food and participating in manufacture and commerce. This inactivity has occurred as the prevalence of obesity has increased across the world (Parry, 2007), suggesting causation.

People now use their cars more and the ready availability and low price of food impact on a population's eating patterns (Lester, 1994). In many countries, the type of food available includes more ready-to-eat, fast and snack foods (Lester, 1994). Foods higher

in fat are often cheaper and more readily available than healthier foods. There is also more advertising of higher fat, processed foods than healthy foods, which encourages consumption.

Socioeconomic status is another factor that has been found to predict obesity in adults (Parsons, Power, Logan, & Summerbell, 1999). According to Parry (2007), those who are socio-economically disadvantaged have higher rates of obesity, as they are more likely to be sedentary and undertake less physical exercise.

Psychological risk factors

Research has found that there is a high prevalence of anxiety and depression in people who are obese (Stotland, & Larocque, 2004; Davis, Rovi, & Johnson, 2005; Greenberg, Perna, Kaplan, & Sullivan, 2005). A high rate of poor body esteem has been found in obese populations (Friedman, Reichmann, Costanzo, & Musante, 2002). Poor self-esteem and depression have been found to be very high in bariatric surgery candidates (Franks & Kaiser, 2008; Sansone, Schumacher, Widerman, & Routsong-Weichers, 2008; Wilde, Kalarchain, Marcus, Levine, & Courcoulas 2008; Buckroyd, Somers, Slater, Biglari, & Mustafa, 2009), who are people who are at least morbidly obese.

It is hard to separate cause and effect when considering psychological risk factors and obesity, but it is most likely that there is both a cause and effect relationship. Indeed, longitudinal studies have found that depression predicts the subsequent onset of obesity (Hasler, Pine, Gamma, Milos, Ajdacic, Eich, *et al.*, 2004) and obesity has been found to predict the subsequent onset of depression (Roberts, Deleger, Strawbridge, & Kaplan, 2003). Successful weight loss has been found to decrease depression (Dixon, Dixon, & O'Brien, 2003), and depression has been found to predict poorer success in weight loss

(Linde, Jeffery, Levy, Sherwood, Utter, Pronk, *et al.*, 2004; McGuire, Wing, Klem, Lang, & Hill, 1999).

A Cochrane systematic review found that studies have generally been unable to detect differences in global aspects of psychological functioning between obese and non-obese people (Shaw, O'Rourke, Del Mar, & Kenardy, 2009). However, this is the opposite of clinical impression, what obese people report and what many studies demonstrating the effects of stigma suggest (Friedman, & Brownell, 1995). It is also at odds with a large amount of data produced by Felitti (Felitti, 1991; Felitti, 1993; Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, *et al.*, 1998; Felitti, 2003) who found a history of abuse and trauma in obese people. The limitations within the studies reviewed by Shaw, *et al.* (2009) might account for the surprising results, rather than the findings being an accurate reflection of the psychological well-being of people who are obese. Furthermore, studies which have found weight loss to correlate with improved self-esteem, social functioning and well-being support the concept that overweight is associated with negative psychological outcomes compared to normal weight (Kushner, & Foster, 2000).

Another risk factor for obesity is Binge Eating Disorder (BED), which is defined as recurring episodes of eating significantly more food in short periods of time than most people would eat under similar circumstances (American Psychiatric Association, 2013). Binge eating is associated with feeling out of control. Following a binge, the individual is likely to feel guilty, embarrassed or disgusted. Approximately 30% of obese people have been diagnosed with BED (Devlin, Walsh, Spitzer, & Hasin, 1992).

People with obesity often use food as a coping mechanism for when they feel sad, anxious, stressed, lonely, and frustrated (e.g. Telch, & Agras, 1996; Chua, Touyz, &

Hill, 2004). Gluck, *et al.* (2004) found that up to 46% of people defined as obese are binge eaters. Binge eating is essentially the same definition as BED, with the distinguishing feature between them being that BED happens more frequently and over a longer period of time. In many obese individuals, evidence of cycles of mood disturbance, overeating and weight gain has been found (Chua, *et al.*, 2004). Upon feeling distressed, these individuals turn to food to ease the pain of emotional discomfort.

If 46% of people defined as obese eat in response to negative emotions (Gluck, *et al.*, 2004), and neurological research findings have demonstrated a relationship between attachment history and the individual's capacity to regulate their emotions (Schorer, 2000, 2002), then emotional eating is related to attachment theory. Attachment theory (Bowlby, 1969; 1977) describes how interactions from early experiences influence the way we form subsequent relationships. Fundamentally, the attachments that we form with other people are either secure or insecure. People who are securely attached are capable of self-soothing and using other people as part of their self-soothing resource. Conversely those with insecure attachment have difficulty in managing their feelings and are more likely to find alternative ways of soothing themselves (Schorer, 2001; Gerhardt, 2004). This can include food, as large quantities of fats and sugars release opioids and cannabinoids in the brain (Colantuoni, Rada, McCarthy, Patten, Avena, Chadeayne, *et al.*, 2002). These are chemicals that are 'feel good' and can fulfil the function of soothing against emotional pain.

Overeating is just one type of behaviour that may be influenced by early experience. Prior and Glaser (2006) stated that approximately two thirds of the population is securely attached. As secure attachment is defined as an ability to self-soothe and insecure attachment is defined as an inability to self-soothe, roughly one third of the

population displays affect dysregulation (Schoore, 2003). This is associated with the inability to manage feelings and hence the desire to pursue activities which distract from the emotional pain and instead produce chemicals in the brain or release hormones that induce a positive mood. These include drug taking, gambling, and excessive engagement in sex, drinking alcohol, and watching pornography.

In order to gain more of an understanding as to why eating is not always about feeling hungry, it may be necessary to consider the influence of attachment in obesity research.

Treatment for obesity

In the treatment of obesity, NICE (2006), which sifts through the best available evidence, recommends dietary and activity changes, CBT, medication and surgery as viable options. However, although interventions often result in fast initial weight loss, with the greatest at six months, (Turk, Yang, Hravnak, Sereika, Ewing, & Burke, 2009) this weight is often regained soon after (Jeffery, Epstein, Wilson, Drewnowski, Stunkard, & Wing, 2000; Wu, Gao, Chen, & van Dam, 2009) because the increased exercise and/or lower food energy diet proves difficult to maintain (Tate, Jeffery, Sherwood, & Wing, 2007). According to Elfhag, & Rössner (2001), factors that pose a risk for weight regain include a history of weight cycling (i.e. repeated dramatic increases and decreases in weight), binge eating, eating in response to negative emotions and stress, and more passive reactions to problems.

Habits which cause people to become obese are life-long and difficult to change. Teixeira, Going, Sardinha, and Lohman (2005) found that intervention consisting of a reduced calorie diet, exercise and behaviour modification was only effective in the long term for 20 per cent of overweight people. This is defined as losing at least 10% of initial body weight and maintaining the loss for at least a year. Women who engage in

emotional eating have been found to regain the weight almost immediately after the intervention (Teixeira, Silva, Coutinho, Palmeira, Mata, Vieira, *et al.*, 2010).

Medication

NICE (2006) recommend the use of Orlistat in some obese individuals, as it blocks the action of a protein in the body that is used to digest fat, so that approximately one third of the fat eaten is not absorbed into the body. Pharmaceutical companies have released data indicating that Orlistat can help prevent further weight gain but that it does not cause weight loss and a low-fat diet and exercise is required alongside the medication. However, there are no studies into the effectiveness of Orlistat beyond one year, which suggests it has limited use in the long term.

Diet and lifestyle

Treatment aims to reduce weight focussing on lifestyle issues such as diet and exercise. Most obese people are advised to reduce the energy intake from their diet by 600 calories a day (NICE, 2006). Instead of choosing unhealthy and dense-energy foods, the advice is to make healthier choices. A calorie-controlled diet is supposed to be combined with regular exercise, as it leads to greater fat loss than either treatment alone (Crest, 2005). Obese people have been shown to have a poor rate of maintaining exercise behaviours that led to weight loss due to a lack of tolerance and enjoyment (Ekkekakis, & Lind, 2006)

Psychological interventions

Psychological weight loss treatments are either one-to-one or in a group. Currently, NICE (2006) guidelines advise that CBT should be employed to effect change in the

treatment of obesity. Other psychological interventions have been less rigorously evaluated for their efficacy as weight loss treatments.

NICE relies on Randomised Controlled Trials (RCTs) to prove the effectiveness of a therapy, which are studies where people are randomly allocated to receive a particular treatment. NICE also views mental health problems as treatable by reducing symptoms (NICE, 2009). RCTs have been criticised for being too unlike real-life situations (Rawlins, 2008) and it has been argued that NICE should not consider mental health conditions in a medicalised way in which symptom reduction is the goal (Guy, Thomas, Stephenson, & Loewenthal, 2011). If more qualitative research findings were considered by NICE or if there was an obvious way of measuring unconscious and relational processes that convinced NICE of therapies that are more interpersonal in approach, the suggested treatment for obesity may be different to the current recommendation of CBT.

Fairburn, Cooper, & Shafran (2003) have found that maintenance factors for some individuals with eating disorders who may not respond to conventional treatments include problems with affect regulation, interpersonal difficulties, and low self-esteem. Given that these themes are relevant to obesity, it might be suggested that obesity treatments could improve by incorporating a more interpersonal approach. These individuals may respond better to therapies that resist the current conceptualisation of ‘evidence’, which includes the consideration of unconscious processes. In psychodynamic therapy, the aim is to resolve the patient’s unconscious intrapsychic conflict through the therapeutic relationship. (MacLoughlin, 1995).

Teixeira, *et al.*, (2005) found that a reduced calorie diet, and exercise and behaviour modification worked for people with a self-directed, self-motivated cognitive style that

had undergone few previous weight loss attempts. However, this treatment was only effective for approximately 20% of obese people (Buckroyd, 2011). Buckroyd (2011, p.67) argues that “changing eating behaviour, for many people, is a psychologically and emotionally far more complex task than has so far been recognised”. Obese people have different psychological needs and it is unlikely that all obese people will respond to only one approach. For example, many people seeking treatment may be best suited to psychotherapy, rather than the more readily prescribed CBT. The need for a variety of treatments was identified over 20 years ago (Brownell, & Wadden, 1992) and yet there is still little treatment choice available for people with obesity.

Behaviour therapy involves restricting excess food consumption, enhancing healthy food choices, and increasing physical activity. Treatment aims to provide methods to enhance motivation to maintain a healthier lifestyle beyond the early stages of weight loss (Wing, & Greeno, 1994). Motivation is defined as the arousal of an organism to act towards a desired goal and to sustain certain goal-directed behaviours (Schater, 2011). In psychology, brief motivational enhancement interventions have been developed to aid with resistance to therapy, such as motivational interviewing (Miller, & Rose, 2009).

The techniques used in behaviour therapy include goal-setting and self-monitoring. Cognitive strategies in CBT for weight loss aim to increase the individual’s awareness of unhelpful thinking patterns and mood states and to modify them to assist weight loss (Wilson, 1999). The aim in weight loss programmes is for a relatively small but sustainable weight loss (5-10% of initial body weight) and improved psychological well-being. 5–10% weight loss for overweight or obese people is recommended because a weight loss of 5% has a beneficial effect on cardiovascular risk factors associated with obesity (Anderson, & Konz, 2001; Vidal, 2002) and reduces the risk for

diabetes (Tuomilehto, Lindstrom, Eriksson, Valle, Hamalainen, Ilanne-Parikka, *et al.*, 2001). Shaw, *et al.* (2009) found support for treatment in which CBT, and dietary and exercise strategies were used to achieve weight loss but they did not comment on this treatment's value for achieving maintained weight loss.

Most weight loss treatment is carried out in group settings (Renjilian, Nezu, Shermer, Perri, McKelvey, & Anton, 2001). This involves education and therapy in the manner of social support, problem solving and encouragement, but rarely involves delving deep into psychological issues. There is a lack of studies into group treatment for obesity, but there is a large body of evidence which has looked at group processes and the effectiveness of group interventions in other areas of psychology (e.g. Smith, E., Murphy, & Coats, 1999; Markin, & Marmarosh, 2010; Harel, Shechtman, & Cutrona, 2011). Considering people's experience of current group treatment for obesity might indicate whether it could be improved by taking more of an interpersonal angle.

Despite the fact that research evidence highlights the psychological causes and consequences of obesity, treatment services are more focussed on targeting diet and exercise behaviours. Intervention may improve with an increased emphasis on psychological treatment but furthermore, treatment which divides people according to their more specific needs. For example, some may benefit from CBT and others may benefit from an intervention with a more interpersonal approach.

LITERATURE REVIEW

Purpose

The purpose of this review is to summarise existing knowledge about obesity and its relationship to the concept of attachment and to consider how attachment relates to different treatment approaches in group therapy. The aim is to identify the gap in literature that this research hopes to fill.

The effectiveness of existing treatments for obesity

NICE (2006) recommends diet and exercise changes, CBT, medication and surgery in the treatment of obesity. However, people following intervention groups for obesity lose on average 9.5% of their starting weight and after 1 year, approximately only 50% of this weight loss is maintained (Anderson, Konz, Frederich, & Wood, 2001; Curioni, & Lourenco, 2005; Barte, Bogt, Bogers, Teixeira, Blissmer, Mori, *et al.*, 2010).

Therefore, at best, people following an obesity treatment programme maintain approximately a 5% reduction in their body weight at 1 year. A systematic review of 18 studies spanning 40 years found that any weight lost is regained after 2 years of a treatment combining reduced calorie and increased exercise (Wu, *et al.*, 2009). In fact, higher percentage weight loss during intervention has been significantly associated with higher percentage weight regain (Weiss, Galuska, Kettel Khan, Gillespie, & Serdula, 2007). Furthermore, repeated attempts to lose weight resulting in weight regain may have a negative impact on psychological factors, which may encourage further weight regain (Petroni, Villanova, Avagnina, Fusco, Fatati, Compare, *et al.*, 2007).

If 25% of our population are obese (NICE, 2006) and numbers of incidence are growing so that over 50% of the population are predicted to be obese by 2050 (DoH, 2009), it is clear that current treatments are not effective at treating obesity and our understanding is limited. The environment undoubtedly has an effect on the growing rates of obesity, with modernisation encouraging inactivity (Parry, 2007), but current understanding of how to stop this growing epidemic is still limited.

Therefore, the question of what constitutes an effective treatment for obesity is left unanswered. It seems clear that existing treatments are not working in the long term. The current research intends to address this by considering the effect of attachment style on outcome in group treatment.

Attachment theory

Attachment theory has become one of the main models to aid our understanding of emotion regulation and interpersonal relationships (Mikulincer, & Shaver, 2007b). Despite this, it is rarely used in the NHS due to the wealth of evidence promoting CBT. It has been suggested that treatment of eating disorders could be improved by attending to problems with affect regulation, interpersonal difficulties, and low self-esteem (Fairburn, *et al.*, 2003). These themes are relevant to attachment theory and other models that draw on early experience, such as Cognitive Analytic Therapy (CAT: Ryle, 1990) and schema therapy (Young, Klosko, & Weishaar, 2003) in CBT. The current study focuses on attachment theory rather than these more recent models because it is by far the best researched. Since its inception by Bowlby (1969), there has been a large body of further research to validate it. Hundreds of studies have investigated the effects of attachment style on relationship satisfaction, communication, support seeking and caregiving (for reviews see Cassidy, & Shaver, 2008; Mikulincer, & Shaver,

2007b). To further validate the use of attachment theory in this project, more recently, Cozzolino's (2010) work has produced evidence from neuroscience for attachment theory.

Attachment theory was developed by Bowlby (1969, 1977) to describe how interactions between a mother and infant could influence the psychological development of the infant and his/her future behaviour. The theory states that infants seek proximity to their primary caregiver, and the use of this figure as a secure base in the exploration of the world. Comfort and security is generated by maintaining closeness to the caregiver in times of distress. The resulting repeated interactions with the caregiver are encoded in implicit memory and an internal working model of attachments is formed which is used as the basis for interaction with the caregiver. An internal working model is a mental representation of an attachment relationship. Over the lifespan, the attachment system is shaped by interactions with attachment figures that yield fairly stable mental representations of attachment relationships (or internal working models), resulting in an attachment style (Gillath, Shaver, Mikulincer, Nitzberg, Erez, & van Ijzendoorn, 2005).

Attachment theory suggests that when parental behaviour fails to make children feel safe, secure, and able to trust the parents in times of need, then children will be less able to regulate their emotions and needs adaptively and will tend to develop negative, insecure views of themselves and others. Attachments are thought of as either secure or insecure (Bowlby, 1977) and a large body of evidence supports this (e.g. Ainsworth, Blehar, Waters, & Wall, 1978; Main, Kaplan, & Cassidy, 1985; Bartholomew, & Horowitz, 1991; Waters, Merrick, Treboux, Crowell, & Albersheim, 2000; Bolen, 2000; Fonagy, 2010). The evidence is in support of the behavioural clusters of attachment security. The difference in the internal process is not known but inferred

from Bowlby's suggestion. Bowlby (1988) suggested that internal working models affect the way that individuals interact with others, their emotion regulation, and how they cope with distress. Early insecure attachment (i.e. negative view of self or other) may cause the infant to become vulnerable to psychopathology in later life (Bowlby, 1977), due to repeated interactions with a caregiver where attention, love and comfort are not readily available, and therefore the infant learns that others are not always responsive. Therefore, it is relevant to consider attachment theory in the formulation and treatment of individuals with emotional problems, which includes eating disorders.

Early research on attachment featured the 'Strange Situation' experiment, which produced a model of child attachment behaviour (Ainsworth, 1979). In this experiment, the child was observed playing for 20 minutes whilst the caregiver left and re-entered the room, recreating the familiar flow of presence and absence of the caregiver in most children's lives. The child's responses were observed and categorised. Three main styles were identified, namely 'secure', 'avoidant' and 'anxious-resistant'. The 'secure' child becomes upset when their parent leaves the room, but on their return, will actively seek the parent and be easily comforted by him or her. 'Anxious-resistant' children become extremely distressed upon separation, and when reunited with their parents will find it hard to be comforted and will often show ambivalent behaviours. 'Avoidant' children do not appear distressed by the separation, and when reunited will actively avoid seeking contact with the parent, preferring to play with toys instead.

A fourth 'disorganised' style was proposed by Main and Solomon (1986) when they found that some children's behaviours could not be classified into the existing three styles. These children displayed behaviour that was described as being 'dazed' because they would appear confused or apprehensive in the presence of the caregiver. They

would both seek and avoid contact with the caregiver (Lyons-Ruth, & Jacobovitz, 1999). It was suggested that the caregiver shows inconsistent behaviour so the child may be afraid and reassured by the caregiver at different times, which results in confusion.

These attachment styles have since been expanded upon and researchers have been interested in how the internal working models developed during childhood can influence subsequent attachments made (Siegel, 1999). Hazan and Shaver (1987, 1990) suggested that the same styles of attachment that were seen in children could be observed in adult romantic relationships. A large body of literature has explored romantic and non-romantic adult attachment and the associated attachment styles since then (see Feeney, & Noller, 1996).

The Adult Attachment Interview (AII: George, Kaplan & Main, 1985) is a clinical tool used to classify adults' attachment styles by tapping their memories of their early relationships to caregivers. The four styles of adult attachment (secure, preoccupied, dismissing, and disorganised) match the four styles of secure, anxious-resistant, avoidant, and disorganised found in the children's literature (van Ijzendoorn, 1995). The following explains what behaviour characterises adult attachment styles:

Secure Attachment

Securely attached adults are able to regulate their emotions effectively (Fuendeling, 1998). They seek support within relationships, are comfortable with intimacy and desire closeness with others (Mallinckrodt, 2000). They show the ability to identify their emotions in the context of their attachment relationships (Main, Goldwyn, & Hesse, 2003). These individuals can predict in others potential feelings, needs and behavioural reactions, showing an understanding of cause and effect.

Dismissing Attachment

People with dismissing attachments (i.e. avoidant) have found that expressing their emotions in proximity seeking does not produce positive results (Fuendeling, 1998). As a result, these individuals have developed coping strategies such as emotional distancing (Fonagy, 2010). They struggle to be aware of emotions in themselves and others (Siegel, 1999) and they tend to be self-reliant (Shaver, & Mikulincer, 2002).

Preoccupied Attachment

People with preoccupied attachments (i.e. anxious) have difficulties regulating their emotions (Mikulincer, Shaver, Sapir-Lavid, & Avihou-Kanza, 2009). They may be aware of their negative emotional states, but their perception is often exaggerated (Mikulincer, & Florian, 1998). The individual is hypervigilant with respect to relationship losses. They tend to focus intensely on relationships, attempting to gain others' love, and put their own needs before others' (Bartholomew, & Horowitz, 1991). An anxiously attached individual will interpret a slight impatience from another as a rejection (Jurist, & Meehan, 2008).

Disorganised States

Disorganized states can occur as a result of childhood trauma (Bakermans-Kranenburg, & van Ijzendoorn, 2009). Adults displaying disorganised states have dysfunctional thinking styles and emotional regulation, which includes feelings of guilt and dissociation (Steele, Steele, & Murphy, 2009).

Bartholomew and Horowitz (1991) suggested that there were in fact two different types of avoidant attachment (Fearful and Dismissing). They argued that underlying their proposed four attachment styles (see Table 1) are two dimensions, 'model of self' and

‘model of other’, which can either be positive or negative (see Figure 1, p.70). An alternative way of categorising these two dimensions is ‘avoidance’ and ‘anxiety’ (i.e. ‘low avoidance’ is ‘positive model of other’, ‘high avoidance’ is ‘negative model of other’; ‘low anxiety’ is ‘positive model of self’ and ‘high anxiety’ is ‘negative model of self’). The four styles and the two theoretical dimensions of ‘anxiety’ and ‘avoidance’ that organise them can be seen in Figure 2, p.70.

Attachment style	Description of individuals
Secure	Confident, good social skills, form stable relationships
Fearful	Lacking in confidence, not comfortable being emotionally close to others, avoid long-term relationships
Dismissing	A positive view of self and a negative view of others, aloof and highly independent
Preoccupied	Negative view of self and positive view of others, lacking in confidence, frightened of rejection and abandonment, desire to be close to others

Table 1: Bartholomew & Horowitz’s (1991) Adult Romantic Attachment Styles

		Model of Self	
		Positive	Negative
Model of Other	Positive	Secure	Preoccupied
	Negative	Dismissing	Fearful

Figure 1: Bartholomew & Horowitz’s (1991) Model of Self and Other and Corresponding Attachment Styles

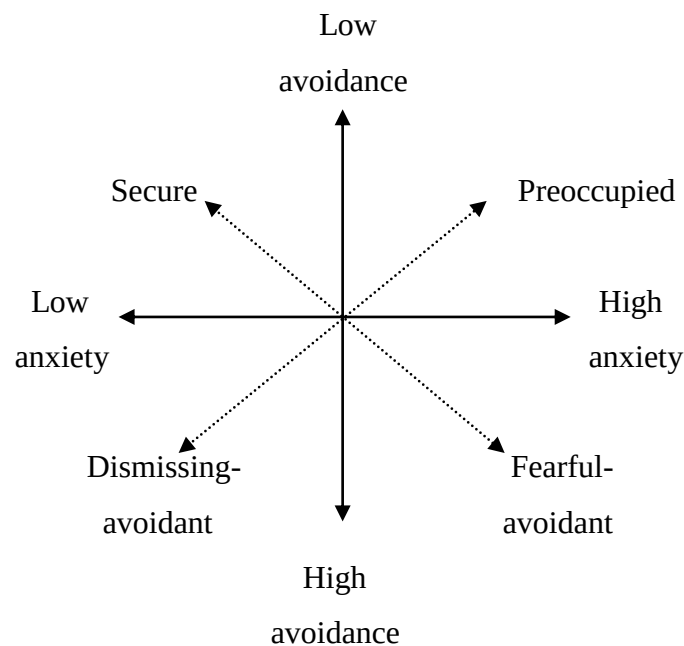


Figure 2: The Two-Dimensional Four-Category Model of Adult Attachment

As the approaches to measure adult attachment vary in both content and assumptions, there is a less cohesive body of evidence relating to the concept of attachment. This is exacerbated by the controversy over how many attachment styles there are and whether categorical or continuous measures should be used. Furthermore, most of the measures of adult attachment assume that participants are in a romantic relationship. Over someone's lifespan, the attachment system is shaped by interactions with attachment figures that lead to fairly stable individual differences in internal working models of attachment relationships, resulting in an attachment style (Gillath, *et al.*, 2005).

Categorical measures of attachment are limited as they imply that attachment styles are mutually exclusive, but evidence shows that attachment styles are weakly correlated (e.g. Carver, 1997; Fossati, Feeney, Donati, Donini, Liliana, Bagnato, *et al.*, 2003) and some individuals are high on both anxiety and avoidance (e.g. Mikulincer, & Shaver, 2003), which suggests that more than two types of attachment insecurity can occur.

Furthermore, while categorical measures show a 30% change in romantic attachment style over a short period of time, (e.g. Kirkpatrick, & Hazan, 1994; Baldwin, & Fehr, 1995), studies using dimensional assessments report up to 87% stability attachment style in adults (Sibly, & Liu, 2004). The Attachment Style Questionnaire (ASQ: Feeney, Noller, & Hanrahan, 1994) was developed to create a measure of attachment style which extended beyond category-based measures and to measure people without experience of romantic relationships. All critical ideas in Bowlby and Ainsworth's work were included in the development of the measure. Five dimensions are considered necessary to capture attachment styles. The measure covers the key qualities found in the three- and four- group models of adult attachment and the major themes of infant attachment theory (see Table 2). Fraley & Waller (1998) support the conceptualisation of attachment patterns in continuous, dimensional terms as they claim there is no evidence for a true attachment typology. They argue that multi-item dimensional measures demonstrate the greatest precision and validity.

	Positive view of self	Negative view of self
Positive view of other	Self-esteem Comfort with closeness Trust Healthy dependence	Overdependence Interpersonal anxiety Aloneness Desire for approval Lack of confidence Preoccupation with relationship
Negative view of other	Avoidance of intimacy Lack of trust Value on independence Compulsive self-reliance Emphasis on achievement	Low self-esteem Lack of trust Interpersonal anxiety Desire for contact and intimacy Need for approval Aloneness Anger/hostility

Table 2: Constructs Included in Feeney, *et al.*'s (1994) ASQ

In summary, the literature theorises that internal working models of attachment relationships are developed from early interactions with the caregiver which inform how we relate to others as adults (Feeney, & Noller, 1996). Attachment theory has been used to understand a broad spectrum of psychological difficulties, including anxiety and depression (Platts, Mason, & Tyson, 2005), psychosis (Berry, Barrowclough, & Weardon, 2007) and eating disorders (Ward, Ramsay, & Treasure, 2000).

Attachment and Obesity

Individuals with secure attachment can self-soothe and use others in that process (Schore, 2001). According to Prior and Glaser (2006), approximately two thirds of the population are securely attached. This suggests that one third of the population are unable to self-soothe and use others in the process of soothing when faced with emotional discomfort. This section of the population might find alternative sources that improve mood to help manage their lives. Some of these are activities that individuals would seek to change, such as gambling, and excessive engagement in sex or shopping. It is possible that overeating could be added to this list, as it has been found that foods high in fats and sugars release opioids and cannabinoids in the brain which make us feel good (Colantuoni, *et al.*, 2002). Therefore, it is possible that a significant contributing factor to obesity is overeating in response to affect dysregulation. On this basis, considering attachment experience in obesity might develop our understanding of the aetiology of obesity.

There is a substantial body of evidence linking emotional eating, binge eating and obesity. Binge eating has been found in response to unpleasant emotional states (e.g. Telch, & Agras, 1996; Chua, *et al.*, 2004). Gluck, *et al.* (2004) found that up to 46% of

people defined as obese eat in response to negative emotions. Canetti, Bachar, & Berry (2002) found that negative emotions are associated with a higher food intake amongst normal weight people and that this link is stronger in obese people. Buckroyd (2011) argues that the collective evidence suggests that approximately half of obese people might be turning to food in response to their unbearable feelings.

Binge eating has been found to predict weight regain (Kalarchain, Marcus, Wilson, Labouvie, Brolin, & LaMarca, 2002; Elfhag, & Rössner, 2005) and Byrne (2002) also found that weight regain correlated with life stress, negative coping style and emotional eating patterns. Therefore, if the reason why weight loss is not sustainable beyond a few years is that people are not equipped with the means to manage their affect regulation, it could be argued that more should be done in treatment to target this specifically.

Studies have found that stress and distress lead to an increased intake of ‘comfort foods’ with high fat and sugar content (Epel, Lapidus, McEwen, & Brownell, 2001; Freeman & Gil, 2004). It has been suggested that continuous stress increases the release of cortisol, which can lead to abdominal obesity (Gluck *et al.*, 2004; Rosmond, 2005). Cortisol production can be suppressed by oxytocin and social support (Heinrichs, Baumgartner, Kirschbaum, & Ehlert, 2003). Social support is a function of group therapy. However, group therapy can also be stressful, and most analysts would argue that support is insufficient in itself and that group therapy is in fact about changing the way we see ourselves by being with others (Lewin, 1947).

A considerable amount of research demonstrates that persistent comfort eating is likely to be linked to psychological issues arising from attachment history. Many studies have explored the relationship between attachment history and emotional regulation.

Neurological research findings have shown the relationship between attachment history, neurological patterns and the individual's capacity to regulate their emotions (Schoore, 2000, 2002). In response to neuroscientific research, Fonagy (2007) has developed a treatment known as mentalisation-based treatment (MBT) for people with borderline personality disorder which is a model of psychodynamic therapy rooted in attachment theory that aims to enhance an individual's ability to represent thoughts, feelings, wishes, beliefs and desires in themselves and in others in the context of attachment relationships. The treatment is unique in its approach as it focuses on enhancing the client's capacity to think about and regulate mental states.

Insecure attachment has been found to be common in eating disorders (Ward, *et al.*, 2000) and Maunder and Hunter (2001) tentatively suggest that overeating is a means of managing insecure attachment, due to a deficit in the capacity to self-soothe. Research has shown that a significant proportion of obese children and their mothers are insecurely attached and that intervention should target this relationship. (Trombini, Baldaro, Bertaccini, Mattei, Montebanocci, & Rossi, 2003). Support for this has come from Vila, Zipper, Dabbas, Bertrand, Robert, Ricour, *et al.* (2004) who found family difficulties for obese children and suggested family therapy. Obesity has been found to be a result of unconscious 'protective solutions to unrecognised problems dating back to childhood' (Felitti, 2003, p.2). Power and Parsons (2000) suggested that unmet emotional needs in childhood may impact on the development of obesity.

Many studies have explored the relationship between early damaging life experiences and obesity (e.g. Lissau, & Sotrensen, 1994; Williamson, Thompson, Anda, Dietz, & Felitti, 2002). Evidence has been found that a relationship exists between childhood sexual abuse and obesity (Gustafson, & Sarwer, 2004), and also binge eating (Grilo, &

Masheb, 2001). Felitti (1993) found that obesity was used to prevent forthcoming sexual interest as well as overeating in response to negative emotional states.

Findings from qualitative studies support the quantitative studies mentioned above, as many have shown overeating to be a response to difficult emotions arising from poor family functioning. The emotions of anxiety, loneliness and stress have been found consistently (e.g. Bidgood, & Buckroyd, 2005; Davis, *et al.*, 2005; Goodspeed-Grant, & Boersma, 2005).

Taking all the findings together, it appears that approximately 50 % of obese people appear to eat in response to negative emotions. If this eating behaviour is due to psychological issues arising from insecure attachment, it may be worth tailoring treatment programmes to target this in the treatment for obesity. For example, Buckroyd (2011) suggests that help for obese people who use food as a means of emotional management may include “development of emotional intelligence, self-soothing, self-esteem, body esteem and relationship”.

Attachment and Eating Disorders

Attachment theory is a way to understand emotional regulation and interpersonal styles. Difficulties in affect regulation are considered to be associated with eating disorders (Wiser, & Telch, 1999), and insecure attachment is common in eating disordered populations (Ward *et al.*, 2000).

Research has found that women with an eating disorder have higher levels of attachment insecurity than those without (e.g. Barone, & Guiducci, 2009; Illing, Tasca, Balfour & Bissada, 2010). Attachment anxiety has been associated with greater eating disorder symptoms and poorer treatment outcomes (Illing *et al.*, 2010). Hutsinger and

Luecken (2004) found that individuals with secure attachment styles participated in healthier preventive health behaviour than those with insecure styles. Insecure attachment has been associated with overeating (Torres, & Nowson, 2007), and being physically less active (Ng, & Jeffery, 2003).

Understanding of a client's attachment insecurity can help the clinician to understand their symptoms and it can help to predict treatment outcomes. When patients with Binge Eating Disorder (BED) received a group psychodynamic treatment, high attachment anxiety was associated with better outcomes (Tasca, Mikail, & Hewitt, 2005), especially when the treatment focused on emotion regulation and interpersonal difficulties (Tasca, Ritchie, *et al.*, 2006). Treatment that focuses on attachment functioning may improve outcomes for people with eating disorders.

Although obesity is not included in the Diagnostic and Statistical Manual of mental disorders and is therefore not classified as an eating disorder, it is accepted that there are similarities between obesity and eating disorders (e.g. Neumark-Sztainer, 2009). 30% of people with BED are obese (Hasler, *et al.*, 2004), and it is irrefutable that eating disorders and obesity have one thing in common: a dysfunctional relationship with food.

Buckroyd (2011) argues that many people who are obese use food to manage their emotions and this habit will not change unless they can learn other strategies. If overeating is a means of managing insecure attachment due to a deficit in the capacity to self-soothe, treatment of obesity might be enhanced by focusing greater attention on attachment relationships.

Attachment and CBT

There is not a straight agreement between the theories of attachment and CBT.

Theoretically, attachment is about early experience (which gives rise to feelings) and from that experience develops an internal working model (which could also be called schemas or templates). CBT, on the other hand, theorises that thoughts give rise to feelings. CBT emphasises how focussing on the ‘here and now’ can help alter behaviour, whereas attachment theory suggests that providing a different experience of being with other people can improve the way people relate to others. A therapy group is an ideal setting in which to do that. Perhaps CBT groups, the current treatment for obesity, could develop a broader understanding of psychological issues in their programs to provide members with a different experience of relating interpersonally in the hope of developing more effective methods of self-soothing/affect regulation.

Attachment theory and CBT are rarely considered as bedfellows in psychological literature, but McBride and Atkinson (2009) argue that attachment theory can inform the practice of CBT. Both Bowlby and Beck (1967; 1976; 1987) developed their ideas in response to their view that psychoanalytic theory and technique were incomplete.

Cognitive therapy (Beck, 1967, 1976, 1987) is one of the major theories developed to understand the nature and cause of psychological problems. The general premise is that our thoughts affect how we feel and behave. Cognitive therapy proposes that we create cognitive representations of our experience, which are known as ‘schemas’ (Beck, 1967). These are constructed during early childhood experiences with significant others and consist of beliefs and attitudes we hold about ourselves, others and the world. Schemas aid survival as they can be adapted depending on the environment. This concept is remarkably similar to Bowlby’s internal working model.

Perhaps therefore, these are just two different ways of describing the same process within the human brain.

A major criticism of cognitive theory is that it overlooks the role of interpersonal and social factors in the development of psychological problems (Coyne, & Gotlib, 1983). In response to this, more interpersonal approaches which retain a cognitive component have developed (e.g. CAT and schema therapy). However, CBT remains the treatment of choice in group therapy for obesity.

Attachment and Group Therapy

Broadly speaking, the definition of group attachment is an individual's internal representation of groups based on previous group experiences (such as early family or peer groups during childhood). These internal representations generally predict expectations when the individual joins a new group and their thoughts, emotions and behaviours are affected by the others in the group. For example, somebody might see themselves as belonging to the group or as a loner who does not want to be part of the group. An individual might generally view groups as warmly accepting or as likely to reject the self, based on early experiences.

Despite clinical studies championing the application of attachment theory to intervention for individuals (e.g. Mallinckrodt, Porter, & Kivlighan, 2005; Gelso, & Hayes, 1998), there is a paucity of existing research examining its relevance to group therapy. Considering the human need for relationship within a group (see Yalom, & Leszcz, 2005), the effect of attachment style on outcome in group treatment is an area that requires investigation. Furthermore, of the small amount of research that has been undertaken in the area, attachment theory has generally been applied to the field of group counselling/dynamic psychotherapy (e.g. Shechtman, & Rybko, 2004;

Shechtman, & Dvir, 2006). Although CBT focuses more on education and teaching strategies than counselling, the group experience inevitably involves the presence or absence of group cohesiveness and collective self-esteem.

As indicated by Shorey and Snyder (2006), it is important to consider attachment theory in understanding therapeutic interactions, for planning therapeutic interventions and for assessing patients for treatment. There is a growing body of literature indicating that attachment-related issues have an impact on outcome in psychotherapy (e.g. Tasca, Balfour, Ritchie, & Bissada, 2007). It has been found that individuals with higher group attachment avoidance are more likely to drop out of a group, will avoid closeness, and will not seek social support from other group members (Dozier, & Tyrrell, 1998; Smith, E., *et al.*, 1999; Rom, & Mikulincer, 2003). They have also been found to underestimate positive interactions in group therapy (Chen & Mallinckrodt, 2002), to misunderstand others (Mallinckrodt, & Chen, 2004), self-disclose less, and experience less empathy and intimacy (Shechtman, & Dvir, 2006; Shechtman, & Rybko, 2004) than people with low scores. Those with group attachment anxiety report less satisfying social support within a group and tend to be preoccupied with concern over whether they will be accepted or rejected by other group members. These individuals are hypersensitive to their own anxiety and the disappointment that they feel in response to actions of group members (Smith, E., *et al.*, 1999; Rom, & Mikulincer, 2003). They also have a negative view of self and positive view of others, so they dramatise their levels of distress in order to gain reassurance from others (Mikulincer, Shaver, & Peleg, 2003; Wei, Mallinckrodt, Larson, & Zakalik, 2005). They also require continual group cohesion in order to achieve positive outcomes (Tasca, Balfour, Ritchie, & Bissada, 2006) in group psychodynamic interpersonal therapy (GPIP) (Tasca, *et al.*, 2005). These findings have implications for counselling

psychology practice as it appears from the findings that different attachment styles require different types of treatment to address their needs.

Supportive relationships in therapeutic groups might depend upon the general group climate (MacKenzie, 1981), which refers to factors such as engagement, intimacy, openness, and warmth (Yalom, & Leszcz, 2005). People with high attachment anxiety function better on measures of self-disclosure, group empathy and group intimacy than those with high attachment avoidance in a group (Shechtman, & Dvir, 2006; Shechtman, & Rybko, 2004).

Supportive relationships may also depend on alliance with group members and the therapist (Johnson, Burlingame, Olsen, Davies, & Gleave, 2005). Harel, *et al.* (2011) suggest that attachment style is likely to be associated with the level of support given in a therapeutic group, in that group members with high levels of attachment avoidance will give and receive less support than members low in attachment avoidance and those with high levels of anxiety will give and receive more support. They also suggest that those with higher attachment anxiety and avoidance perceive the group climate as less favourable than those with lower scores, and that this affects perceived social support.

Shorey and Snyder (2006) suggested that women with BED with avoidant attachment styles may fear dependency and therefore show more resistance to group therapy.

Attachment avoidance has been found to be related to drop-out rates in hospital treatment for anorexia nervosa (Tasca, Taylor, Bissada, Ritchie, & Balfour, 2004) and attachment avoidance has been related to a patient-perceived reduction in the therapeutic bond for women with BED receiving GPIP (Tasca, *et al.*, 2007; Kanninen, Salo, & Punamaki, 2000).

Research shows that adult attachment style may influence treatment outcome according to treatment type. Tasca, Ritchie, *et al.* (2006) assessed the role of attachment in predicting outcome in two group treatments for BED, one psychodynamic-interpersonal and one CBT. They found that women with high attachment anxiety improved when they received GPIP, whereas women with low attachment anxiety improved with group CBT. The authors concluded that the focus on interpersonal functioning in GPIP was beneficial for those with high attachment anxiety but the educational and skills-based approach of group CBT was better for those with lower attachment anxiety.

A randomised controlled trial investigating attachment anxiety and avoidance on treatment outcomes for people with depression undergoing CBT or interpersonal therapy (IPT: Weissman, Markowitz, & Klerman, 2000) found that avoidant clients receiving CBT showed a greater reduction in depression than those enrolled in IPT (McBride, Atkinson, Quilty, & Bagby, 2006). The focus in CBT on logic might be attractive to avoidant clients who will try not to get in touch with painful emotions. Anxiously attached clients responded to both IPT and CBT. These studies show that considering attachment theory and research can inform what the best treatment approach for a client might be. McBride and Atkinson (2009) suggest that CBT would be most suitable for clients who score low in avoidance and anxiety (i.e. secure), followed by clients who score high in avoidance and low in anxiety (i.e. dismissing), followed by clients who score low in avoidance and high in anxiety (i.e. preoccupied). They say that CBT would be least suitable for clients who score high in both avoidance and anxiety (i.e. fearful).

Mikulincer and Shaver (2007a) propose that research studies that increase attachment security in groups have produced beneficial effects on mental health, prosocial

behaviour, and intergroup relations. Research has found that positive changes toward attachment security can result from therapy that is psychodynamic or that focuses on interpersonal relations (Travis, Binder, Bliwise, & Horne-Moyer, 2001).

Attachment theory and CBT are complementary, and knowledge of the client's attachment style is useful for a therapist working in the CBT approach as it can inform formulation and improve the intervention used (McBride, & Atkinson, 2009). A consideration of attachment can allow the therapist greater understanding of the developmental and interpersonal issues that maintain schemas.

It appears from the literature that different attachment styles respond to group treatment in different ways and demonstrate varying results in outcome. The majority of people referred for treatment for obesity receive intervention in the form of group CBT. With attachment style being relevant to the eating behaviour of people with obesity, the effect of attachment style on outcome in group treatment for obesity requires investigation. Having more of an understanding of which attachment styles obtain better outcomes in group CBT therapy might help to identify treatment responders and suggest candidates who may benefit from a more interpersonal therapy.

Complementing this research with investigating group members' experience of this therapy might be able to offer further information to clarify whether they report themes that are relevant to attachment, which could inform who responds better to group CBT treatment and who might benefit from a different approach.

Personal reflexivity

I had an obesity placement in my second year and I wondered about one of my clients who did not disclose any complaints of emotional eating. The idea that there are people who become obese simply because they enjoy food did not seem plausible to

me. I know that the pharmaceutical companies would have us believe this so that their drugs will continue to sell, and that there are some endocrinologists who may believe that obesity is simply a genetic inheritance, and that there are also some bariatric surgeons who believe that obese people cannot lose weight. Having worked with this clinical population, I was aware that the penalties of obesity are vast and that for someone to become obese actually takes considerable effort. I could not believe that the main contributing factor to becoming obese is not psychological in nature.

People opposed to my view might argue that the cause of obesity lies in the obesogenic environment: our activity has dramatically diminished, we are surrounded by food, and due to evolution we prefer high fat foods and have a high threshold for satiety.

However, if that was the case, everyone would be obese. If, as Prior and Glaser (2006) say, approximately two thirds of the population are securely attached and attachment insecurity is marked by an inability to manage difficult feelings, and one in four people (i.e. 25%) are obese, to me this suggests a significant reason to pursue psychological research in this area.

With endocrinologists claiming that obesity is a genetic inheritance and pharmaceutical companies and bariatric surgeons claiming that there is no psychological component to obesity, those of us who argue that there is have to work harder to produce research that bears out what we hypothesise.

During a lecture in the second year of training my tutor was talking about the link between attachment and anorexia nervosa and bulimia nervosa. I was astounded by how complex and intricate the dynamics can be behind the decision not to eat. I became interested in finding out what research had been done into the relationship between attachment and obesity, and that is where my literature search for this project

commenced. The idea that eating is a means of managing insecure attachment due to a deficit in the capacity to self-soothe is fascinating to me.

Summary

The literature shows that there are differences in outcome according to attachment style in group treatment. Group CBT is the predominant treatment for obesity. People with different attachment styles vary in their abilities in affect regulation and to self-soothe and use others in that process. Emotional eating is found to be common in people with obesity (i.e. food is used to self-soothe). Therefore it is necessary to investigate the effect of attachment style on outcome in group treatment for obesity. By taking the investigation in both qualitative and quantitative directions, hopefully a richer picture may be achieved of whether attachment style predicts outcome in treatment and whether the group experience can inform if attachment appears to be important in that treatment.

Research aims and questions

The aims of this study are twofold:

- 1) To investigate whether attachment style can predict outcome in group CBT treatment for obesity. It is hypothesised that participants with insecure attachment will lose less weight on average than participants who are securely attached.
- 2) To explore the lived experience of being part of a group in treatment for obesity. It is hoped that qualitative interviews may provide a broader and integrated understanding of the group experience.

RESEARCH METHODOLOGY

Mixed methods design

During the late 19th century social scientists began to conduct studies using the methodology applied in physics. This approach, known as psychophysics, involved testing hypotheses with data collected by quantitative measurements within the social world (Atkinson & Hammersley, 1994). Since then quantitative methods have been widely used in psychology and have been regarded as the gold standard of scientific research. However, critics of the quantitative method have said that this method cannot capture the richness of human experience and simplifies it by transforming it into objective data (Willig, 2008). Nevertheless, quantitative studies allow for the investigation of large groups, and the results can be generalised to a particular sample in the population (Brennan, 2001).

In the early 20th century, some researchers favoured the qualitative paradigm over the positivist stance that there is an objective reality which can be summarised by numerical data (Smith & Heshusius, 1986). Proponents saw the value in understanding subjectivity and intersubjectivity and therefore rejected traditional science (Guba & Lincoln, 2005). It was in the late 20th century that qualitative methods became widely used in psychology (Denzin & Lincoln, 2005) and it is now accepted that they allow for in-depth investigations that produce rich data (Willig, 2008).

The mixed methods approach, which combined quantitative and qualitative approaches, gained popularity in the social sciences during the 1960s (Leech & Onwuegbuzie, 2009). It began with Campbell and Fiske's (1959) use of multi-method, which was further developed by Webb, Campbell, Schwartz & Sechrest (1966) with triangulation (i.e. using different methods to research the same phenomenon to confirm results). The

use of mixed methods has increased considerably since Tashakkori and Teddlie (1998) argued that the approach can enable richer results than either qualitative or quantitative data alone. Indeed, the strengths of both approaches can be harnessed in a combination study (Onwuegbuzie & Leech, 2005) and the different methods can answer different questions, so the approaches are ‘complementary’ (Vidich & Shapiro, 1955, p.33).

As well as triangulation and complementarity, Greene, Caracelli & Graham (1989) highlighted the use of mixed methods for development (i.e. when the results of one method inform the other), initiation (i.e. when inconsistencies are uncovered that inform a new research question), and expansion (i.e. the use of different methods to answer different questions, thus expanding the scope of inquiry). All of these uses of mixed methods research could be why Haverkamp, Morrow, & Ponterotto (2005) have recently encouraged counselling psychologists to employ a mixture of methods in research.

It was thought that the aims of this study would be best met by following a mixed methods approach to produce a richer understanding of the topic under investigation. Utilising two different types of methodology is also likely to enhance the authenticity of the results and it is hoped that the findings will be helpful for both practitioners and clients (Gergen, 2001). It is important that the researcher understands what sort of knowledge they want to discover in order to decide how to collect and interpret the data (Willig, 2012). Epistemology questions how knowledge can be acquired and it is necessary to consider from what epistemological stance the research question is asked.

Epistemological positioning

Epistemology came from philosophers questioning the nature of knowledge, specifically how and what we can know. It is important for the researcher to be able to see objectively how the approach they are using answers questions about how – and what – we can know (Willig, 2001). Therefore the aims of the research shed light on the researcher's epistemological positioning.

The research questions are both asked from a pragmatist perspective. Pragmatism is a philosophical tradition that began in the United States in approximately 1870 (Goodman, 1995) and is centred on the idea that the function of thought is as a tool for prediction, action, and problem solving. Pragmatism does not assume that the function of thought is to represent reality. Therefore science is best viewed in terms of its practical use rather than in terms of representative accuracy. There are different ways of viewing the same scientific concept, and in that sense the mixed methods approach is dialogical (i.e. the same concept is being viewed from two different perspectives).

Epistemology for Part I – quantitative survey questionnaire

The aim to investigate whether attachment style influences the outcome of BMI in a group treatment for people with obesity was based on both the information gleaned from a literature review and from the researcher's own interest. The knowledge that this research would produce is numerical and specific and furthermore attachment style is categorical, so it would be quantitative. Therefore the research question is asked from a post-positivist epistemological stance in the quantitative part of this research project.

Post-positivism is a branch of realist philosophy which seeks to find answers that can enable prediction (Ponterotto, 2005). Some say post-positivism is rudimentary, but qualitative method (which produces richer data) was not a suitable method to gain the type of knowledge required by this part of the research. Although attachment style can be assessed wholly via qualitative interview, the aim of this part of the research was to produce findings that might be generalisable in order to potentially inform the practice of counselling psychology, and for that, large numbers are required. Assessing attachment style by interview takes approximately one hour and would have been too time-consuming to use in order to produce large numbers in the current study, whereas a questionnaire can be completed in 10 minutes. The post-positivist perspective is that there is a reality that exists but this reality cannot be known perfectly and accurately (Robson, 2002), so it accepts that the researcher cannot obtain a purely “*objective reality*” (Ponterotto, 2005, p.129). The epistemological stance is post-positivist rather than positivist because positivism sees that we can only know what we can directly observe and measure and the researcher does not subscribe to there being an entirely objective reality.

It is scope that is being stressed in Part I of the research project, whereas depth and richness of data from interviews is emphasised in Part II. The aim of Part I is to find out whether insecure attachment predicts smaller changes in BMI in group treatment for obesity. A survey questionnaire was considered to be an appropriate method for data collection given the epistemological positioning of post-positivism.

Epistemology for Part II – qualitative interviews

The interviews were intended to further understand how attachment style mediates weight loss. The research question (to explore the experience of group treatment for

obesity) is phenomenological/relativist. A phenomenological approach was considered to be beneficial as there is a paucity of existing research in group treatment for obesity and therefore the nature of the research is exploratory. As the phenomenon of the group experience is likely to be idiosyncratic due to each individual's perceived reality, the epistemological positioning of data collection is also relativist. Therefore, a phenomenological/relativist epistemological positioning to the data collection shows that the researcher appreciates that each interview will be distinctive but that there might be similarities in the overall experience of the group treatment.

Hermeneutics is the theory of text interpretation (Audi, 1999). The analysis of interview transcripts requires the researcher to interpret the text, and therefore the epistemological positioning is hermeneutic. The researcher draws on her own knowledge and experiences to make sense of the interviews (i.e. double hermeneutic). As the aim of Part II of this research is to gain knowledge of the lived experience of group treatment for obesity and the epistemological positioning is phenomenological/relativist, the researcher felt the most fitting of the qualitative methods would be Interpretative Phenomenological Analysis (IPA: Smith, 1996), in which semi-structured interviews are conducted.

IPA was considered more appropriate than other forms of interpretive phenomenology because of the unique type of findings that IPA can produce. The longest established phenomenological psychology is considered to be Giorgi's (1997) approach, which draws solely on Husserl's (1906) original conceptualisation of phenomenology. Instead, IPA attempts to include a wider conceptualisation of phenomenology rather than operationalising a specific version of it (Smith, Flowers, & Larkin, 2009). Giorgi (1997) emphasises that his approach is descriptive, whereas Smith *et al.* (2009) put forth that IPA is also interpretative. Whilst Giorgi's method looks for shared

experience so that the general structure of a phenomenon can be described, IPA attempts to provide a detailed analysis of the similarities and differences across cases, capturing the idiographic experience of each participant. Therefore IPA produces a more idiographic interpretative commentary (Smith *et al.*, 2009).

IPA has similarities to related approaches which operationalise a hermeneutic phenomenology, such as Van Manen's (1990) approach, which was used to investigate the everyday practice of parenting and pedagogy. However, IPA is unique in its combination of psychological, interpretative, and idiographic components. IPA is different from the critical narrative analysis approach (Langdridge, 2007) as it involves analysing texts through the lens of social theory and therefore the emphasis of the analysis is different.

Furthermore, IPA was chosen above other phenomenological approaches in the current study because it has been utilised in a burgeoning number of published studies (Chapman, & Smith, 2002).

Tensions in phenomenological research

There is a discrepancy between the belief that each individual's experience is different and the act of looking for overall commonalities in the group experience. This study aims to respect both of these by highlighting experiences that are shared in the group but also by paying attention to any differences within the group. Considering the fact that qualitative research findings from IPA are difficult to generalise (Willig, 2008), the findings of shared experience in this study might tentatively suggest that the experiences would extend to the wider population of people with obesity. The transferability of findings can be enhanced if the research is conducted with a specific sample, which has been achieved in the current study by researching only those who

were in receipt of a specific treatment for obesity. It could be argued that Grounded Theory is a qualitative methodology which expects to generalise research findings less tentatively than IPA by using saturation and purposive sampling. The reasons why Grounded Theory was not used in the current study are discussed later.

Tensions between epistemologies

Tensions exist between the epistemologies of the two different parts of this study in that they are very different ways of looking at the same phenomenon. Bryman (2004) and Morgan (2007) argue for a more pragmatic approach; one that is free from the entrapments of the paradigm debate between qualitative and quantitative epistemologies. They see the value in an epistemological approach that recognises the themes that connect quantitative and qualitative research and one that sees the benefits of blending these methods. Mason (2006) supports this line of thinking, as she highlights the value of mixed-methods approaches for researching questions about lived realities as multi-dimensional strategies which transcend or even subvert the qualitative-quantitative divide.

Mixed-methods approaches raise challenges in reconciling different epistemologies, and in integrating different forms of data and knowledge. Mason (2006) argues that we should think more in terms of integrating data and method using dialogic explanations that allow the distinctiveness of different methods and approaches to be held in creative tension.

Part I – Quantitative methodology: A survey questionnaire to determine attachment style

Why use a survey questionnaire?

A survey questionnaire was chosen after considering the aim and epistemological positioning of Part I. Since Allport (1937) pointed out to psychologists that they were relying on nomothetic research to the exclusion of the ideographic perspective, the merits and weaknesses of both types of approach have been widely debated. The nomothetic approach has been criticised for missing out information particular to the individual by generalising to a population (Lamiell, 1981; Runyan, 1983). However, the aim of Part I is not to produce findings that are an absolute truth but rather to produce information that might complement the findings from the interviews in Part II. The findings from the survey questionnaire could also validate the findings from the interviews in Part II, thus acting as a triangulation tool (Bogdan & Biklen, 2006). For example, if the quantitative findings demonstrated that those with higher scores on ASQ dimensions that indicate an insecure attachment did not achieve significant weight loss and these individuals also spoke in their interviews about how difficult they found it to be with others in the group, the quantitative findings could validate the qualitative findings. Viewing the two methodologies within a triangulation does not sit well with their opposing epistemologies. However, it does support the epistemological positioning of pragmatism that encompasses both quantitative and qualitative methodologies.

A questionnaire was chosen to answer specific questions regarding attachment style. Quantitative results produce specific data on a large number of people, whereas qualitative results produce in-depth information that may enhance the quantitative

results. Hopefully the mixture of quantitative and qualitative results in this study will enrich the overall findings and build foundations for future research to test hypotheses.

Participants

Inclusion criteria

Participants were recruited through an NHS Foundation Trust that provides a weight loss treatment programme for people with obesity. It is important to have a comparatively homogenous sample in order for the results to be generalisable (Greene & Caracelli, 2003). The sample in this study was recruited for having certain characteristics. These were to have a BMI ≥ 40 , to be adult (i.e. 16 years old and older), and to be in receipt of group CBT treatment from a particular service. The exclusion criteria included the participant being unable to use the treatment programme due to disability or significant health problems.

Sampling procedures

The people who took part in the weight loss programme had sought help from their GP for weight loss intervention before the GP then referred to the service. Therefore their level of motivation for weight loss was expected to be at least moderate.

The researcher attended a total of 26 intervention groups to ask if people wanted to participate in the research project. A total of 55 men and 208 women attended these 26 groups; a ratio of approximately 1:4. The ratio of obesity in men and women in England is 1:1 (Health Survey for England, 2012). This demonstrates that men sought help for their difficulties from this service significantly less than women, which is a common problem in general (e.g. Tudiver, & Talbolt, 1999; Oliver, Pearson, Coe, & Gunnell, 2005). The ratio of men to women being 1:4 across all of the people who

were invited to participate in the study and the ratio of those who took part being 1:5, it was thought that this was a reasonable gender representation of those who sought help from this service. Furthermore, the researcher could not find evidence in the literature that suggests men and women respond differently to intervention for obesity.

A statistical power analysis program (Faul, Erdfelder, Lang & Buchner, 2007) was used to calculate the sample size required for Part I. The suggested sample size was 27, which would detect a medium effect size. (A sample of 28 would detect a large effect size). For survey questionnaire quantitative answers, the analysis program estimated that a sample this size would provide a 95% chance of detecting a large effect size ($d=0.8$).

Design

The study examined whether there is a difference in participants' measures in BMI from pre- to post-treatment, in a repeated measures design and whether these differences are mediated by attachment style (i.e. that those with secure attachment have a greater change in their BMI) in a within-participants design. This expectation was formed in response to existing findings on attachment style and outcome in group therapy. The NHS weight loss service from which the study recruited began approximately 3 treatment groups per month. Participants were recruited from groups that began in July 2012 through to April 2013.

Participants' BMI measures were taken during the first treatment session. Paper versions of the Attachment Style Questionnaire (ASQ) were given out at the end of the first treatment session. The ASQ was chosen because the authors claim it is a more precise measure of attachment style than the category-based measures. It assesses attachment style for people with little or no experience in romantic relationships, and

with 5 dimensions, the measure is more sensitive than those with fewer dimensions (Karantzas, Feeney, & Wilkinson, 2010).

Also at the end of the first treatment session, participants were given an Invitation Letter (Appendix A), the Participant Information Sheet (Appendix B), Consent Form 1 (Appendix C) and a Debrief Information Sheet (Appendix D). Participants took the Information Sheet, Consent Form and ASQ home if they wanted to. They could then read about what the study was about before agreeing to take part. For those who wanted to take part, the Consent Form was to be signed and returned with the completed and named ASQs at Session 2 of the treatment program (i.e. one week later). The Participant Information Sheet also included details of Part II of the research study and there was a box to tick on the Consent Form if participants were keen to participate in Part II. As pointed out on the Consent Form, participants could either contact the researcher by e-mail or telephone or provide an e-mail address to request access to the research findings. No reward was offered for completing the questionnaire. BMI measures were taken again at the start of the 12th treatment session.

The group facilitators were one dietician and one psychologist. The researcher of this project was not the facilitator. The treatment programme consisted of 12 weekly sessions of 90 minutes each. The psychological component of the course was CBT-based, in that it was problem-focussed, goal-oriented and it involved psycho-education, skills-acquisition and challenging the cognitive processes and behaviours that maintain the weight problem. The topic of mindfulness (Kabat-Zinn, 1979), which is recognised as a third-wave CBT intervention was also covered in relation to eating. This involves paying attention to taste, smell, and textural experiences during eating so that eating is slowed down and appreciated more with the idea that a reduction in quantity is consumed. Most of the topics were taught in the manner of psycho-education and there

were brief interludes in the schedule where topics could be discussed amongst group members.

The topics covered in the group treatment were: building motivation and goal setting; healthy eating and self-monitoring; portion sizes and planned eating; understanding food labels and reducing fats; increasing physical activity; linking thoughts, feelings and behaviour; breaking habits; eating out and mindful eating; identifying and managing emotional eating; tackling snacking and managing plateaus; building social support and relapse prevention; and weight maintenance. Please see Appendix E for the group treatment protocol.

The course is thought to be relevant to attachment because the people taking part in the group are all together for 90 minutes for 12 weeks and whenever human beings are put together, attachment styles are activated (Niedenthal, Brauer, Robin, & Innes-Ker, 2002; Fraley, Niedenthal, Marks, Brumbaugh, & Vicary, 2006; Fisher, Aron, & Brown, 2006; Mikulincer, & Shaver, 2007b). Attachment theory relies on the assumption that every human being is born with an innate attachment system, whose biological function is to obtain or maintain proximity to significant others to regulate support-seeking behaviour (Bowlby, 1988). Different attachment styles may be activated with other group members and with the course facilitator. In therapy, a client may form an attachment to his/her therapist in that the client may experience the therapist as rejecting or accepting, based on previous experiences of caregivers (Jacobs, 1999). Previous experiences have contributed to each individual's internal working models, which have encoded expectations of care and a prediction of likely outcomes of various attachment behaviours (Mikulincer, & Shaver, 2007b).

Ideally, with more time, funding and resources, this project would have been extended to compare a CBT treatment group with an interpersonally-focussed treatment group, as this would demonstrate clearly whether attachment style mediates outcome according to therapeutic approach.

Measures

Body Mass Index (BMI)

Whilst consensus over the best measure of body fatness has not been achieved (Burkhauser & Cawley, 2008), BMI is currently the agreed measurement in medicine and in social science research and is used in the vast majority of studies and across weight management services nationally in the NHS. BMI is calculated as weight in kilograms divided by the square of height in metres. BMI calculations were made using height measurements with a stadiometer, and weight measurements with a calibrated scale.

Attachment

The Attachment Style Questionnaire (ASQ: Feeney, *et al.*, 1994), a widely used adult attachment measure in both normative and clinical contexts (Fossati, *et al.*, 2003), is a self-report measure containing 40 items, each with a 6-point Likert-type response scale. Participants rate aspects of themselves and others with reference to relationships in general rather than romantic or close relationships. (See Appendix F for a copy of the ASQ).

The ASQ can be scored as five subscales: Confidence (in relationships), Discomfort (with closeness), Relationships as Secondary (to achievement), Need for Approval, and Preoccupation (with relationships). The measure Confidence considers the individual's

confidence in the self in terms of relating to others and also confidence that others will be there for them. Discomfort (with closeness) assesses how uncomfortable an individual is when getting close to others in relationships. Relationships as Secondary (to achievement) considers how much an individual rates achievements to be more important than personal relationships. Need for Approval assesses how much the individual needs to feel approved of by others to feel accepted. Preoccupation (with relationships) considers how much the individual becomes anxious and thinks about his/her personal relationships with others.

The ASQ supports Bartholomew's (1990) four-way classification of attachment styles (which are Secure, Dismissing, Fearful and Preoccupied) and Hazan, & Shaver's (1987) conceptualisation of attachment (Secure, Avoidant and Anxious/ambivalent). Feeney, *et al.* (1994) established this with a cluster analysis for classification and found that Confidence represented secure attachment, and the other four dimensions represented aspects of insecure attachment. Discomfort (with closeness) is central to Hazan, & Shaver's (1987) conceptualisation of avoidant attachment. Need for Approval characterizes both fearful and preoccupied groups in Bartholomew, & Horowitz's (1991) model and reflects an individual's need for acceptance and confirmation from others. Preoccupation (with relationships) involves anxiously reaching out to others in order to fulfil dependency needs. This is central to the original conceptualisation of Hazan, & Shaver's (1987) anxious/ambivalence and to Bartholomew's (1990) Preoccupied group. The dimension Relationships as Secondary (to achievement) is consistent with Bartholomew's (1990) concept of the dismissing style, in which individuals emphasise achievement and independence in order to protect themselves against becoming vulnerable in relationship with others.

Many studies have supported the validity of the ASQ. Support was found for the ASQ items reflecting the five-factor structure in a sample of psychiatric participants and a nonclinical sample (Fossati, *et al.*, 2003). They concluded that adult attachment patterns are best considered as dimensional constructs (which the ASQ does).

Brennan, Clark, & Shaver (1998) performed a factor analysis assessing the factor loadings of 60 different attachment subscales on the two factors of Anxiety and Avoidance. From among all the self-report attachment measures, the ASQ Preoccupied and Discomfort with Closeness scales produced the highest (.86 and .90) factor loadings on the Anxiety and Avoidance factors. The Need for Approval had a high loading on the Anxiety factor (.62) and the Relationships as Secondary had a high loading on the Avoidance factor (.61).

Analysis

Descriptive statistics and inferential statistics

A backwards multiple regression tested whether change in BMI was influenced by the five dimensions: Confidence; Discomfort; Relationships as Secondary, Need for Approval; and Preoccupation. The independent variables (or predictors) were attachment style and the dependent variable was change in BMI. Participants' starting BMI was also entered as a sixth predictor to check whether it had a significant effect on the outcome of the other five predictors. The control procedure of counter-balancing of participants was employed, as the same participants were in each condition.

Validity and reliability

Three studies have attempted to confirm the factor structure of the ASQ: Feeney, *et al.*, (1994) used a Principal Components Factor Analysis; Fossati, *et al.* (2003) used

Exploratory Factor Analysis to compare factor structures across clinical and non-clinical groups; and Karantzas, *et al.* (2010) used Confirmatory Factor Analysis to validate the ASQ's factor structure.

Feeney, *et al.*'s (1994) Principal Components Factor Analysis, with orthogonal rotation was based on an examination of eigen values and the scree plot to examine the five-factor solution. The five-factor solution accounted for 43.3% of the total variance, and yielded the factors of Confidence (in self and others), Discomfort with Closeness, Need for Approval, Preoccupation with Relationships, and Relationships as Secondary to Achievement. These factors related to Hazan and Shaver's (1987) and Bartholomew & Horowitz's (1991) models of attachment, proving that the ASQ measures the concept of attachment as put forward in the theory.

Fossati, *et al.*'s (2003) study examined the utility of the ASQ in a sample of 487 psychiatric participants and 605 non-clinical participants. They found that a minimum average partial analysis of data from the psychiatric sample supported the five-factor structure and a multiple-group component of this five-factor structure was not an artefact of differences in item distributions. They also found that the ASQ five-factor structure was replicated in the non-clinical sample.

In Karantzas, *et al.*'s (2010) study, 1027 participants completed the ASQ. Maximum Likelihood Estimation (Muthén, & Kaplan, 1985) was used to estimate the structure of the ASQ. Using AMOS 7.0, Hu and Bentler's (1999) combination approach evaluated model fit. The Akaike Information Criterion Index (AIC) was also used to evaluate non-nested models. To guard against Type II error in identifying significant differences between models, a practical difference test (i.e. TLI difference of .01 between models) was employed. A good model fit was found when broad attachment

factors (avoidance and anxiety) were included with the five attachment dimensions in a nested factor model, demonstrating that the ASQ is conceptually related to other attachment measures (e.g. the ECR-R). These findings indicated that most ASQ items tap both people's generalized mental models of attachment while also assessing distinct components of anxiety and avoidance, suggesting that the multi-dimensional structure of the ASQ allows for important distinctions in people's attachment cognitions and behaviours and therefore the measure captures major elements of attachment styles that are important in understanding the nature of human attachment.

The findings from the latter study confirmed that ASQ items tap into people's generalized mental models of attachment. The specific attachment dimensions in the ASQ are necessary in revealing important distinctions across distinct sub-populations and criterion outcomes (Fossati *et al.*, 2003). For example, Fossati, *et al.* (2003) found that a non-clinical sample scored significantly higher on Confidence, and significantly lower on Discomfort, Preoccupation and Need for Approval than did a clinical sample. They also found that ASQ factors related in distinct and meaningful ways to styles of parental bonding (the Parental Bonding Instrument; Parker, Tupling, & Brown, 1979). Feeney (2005) also found that children who were adopted scored significantly lower on Confidence and significantly higher on the four insecure factors than a comparison sample of non-adoptees. Therefore this measure is important to use in counselling and clinical contexts where therapy looks to remedy difficulties in interpersonal functioning. Furthermore, the ability to diagnose an individual with a problem with non-prioritization of relationships (Relationships as Secondary) or Discomfort (with closeness), which are both subsumed under attachment avoidance, is likely to lead to different issues within therapy.

A test is considered to be reliable if it produces the same result repeatedly across different populations and conditions. Feeney, *et al.* (1994) collected two types of reliability data for the 40-item measure of the ASQ: internal consistency, as measured by Cronbach's alpha, and test-retest reliability coefficients. For the five factors of Confidence in self and others, coefficient alphas were: .80 (Confidence); .84 (Discomfort with Closeness); .79 (Need for Approval); .76 (Preoccupation with Relationships); and .76 (Relationships Secondary to Achievement). These coefficients were calculated on a sample of 470 participants, and suggest that the scales have high levels of internal consistency (Feeney, *et al.*, 1994).

The test-retest reliability was calculated on the basis of data collected from a subsample of 295 participants. Reliability coefficients for the five scales over a period of approximately ten weeks were: .74 (Confidence and Discomfort), .78 (Need for Approval), .72 (Preoccupation with Relationships), and .67 (Relationships as Secondary). These coefficients represent acceptable levels of stability (Feeney *et al.*, 1994).

A test is considered to be valid if the result is an accurate reflection of the dimension being assessed. Pairwise correlations between the five dimensions were found to be significant by Feeney, *et al.* (1994): Confidence correlated negatively with the other four scales. All four insecurity dimensions were positively correlated. They also correlated the five attachment dimensions with Hazan, & Shaver's (1987) measure and found that Secure Attachment was positively correlated with Confidence, and negatively correlated with the four insecure scales. Hazan, & Shaver's (1987) Avoidant Attachment was strongly correlated with Discomfort and moderately correlated with Relationships as Secondary. Hazan, & Shaver's (1987) Anxious-ambivalent Attachment was strongly correlated with Preoccupation and Need for Approval. These

correlations support the validity of the ASQ dimensions in assessing the constructs proposed by Hazan, & Shaver (1987).

A cluster analysis using Ward's method and squared Euclidian distance was performed to see whether distinct clusters of individuals could be identified using the ASQ and whether these clusters were consistent with existing theory on attachment styles. There was clear support for the two-cluster solution for a secure group and an insecure group. In fact, Feeney, *et al.* (1994) state that the most robust distinction in attachment scales is between secure and insecure. The secure group obtained higher scores than the insecure group on Confidence and lower than the insecure group on all other scales. In other words, members of the secure group have high self-esteem, are confident relating to others, are comfortable with closeness and see relationships as important but do not obsess about them. The insecure group obtained lower scores on Confidence and higher scores on the other scales, so would lack confidence in themselves and others, and either be uncomfortable being close to others (Discomfort), or worry a lot about their relationships (Preoccupation) and whether people approve of them (Need for Approval), or emphasize achievement to the exclusion of relationships (Relationships as Secondary), or have a combination of these.

Ethics

This study meets the ethical standards of the British Psychological Society (BPS: 2007). A research proposal with appendices was approved by City University, London. NHS ethical approval was also gained before conducting the research with NHS patients (NHS REC approval reference number: 12/SC/0183). It was not expected that participants could come to any harm completing the questionnaire but it was possible that considering attachment style might cause upset. Participants were given an honest

explanation of the study and were verbally reassured that their right to withdraw from the study at any point would be honoured and would not result in negative treatment from the researcher, nor would it affect their treatment. All participants were provided with a Debrief Information Sheet (Appendix D) with numbers to call should they wish to talk to someone. All participants received a Participant Information Sheet (Appendix B) describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details. Participants were informed that once their data was entered into the researcher's database, they would become anonymous as their information was stored in an SPSS database and numbers instead of names were allocated to participants.

Part II – Qualitative methodology Interpretative Phenomenological Analysis of interviews

Why use IPA?

IPA is a relatively recent addition to qualitative methods. Smith (1996) developed the approach to attend to the experience of a phenomenon, as research in psychology was lacking in the experiential. The approach attends to the meanings people attribute to their experiences (Smith, J., Jarman & Osborn, 1999) and pays particular attention to the fact that people's behaviour reflects their thought processes (Smith, J., *et al.*, 1999), attempting to identify the cognitions that lead to verbal responses. IPA has become a popular research tool to explore lived experiences. It is able to address general research questions rather than specific hypotheses, making it appropriate for exploratory research such as Part II of this study. By paying attention to the participants' subjective experiences, the completed analysis contributes to a richer understanding of the phenomenon under investigation. IPA acknowledges the symbolic interactionist view

that analysis is interpretive, as the researcher attempts to make sense of the participant's own experience (Langdridge, 2007). Therefore the experience is explained, rather than merely described.

IPA is aligned with the philosophy of knowledge of Phenomenology, Hermeneutics, and Idiography, with all of which the epistemological positioning for Part II of the research is concordant. Husserl (1906) was the founder of phenomenology, which has come to be known as the study of subjective experience. Smith, *et al.* (2009) describe phenomenology as the attempt to study and understand individuals' lived experiences. The researcher aims to gain an understanding of an individual's experience of a phenomenon and the meanings they attribute to their experiences (Smith, J., *et al.*, 1999). In phenomenological research, it is important that the researcher acknowledges any pre-existing biases about the phenomenon under investigation and reactions to the interviews whilst engaging with them. This is so that researcher biases can be bracketed during the analysis and it demonstrates reflexivity.

Other philosophers, notably Sartre (1943/1956), combined Phenomenology with Hermeneutics, the theory of text interpretation, making phenomenology more interpretative. Schleiermacher (1838/1998) put forward the idea that Hermeneutics emphasises a deep understanding of the text and the person interpreting it. Therefore, it looks at the textual meaning but also acknowledges the uniqueness of the researcher. Phenomenology that considers Hermeneutics takes into account that the researcher cannot engage with the data without having his/her own beliefs and understandings about the world. This echoes the importance of the researcher acknowledging any pre-existing biases before engaging with the data, yet it is impossible to infer subjectivity in interpretation without the researcher employing subjectivity him/herself. In IPA, the researcher's own conceptualisations affect the analysis, but this is necessary in order to

make sense of the experiences of others (Smith, 1996). This is known as the hermeneutic circle – the researcher is trying to understand the participants trying to understand their own experiences (Smith, *et al.*, 2009).

IPA was also informed by Idiography, which is the study of the individual. As IPA pays attention to subjective experiences, it therefore acknowledges the fact that people's responses to an event are unique to them (Chapman & Smith, 2002).

Understanding the experience of the individual might provide insight into a group experience.

IPA was considered to be more appropriate than the qualitative approach of grounded theory which looks to generate a theoretical-level account of a phenomenon. Grounded theory was originally developed in order to offer researchers a systematic guide to qualitative research (e.g. see Glaser, & Strauss, 1967). In developing the theory of a phenomenon, sampling is often required on a large scale. In grounded theory, the researcher asks a general question about the topic under investigation and then codes and analyses the interview. The researcher then decides what question to ask in the next interview based on these findings. Each interview is modified according to the outcome of the previous interview to investigate emerging areas of interest, using purposive sampling and saturation (Glaser & Strauss, 1967). Of the different versions of grounded theory, constructivist grounded theory (e.g. Charmaz, 2006) is likely the most widely used.

Although IPA and grounded theory can produce a similar type of research findings and both have an inductivist approach to inquiry, IPA is likely to offer a more detailed analysis of the lived experience of a small number of participants with an emphasis on the similarities and differences between participants. Grounded theory however, is

likely to produce a more conceptual explanatory level based on a larger sample which uses examples from participants' accounts to illustrate the theoretical claim produced.

IPA is concerned with the micro analysis of individual experience which produces a rich texture of human experience, following a detailed exploration of the data.

Grounded theory, on the other hand, aims to produce theoretical accounts of psychosocial phenomena. IPA "asserts the value of complementary micro analyses, analyses which may enrich the development of more macro accounts" (Smith, *et al.*, 2009, p.202). Therefore, an IPA study could lead onto a subsequent grounded theory study.

IPA was chosen over grounded theory in the current study because CBT (which is the approach used in the treatment being investigated) accepts the primacy of thoughts and IPA emphasises the fact that people's behaviour reflects their thought processes (Smith, J., *et al.*, 1999). It attempts to identify the cognitions that lead to the verbal responses.

It was also decided that IPA was more suitable than the qualitative approach of Discourse Analysis (see Potter & Wetherell, 1987). Although IPA and Discourse Analysis both pay attention to participants' language, IPA emphasises the fact that people's behaviour reflects their thought processes (Smith, J., *et al.*, 1999). It therefore attempts to identify the cognitions that lead to the verbal responses, whereas Discourse Analysis equates verbal responses with behaviour, without paying attention to the link between behaviour and underlying cognitions. Discourse Analysis assumes that language structures the relationship between what exists outside the person and how it is represented or understood inside the person. Assuming that people's verbal accounts reflect their underlying cognitions, utilising IPA in the present study reveals explanations of behaviour in the group treatment programme (Smith, 1996).

Therefore, IPA was felt to be the most appropriate qualitative approach to use to accomplish the research aim after considering: the epistemological positioning, the researcher's interest in understanding the group experience, the lack of research in the area, IPA's philosophical roots, and the use of other available qualitative approaches.

Participants

Inclusion criteria

The inclusion criteria for **Part II** of this research were the same as for **Part I**.

Sampling procedures

Different authors suggest different sample sizes for IPA. Smith, *et al.* (2009) believe that IPA is fitting for small samples. For this study, it was felt that a sample of seven would be adequate. In order to achieve a sample that was approximately representative of the people who participated in Part I of the study, the qualitative sample size consisted of 2 men and 5 women. Although the aim is for IPA research samples to be homogenous (Smith, Flowers, & Larkin, 2009), it was considered necessary in this project to select participants from different groups, as selection from only one group may be representative of a unique group experience. The participants in Part II of the project were from 5 different intervention groups altogether; 2 of which contained 2 participants, with the remaining 3 groups containing 1 participant.

The Consent Form in Part I of the study contained a box at the bottom to tick if participants were interested in taking part in Part II. Participants were recruited if they said that they were still interested in taking part when the researcher telephoned them.

Design

The most suitable method of data collection was considered to be semi-structured interviews because an interview schedule would ensure that the phenomenon of group experience would be explored whilst allowing for participants to offer up information that they deem to be important. This is possible due to the open-ended nature of the questions and to the researcher being flexible and ready to veer away from the interview schedule if needed (Smith, *et al.*, 2009).

The guidelines by Smith, *et al.* (2009) were followed to generate an Interview Schedule, which was checked by the research supervisor. The questions were aimed at uncovering the quality of the individual's experience of being in the group treatment, specifically how they found it to be with others and what was good and bad about being in the group. Further questions could be asked if the participant disclosed little information (please see Appendix G for the Interview Schedule). Interviews took place when participants had completed or had nearly completed the 12-week programme and lasted approximately 60 minutes.

All participants received a phone call and were asked if they were still interested in taking part in Part II of the project. They were asked if they still had the Invitation Letter (Appendix A) and the Participant Information Sheet (Appendix B) describing the aims, procedure and possible risks of the research, as well as what would happen with the results. They were sent out another copy if they did not. Contact details for the researcher and the supervisor were provided. All participants for Part II were asked to sign a Consent Form 2 (Appendix H) and were able to ask any questions they had prior to their interview commencing. Following each interview the participant was verbally debriefed, provided with the Debrief Sheet (Appendix D) and given the opportunity to

ask questions. Participants were also asked whether they would like to receive a copy of the results of the study.

The interviews took place in small quiet rooms within various buildings: a leisure centre, a health centre, and two village halls. All interviews were recorded using a digital voice recorder. The interviews were downloaded to a standard IBM compatible data-protected computer in order to ensure confidentiality for participants. Interviews were anonymised and any identifying details were omitted from the transcripts during transcription. The transcripts were stored in a password-protected personal computer and hard copies were kept in a locked cabinet that only the researcher could access.

None of the participants were offered any reimbursement rewards as there was no financial budget for the study.

Analysis

Once transcription was complete, Smith, *et al.*'s (2009) description of the procedure for analysis was followed:

- Transcripts were formatted with wide margins and numbered lines;
- One transcript was carefully read and re-read;
- Initial notes were made in the right-hand margin;
- Emerging themes in the transcript were noted in the left-hand margin;
- A summary table was made of the themes and included every example of a theme taken from the transcript, including the page and line number;
- The themes were arranged in a logical order, so that a more comprehensive understanding of the participants' experience was accomplished;

- On completion of the first transcript, the same steps were applied to all other transcripts individually;
- The summary tables from each transcript were compared to look for patterns across cases;
- Any themes that were not present in the majority of the transcripts were discarded, so that the participants' experience as a whole could be reflected;
- These less common themes were retained, however, for the purposes of providing information to the researcher regarding individual differences, so that any interesting points for discussion could then be covered;
- Themes were grouped under super-ordinate headings.

Validity and reliability

Validity and reliability are terms derived from quantitative research, which has different epistemological roots to qualitative research. Williams & Morrow (2009) suggest that instead we apply the term 'trustworthiness' to qualitative research, which is based on three factors: that clear guidelines are provided so that the study is possible to replicate; that there is a balance between what the participant says and what the researcher interprets, which triangulation and reflexivity can help with; and that the findings are clearly communicated. These have been considered throughout this study, which strengthens the trustworthiness of the research.

Willig (2008) acknowledges that converting audio recordings into verbatim transcriptions will inevitably impact on the validity and reliability of the research. She gives advice on how to enhance validity and reliability in qualitative research. She encourages the researcher to be reflective throughout the research process and to address any pre-existing biases based on previous experience that might affect the

research. A study's ecological validity can be enhanced if it takes place in real life settings because any extraneous variables are eliminated. In the current study, as far as possible, data was gathered in the same building where the weight loss sessions took place in order to enhance ecological validity. Silverman (1993) argues that research conducted rigorously increases the reliability of qualitative research. In the current study, IPA was followed step-by-step to ensure research rigor (See Appendix I for an illustration of the steps followed with an extract from a transcript).

There is an interactional relationship between the investigator and the data in IPA. Smith, *et al.* (2009) emphasise that the subjectivity of the researcher cannot be entirely eliminated. It is therefore important to consider the researcher's background and viewpoints on the subject, which might impact on the data collection and analysis. Although the research process cannot demonstrate that the analysis is completely free from bias, steps were taken to minimise bias so that the data was examined as objectively as possible:

- The researcher acknowledged any pre-existing biases;
- Reflexive notes were made throughout the process;
- Every instance and title of a theme in the analysis comprises verbatim quotes;
- The analysis and coding of individual transcripts were reviewed by the research supervisor to check consistency with other transcripts.

Ethics

It was not expected that any major ethical issues would arise during interviews. City University approved the ethics of the study after a research proposal with appendices had been submitted for marking. The NHS REC also approved Part II of the research, as they did Part I. There was no physical risk involved in participating in this study,

but it was possible that the subjects of group treatment experience or obesity could cause emotional distress. Talking about any psychological condition or treatment may be emotionally laden. The experience of the researcher in providing therapy and working with client groups with psychological difficulties enabled participants in this study to be approached and treated in an empathic and sensitive way.

Precautions were taken to address the potential risks. Prior to the qualitative interviews, participants were given an honest explanation of the study and were verbally reassured that their right to withdraw would be honoured and would not result in negative treatment from the researcher, nor would it affect their treatment. The participants were informed that the intention of this study was to gather information and not to provide therapy. However, the researcher was sensitive to the participant's mood during interviews.

Participants received details of a psychological therapies service which they could self-refer to if they felt they would like therapy after taking part in this research project.

To address any possible risks to the researcher, interviews took place in buildings which contained other professionals and receptionists so that they could be called upon if a problem arose.

Smith, *et al.* (2009) acknowledge that it is impossible to attain unequivocal confidentiality in the qualitative data collection and analysis in IPA. For the qualitative part of this study, only the researcher has borne witness to any identifying details.

ANALYSES

The data for **Parts I** and **II** were gathered concurrently, as some researchers accept that data analyses and integration can occur at any point in mixed methods research (Hanson, Creswell, Clark, Petska, & Creswell, 2005).

Response rate for Part I – ASQ and BMI measurements

The researcher attended 26 groups (every intervention group that was on the rolling programme from July 2012 to May 2013), each of which had approximately 10 group members (a total of 263), to ask if they wanted to take part in the study by completing the ASQ. 60 people returned the completed ASQ, which represents a return rate of approximately 23%. The research data of 8 participants could not be included in the final analysis because they did not attend Weeks 10, 11 or 12 of the course. 5 of these participants had their final weight scores between Weeks 7 and 9. The other 3 participants had dropped out of treatment before Week 7. No participants' data was included unless there was a weight value for them for at least Week 10 as this is an appropriate time to achieve the weight loss goal of the course.

A response rate of 23% is not considered to produce generalisable findings because there is a non-response bias of 77%, which raises questions about whether the type of people who responded were particularly different to those who did not respond. For example, the people who responded may be people who want to help others out and please others by agreeing to participate and therefore they might score higher on the attachment questions relating to anxious attachment on the ASQ (particularly the dimension Need for Approval).

Response rate for Part II – Qualitative interviews

Of the 60 people who agreed to participate in Part I of the study, 28 people ticked the box on Consent Form 1 (Appendix C) indicating that they were willing to participate in the interview part of the project. This was a response rate of 47%. It is important to note that participants who self-selected to take part in the interviews might represent a particular type of person and therefore might not be representative of the sample as a whole. For example, people who self-selected to take part in the interviews may enjoy talking to other people and therefore might score highly on dimensions such as Confidence, Need for Approval, and Preoccupation on the ASQ (dimensions which translate to Secure and Anxious attachment styles), whereas individuals with a more avoidant attachment style may have been less likely to self-select.

Ignoring the 2 participants who had withdrawn from the intervention at Week 4 and Week 6, the first 10 people who had taken part in **Part I** of the study and had ticked the box on the Consent Form 1 (See Appendix C) to confirm their interest in taking part in **Part II** were telephoned by the researcher to ask if they were still interested. 1 potential participant was going to be on holiday on the days that the interview rooms had been booked. 1 potential participant was too unwell to participate. Another said that he was too busy during the time the interviews were to take place. The remaining 7 all re-confirmed their interest in taking part and interview times were agreed. A Letter of Confirmation was sent out in the post (see Appendix J). Of the 7 participants, 5 were female, which is very approximately representative of the male:female ratio for the participants who took part in Part I. The age range of participants was between 40 and 66 years old (mean age = 51).

Quantitative Results

Below is a report of the results of a stepwise (backward elimination) linear multiple regression for the dependent variable (outcome) BMI Change and the independent variables (predictors) of the 5 ASQ dimensions. BMI Pre was entered as an extra independent variable to see whether BMI pre would affect any relationship between BMI Change and the other predictors (as either a mediator or moderator variable).

Testing for normality

A probability–probability (P-P) plot of BMI Change (dependent variable) against the cumulative probability of a normal distribution showed deviations from normality (i.e. deviations from the diagonal line). A histogram showed that the data were positively skewed, suggesting a non-normal distribution. To confirm that the data were not normally distributed, the Kolmogorov-Smirnov and Shapiro-Wilk tests of normality were performed on the dependent variable (see Table 3).

BMI Change	Statistic	df	Sig.
K-S	0.17	52	0.00
S-W	0.92	52	0.00

Table 3: The Komogorov-Smirnov (K-S) and Shapiro-Wilk (S-W) tests for Normality for the Dependent Variable BMI Change

The K-S is the standard goodness of fit test and the S-W is generally used for samples less than 50. The current sample size is on the cusp of being K-S and S-W appropriate. Both K-S and S-W tests show that BMI Change is significantly non-normally distributed < 0.05 . Therefore the data for the dependent variable were transformed to make the distribution normal.

Transforming the data

The data for the dependent variable BMI Change were not normally distributed, so a logarithm was taken to reduce the positive skew. However, the data had negative numbers (for the participants whose BMI had increased rather than decreased), so a constant was added to all of the data before the log transformation. When negative numbers are in the data, the value that makes the smallest number in the data set positive needs to be added, which in this case was -6.3. Therefore a constant of the minimum negative value was added and a base 10 logarithm transformation was applied to that. This produced a variable that contains the logarithmic (to base 10) values of the variable BMI Change. Therefore the equation used to transform the data was $\log_{10}(\text{BMI Change} + 6.3)$.

Testing for normality after the transformation

Figure 3 (p.121) shows a histogram of the distribution of the transformed BMI Change data. It is possible to see that the data now appear to be normally distributed.

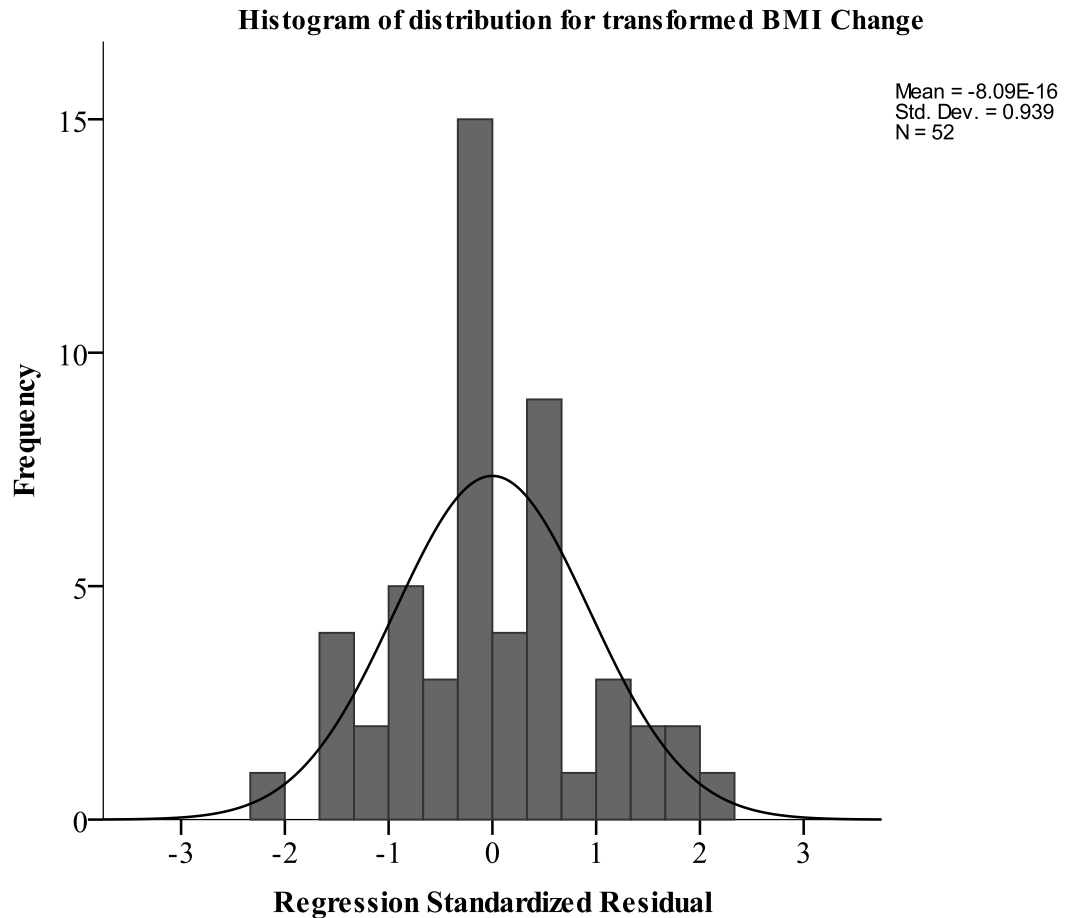


Figure 3: A Histogram to test the Normality of the Transformed Dependent Variable BMI Change

BMI Change	Statistic	df	Sig.
K-S	0.12	52	0.04
S-W	0.70	52	0.22

Table 4: The Komogorov-Smirnov and Shapiro-Wilk tests for Normality for Transformed BMI Change

The current sample size is on the cusp of being K-S and S-W appropriate. Both K-S and S-W tests show that BMI Change is significantly non-normally distributed < 0.05 (see Table 4). Therefore the data for the dependent variable were transformed to make the distribution normal.

The S-W test for the transformed BMI Change scores was > 0.05 , indicating that the data were normally distributed. Although the K-S test was non-significant, this was

only marginal and furthermore the sample size lay on the cusp of being appropriate for K-S and S-W, so it was considered that the distribution of the sample was not significantly different from the normal distribution.

Although the transformation achieved a more normal distribution of the dependent variable, it is worth noting that a P-P plot of the transformed BMI Change (dependent variable) against the cumulative probability of a normal distribution still shows some deviations from normality in the middle of the data (See Figure 4). Although this is not a major deviation, it may need to be considered in the discussion section of this study.

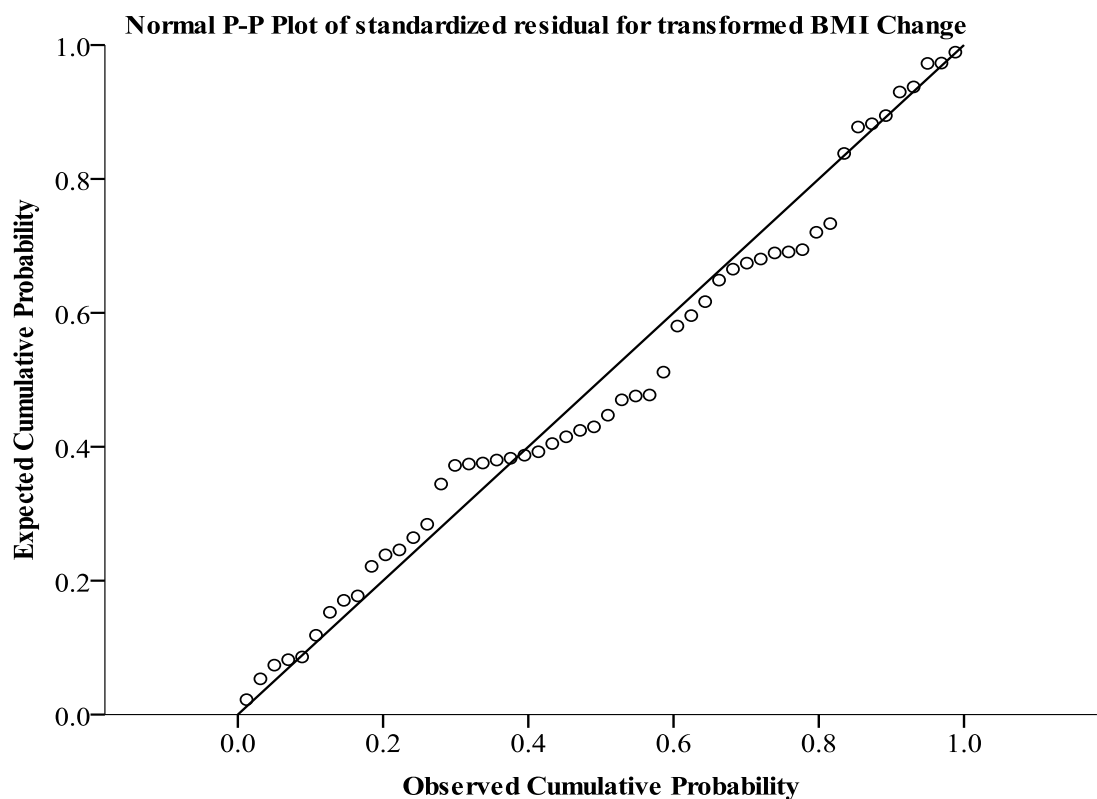


Figure 4: A P-Plot to show where the Deviations from Normality lie for the Transformed Dependent Variable, BMI Change

Regression analysis for BMI Change

A backward elimination multiple linear regression was conducted to evaluate whether the five dimensions of the ASQ (Confidence, Discomfort, Relationships as Secondary,

Need for Approval, and Preoccupation) were necessary to predict BMI Change. A regression was chosen because it can go one step further than assessing whether there is a relationship between variables: It demonstrates whether changes in the dependent variable can be predicted by the independent variables. Results of analyses like these are useful in a clinical context because they could inform what type of individual is likely to achieve a better outcome in this type of treatment. The regression was ‘multiple’ because there was more than one predictor being tested. Backward elimination was used because it gives the opportunity to look at all the independent variables in the model before removing the variables that are not significant, giving a thorough indication of what influence the predictors have on the dependent variable.

Descriptives

The total number of participants was 52: of these 42 were female and 10 were male. Participants’ ages ranged from 22–72 years old, with the average age being 47.54 (SD = 11.14). Table 5 shows that the average starting BMI was 46.97.

Variables	Confidence	Discomfort	Relationships as Secondary	Need for Approval	Preoccupation	BMI Change	BMI Pre
Mean	3.83	3.85	2.70	3.60	3.67	0.86	46.97
Std Dev	1.05	0.97	0.85	1.07	0.90	0.10	7.42

Table 5: Descriptives for the Variables in the Regression

Correlations

Table 6 shows the Pearson’s correlation coefficient between every pair of variables that were entered into the regression.

Variables	BMI Change	Confidence	Discomfort	Relationships as Secondary	Need for Approval	Preoccupation
Confidence	-0.28*					
Discomfort	0.18	-0.70**				
Relationships as Secondary	0.04	-0.27*	0.61**			
Need for Approval	0.10	-0.63**	0.59**	0.34**		
Preoccupation	0.16	-0.25*	0.41**	0.20	0.63**	
BMI Pre	0.04	0.31*	-0.26	-0.07	-0.20	-0.32*
<i>Note</i>						
* p<.05						
** p<.01						

Table 6: Correlations for Variables in the Regression

The predictor Confidence is significantly negatively correlated with the dependent variable ($p<.05$), which suggests that higher scores in confidence produced less change in BMI scores. The remaining four dimensions were positively (but not significantly) correlated with BMI Change scores, indicating that participants with higher scores on insecure attachment were more likely to have larger BMI Change scores, generally speaking.

The dimension Confidence correlated significantly negatively with the other dimensions of Discomfort, Relationships as Secondary, Need for Approval and Preoccupation ($p<.05$). These correlations are not surprising as Confidence is an indicator of attachment security, whereas the other four dimensions are indicators of attachment insecurity.

There are highly significant positive correlations between the dimensions of insecure attachment (Discomfort and Relationships as Secondary; Discomfort and Need for Approval; Discomfort and Preoccupation; Relationships as Secondary and Need for Approval; Need for Approval and Preoccupation, $p < .01$). There is a significant positive correlation between BMI Pre and Confidence ($p < .05$). There are also significant negative correlations between BMI Pre and Discomfort and BMI Pre and Preoccupation. This shows that those scoring higher on Confidence had a higher BMI at the start of treatment, whereas those scoring higher on Discomfort and Preoccupation had a lower BMI at the start of treatment. Table 6 also shows that the best predictor of BMI Change is Confidence.

Regression

All predictors (the five dimensions on the ASQ and BMI pre) were entered into a backward regression, in order to assess which would form a model that significantly predicts BMI Change. BMI pre (or participants' starting weight) was entered into the model to test whether BMI Change varies depending on participants' starting weights.

A backward elimination involves starting with all the predictor variables, and then deleting the variable that brings about the greatest improvement in the model (defined as having the most impact on the dependent variable), and this process is repeated until no further improvement is possible. At Stage 1, the model took out the predictor Relationships as Secondary as that was the least significant predictor of BMI Change ($F = 1.406$, $p > .05$). At Stage 2, Discomfort was also taken out ($F = 1.725$, $p > .05$), then BMI pre at Stage 3 ($F = 2.178$, $p > .05$), then Preoccupation at Stage 4 ($F = 2.322$, $p > .05$), then Need for Approval at Stage 5 ($F = 2.411$, $p > .05$). Therefore the backward regression took six steps to get to the significant model, which had one predictor Confidence

which predicted BMI Change (See Table 7). The regression analysis took out the predictor BMI Pre at Stage 3, which shows that it is not significantly related to BMI Change.

Variable	B	Beta	SIG.	R Square	Adjusted R Square	Std Error
Confidence	-0.03	-0.28	0.04	0.08	0.06	0.10

Table 7: Regression Analysis Results from Final Model; BMI Change as Outcome Variable

The results of the regression indicated that the predictor Confidence explained 8% of the variance ($R^2=0.08$, $F(1,50) = 4.32$, $p < .05$). Therefore, at Step 6 of the analysis, Confidence was the only variable that remained which was significantly related to BMI Change. However, the significance value of 0.04 of Confidence predicting BMI Change was slightly less than 0.05.

Confidence accounted for 8% of the variance in BMI Change, which means that 92% of the variation in BMI Change could not be explained by Confidence alone.

Therefore, there must have been other variables that had an influence.

A forward regression was also performed to confirm the findings. The forward regression analysis produced the same findings.

Model parameters

As the B value was negative, there was a negative relationship between Confidence and BMI Change. (As the scores on Confidence increased, BMI Change decreased).

The standardised versions of the B values (labelled Beta) inform us of ‘the number of standard deviations that outcome will change as a result of one standard deviation change in the predictor’. Due to the fact that the standardised beta values are measured

in units of standard deviation, these figures are a better indicator of the impact of a predictor in the model. The value for Confidence was higher than the value for the other four predictors, suggesting that Confidence had more importance in the model. Standardised B BMI Change is -0.46 so as Confidence increased by one standard deviation, BMI Change decreased by 0.46 standard deviations.

Confidence intervals

If the model is reliable then we would hope to find similar parameters in larger samples, so these models would produce approximately the same B values. 95% confidence intervals estimate whether 100 samples of data would contain the true value of B. The confidence intervals for Confidence in the significant model were -0.052 and -0.001, which is a small confidence interval, indicating that the B value in this sample was close to the true value in the population, but the confidence interval value almost included zero, which confirms how small the effect size was.

Checking assumptions

Checking the assumptions of regression ensures that the model generalizes beyond the current sample (i.e. that the model is valid).

Assumptions using linear regression analysis using SPSS

All of the following assumptions were met:

- The variables have continuous data;
- There is a linear relationship between the two variables (See Figure 5, p.129).
There is no curve in the graph, so the data have not broken the assumption of linearity;
- There are no significant outliers in the data;

- There is independence of observations tested with the Durbin-Watson test. The value is 2.508, which is not less than 1 or greater than 3 and is close to 2 so the residuals are uncorrelated (Field, 2009);
- The data shows homoscedasticity (where the variances along the line of best fit remain similar as you move along the line). According to Field (2009), the graph of residual against predicted values for the dependent variable should look like a 'random array of dots evenly dispersed around zero' (See Figure 6, p.130). The graph meets this requirement and it does not funnel out. Therefore the assumption of homoscedasticity has been met;
- The residuals of the dependent variable BMI Change are approximately normally distributed (See Figure 3 and Table 4, p.114)
- There should be no perfect linear relationship between two or more of the predictors to meet the assumption of multicollinearity. The significant model only has one predictor, so there is no collinearity within the data.

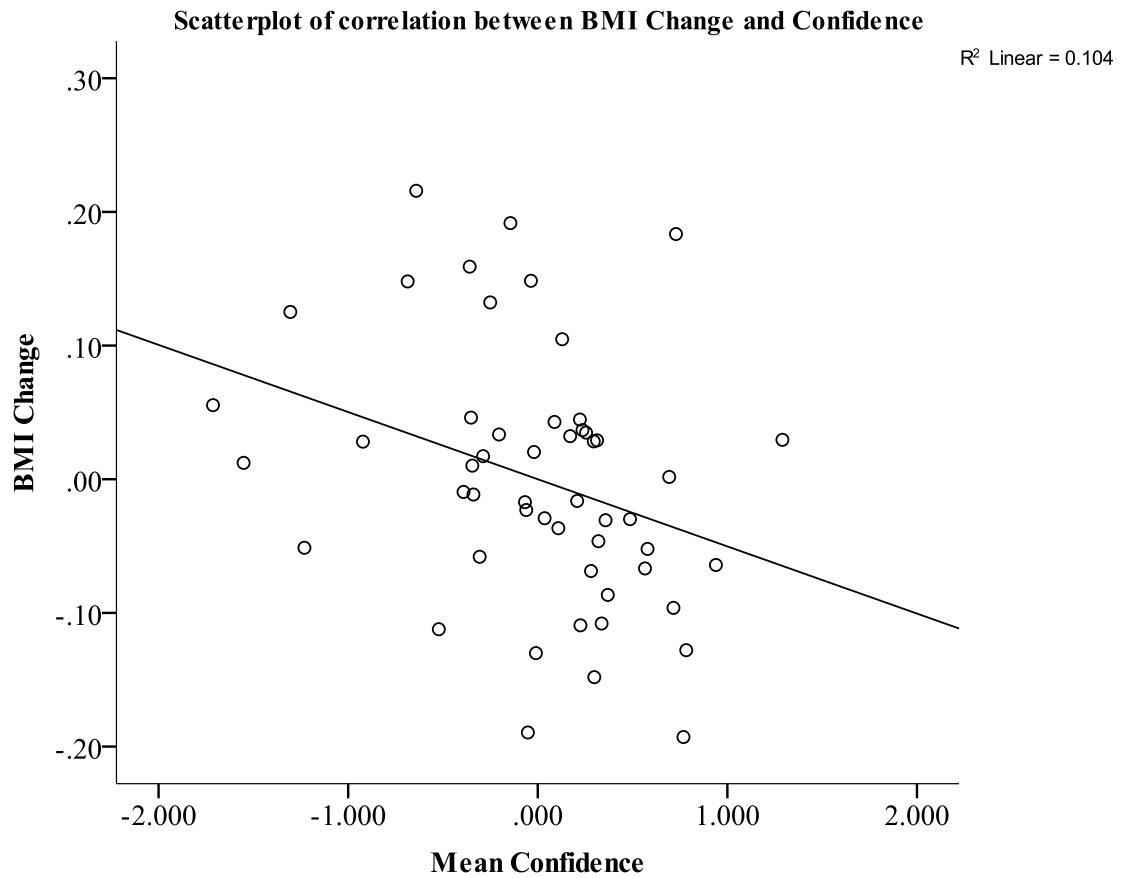


Figure 5: Scatterplot Demonstrating the Linear Relationship between the Dependent Variable (BMI Change) and the Predictor Confidence

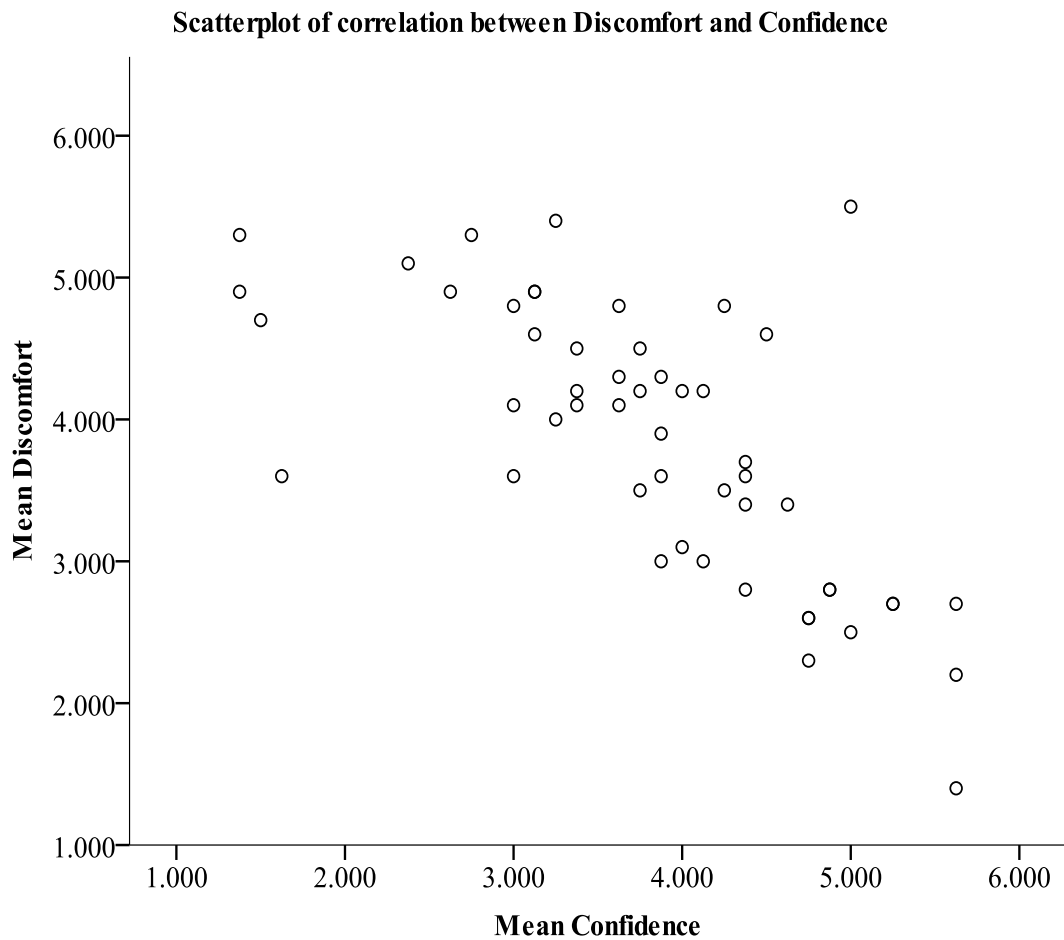


Figure 6: Scatterplot Demonstrating the Variance of the Predicted against Residual Values for the Dependent Variable, BMI Change

Predictors with a strong correlation to Confidence

It is necessary to consider the relationship between the significant predictors and other predictors as this has implications for what conclusions can be drawn from the data. As scores on Confidence increase, scores on Discomfort and Need for Approval both decrease, which is to be expected because Confidence is a measure of attachment security and Discomfort and Need for Approval represent attachment insecurity. Given the high level of inter-correlation, it could be argued that there is a large amount of shared variance between the attachment factors.

Confidence and Discomfort are strongly correlated ($r = -0.70$, $p < .001$) and Confidence is related to BMI Change (see Table 6, p.117). Therefore the higher the scores of discomfort and the lower the scores on confidence, the more likely it is that the participant will have lost more weight during the course. (See Figure 7).

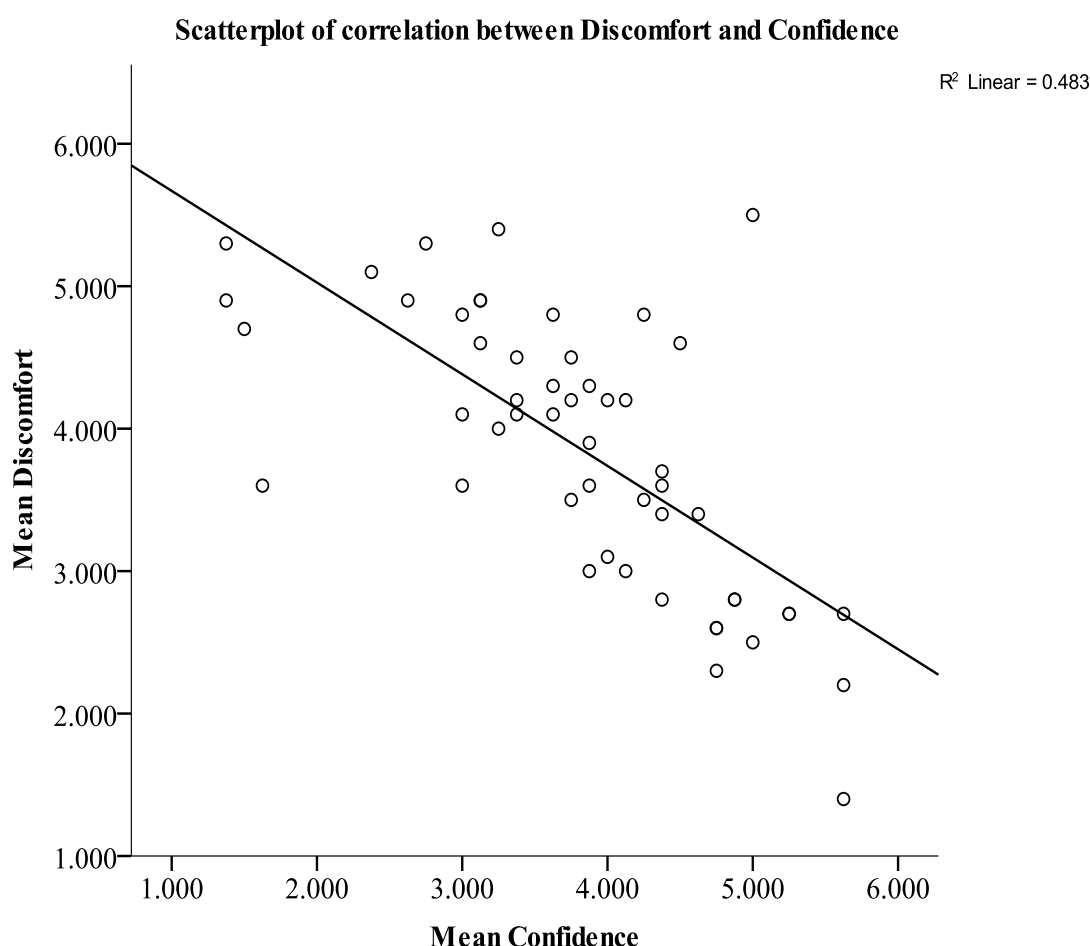


Figure 7: Scatterplot Demonstrating the Relationship between Confidence and Discomfort with Line of Best Fit

Confidence and Need for Approval are also strongly correlated ($r = -0.63$, $p < .001$). (See Table 6, p.117). Therefore the higher the scores of Need for Approval and the lower the scores on Confidence, the more likely the participant will have lost more weight during the course. (See Figure 8, p.132).

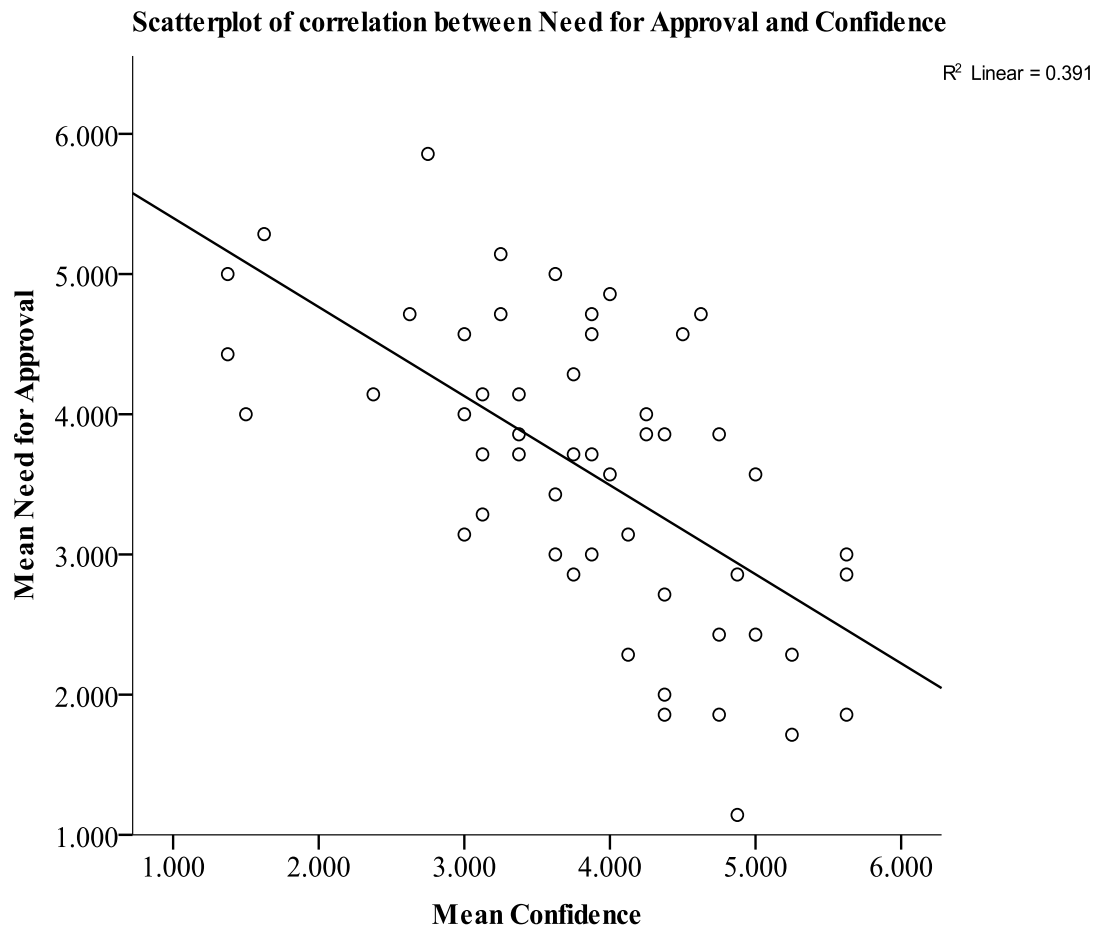


Figure 8: Scatterplot Demonstrating the Relationship between Confidence and Need for Approval with Line of Best Fit

The relationship between starting BMI and predictors

The relationships between starting BMI and Confidence, Discomfort and Preoccupied are all significant ($r = 0.31$, $p < .05$; $r = -2.61$, $p < .05$; $r = -0.32$, $p < .05$). This means that those with a higher score on Confidence had a higher starting BMI than those low on Confidence, and those higher on Discomfort scores had a lower starting BMI. Also those higher on Preoccupation scores had a lower starting BMI.

Summary

The model appears to be accurate for the sample and can potentially be generalisable to the population, but there are deviations from normality in a proportion of the sample so

more data would be needed to create a more normal distribution. In the current sample, Confidence can predict BMI Change with slight significance. This indicates that people with higher scores on Confidence (a measure of attachment security) lost less weight on the course than those with lower scores. This means that the hypothesis for this study (that participants with insecure attachment will lose less weight on average than participants who are securely attached) is rejected. The aim of the research was to find out whether outcome of group treatment varies according to attachment style. It was found that Confidence (in relationships) predicts less weight loss than other predictors (which represent attachment insecurity). This is the opposite of the hypothesis of this study. Nevertheless the significant finding is only marginally significant and Confidence only accounts for 8% of the variance, therefore this model is not considered to be robust and would not be recommended.

The assumptions have been met so it might be possible to assume that this model would generalise to any group of people undertaking the weight loss programme. Confidence is strongly negatively correlated to both Discomfort and Need for Approval, so the higher the score on Discomfort and the lower the score on Confidence, the less likely it is that the participant will have lost weight on the course. (The same is true for Need for Approval). Participants with higher Confidence scores had higher starting BMIs than those with lower Confidence scores. Those with higher Discomfort scores and Preoccupation scores had lower starting BMIs.

Qualitative Results

Analysis of Transcripts

The mean interview duration time was 64 minutes. The interviews were transcribed and analysed according to IPA guidelines (Smith, *et al.*, 2009). The order in which the transcripts were analysed was the order in which the interviews took place. The analyses involved various stages, which included the researcher's immersion in the data whereby the interviews were listened to several times. The researcher's exploratory comments on the transcripts were on the levels of "descriptive comments", which summarised interview extracts in a descriptive manner; "linguistic comments", which paid attention to participants' use of words and the tone in which they spoke; and "conceptual comments", which included questions that the researcher had in response to the transcript and may have included points which were not explicitly explored by participants. Any emerging themes from these notes were given a name. The emerging themes were then typed into a Word document with all the examples of quotes which illustrated that theme. Themes were then grouped into similar categories of "sub-themes" which captured the overall quality of emerging themes. At this point, some emerging themes were discarded or given a different name. A table of sub-themes was developed for each participant.

The analysis of the transcript for the first 51-minute interview provided 29 sub-themes. This process lasted 4 days and was then repeated for each interview transcript.

Subsequent interviews took on average 3 days each to be fully analysed. When all the transcripts had been analysed, a similar process was carried out at a group level. A table of master themes for participants was then created.

This process is demonstrated with a quote from Participant 4 at 1 minute and 45 seconds into the interview: *“And probably if I was truthful, a bit upset with the group because I’ve tried **so** many different ways to lose weight and I thought- When I went to see my doctor, I really thought this was going to be the one that would really help me. And it was- It didn’t help because it wasn’t- It was a bit confusing”*. A ‘linguistic exploratory comment’ was noted at “**so**” to highlight the way the word was emphasised to express that the participant had tried many ways to lose weight. A ‘conceptual exploratory comment’ was noted to highlight the idea of feeling let down and disappointed with the course, signifying external agency (it was the fault of the course that she had not lost weight). A ‘descriptive exploratory comment’ was noted that the course did not help this participant because she had found it confusing.

The ‘emerging theme’ that was associated with these comments was ‘disappointment with the course’, which was grouped with other emerging themes under the third sub-theme called ‘needs unmet by the course’. Once the master list of themes was constructed, this quote ended up within Sub-theme 4a ‘Frustration/Dislike of this group’, which was grouped under the super-ordinate theme ‘Negative aspects of the course’. It was hoped that the detailed analyses of the transcripts (that IPA requires) could lead to an in-depth understanding of the collective experience underlying the group treatment.

When themes were being considered at the group level, they would continue to be re-organised, re-named and discarded. A Master List was created which included every instance of each theme from every participant (see Appendix K for an example of some Master List themes). Making sense of the themes involved many changes until the ‘sub-themes’ fitted well within the overall ‘themes’. The final analysis contained 4 super-ordinate themes and 11 sub-themes, which are shown in Table 15 (p.134).

Within the qualitative findings, the aim was to describe the overall thematic structures capturing the phenomenon of the group experience whilst also demonstrating the more individual experiences of participants.

Descriptive information of participants

All names and certain biographical/personal identifying details have been changed throughout in order to preserve confidentiality.

Frances

Frances is a 64-year-old woman. She is a retired teacher. Her starting BMI was 44.4 (weight 128.3 kg) and finishing BMI was 42.9 (weight 124.0 kg). Her goal weight loss (5-10% of starting body weight) was between 6.4 and 12.8 kg. Her actual weight loss was 4.3 kg (3.4% of her starting weight). Frances lives alone and my impression of her was that she spends much of her time alone. She mentioned that she did not form friendships on the course and that she felt separate from the group. Frances's profile of scores and her BMI Change is shown in Table 8.

μ Confidence	μ Discomfort	μ Relationships as Secondary	μ Need for Approval	μ Preoccupation	Weight loss
3.0	4.1	3.1	4	3.3	3.4% loss
<i>Note: Minimum score = 0; Maximum score = 6</i>					

Table 8: Frances's Profile of Mean Scores on the ASQ and her BMI Change

Lynette

Lynette is a 54-year-old woman. Her starting BMI was 42.7 (weight 120.4 kg) and her finishing BMI was 43.5 (122.7 kg). Her goal weight loss (5-10% of starting body weight) was between 6.0 and 12.0 kg. Lynette gained 2.3 kg in weight (an increase of

1.9% of her starting weight). Lynette talked about being shy in a group and she said that she has two sides: one is “stand-offish” and the other is the “life and soul of the party”. She said that she found it daunting to be with others in a group but opened up with time. Lynette’s profile of scores and her BMI Change is shown in Table 9.

μ Confidence	μ Discomfort	μ Relationships as Secondary	μ Need for Approval	μ Preoccupation	Weight loss
5.6	2.7	3.1	2.9	4.0	1.9% gain
<i>Note: Minimum score = 0; Maximum score = 6</i>					

Table 9: Lynette’s Profile of Mean Scores on the ASQ and her BMI Change

Susan

Susan is a 58-year-old woman. She works part-time as an administrator. Her starting BMI was 42.8 (105.3 kg) and her finishing BMI was 40 (98.4 kg). Her goal weight loss (5-10% of starting body weight) was between 5.3 and 10.5 kg. Her actual weight loss was 6.9 kg (6.6% of her starting weight). Susan also talked about there being two sides to her: a quiet person who wants to be alone and a very outgoing person. My impression of Susan was that she was not shy. She said that she feels confident going into a group of people but she also mentioned that she did not want to make friends in the group and that she likes to be a ‘loner’. Susan’s profile of scores and her BMI Change is shown in Table 10.

μ Confidence	μ Discomfort	μ Relationships as Secondary	μ Need for Approval	μ Preoccupation	Weight loss
3.9	3.6	3.0	3.7	3.1	6.6% loss
<i>Note: Minimum score = 0; Maximum score = 6</i>					

Table 10: Susan’s Profile of Mean Scores on the ASQ and her BMI Change

Nicola

Nicola is a 44-year-old woman. She works part-time in an old people's home. Her starting BMI was 44 (108.2 kg) and her finishing BMI was 45.2 (111.2 kg). Her goal weight loss (5-10% of starting body weight) was between 5.4 and 11.1 kg. Nicola gained 3 kg in weight (an increase of 2.8% of her starting weight). What struck me about Nicola was how upset she was that she had not lost weight on the course, and she was disappointed in the course. She said that she is wary in groups and was shy being in a group on the course. She said how much she would have liked individual therapy to target her emotional eating problem. Nicola's profile of scores and her BMI Change is shown in Table 11.

μ Confidence	μ Discomfort	μ Relationships as Secondary	μ Need for Approval	μ Preoccupation	Weight loss
4.4	2.8	1.7	3.9	3.6	2.8% gain
<i>Note: Minimum score = 0; Maximum score = 6</i>					

Table 11: Nicola's Profile of Mean Scores on the ASQ and her BMI Change

Joe

Joe is a 46-year-old man. He is a shop assistant. His starting BMI was 52.1 (168.8 kg) and his finishing BMI was 50 (162 kg). His goal weight loss (5-10% of starting body weight) was between 8.44 and 16.9 kg. His actual weight loss was 6.8 kg (4% of his starting weight). Joe came across as very confident and he said that he likes being in a group. I got the impression that he very much enjoyed being with others in the group and being an outspoken and humorous member of the group. Joe's profile of scores and his BMI Change is shown in Table 12.

μ Confidence	μ Discomfort	μ Relationships as Secondary	μ Need for Approval	μ Preoccupation	Weight loss
3.1	5.0	3.6	3.3	2.9	4% loss
<i>Note: Minimum score = 0; Maximum score = 6</i>					

Table 12: Joe's Profile of Mean Scores on the ASQ and her BMI Change

David

David is a 51-year-old man. He is a machine operator in a factory. His starting BMI was 50 (165.6 kg) and his finishing BMI was 48.9 (162.0 kg). His goal weight loss (5-10% of starting body weight) was between 8.28 and 16.6 kg. His actual weight loss was 3.6 kg (2.2 % of his starting weight). David said that he is shy in a group but that he feels a bit more able to open up as he gets to know people better. He was particularly frustrated by other people in the group being distracting by making too much noise. David's profile of scores and his BMI Change is shown in Table 13.

μ Confidence	μ Discomfort	μ Relationships as Secondary	μ Need for Approval	μ Preoccupation	Weight loss
5.6	2.2	1.3	1.9	4.5	2.2% loss
<i>Note: Minimum score = 0; Maximum score = 6</i>					

Table 13: David's Profile of Mean Scores on the ASQ and her BMI Change

Lucy

Lucy is a 40-year-old woman. She is an accountant. Her starting BMI was 44.3 (123.5 kg) and her finishing BMI was 43.7 (121.8 kg). Her goal weight loss (5-10% of starting body weight) was between 6.2 and 12.4 kg. Her actual weight loss was 1.7 kg (1.4% of her starting weight). Lucy said that she is very shy in groups because she had

found previous groups to be judgemental. She said that she was still shy of speaking out in the group up until the end but that it was easier as time progressed. Lucy's profile of scores and her BMI Change is shown in Table 14.

μ Confidence	μ Discomfort	μ Relationships as Secondary	μ Need for Approval	μ Preoccupation	Weight loss
2.6	4.9	3.4	4.7	2.8	1.4% loss
<i>Note: Minimum score = 0; Maximum score = 6</i>					

Table 14: Lucy's Profile of Mean Scores on the ASQ and her BMI Change

Theme 1: Sadness at the course ending: <i>I will miss it when we're not there any more.</i> (Lucy)	1a. Loss <i>I might be...sad because we had a good time and made interesting friends and it's been worthwhile.</i> (David) 1b. Lapse <i>It's been my motivation...Will I lapse if I get back into my old ways?</i> (Lynette) 1c. Wanting more <i>I wish it could go on forever.</i> (Susan)
Theme 2: Feeling supported and comforted by the group experience: <i>Social support from the group...was very important.</i> (Nicola)	2a. Support received from group members and facilitators: <i>I felt like I was under some sort of care.</i> (Susan) 2b. Identification/the shared experience of being obese <i>It's like-mindedness. You're in the same boat as me; I can relate to your problem.</i> (Joe) 2c. Positive comparison <i>I'm not as far down the line as other people.</i> (Susan)
Theme 3: Positive aspects of the group <i>It's made me realise that actually it does work.</i> (Lynette)	3a. I will get there The course engendering motivation for weight loss: <i>It has given me more of a sense of determination.</i> (Frances) 3b. Some useful learning compared to other slimming groups <i>It has been approached from a slightly different angle.</i> (Frances)
Theme 4: Negative aspects of the group <i>I have been a bit semi-half-hearted about the course.</i> (David)	4a. Frustration/dislike of this group <i>[I was] upset with the group.</i> (Nicola) 4b. Negative relation to groups generally; little new in this group <i>I find it hard to make friends with people in a group.</i> (Nicola) 4c. Preference for one-to-one <i>I think one-to-one is actually better.</i> (Frances)

Table 15: Table of Themes

Introduction to themes

Theme 1 (Sadness at the course ending) reflects the sadness expressed by participants at the prospect of the course ending. Subtheme 1a (Loss) captures the loss experienced. Many participants felt they would miss the people on the course. This is echoed in

Theme 2 (Feeling supported and comforted by the group experience), which describes the importance of support gained from other group members and health professionals (Subtheme 2a: Support received from group members and facilitators).

One reason for the sadness at the course ending was the worry about lapsing in the absence of the course and its structure. The course had acted as a motivator and participants were concerned that they would not be able to maintain their weight or lose weight following the termination of the course (Subtheme 1b: Lapse).

Participants expressed the wish for the course to continue and the wish to undertake the course again, suggesting a dependency on the course for weight loss/maintenance. Some participants arranged within their group members to continue to meet beyond the course ending, suggesting the support derived from others was useful and they felt they could not cope without it.

Theme 2 (Feeling supported and comforted by the group experience) describes the support and comfort derived from group membership. The support received from group members and facilitators was a potent theme in the analysis (Subtheme 2a: Support received from group members and facilitators). Identification with others as being obese created an environment that felt accepting and non-judgmental (Subtheme 2b: Identification/the shared experience of being obese). Conversely, the competitiveness and positive comparison (i.e. comparing the self to others to put the self in a favourable light) to each other also represented a source of comfort, because participants felt better about themselves at the thought “I’m thinner than you” (Subtheme 2c: Positive comparison).

Participants talked about positive aspects of the course and how much they valued it (Theme 3: Positive aspects of the group). Some felt that the course had inspired them

to achieve their weight loss goal, despite not achieving significant weight loss during the course (Subtheme 3a: I will get there). Behind this subtheme is a sense that participants were putting off what they could do today until tomorrow. Useful learning had been achieved on the course, especially compared to slimming groups attended previously (Subtheme 3b: Some useful learning compared to other slimming groups).

Negative aspects of the group were represented in Theme 4. Some expressed frustration and disappointment or dislike of this group (Subtheme 4a: Frustration/dislike of this group). The reasons for this were varied and rarely shared between participants, from one participant's frustration at not having received personalised emotional support for her difficulties with emotional eating to another participant's discomfort with the amount of personal information that group members shared. They mostly had their own reasons why they were disappointed with the course. Participants mentioned their negative relation to groups generally and claimed that the current group experience was nothing new (Subtheme 4b: Negative relation to groups generally; little new in this group). A preference for one-to-one interventions over the group treatment was shared by many participants (Subtheme 4c: Preference for one-to-one). The subthemes within this super-ordinate theme could be interpreted as the desire to keep others away.

Super-ordinate theme 1: Sadness at the course ending:

I will miss it when we're not there anymore (Lucy)

Theme 1 refers to the shared feeling of sadness at the course ending. There was a sense that participants had come to rely on the course for regular support and to maintain motivation for weight loss. Some were concerned that they would put weight back on without the support of the course. For some it was specifically contact with other

group members that they would miss and as a result their groups had arranged to continue meeting beyond the course ending. Some explicitly stated that they would not miss the people.

Subtheme 1a (Loss):

I might be...sad because we had a good time and made interesting friends and it's been worthwhile (David)

Six of the seven participants shared a sense of loss at the course ending. For some this was particularly because they would miss others in the group:

I will miss the people (Lucy)

These participants talked about the course being a social event that they looked forward to each week. They talked about the enjoyment of being part of the group. For these people it was the support gained from other group members that was their main source of support:

With the group, to me that is my big support. That is the real one (Joe)

Two participants stated outright that they would not miss the people in the group:

A lot of people were sad [that the contact with group members was ending] but I wasn't at all...I wasn't happy it was finished or sad it was finished...They were saying 'Oh it's really sad' and I'm thinking 'Why do they think it's sad?' (Susan)

For one of them, it was the health professionals rather than the people that she would miss:

I'm in a different situation to most people...I think some of the others will miss it' It's more the health professionals that I shall miss having in a group (Frances)

For this participant, it seemed that it was the health professionals who she had formed an attachment to, rather than the other group members. This indicates a difference in what group members found therapeutic: the other group members; the health professionals; or being unable to get answers to their questions about weight loss in the absence of the course:

I will miss...the fact that it's there and you can ask questions and get reassurance

(Lucy)

Within this subtheme is the idea that group members had formed an attachment to the group, almost as if the group had become some sort of caregiver providing the main source of support.

Subtheme 1b (Lapse):

It's been my motivation...Will I lapse if I get back into my old ways? (Lynette)

For five participants, the course has acted as a constant reminder of why they want to lose weight and has maintained their drive for weight loss. Possibly the reason for participants doubting their ability to achieve weight loss after the course is because the agent of motivation is specifically the contact with other members, perhaps in the form of support, which ceases on completion of the course.

Participants were concerned that without the support from the course, they would lapse and regain old habits that would cause them to gain weight. There was the sense that it would not be worth achieving weight loss if they were only doing it for themselves:

I shall slip back if I don't [continue with the course]...but if I know it's

continuing...there's a reason where, if I do slip, I've got a target to get back...I'm not sure that I'll be able to succeed without support of some sort (Frances)

This suggests that the reason to lose weight is for others, not for the self. This echoes the interpretation of needing another to provide support. Being independent in weight loss is a daunting prospect, despite the fact that the aim of the course is to provide members with the ability to independently manage their weight (and this is a problem if obesity represents a problem with independence):

I'm on my own and I've got to do it for myself...and that frightens me...If [the support] stops, you haven't got that anymore, so it's like, 'What do I do now?' (Lynette)

This sense of dependence is echoed, as one participant reports that the weeks when his course had not taken place resulted in group members gaining weight:

We as a group have found that we do better with the support...The weeks that we weren't here, lots of people put weight back on...Once you stop going, the weight goes back on' (Joe)

It is interesting to note that there is a shared sense of reliance on the course for achieving goals when the idea behind the course is that members improve their self-awareness and develop strategies to be independent managers of their own weight loss. In considering the reasons for the lack of confidence in participants' own abilities, perhaps the course has unintentionally fostered the dependency of course members. Dependency in itself is not a problem but it could be if it underlies a symptom of obesity.

Subtheme 1c (Wanting more):

I wish it could go on forever (Susan)

All the participants showed that they wanted more of the course, either for it to continue or to start the course again. The reasons for wanting to repeat the course

varied from not having achieved weight loss to wanting to prevent weight from being regained to gaining more information. One participant iterated that going through the course again would not scare her because the staff would be helpful in reframing the problem for her:

They would say 'Right, we need to re-cap what we did last time to see where we could tweak it to help you' (Lynette)

It was noted that the support that is available beyond the 12-week programme, such as weekly weighing and telephone contact, was no consolation:

Although they're still going to be there for you, it's different because ...I need to ring them up but I can't talk to them face-to-face or discuss and come up with ideas (Lynette)

The words "I need to ring them up" suggest that the participant is passive in the process of her care. The 12-week course that is intended to develop independence has in fact resulted in the desire for more support. One participant mentioned that she would pay for the course to continue:

If you could maybe do it on a rolling programme...I'd be happy to pay to come to this course (Lucy)

And others said that they would like to undertake the entire course again:

I wanted to do [the course] again (Nicola)

These last two examples show that the support from the course was so valuable that it would be repeated, even if it meant paying for it. The stopping of regular contact with

group members was so daunting that some groups had arranged to meet beyond the course ending:

We've been talking about 'Shall we do our own group?' (Lucy)

The idea of only feeling supported by others and not by the self is potent within this theme. It is as if the participants need everlasting, helpful, unconditional regard from another (perhaps this is the caregiver). If overeating is a means of managing insecure attachment, due to a deficit in the capacity to self-soothe, it could be argued that participants feel they will regain weight without the support of others because others represent some kind of support to them that they lack themselves.

Super-ordinate theme 2: Feeling supported and comforted by the group experience:

Social support from the group...was very important (Nicola)

The support and comfort participants felt from the group experience were captured in Theme 2. All the participants either felt support from the other group members or the health professionals. Equally, they all felt comfort from the shared experience of being obese within a group. Some also felt comforted when they compared themselves to others in the group, feeling pleased if they considered themselves to be thinner than other group members.

Subtheme 2a (Support received from group members and facilitators):

I felt like I was under some sort of care (Susan)

The help from health professionals and the group, but particularly the latter, was a potent subtheme. Participants felt supported by the health professionals because they

were accepting and non-judgemental and they had in-depth knowledge of dietetics and psychology relating to obesity:

They wouldn't judge me that 'Oh she didn't lose weight so she's had to come back again' (Lynette)

At last I've got someone who's understood...how my body reacts...It's a revelation...[There's] no condemnation [from the health professionals],...[just] acceptance that this is where we are...The health professionals...understand your point of view...They know what they're talking about (Frances)

Participants expressed how useful it was to share strategies amongst each other.

The main things [gained from other group members] are encouragement, support and strategies to try and help you think of other ways to do it (Nicola)

This participant also mentioned that it was helpful to know what had been the cause of others' weight gain. Perhaps it is helpful to feel a sense of belonging in order to feel the strength to overcome the weight problem.

The friendliness, acceptance and lack of judgment from the group members were appreciated by many:

If you'd had a whinge or something, it stays there. It doesn't go out the room...There's none of this 'Well fancy saying that'. There's no judgement of you...There's no judging for who you are or what you are or where you come from...It's the acceptance and they're non-judgemental of you (Lynette)

The words "it doesn't go out the room" imply that there is a robust container, which gives the idea of a limit enclosing the course, reinforcing the idea that the support felt

from inside the group is powerful. As well as friendliness and acceptance, humour was another medium through which support was felt:

And they do make things a laugh (Lucy)

One participant referred to the support from the professionals as being knowledge-based whereas the group provides emotional support because they have a shared experience of being overweight. This shared experience is an important subtheme in itself and is discussed in Subtheme 2b (Identification/the shared experience of being obese) but it is interesting to note that for many, emotional support is only gained from people who truly know what it feels like to be obese (i.e. people who can be identified with). Perhaps this is why participants were also able to motivate, and feel motivated by, each other:

It helps me to think that if I achieve something, it's not just for me – it's for the group as well (Joe)

This comment seems to be about being able to take by giving something of value to another, suggesting some sort of reciprocal relationship. For two group members, social support was not important.

[Social support from the group was] not very important...There are a couple that I wouldn't mind meeting again...but apart from that...I don't think if I met the same people without the professional support that it would work (Frances)

These participants mentioned that they did not care what anyone in the group thought of them and that they would happily not meet any of the group members again. Frances emphasised that she was only there for the health professionals' advice and support, not for support from the group. Frances's comment (above) suggests some

sort of attachment style that is avoidant of other group members. Feeling separate from the group may possibly have encouraged a feeling of competitiveness. Indeed, Frances did express jealousy at other group members when they lost more weight than her:

[I feel] slight jealousy of the ones doing better than me...As they come out from being weighed they go 'Ooh, that's a stone now I've lost...I don't mind comparing notes but it doesn't make me feel good...(I think) lucky them...Shame that I haven't succeeded in doing likewise' (Frances)

This was in stark contrast to the attitude of other group members who viewed others as a support in the process of sharing weight each week:

To share (weights) with the group I think is good...When you lose weight and people are really happy for you, that makes you feel even stronger...If someone [gets] weighed and she has lost a pound...we can all go 'Well done, that's really good' and if she [puts] on a pound, people can say 'Don't worry about it. Next week. Everybody puts on a pound' (Nicola)

Overall, there seems to be a split between those who are found helpful: the leaders or the group members.

Subtheme 2b (Identification/the shared experience of being obese):

It's like-mindedness. You're in the same boat as me; I can relate to your problem
(Joe)

All the participants conveyed that they got a feeling of comfort and support from the fact that the other group members were similar in size. They seemed to perceive the similarity in size to mean also a similarity in mind. They often expressed relief that they were not the only one; that others shared the same struggles. It seemed to be more

than simply this though, as there was a collective opinion that someone could only really understand what it was like to be obese if they had been obese. The notion of shared experience of overweight facilitating bonding was emphasised by one participant who doubted whether the friendship would remain if some group members lost weight and they were different sizes. Therefore, not only would someone have to be the same size to understand what being obese was like, but they would have to be obese at the same time to be accepted as a support.

It was commonly expressed that the realisation of others being a similar size brought comfort and automatically enabled participants to feel more supported:

You got more support because you knew you weren't the only one (Nicola)

This comfort was derived from the belief that they are up against the same hardships associated with obesity:

You know that other people are going through the same thing – it's not just you (Lucy)

The theme of shared experience providing support was potent, which might explain why for some participants in Theme 2 (Feeling supported and comforted by the group experience) there was a stronger sense of satisfaction in the support felt from other group members than from the health professionals. Therefore, perhaps those who did not find other group members helpful present with a different psychic structure.

Many participants suggested that a person would really need to have the experience of being obese to understand it:

I felt it more rewarding to be able to talk to people that were in the same boat as me that knew the deep [side] of what I'm going through (Nicola)

The idea that no one else could empathise with the struggles associated with being obese is possibly a result of identification, in which they feel that the only people they can really trust are also obese:

It just made you feel you didn't have to prove your point to anyone 'cause they were all there for the same reason, and it just made it easier (Lynette)

There was a view that participants were only able to show their true selves (or their “deep side”) to people who were also obese and they had to put on some sort of a front for those who were not:

There was a sense of you haven't got to put forward this show (Susan)

This comment begs the question of why there is a need to put on a show elsewhere. It suggests that it is necessary to ‘pretend to be someone they are not’ to people who are not also obese: as if something lies beneath the surface that is too grotesque to show. It is possible that this represents emotional pain:

I don't want anybody to know what I'm really like, or who I am inside...I've been with [my partner for 20 years] and the last two years was the first time he'd ever seen me cry...[I] shut myself in a room where no-one can see me cry because to me it's weakness...I've always looked at situations as 'I'm on my own so I need to do it on my own' (Lynette)

Another participant stated that she would not share her sadness with others:

I wouldn't be sad out...I do care about making everybody feel quite nice...The sadness is when I'm on my own (Susan)

The acceptance and lack of judgement of group members was commonly expressed in allowing people to feel comfortable. Identification with others facilitated acceptance of each other:

I can accept you for who you are because we are the same person (Joe)

It is interesting that people felt that they were accepted by others simply because they were also obese, when in fact they could have been thinking anything. The essence of shared experience was certainly about having a particular relationship with food, but there were also other shared factors, such as receiving hurtful comments from the public, having low self-esteem, physical problems and depression:

Overweight people have the same problem...You're overweight, low self-esteem, physically incapable of doing the things that you want to do, inactive, got bad legs, and normally sad most of the time (Joe)

Captured within the shared experience theme is a common goal which is unifying:

We all say we want to lose weight; we want to get healthier; we want to be fitter (Lucy)

It was obviously important for participants to feel like they 'belonged' to the group, which is a human need no matter what the person's attachment style. Clearly a sense of belonging for these individuals was the concept 'we're all obese', rather than any other commonalities they may have shared.

Subtheme 2c (Positive comparison):

I'm not as far down the line as other people (Susan)

This subtheme juxtaposes itself to Subtheme 2b (Identification/the shared experience of being obese) as it captures the opposite side of the coin to the support derived from the

shared experience of being overweight. It represents comfort gained from positive comparison to other group members. Although this subtheme was less potent than Subtheme 2b (Identification/the shared experience of being obese), it was nevertheless present in over half of the sample (four out of seven). This makes sense, as not everyone will be able to make positive comparisons (as the larger people will not have anybody larger to compare with).

Amongst these participants, there was a sense of relief that they considered themselves to be smaller in size than others:

I was really quite relieved because I felt I was the slimmest there (Frances)

This demonstrates that the comfort derived from the shared experience of being obese due to people's non-judgemental attitude was undermined by what some people were really thinking. Some people were in fact thinking that they were relieved because there was actually nothing to worry about if others were worse off:

I certainly didn't feel nervous after walking into the room...As soon as I walked into this course... I certainly didn't feel anywhere close to the biggest...Then I thought, 'Oh what have I got to worry about?' (David)

There were comparisons that went beyond simply weight and these included healthiness, inactivity and physical problems:

I look at their legs and I think 'Oh God', like the kid complaining they've only got a little ice cream and the kid next to them got a big ice cream...My problems are nothing compared to theirs (Joe)

Sometimes the comparison to others was conveyed in a competitive way (regarding weight loss):

You're thinking, I bet he's lost bloody weight this week, I bet she's lost weight...I don't want to be the one to put the weight on (Joe)

It appears that participants felt accepted by each other due to their size but conversely felt competitive with each other over their size. From the majority of participants came the sense of 'I'm thinner than you are' and this provided comfort and relief.

Super-ordinate theme 3: Positive aspects of the group:

It's made me realise that actually it does work (Lynette)

Theme 3 (Positive aspects of the group) reflects what participants found to be positive about the course. For some the course had inspired them to achieve their weight loss goal. Many were appreciative that this course took a different approach to other slimming groups. Some useful learning had taken place in psychological, dietetic and physical activity aspects of weight loss.

Subtheme 3a (I will get there):

It has given me more of a sense of determination (Frances)

Subtheme 3a (I will get there) is about the course engendering motivation for weight loss. For 6 members of the sample, the course had helped them to believe that they can and will lose the weight they intend to. The origin of this motivation is not clear. 1 participant mentions that the course has helped her to understand herself better, which has increased self-belief. 1 mentions that she now feels she has the support to achieve her goal. Whatever the reason, the presence of determination is clear:

The whole course in general has made me think about things and that I can do it (Lucy)

All the participants had tried many diets and slimming programmes in the past but this course had given them the feeling that they would succeed:

Previous diets have just come and gone, and I've lost a few pounds and put them back on plus more (David)

Two participants talked about being unable to succeed in losing weight during the course but despite that expressed the belief that they will in the future. For 1 participant the timing was not right but she had all the course information in a folder and intended to return to it. For another, significant weight loss had not been achieved but she was committed to continuing to practise what she had learned:

I think I can lose the weight...I just need to get into the right mindset, which I'm not at the moment...When my training course is finished, I can devote more time to concentrating on it (Lucy)

Reading this comment leaves a question as to what the “right mindset” is. There is a feeling behind this of ‘I’ll start tomorrow’, as if physically being there for the 12-week course was not motivating enough but somehow motivation would appear after the course had ended, when no one is watching.

Subtheme 3b (Some useful learning compared to other slimming groups):

It has been approached from a slightly different angle (Frances)

Participants had achieved some useful learning compared to other slimming groups they had been part of. 5 of 7 participants talked about the difference between the current course and other courses, mostly favouring the current course for the way it targets people’s reasons for unsuccessful weight management, whether they be psychological, dietetic, or due to inactivity. Some participants favoured the current

course because group members were similar in size and some mentioned that they like the friendliness of the group and course leaders, whereas in previous slimming groups it had felt impersonal. Although some said that they liked the way the course encouraged independence in weight management, others would have preferred a more prescriptive weight-loss plan. The most common observation of the course adopting a different approach was the psychological component:

This course was dealing with the mind (David)

Participants mentioned how helpful it was to analyse their own eating behaviour and to become more self-aware generally:

[The course] is here to try and make you understand why you're doing it, [understanding your behaviour], not to be strict like other slimming clubs (Susan)

This sentiment was echoed by a few participants who appreciated that the current course was not simply giving out a diet plan but instead tackled all the factors to consider in weight management (psychology, dietetics and exercise).

As in Theme 2b (i.e. participants felt comforted by the shared experience of being similar in weight), 2 participants mentioned a difficulty with other slimming groups, being that members were simply overweight and not obese:

The slimming clubs...were wondering why because you're big you hadn't lost 6 lbs in your first week...So immediately you feel like a failure because you've only lost 2 lbs instead of 6 (Susan)

It is possible that this course did not engender a sense of failure. The importance of support from other group members in Theme 2 (Feeling supported and comforted by the group experience) was echoed by participants comparing the current course to

previous slimming groups. It was important to 2 members that they got to know other members of the group; they had found previous courses impersonal.

You actually get to know the people that you're with (Lynette)

Getting to know other group members was obviously important for some participants to feel comfortable, whereas for 2 of the participants, the importance of being there was to learn from the professionals, not to make friends:

I didn't go on the course to have a friendship...I went to try and get my head round why I was overeating...I was quite business-like with other people...I was here to listen...At the end of the meeting I would get up and I would go...There weren't relationships formed...It was almost like a business meeting (Susan)

This might possibly suggest that people with different attachment styles tend to want different things from the group experience. Within the transcripts, it is clear that for some people, support from other group members was important (particularly Joe, David, Nicola, and Lucy); whereas for others, what seemed most important was the information that is available from being part of the course (Lynnette, Susan). For Frances, the support from the health professionals was most important. This suggests that treatment could be better tailored to the needs of the individual.

The uncompetitive nature of the course was appreciated by one participant, which echoes the support derived from the shared experience of being obese, in that there is a common goal and group members want to help each other to achieve weight loss:

When you went to other slimming groups it was 'How much did you lose then?' but there was none of that (Lynette)

The current course encourages independence in weight management which suited some members but not all:

It's sometimes nice to be vague but sometimes it's nice to be told 'Don't' (David)

All of the participants remarked that they had learned helpful information on the course. For many, the psychological aspect of the course had been helpful, and it seems that people differed on which tips they found most useful. For some the dietetic side of the course was particularly useful and for some the exercise aspect of the course. This proves how individualised a course like this needs to be if it is to help as many members as possible. Although Subtheme 2b (Identification/the shared experience of being obese) shows that members felt that their experience of being overweight was the same, it would appear that the strategies that are helpful in weight loss differ widely between individuals. 6 of the 7 participants mentioned that they saw the value in the psychological side of the course. For 1 participant, targeting how stress impacts on eating behaviours was particularly useful. For another, increasing her self-awareness around emotional eating was helpful. Others found it useful to learn about: increasing self-awareness; increasing self-acceptance; self-sabotage; and taking small steps in weight loss:

It did make me a lot more aware that I did eat when I was angry, upset, down – that I was turning to food (Nicola)

The dietetic side of the course was helpful and participants learned about food labels and that they did not have to deny themselves the less healthy foods because it is about eating in moderation:

The dietetics stuff has been the biggest thing...When I now go shopping, I look at all the labels... It's made me realise I eat the wrong things or I eat at the wrong times (Joe)

One participant found the exercise session especially useful and the information he gathered about gastric band surgery, and another found that she learned information from other group members:

There were some bits that were particularly good. I liked the session we had on exercise (David)

Some participants found it useful to keep a folder of all the information from the course to refer to in the future:

I have a big folder that I find quite useful to go back through...There's an awful lot of information stored in there...And if I forget then I go back over my notes (Susan)

Within Theme 3 (Positive aspects of the group) is the finding that people found this course to be helpful in aiding people's learning and in the support provided. The level of support participants experienced echoes their desire for support beyond what the current course offered, and their sadness at the course ending.

Super-ordinate Theme 4: negative aspects of the group:

I have been a bit semi-half-hearted about the course (David)

In opposition to the positive aspects of the course experienced in Theme 3 (Positive aspects of the group), Theme 4 reflects the negative aspects. All of the participants were either disappointed or frustrated with the course in some way. 6 participants said how difficult they found it to make friends in a group and that this was similar to previous group experiences. It could be possible that this was because they were

constantly comparing themselves for similarity or difference with group members (as in Subthemes 2b and 2c). 4 participants (Frances, Susan, Nicola and Joe) thought that individual therapy would be preferential to being in a group. Although Frances and Susan did not find value in the other group members, Nicola and Joe did, and yet they indicated a preference for one-to-one. They both said that they had more personal issues they wanted to talk about which was not possible in a group setting.

The subthemes within this theme could be interpreted as wanting to be separate from others and not wanting to form an attachment with them.

Subtheme 4a (Frustration/dislike of this group):

[I was] upset with the group (Nicola)

6 of the 7 participants were either frustrated or disappointed with the course in some way. The particular frustrations varied from person to person and not one was shared. 1 participant had not achieved weight loss on the course and there were many reasons why she was upset with the course. It seems that her difficulties with emotional eating were not targeted effectively:

I thought they were going to help me break this and it wasn't happening...[My problem] was quite deeply emotional eating and it just wasn't being targeted...I kept saying that it was emotional but there was no help...They didn't understand that 'No, it's deeper than that'...I wanted and needed more... My problem] was quite deeply emotional eating and it just wasn't being targeted...I went there full of willing, wanting to do this...I was thinking 'I'm going to do this'...I've left there and put on more weight...I haven't lost it (Nicola)

This complaint suggests the course had caused her weight gain. This demonstrates the bitterness this participant felt at not having lost weight on the course and this is perhaps because she was not getting the right sort of help in a group setting, but instead needed one-to-one therapy. It seems Susan would also have benefited from treatment that focused on her difficulty with emotional eating:

I kind of use food still for - I think it makes me feel happy, but I know that's only momentarily (Susan)

Nicola had wanted the emphasis of the course to be less about strategies and more about the group sharing their experiences and receiving individual support:

I wish...the ladies...got people to talk more about why, not give people strategies but why...It was all writing on the board and doing little pictures and I was staring at it blankly...You want them to go deeper and care more and know you as an individual (Nicola)

Another participant's complaint about the course was that she felt different to the rest of the group. She said that she wished the rest of her group had been more equally matched with her in terms of intelligence:

I've got to respect the other people and...if I don't respect them as knowing more than me, then it doesn't work...The group was very mixed. There were a couple of people who were fairly intelligent...the rest aren't [which makes a difference to me] in terms of whether I respect their opinion (Frances)

The same participant struggled with the fact that she felt her lifestyle was different to the rest of her group and therefore much of the group discussions would not have been helpful for her weight loss:

I don't think their problems were necessarily the same as mine...I think I'm in a different situation to most people...because I'm the only one that's not married...so I don't have the support of anyone around me anyway...They were talking about the family or their spouse,...about the problems of buying food...they were talking about multi-buys which I avoid like the plague (Frances)

Another participant thought that group members often talked too much about their own personal problems and treated their 'check-in' or 'check-out' time as a counselling session. She came to the course to learn and not to hear too much about other people's problems:

It wasn't a counselling session...There was time for a quick talk, 'Yes I've had a good week' or 'Yes I've had a bad week'...but it wasn't a counselling session...I didn't particularly want to hear all their masses of problems and illnesses and things like that...We were there for an hour and a half to be taught...I didn't like the too much chat about personal feelings...I thought 'Do you know, we're here for an hour and a half. We've spent 15 minutes listening to you. Please can we get on with the business in hand?' (Susan)

These last two examples came from the 2 participants who said that they would not miss being around others in the group when the course ended. It seems from this that being in a group did not allow them to feel 'special' enough. Perhaps participants who demonstrate this would benefit from some specific work from a therapist who could represent a secure attachment figure. The fact that their disappointment with the course was to do with the behaviour of other people might suggest that they are more avoidant in their attachment style and that this makes them less suited to therapy in a group.

2 participants said that they would sometimes take on others' negativity from the course:

If I see the rest of them starting to give up, it does have a negative effect (Joe)

2 participants struggled because they felt that some group members had been a distraction by joking around too much:

I...felt the group maybe had too much fun...It was making a slight mockery of it...That's a shame because I'm sure we could have got more information out of it (David)

3 participants objected to the course leaders' purposeful approach in encouraging independency in weight management. Instead they wanted the approach to be more firm:

I'd like to see something a little bit firmer...They are there to help you lose weight, they're there to advise you, but they're not forcing you to do it...They're more of an advisor...I'd like to see something a little bit firmer (Joe)

This quote echoes the dependency on the course to achieve weight loss rather than the participants taking responsibility for their own weight loss. It resonates with the idea that support needs to come from elsewhere rather than from within.

The quote above, in which Joe mentions he would have wanted something "a little bit firmer" in comparison to others (such as Lucy and Susan) who expressed their appreciation of the professionals fostering of independence in weight loss, suggests that some people need no pressure and others need firm limits. This represents a problem in a group setting, unless there are certain dynamics that can be assessed, formulated and intervened with, even in CBT groups.

Four people were unhappy that the course covered information that they had already heard. They found covering this material either frustrating or boring:

They talked about a lot of things that I knew already...You're given strategies and deep down, you know the strategies. You know what you're doing wrong. I know I should be out there exercising...I'm not stupid...You're like 'I don't wanna overeat, I don't wanna do food binges. I don't wanna do this, I really don't. But I do' (Nicola)

This last quote suggests that the course is expected to go beyond what the group members already 'know'. This potentially demonstrates that currently group CBT intervention is deficient because it is not that the participants need to learn strategies, but in the case of Nicola, what was needed was a treatment which focussed on emotional eating. This suggests that some participants would benefit from a treatment approach which attends to interpersonal issues and affect regulation.

Subtheme 4b (Negative relation to groups generally; little new in this group):

I find it hard to make friends with people in a group (Nicola)

This subtheme demonstrates 6 of the 7 participants' negative relation to groups generally. They described how they felt wary of people in a group and they would not want to talk about anything personal:

I find it hard to make friends with people in a group...I'm just wary of people...I couldn't speak to a stranger about how I feel in a group (Nicola)

Nicola's difficulty with being around other people was perhaps the 'deep problem' that she mentioned which needs to be treated. This is another suggestion that group members have different individual needs for treatment. It seems to be a shared

perception across participants that there is a concern about what others will see about them if they are in a group, which is at odds with the idea portrayed in Subtheme 2b (Identification/the shared experience of being obese) that ‘these people are the same as me’.

A participant who consistently stressed her feeling different from others in the group deliberately set herself apart in her group:

I set myself apart [from the rest of the group]...I didn't want to [speak out in the group]
(Frances)

It was common that participants would not feel comfortable to talk in a group. These people exhibited avoidant behaviours towards the group:

I put a shield up...I can be very stand-off-ish (Lynette)

For the 2 participants who expressed how support from group members was not important to them, the course was an opportunity to make friends:

I'm not a bonder very much...I'm quite a loner but happy to be a loner...I don't feel that I particularly want to make the relationships (Susan)

The same 2 participants stood out from other participants in that they did not feel apprehensive to be with others at the start of the group:

It didn't worry me going into the group with other people (Frances)

This suggests that bonding and making friendships within the group was not important to them so they did not feel apprehensive prior to the group commencing, as an individual with anxious attachment might. Three participants mentioned how

concerned they were at the prospect of being in a group prior to the course commencing:

I was like 'How am I going to cope?' beforehand...I was apprehensive that I was going into a room where there was going to be X amount of people that I've never met in my life....[I was thinking] 'Would I be able to join in?'...I was a bit wary that we'd come across something and there's me going no I'm not talking about that, 'cause I'll shut down...One of the things that was daunting to me was: was I going to come to a group and find all these people sat there going 'Oh well I'm not as big as what you are'
(Lynette)

This last sentence re-iterates how participants fear being judged and therefore appreciate the non-judgemental attitudes of group members (Theme 2b: Identification/the shared experience of being obese) and yet at the same time, Theme 2c (Positive comparison) suggests that there is some form of judgement by way of comparison.

The reasons why participants were wary in a group varied for different people but there was a general theme that past experiences had led them not to trust people:

It's not wanting to rely on anyone else [in friendships] and I don't want people to rely on me [because then you get hurt] (Frances)

This suggests that experience has led these participants to develop a more avoidant style of attachment.

4 of the participants who mentioned feeling shy in a group situation said how they felt more comfortable as the course progressed:

It's got more relaxed as the weeks have gone on because you get to know people

(David)

It was noted by 4 participants that this group experience was similar to group experiences in the past. These group experiences included school, family and other organised groups, such as evening classes:

Once again I was the one that stood out [in the group]...So it was very similar to [previous group experiences] (Joe)

This suggests that individuals have their idiosyncratic group attachment style that is possibly fairly stable across experiences. Therefore, in assessing people for treatment, it might be beneficial to consider the nature of their previous group experiences.

Subtheme 4c (Preference for one-to-one):

***I think one-to-one is actually better* (Frances)**

4 participants showed a preference for one-to-one therapy rather than group therapy.

Some participants mentioned that individual therapy would have met their emotional needs more effectively than the group did:

[I] perhaps would have liked more one-to-one emotional support (Susan)

It is questionable whether certain members would have benefited from either a one-to-one intervention or a group intervention that was more interpersonally focussed, as 1 member noted that some group members lacked interpersonal skills, and this could have been a problem that was underlying their eating problem.

There are people there which are...less than approachable. It's very hard to talk to them. They're so in their little shell...You can see they're very nervous...even after 12 weeks (Joe)

Within Theme 4 (Negative aspects of the group) is the preference to keep others away; participants said that they did not like being in a group and they were wary of others, and they also stated a preference for individual therapy. Individual therapy would have provided more emotional support than group therapy and this is consistent with the idea that participants felt like they needed help with deeper problems than the group treatment allowed, either in the form of more group therapy or individual therapy. The preference to keep others away would be consistent with avoidant attachment styles. This suggests that they did not want to deal with real relationships.

Disparity between qualitative and quantitative findings

Discrepancies were found between the quantitative and qualitative data for individual participants which might support that the ASQ could be an inaccurate measure, or that participants did not say what they feel or do what they say. 1 participant who had scored 5 on Discomfort (which is a high score suggesting that he felt uncomfortable in relation to others and would display avoidant behaviour) said the following in his interview:

"I'm a very outgoing person...I can socialise with everybody...I've always got on with so many people...It's easy for me to communicate...It's just an easy thing for me to do so I like to share that...I'll stand up, say anything loud, get [others] to...join in and say something...I can relate to people with big problems [and] little problems" (Joe)

The ASQ measure and the participant's words therefore seem to be saying the opposite about this man's attachment style. More examples like this were found on close

inspection of the participants' ASQ scores. 1 participant scored very highly on Confidence (5.6) and yet in her interview she made numerous comments that indicated that she did not feel confident that others would accept her for who she was and would be there for her when she needed it:

"I don't want anybody to know what I'm really like, or who I am inside...I've always looked at situations as I'm on my own so I need to do it on my own...In a group I'm like 'Let everyone else talk'...I don't know 'em and I don't want to comment...I put a shield up...My partner says I'm stand-off-ish." (Lynette)

Susan only scored 3.6 on Discomfort (a score close to average) when in her interview she expressed that:

"I'm not a bonder very much...I'm quite a loner...I don't feel that I particularly want to make the relationships." (Susan)

Nicola scored less than average on Discomfort (2.8) and yet she spoke of being "wary of people in a group" and found it "hard to make friends" and "couldn't speak to a stranger about how I feel in a group".

These discrepancies found between the ASQ scores and individual interviews suggests that possibly the ASQ is not an accurate measure of attachment style or that attachment is more unconscious or complex than the measure allows. Or it could show that people simply are not very good at discussing attachment. The interviews took place with the interviewer, which may or may not have triggered participants' attachment modes. Therefore the relational (qualitative) data may be equally constrained as a result.

Validity and Reliability

Counting the recurrence of themes can enhance the validity of a study's findings (Smith, *et al.*, 2009). Due to the size of this project, recurrence of themes was not counted in each individual interview but it was documented which subthemes were present in which participants' transcripts (Please see Table 16, p.173).

Super-ordinate themes and Subthemes	Frances	Lynette	Susan	Nicola	Joe	David	Lucy	Present in at least 4?
1. <i>I will miss it when we're not there any more</i> (Lucy)	✓	✓	✓	✓	✓	✓	✓	Y (7)
1a. <i>I might be...sad because we had a good time and made interesting friends and it's been worthwhile</i> (David)	✓	✓	✓		✓	✓	✓	Y (6)
1b. <i>It's been my motivation...Will I lapse if I get back into my old ways</i> (Lynette)	✓	✓	✓		✓		✓	Y (5)
1c. <i>I wish it could go on forever</i> (Susan)	✓	✓	✓	✓	✓	✓	✓	Y (7)
2. <i>Social support from the group...was very important</i> (Nicola)	✓	✓	✓	✓	✓	✓	✓	Y (7)
2a. <i>I felt like I was under some sort of care</i> (Susan)	✓	✓	✓	✓	✓	✓	✓	Y (7)
2b. <i>It's like-mindedness. You're in the same boat as me; I can relate to your problem</i> (Joe)	✓	✓	✓	✓	✓	✓	✓	Y (7)
2c. <i>I'm not as far down the line as other people</i> (Susan)	✓		✓		✓	✓		Y (4)
3. <i>It's made me realise that actually it does work</i> (Lynette)	✓	✓	✓	✓	✓	✓	✓	Y (7)
3a. <i>It has given me more of a sense of determination</i> (Frances)	✓	✓	✓		✓	✓	✓	Y (6)
3b. <i>It has been approached from a slightly different angle</i> (Frances)	✓	✓	✓	✓	✓	✓	✓	Y (7)
4. <i>I have been a bit semi-half-hearted about the course</i> (David)	✓	✓	✓	✓	✓	✓	✓	Y (7)
4a. <i>[I was] upset with the group</i> (Nicola)	✓		✓	✓	✓	✓	✓	Y (6)
4b. <i>I find it hard to make friends with people in a group</i> (Nicola)	✓	✓	✓	✓		✓	✓	Y (6)
4c. <i>I think one-to-one is actually better</i> (Frances)	✓		✓	✓	✓			Y (4)

Table 16: Identification of Recurrent Themes in Participants' Transcripts

It is worth noting that 100% of the participants made statements supporting the 4 super-ordinate themes. The subthemes were covered by 93% of participants.

DISCUSSION

Summary of findings

This study aimed to increase understanding of the relationship between attachment style and obesity to potentially inform a more appropriate treatment pathway. In two parts, the study investigated whether attachment style predicts outcome in a 12-session group treatment for obesity and explored participants' subjective experiences of the treatment programme.

In Part I, the quantitative data demonstrated the opposite of what was hypothesised, as the predictor Confidence, which signifies attachment security, significantly predicted BMI change in a negative direction. That is to say, participants with higher scores on Confidence lost less weight on the course than those who had lower scores on Confidence. It had been predicted that those with higher scores on insecure attachment (i.e. the remaining four predictors of Discomfort, Relationships as Secondary, Need for Approval and Preoccupation) would have lost less weight on the course than those with lower scores. The overall model comprising Confidence was indeed a faint predictor of change in BMI because it could only account for 8% of the variance in BMI change scores, meaning that 92% of the variation in BMI Change could not be explained by Confidence alone. The model is not robust and is therefore not recommended.

In Part II, the IPA analysis illustrated the participants' experiences of the group CBT treatment, yielding four super-ordinate themes: sadness at the course ending; feeling supported and comforted by the group experience; positive aspects of the group; and

negative aspects of the group. Within these themes, different participants expressed different preferences and dislikes about the course, suggesting that treatment could be tailored to suit individual needs. Participants with different attachment styles within the group process claimed that they benefited from different aspects of the course. It is possible that treatment could incorporate an interpersonal focus, informed by people's attachment experience. Some participants valued the support of other group members whilst others preferred either the help of professionals or the learning of information. This also has implications for treatment. Throughout participants' transcripts there was a sense of dependency on the course and perhaps a denial of personal responsibility for weight loss, which could explain why weight loss is not well maintained following existing treatments.

The interaction between ASQ scores and participants' feedback in interviews did not seem to match. Many instances were found where a score high on an ASQ dimension (e.g. Confidence) did not reflect what was said in the participant's interview (e.g. what was described was a difficulty in relating to others). This either suggests a flaw in the ASQ measure, or that participants were not sharing how they really felt in their interviews. It could also suggest that much of their behaviour in the group was in fact unconscious and therefore was not spoken about in the interviews.

One participant met the weight loss goal of at least 5% of her starting weight and her scores were basically average on all dimensions. She also mentioned that she was confident in a group of people but that she was "happy to be a loner" and was not hoping to make relationships in the group. All other group members either had high scores on Confidence or Discomfort. Although no conclusions can be drawn definitively from an IPA investigation, this suggests that those without high scores on either Confidence or Discomfort may do less well in weight loss in CBT treatment for

obesity. Indeed 2 of the participants with the highest scores in Confidence actually gained weight rather than lost it. This corresponds with the quantitative findings of this study that those with higher Confidence scores lost less weight than those with lower Confidence scores. A tentative conclusion may be drawn from this that those with high Confidence scores are more content with themselves as they are (as they feel confident that others will be there for them when they need it) and are therefore less likely to feel the need to change.

Part I – Interpretation of quantitative findings

Confidence was found to significantly predict BMI change. Participants with higher scores on Confidence lost less weight on the course than those who had lower scores on Confidence. The model is not recommended because Confidence was not a strong predictor of BMI Change and it could only account for 8% of the variance in BMI Change scores. Furthermore, there is a deviance from normality in the middle of the data (see Figure 4, p. 115), which suggests that data from more participants would be required to fill the line of best fit and this would then be more representative of the population.

The findings in this study that Confidence predicts BMI Change suggest that people with higher attachment security lost less weight on the course than people with lower attachment security. These results are not compatible with findings from past research. Tasca, Ritchie, *et al.* (2006) had found that women with high attachment anxiety improved on outcome (a reduction in the days that women binged) when they received group psychodynamic interpersonal therapy, whereas women with low attachment anxiety improved with group CBT. Their conclusion that group CBT is better for people with lower attachment anxiety, was not supported by the current research study.

However, there was no alternative to group CBT in the current study and results may have been more illuminating if there was also a group who had undergone interpersonal therapy. Running another group would have been outside the scope of this research project, without access to resources or funding. As for Weissman, *et al.* (2000), who found that avoidant clients receiving CBT showed a greater reduction in depression than those receiving IPT, the results of the current study may have been more informative if there had been an interpersonal-type treatment to compare to.

McBride and Atkinson (2009) suggest that CBT is most effective for clients who are securely attached (i.e. low on avoidance and anxiety). The results of the current study suggest the opposite to be true, as those with higher scores on attachment security (i.e. Confidence) lost the least weight during the course. However, it is perhaps worth noting that the current study took the five dimensions of the ASQ separately, so there were no overall scores for attachment avoidance and attachment anxiety. The reason for this is that the authors of the ASQ, Feeney, *et al.* (1994) and Karantzas, *et al.* (2010), do not endorse splitting the scores into the three attachment styles on the ASQ, despite the fact that they state that two dimensions indicate avoidance (Discomfort and Relationships as Secondary) and anxiety (Need for Approval and Preoccupation).

The thesis of the current study is that attachment style is relevant to the eating behaviour of people with obesity and that this client group may benefit from treatment that attends to emotional regulation and interpersonal skills. Although the quantitative results cannot offer support for the hypothesis in this study, attachment style is still relevant to eating behaviour in obesity – it is just not clear exactly how. The findings showed that people with more confidence in relationships (indicating attachment Security) lost less weight than those who had a more Insecure attachment. The reason for this could be that people who are more confident in their relationships and secure

within themselves might be happier being just the way they are. If they are confident that others will always be there for them and support them, perhaps there is less need to change (by losing weight) if they are already secure. It is possible that those who are confident relating to others are more in denial of their need to lose weight because they gain positive reinforcement from relating to others. Furthermore, the definition of Confidence in relationships may vary from person to person. One participant's 'confidence' is another's 'distancing from others (or arrogance)' due to not needing others. This suggests that even within Confidence, there is a question about whether some are happy within themselves without needing others, which would mean that those that score high on Confidence may lose less weight because they do not feel that they need the group.

To have a comparison group treatment that was interpersonally focused may have produced more informative results. This was not possible in the current study as the treatment of choice for obesity is CBT (NICE, 2006) and that is the treatment that is currently available. The service and the researcher were constrained in their ability to run a more interpersonal group to compare findings by a lack of funding and resources.

Limitations and strengths

The lack of findings in the direction that was expected in the current study can be the result of many factors. For example, it is possible that the ASQ is not a sensitive enough measure of attachment. Indeed, Fraley, Waller, & Brennan (2000) noted that there was no simple structure to attachment, which they say could include more than 30 sub-factors at the lowest order. The authors of the ASQ themselves state that it only lends partial support to the four styles hypothesised by Bartholomew (1990). Furthermore, Fraley, *et al.* (2000) argue that it is not known whether existing

attachment scales have the requisite psychometric properties to answer the diverse questions that attachment researchers ask. They state that a limitation of many scales is that “they are scored in ways that are not based on strong measurement models” (p. 350). For example, the ASQ measures an individual’s security or insecurity by averaging responses to statements thought to be manifestations of a certain type of attachment. However, psychometricians have demonstrated that these scaling techniques are problematic for many reasons (e.g. Embretson, 1996). Measures scored like this do not guarantee that measurement precision is equally distributed across a particular attachment style. Fraley, *et al.* (2000) suggest measurements like this could be improved by using item response theory (IRT; Hambleton, & Swaminathan, 1985; Lord, 1980) to select items with optimal psychometric properties. IRT is a framework for relating latent variation in attachment organisation to observed scores on self-report attachment scales. IRT does not assume that each item on the questionnaire is equally difficult. This distinguishes IRT from Likert scaling where “all items are assumed to be replications of each other or in other words items are considered to be parallel instruments” (van Alphen, Halfens, Hasman, & Imbos, 1994, p.197). By contrast, IRT treats the difficulty of each item as information to be incorporated in scaling items.

It could also be suggested that the method in the current study could have been improved to find more informative results that may exist. For example, attachment style may be a valid cause at the onset and maintenance of obesity, but perhaps it is not a relevant construct in the success of outcome in group CBT treatment. Perhaps success in losing weight in this type of programme is more likely to be related to motivation (or will power) to lose weight and how well the CBT strategies are taught. The definition of will power is making ourselves do something that we do not want to do. This is difficult to treat, as most of the health promotion literature shows that

education does not work, whereas theories of therapy in which internal causation is stressed are more likely to see motivation itself as an ongoing focus of treatment (Ryan, Lynch, Vansteenkiste, & Deci, 2011).

Within the field of psychology, there have been increasing trends toward the use of brief motivational enhancement interventions, such as motivational interviewing (Miller, & Rose, 2009), the Socratic method (Vitousek, Watson, & Wilson, 1998), the transtheoretical model of change (Prochaska, & DiClemente, 1986) and motivational enhancement therapy (Treasure, & Ward, 1997). Perhaps treatment programmes for obesity could be enhanced by addressing motivation (using one of these interventions) before therapy begins or throughout treatment using nonspecific factors (Norcross, 2002; Wampold, 2001; Zuroff, Koestner, Moskowitz, McBride, Marshal, & Bagby, 2007), which are aspects of the counselling relationship viewed as having motivational implications and are empirically associated with positive outcomes.

It is possible that this study may have found robust differences in long-term weight loss according to attachment style. It is widely known that the main problem with obesity treatment is its long-term success (Anderson, *et al.*, 2001; Curioni, & Lourenco, 2005; Barte *et al.*, 2010), and follow-up measures of BMI may potentially have produced some different results. Losing weight is not that difficult to achieve but maintaining it is, and if there had been a comparison group which attended to attachment-related themes and long-term follow-up, findings that support the current study's hypothesis may well have been uncovered. Therefore, the psychology of lapse may be informed better by attachment.

Another possible reason for the current study not finding the predicted relationship between variables could be that this particular sample was an unusual sample in which

there is no relationship between attachment insecurity and BMI Change in group CBT for obesity. As there was possibly significant unconscious, dynamic behaviour within the group, perhaps the treatment did not seem like CBT to participants. Perhaps this group were very different from the gold-standard CBT group that NICE bases its recommendations on.

Part II – Interpretation of qualitative findings

Super-ordinate Theme 1 (**Sadness at the course ending**), which described participants' sadness over the ending of the course, was divided into loss, concern over relapse and wanting more. All participants had come to rely on the course for the regular support that was available. Some were concerned they would regain weight without it. For some participants, it was contact with other group members that they would miss. Others said they would not miss the people at all. This suggests that people with different attachment styles differed in what they found helpful in the group. All participants wanted more from the group possibly suggesting that they were passive in the course of their care. Indeed, participants lacked conviction in their own abilities to achieve weight loss or maintenance beyond the course ending. There was a sense that it would not be worth achieving weight loss if they were only doing it for themselves, which might suggest that dependency underlies the symptoms of obesity. It may also explain why weight loss is rarely successfully maintained after treatment (e.g. Wu, *et al.*, 2009).

The sadness expressed by participants at the prospect of the course ending is in accordance with previous research findings. The importance of the end of psychological therapy has been well documented in the literature, across psychotherapy particularly but also across cognitive-based approaches. Baum (2005) and Zilberstein

(2008) have supported earlier studies (e.g. Friestein, 1974; Weddington & Cavenar, 1979) that treatment termination produces an experience of loss. The suffering experienced at the end of therapy is what really tests the value of the therapy, according to Coltart (1993). Ryle and Kerr (2002) suggest that the patient has not truly felt the reality of the end if they do not approach the ending with anxiety and disappointment. Johnson (1963) proposes that at the end of group therapy, members experience separation anxiety, which might include anger, guilt, depression and low self-esteem. He argues that the ending of therapy might be perceived as meaning rejection and a loss of dependency. This might be understood in the current study in terms of attachment theory, as participants' experiences of loss and dependency were transferred onto the ending of treatment. Also, participants expressed their concern about regaining weight once the course had ended.

Throughout participants' transcripts in the current study ran the theme of dependency, such as the expressed desire for the course to continue beyond its end. This wanting more and the participants' saying that they may regain the weight, might be a way for us to understand the well-documented problems with long-term weight loss maintenance in current treatment programmes for obesity (Jeffery, *et al.*, 2000; Anderson, *et al.*, 2001; Curioni, & Lourenco, 2005; Weiss, *et al.*, 2007; Wu, *et al.*, 2009; Barte, *et al.*, 2010). If dependency underlies the symptom of obesity, it could explain why weight loss rates are found to be good during treatment programmes (Turk *et al.*, 2009), which is when the help is still available but not afterwards (when the help is withdrawn). This therefore begs the question of how dependency is treated. Dependency can be treated in one-to-one therapy which attends to the relationship where the therapist intends to become a secure base from which the client feels he/she

can leave in the knowledge that the therapist keeps the client in mind and is there when needed.

In the current study, many participants felt they would miss the people from the course and they also perceived a strong sense of support gained from other group members. Cohesion is a popular construct in group therapy. Yalom (1995) proposed that a mechanism of change in group therapy is group cohesion, which he conceives as the experience of a sense of belonging. This includes acceptance, support and trust. Indeed, in the current study Subtheme 2b (Identification/the shared experience of being obese) echoes the sense of belonging in identification with others. Although Yalom's original work is nearly twenty years old, a wealth of more recent research supports his contributions to CBT as well as psychodynamic treatments (e.g. Woody, & Adessky, 2002; Andel, Erdman, Karsdorp, Appels, & Trijsburg, 2003; Bieling, Perras, & Siotis, 2003; Taube-Schiff, Suvak, Antony, Bieling, & McCabe, 2007).

The fact that some participants said that they would not miss other group members at all and that they would either miss the health professionals instead, or the fact that no more information will be learned, suggests that different attachments were made during the treatment. Some members obviously found the help from others most important, whereas others did not. This has implications for treatment, in that it could be more tailored to individual needs, and that could be the opposite of what people think they want. For example, if someone says that they do not benefit from being around others, it could be exactly this type of treatment that could help them to overcome their interpersonal difficulties.

Yalom (1995) proposed that groups develop a variety of processes that enable therapeutic change. As well as group cohesion, he also identified: the instillation of

hope (which is gained from feedback from other group members and from having faith in the treatment); normalisation (which is that others share the same problem); imparting information; altruism (receiving support by giving it to others); interpersonal learning; the development of social skills; imitative behaviour; and catharsis. These processes are all relevant to CBT groups but Bieling, McCabe, & Antony (2013) argue that this is not recognised because group protocols on CBT tend to be based on individual treatment strategies, which emphasise specific teaching of CBT principles and strategies. They state that these strategies are being taught to an interacting, evolving group and therefore Yalom's (1995) processes are relevant. The processes that Yalom (1995) identified are relevant to Super-ordinate Theme 2 (Feeling supported and comforted by the group experience).

Super-ordinate Theme 2 captured the feeling of support and comfort that the group experience engendered. It was divided into the support received from other group members and professionals, identification with others (due to being similar in size), and the comfort derived from comparing the self to others. Yalom (1995) proposed that the instillation of hope, gained from feedback from other group members, is a process through which therapeutic change is achieved in groups. This has also received more recent support (e.g. Yalom & Leszcz, 2005; MacNair-Semands, Ogrodniczuk, & Joyce, 2010; Gladding, 2012).

In the current study, participants expressed at length how much support they gained from receiving feedback from other group members. Some emphasised the learning they achieved from information-sharing between group members more than the teaching from the professionals. This suggests that Yalom's (1995) processes of instillation of hope and imparting of information was achieved through interaction between group members. The supportive atmosphere described by participants in the

current study supports Yalom's (1995) process of altruism. Throughout their accounts were examples of showing support to others and receiving support from others. Yalom (1995) describes altruism as a solution to the self-preoccupation that often occurs in distressed individuals. One potent subtheme within the current study was the sense of identification and normalisation achieved due to group members sharing the same symptoms. The comfort derived from the shared experience of being obese was widespread throughout participants' accounts. The current study therefore lends support to Yalom's (1995) group processes but also to Bieling, *et al.*'s (2013) suggestion that group process factors and CBT would benefit from being integrated in group therapy, and also to Safran, & Segal's (1990) suggestion of over 20 years ago that interpersonal factors should be incorporated into individual CBT. Bieling, *et al.* (2013) believe that giving attention to group processes in group CBT treatment will enable a more sophisticated and integrated model of intervention.

A minority of the participants in the current study stated that it was not important to receive support from other group members and one claimed that it was only the health professionals' support that she wanted. This suggests that different aspects of the group were helpful to different people. It may also suggest that treatment could be improved by attending to those who outwardly appear avoidant of others in the group as it could be that interpersonally-focused therapy is exactly what these people might benefit from. Yalom's (1995) group process known as the 'corrective capitulation of the primary family group and interpersonal learning' could be relevant here.

Individuals with early experiences of mistrust may have difficulty becoming meaningfully engaged with other group members. Indeed, the participant who claimed only to find the support of the professionals to be of use also talked about being on her own a lot as a child and feeling independent from the family. Yalom (1995) argues that

the experience of the group and the leaders can have a corrective function where something new is interpersonally experienced. Rather than the dysfunction being reinforced, the group can respond in a way that raises the individual's awareness of their behaviour and therefore their interpersonal functioning can become more adaptive. The treatment in the current research may have benefited from incorporating this idea about dynamics into the intervention to provide people with new relational experiences.

Researchers studying the construct of group cohesion have also included concepts like bonding, working towards mutual goals, mutual acceptance, identification and support (e.g. Marziali, Munroe-Blum, & Mc Cleary, 1997). The normalising effect of being in a group in which others were similar in size was powerful. It appeared that similarity in size was perceived as similarity in mind. There was a shared sense of relief that others were experiencing similar struggles. There was a strong sense that people could only truly empathise with the struggles of being obese if they were obese themselves. One participant even doubted that friendships would remain if some members lost weight and they therefore lost the shared identity of being obese. There is a wealth of evidence to support the role of normalising in group therapy across the psychological literature (e.g. Van den Broeck, Emery, Wischmann, & Thorn, 2010; Ruddle, Mason, & Wykes, 2011; Dunn, Hanieh, Roberts, & Powrie, 2012). Normalisation is undoubtedly important in making people feel supported in the current study.

Within the sub-theme relating to identification, there was a sense that participants only felt able to show their true selves (or their "deep side") to people who were also obese and they would put on a show for those who were not. Comments from some people suggested that what lay beneath the surface was too grotesque to show to others and many stated that they would not share their sadness with others. This might suggest

that intervention could perhaps benefit from incorporating some experiential work that allowed group members to truly feel accepted and empathised with by people who are not necessarily also obese. This may then help the individual to achieve self-acceptance and compassion for the self.

In contrast to the idea that participants gained strength and support from identification, there was also evidence throughout the transcripts that comfort was gained from comparing themselves to others, so that they perceived themselves to be 'thinner' or 'healthier'. Amongst the transcripts was the idea that there was nothing to worry about if you saw that others were bigger than you. Therefore, despite the potent theme of support and acceptance amongst group members, there was obviously a certain amount of judgement occurring.

Super-ordinate Theme 3 (Positive aspects of the group) was divided into: the notion that individuals experienced the course as engendering motivation for weight loss; and also that participants had learned some useful information, especially in comparison to previous slimming groups they had attended. The cognitive understanding that members attribute to the group experience is important according to Stockton, Morran, & Nitza (2000). They say that the ultimate goal in the process of group therapy is to help members use the information to make meaningful changes in their lives. Indeed, participants felt a shared determination to lose weight, having been inspired by taking part in the course. If the way group members use information to make changes in their lives is key to making meaningful changes in their lives, it may be important to help clients to understand their attachment behaviours in group therapy. Understanding our attachment style informs us of how we relate to others, how we help others and how we use them to help us. If group members were led to understand themselves better

interpersonally, they may use this information to make meaningful changes in their personal relationships.

It is interesting to note that for some participants the idea of 'I'll lose weight tomorrow' absolves them from the responsibility that they have not achieved it 'today' and may support the idea that dependency needs to be addressed in obesity treatment. Only 1 participant of the 7 achieved the goal weight loss of between 5 and 10% of their starting body weight. This suggests that there was not enough conscious individual responsibility to achieve the weight loss goal and it reinforces the idea of dependency (and a lack of responsibility), being a problem which underlies obesity. (It is the researcher's understanding that this lack of responsibility is unconscious). Indeed, the participant who achieved the goal weight loss, Susan, expressed in her interview that she was not sad to say goodbye to others on the course and that she did not particularly want to form relationships in the group, which may suggest that she was less dependent on the support of other group members than others were. The participants who conveyed the idea that they would lose weight in the future were Lucy, Lynette, Nicola and Frances. These participants either gained weight or lost little.

The group treatment was compared favourably to previous slimming groups. This was partly due to the professional input, so that new information was learned in the areas of dietetics, psychology and physical exercise. The use of the psychological aspect of the course was widely shared and indicated that treatment could benefit from taking more of a psychological approach. Participants often talked of the benefit of improved self-awareness from the psychological strategies taught. Another advantage of the current course was the non-judgemental attitude from professionals and other group members, enhancing people's experience of feeling accepted and understood. The main reasons for this treatment being compared favourably to previous treatments were the shared

experience of being the same size and the feeling that participants got to know each other. All of Yalom's (1995) group processes which effect change in therapy groups are related to the relationships between group members. Given that the current findings support the existence of these processes, it could be suggested that CBT treatment for obesity would do well to emphasise more of a relational process, rather than focusing mostly on the teaching of strategies.

Different participants found different aspects of the course useful. For one participant, it was useful to consider how stress impacts on her eating behaviour. For another, increasing her self-awareness around emotional eating was helpful. Others found use in learning about: increasing self-awareness; increasing self-acceptance; self-sabotage; and taking small steps in weight loss. This proves how individualised a course like this needs to be if it is to help as many members as possible. There could be a more rigorous assessment process which identifies which people will benefit from an emphasis on certain topic areas and then they could be allocated to slightly different treatment groups accordingly.

There was an indication that certain dynamics could be assessed, formulated and intervened with in group treatment for obesity. For example, some participants felt that they wanted a firmer approach on the course; that they wanted to be told what they can and cannot do, whereas other participants expressed their appreciation of the independence in weight loss that the course encourages. Therefore, some people need no pressure but others need firm limits. To solve this problem, perhaps these combinations could be worked through with a skilled dynamic therapist.

Within Super-ordinate Theme 3 (Positive aspects of the group) is the desire for continued support, so much so that it is unbearable that the course is ending.

The negative aspects of the group were captured in Theme 4, which was divided into the frustration and dislike of this group, the negative relation to groups generally and also the preference for one-to-one therapy instead of group therapy. All the participants were frustrated or disappointed with the course in some way, but their reasons varied – lending more support to the idea that treatment could be more tailored to the individual.

Almost all the participants said how hard they found it to make friends in a group, which suggests that they would benefit from Yalom's (1995) group process that involves interpersonal learning. This could be achieved through focusing on relational aspects of the group. The focus on learning strategies in CBT might appeal to those with avoidant attachment styles who avoid intense emotional experiences with others, but the treatment could benefit from focusing on relational aspects. Similarly to unconditional positive regard (Rogers, 1961) in individual therapy, ideally the group provides its members with an environment in which they can disclose their most private thoughts and emotions and experience understanding and empathy from the group (Bieling, *et al.*, 2013). Participants commonly noted that they had wanted to share information that was too personal to share in a group setting. However, the group setting is an ideal place in which to address personal problems. The reliance in CBT group treatment on the teaching of strategies occluded some people's opportunity to share personal difficulties which would likely have resulted in catharsis. Catharsis, or the act of unburdening is one of Yalom's (1995) group processes and it is other group members' response to the unburdening that has a potentially therapeutic effect, as "no one ever obtains enduring benefit from ventilating feelings in an empty closet" (Yalom, 1995, p.81). However, the participants in the current study did not seem to be able to share their private thoughts and emotions with the group, which could be why the

expected hypothesis was not supported, because very strong defences prevented participants from taking enough in or giving enough out in the therapeutic process. However, the ability to unburden onto others depends on the expected response of the other who is unburdened to and this expectation may be particularly negative for those with insecure attachments.

It seemed that the course did not help target problems with emotional eating. Emotional eating is a common problem in people with obesity (e.g. Telch, & Agras, 1996; Chua, *et al.*, 2004; Gluck, *et al.*, 2004). The two participants who mentioned having a problem with emotional eating did not feel that this was addressed. The complaint was that the problem is “deep” and not one that can be overcome by learning CBT strategies. Considering the link between emotional regulation and attachment theory (Mikulincer, & Shaver, 2007b), this finding supports the idea that treatment for eating disorders (and obesity) could be improved by attending to problems with affect regulation, interpersonal difficulties, and low self-esteem (Fairburn, *et al.*, 2003). The fact that one of the complaints about the current group was that people talked too much about their personal issues lends more support to the need to attend to emotional difficulties associated with obesity, as clearly group members felt they had many personal issues to share. Interestingly, the complaint that people talked too much is at odds with the finding that participants did not feel able to share their personal information with the group. This lends further support to different types of people having different needs in their group treatment.

Another complaint of the group was that 1 participant felt different from the rest of the group. This is also something which may be remedied with some attention to the process of interpersonal learning (Yalom, 1995). Furthermore, the complaints of this participant and 1 other – the 2 who also said that they would not miss other group

members upon the course ending – centred on other group members getting attention from the health professionals. This supports the idea that being in a group did not allow them to feel that they had received enough attention. Perhaps these participants would benefit from specific work with a therapist who can represent a secure attachment figure, or a group therapy which allows interpersonal learning so that all members learn to ‘share’ the caregiver’s attention.

A common reaction was that parts of the course were ‘boring’ because they covered information that participants already knew. If the focus was not entirely on strategies and more on relational growth, this may have provided more success in outcome in the group, because covering material that has been covered before and has not been effective is not going to suddenly effect change.

The difficulty participants have with being around other people in a group is perhaps part of the obesity problem that would benefit from being treated. There was a shared perception across participants of concern about what others would see about them if they were in a group, which presents the opposite of the identification and acceptance experienced by participants. It is possible that this is because by its nature, the CBT treatment does not achieve depth in the course, so although all the ingredients were there to have “deep” and empathic experiences (due to the identification experienced), there was no attention to this, so participants were inhibited by self-consciousness from disclosing any personal information.

Participants who described themselves as “a loner” or “stand-off-ish” or as setting the “self apart from the group” also described incidents in their past which led to them becoming avoidant. This offers more support for the idea that a treatment which fosters interpersonal learning could benefit these group members. Indeed, some of the

participants mentioned how they felt more comfortable as the group progressed. It could also be argued that different individuals had their idiosyncratic group attachment style (as their previous group experiences had been similar), and that these styles were stable and therefore that considering the nature of group members' previous group experiences might be important in assessing people for treatment by grouping them more effectively. Indeed, as Shorey and Snyder (2006) argue, it is important to consider attachment theory in understanding therapeutic interactions, for planning therapeutic interventions and for assessing patients for treatment.

The preference expressed for one-to-one therapy, the dislike for being in a group, and being wary of others could all be interpreted as a desire to keep others away.

Individual therapy might provide more emotional support than group therapy because there is individual attention from a therapist and the desire to keep others away suggests not wanting to be in 'real' relationships. The argument within this discussion is that possibly these individual needs could be met by a group treatment that focuses on relational dynamics within the group.

Limitations and strengths

This study used a small sample of group members recruited from one NHS service and thus the findings presented here cannot be extended to all people participating in group treatment for obesity in general, and are only representative of this particular sample. Nevertheless, it is a rigorous assessment of this particular group.

Further research could be undertaken to discover whether the proposed findings are applicable to more people undergoing CBT group treatment for obesity. For instance, this sample was of those of white British ethnic origin, and findings may differ cross-

culturally. Similarly, there may be differences in group members' experiences of group treatment across different services.

As the sample in this study appeared to have different attachment styles, which is an advantage in showing the overall similarities in experiences of group members receiving group treatment, it could be argued that with a small sample size, we can be less sure of the generalisability of the findings. Thus further research may benefit from larger sample sizes that divide group members by attachment style to test whether and how the experiences differ across groups.

Furthermore, the accounts were retrospective and memories can sometimes be selective or inaccurate. The method of interviewing is advantageous in that it can facilitate rapport and therefore encourage participants to express their feelings in depth.

However, it can also be limited by the participants' relationship with the interviewer and by the interviewer's interpretation of what the participants say. Perhaps it would have been advantageous in this study to present the participants with the finished analysis to check that they believed it was accurate. However, this is controversial, as employing this method could encourage participants to deny what they had in fact said in order to come across in a more favourable light. Similarly, as stated above, memories can be inaccurate, and participants may not believe what they had actually said, without the benefit of an audio-recorded version of the interview, which the researcher had with her in the analysis process. Furthermore, opinions about an experience can change with the passage of time, as the individual goes through a stage of 'processing' their responses to an experience.

The interpretation required to analyse subjective experience is complicated, and as a result, IPA encourages the reflection required to make sense of the transcripts. This presents an obstacle in maintaining the objectivity of the findings.

Various steps were taken throughout the analysis to reduce bias and thus strengthen credibility. Memos were taken during the reading of each transcript to alert the researcher to any existing or developing biases. Preconceptions that became apparent prior to the analysis included optimism regarding group members' experiences (i.e. that members would have all had only positive feedback about the course), an expectation of significant weight loss during the course for all participants, and prejudices that there would be clear-cut relationships between early family relationships and current attachment styles. Furthermore, emotional reactions to the transcripts during the analysis that may have biased it included frustrations felt in sympathy for group members' dislikes of the course and also any factors that lead to obesity that the course had not attended to. As group members recounted the negative aspects of the treatment, the researcher came to sympathise with their experiences, especially when she felt that the treatment had not met certain needs.

The researcher's emotional reactions to the data were processed in discussions that took place with the research supervisor. This allowed for any personal reactions to be bracketed so that the researcher could achieve a more holistic view of group members' experiences of the treatment. Discussing the challenges of cost that face psychological services was helpful to remind the researcher that treatments to meet the various psychological needs of obese people would be expensive. These discussions aided in focussing the researcher on only attending to the group members' experiences of the treatment that was apparent in the transcripts, without clouding the analysis with biases.

To further strengthen the validity of the analysis, the participants' own words from the interview transcripts were used in generating the thematic account of their experiences. Direct quotations were used for the theme titles, sub-themes and extracts of each theme.

Although the findings proposed in this study need further investigation to test their applicability, they still give valuable insights into how this sample of group members experienced group treatment for obesity. They also suggest points of focus for intervention in attending to which aspects of treatment are helpful to different types of individuals.

The analysis suggested that intervention may benefit from paying attention to individuals' attachment styles and also to what dynamics they respond well to. It also suggested that different types of treatments might suit different people and this could be tested for more rigorously at the assessment stage. For example, some may require one-to-one intervention to focus specifically on certain topics, such as motivation, whereas group interpersonal treatment may help with difficulties with emotional eating.

If services are aware of what constitutes more effective intervention for different people, that awareness can enable different individuals' needs to be met.

Future work

It could be useful to carry out a similar study in which a different measure of attachment is used, such as the Adult Attachment Interview (AII: George, Kaplan, & Main, 1985) as the problems with measurement precision that are found in self-report measures could be avoided (Fraley, *et al.*, 2000). The AII is a clinical interview which taps into a person's internal working models of attachment in their family of origin. It takes approximately one hour to administer. Furthermore, an alternative self-report

measure such as Fraley, *et al.*'s (2000) ECR-R, which is highly recommended by attachment researchers (e.g. Shaver, & Fraley, 2010), could produce different results, and due to the strength of the existing research in the area of attachment and obesity, it would be worth pursuing this line of research.

Although the findings in the current study did not complement previous research findings that insecure attachment style impacts negatively on the success of outcome in therapeutic groups, it does not mean that no relationship exists. The effect of attachment style on outcome in obesity treatment is a research topic in its infancy and more research is needed to enable the development of more conclusive results.

Comparing group CBT treatment with interpersonal treatment might yield results that complement the existing literature on attachment and outcome in clinical groups. It is difficult to draw any firm conclusions about a CBT treatment alone without a comparison treatment group.

Future qualitative research would benefit from repeated interviews with more group members to gain a richer picture of the experience of group treatment (Smith, 1994). Exploring the group experience in more depth will give more of an understanding to how different attachment styles interact in the group and comparing these interviews with attachment scores may yield more findings which indicate what sort of people require what sort of treatment.

Research attempting to verify the use of interpersonal treatments for obesity would also be beneficial. The design could include assessing participants' behaviours that are problematic for their obesity (for example, inactivity or emotional eating) and allocating them to strategy-based or relationally-based treatments. However, this sort of design would still rely on retrospective memories which may not be precise or in-

depth enough to enable understanding of the complete picture. An alternative design could be to conduct interviews whilst the group experience unfolds.

Implications for counselling psychology

As counselling psychologists, it is our mission to attempt to aid in alleviating people's distress. If we can better understand what treatment is effective for different individuals, we can better meet the needs of people who are morbidly obese and who desperately struggle physically and psychologically in their day-to-day lives. If treatment could improve with longer-lasting results, we would have a healthier society and one which is cost effective. This in turn could enable money to be spent on more services that aim to treat diverse and debilitating mental health conditions.

The unique contribution of this study to counselling psychology practice is for those working in the field of obesity to consider that it is possible that people with more confidence in relating to others may not benefit as much from group CBT treatment than another form of treatment. Counselling psychologists might want to consider whether this is because these patients are content with the way they are and therefore group CBT does not get to the heart of their reasons for being overweight or whether their confidence keeps others away (following the idea of not needing anyone else and being confidently self-reliant). If either of these are the case, some counselling psychologists may consider running more interpersonal-based groups for these individuals as there may be relational maintaining factors in their weight problem.

Further implications to counselling psychology practice include that it might be beneficial to consider whether dependency underlies obesity. If dependency underlies obesity, current treatment may be missing a vital mechanism to help with weight loss if it does not address the issue of dependency in treatment. This could be achieved by

delivering more one-to-one interpersonally-oriented treatment where the therapist becomes a secure base for the client and independence is fostered. The current study also demonstrates how group members feel supported in group treatment and the importance of others in the group experience. For counselling psychology, this study could either provide information on how to foster that sense of support between group members or it could suggest that attention to the dependency on other group members could be incorporated into treatment. The study also suggests that group members should be given the opportunity to share more personal thoughts and emotions in a group treatment. Participants said that they did not feel that they could share personal information, which suggests that less emphasis on learning strategies and more on sharing personal information may improve therapy. It may also suggest that some may benefit from one-to-one therapy, and this information may be gained from a thorough assessment.

The current study also demonstrates to practitioners how important the shared experience of being obese is to clients. There is a common feeling that people who are not also obese do not understand what it is really like to be obese. This either suggests that group treatment is valuable in the treatment of obesity or that health professionals who are not obese could pay special attention to demonstrating empathy and sensitivity to show understanding. It is also important for health professionals to bear in mind that clients with obesity are likely to compare themselves to other obese people to tell themselves that they are not as large as others. This is likely not to be a helpful frame of mind to be in and health professionals could help clients to appraise this more realistically. This study has shown what people have found useful to learn and particularly that a weight loss treatment will benefit from incorporating a psychological perspective in teaching strategies. Considering what was frustrating and unhelpful

about treatment in the current group may inform practitioners how best to tailor their treatment programme.

Candidates for therapy who talk about a history of having a negative relation to groups in general and who express a preference for one-to-one in assessment may benefit from having a group therapy that is more interpersonally focussed. It is quite possible that a contributing factor to the difficulties with weight management for these individuals is their inability to relate to others and to use others in the process of self-soothing.

Currently NICE considers research which demonstrates the efficacy of therapy and only recommends therapy to be used in practice if its effectiveness has been clearly demonstrated. This is becoming controversial, however, as the type of experiment considered to be acceptable by NICE has come under scrutiny (Guy *et al.*, 2011). Guy, *et al.* (2011) criticise NICE for adopting a biomedical approach to mental health when in reality the aetiology and treatment of mental health is far broader and less conclusive than biomedical health. NICE studies assume that conditions underlie symptoms and that treatment should focus on symptom reduction. The reality is that mental health problems are biopsychosocial in nature (Pilgrim, Rogers, & Bentall, 2009) and require a more holistic approach to treatment.

Pilgrim, *et al.* (2009) argue that a vast body of research proves that it is the quality of the relationship in therapy that predicts outcome, regardless of the approach being used, demonstrating that therapy is primarily relational and not symptom-based. The current recommendation for obesity is CBT, which focuses on strategies for weight reduction. However, if NICE starts to consider methodologies that are not Randomised Controlled Trials (RCTs), and are relational (which is a concept much supported: e.g. McLeod, 2001, 2003; Schmitt Freire, 2006; Marshall, & Rossman, 2006; Bohart, & House, 2008;

Guy, *et al.*, 2011), then research such as the current study, which looks at participants' experience of therapy, might be considered by NICE. If NICE would consider research which investigates the quality of experience as it does with cause-effect relationships, treatment for obesity may be viewed in a new light, with more consideration to the relational maintaining factors.

The DoH has an economic and political agenda and in the current economic climate there is a tendency to promote CBT treatments because they are more cost-effective (due to the fact that therapy is shorter and focussed on treatment goals). However, if group CBT treatment is not producing lasting effects for weight loss and maintenance (e.g. Jeffery, *et al.*, 2000; Teixeira, *et al.*, 2005; Wu, *et al.*, 2009), it might in fact be more cost-effective in the long-term if different types of treatment are considered, ones which are more dynamically-focused than strategy-focused.

Concluding remarks

This study has assisted the understanding of attachment and obesity and how people experience group treatment for obesity. It contributes to our understanding of processes involved in the group treatment process. It has made suggestions to weight-loss services to undertake more thorough assessments to facilitate more appropriate treatment pathways where individual needs can be met. For example, considering an individual's attachment style and also what their preferred dynamics are in a group might indicate whether they would be better suited to group psychotherapy, group CBT or one-to-one intervention. Developing our understanding of what is effective treatment for obesity is crucial, so that we can continually improve services and enhance the quality of intervention, in order to tackle this worrying and ever-worsening obesity epidemic.

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Chapter D: Professional Case Study

THIS PART OF THE PORTFOLIO HAS BEEN
REMOVED TO PROTECT CLIENT
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Appendices

Appendix A: Invitation Letter

**THE NUS TRUST LOGO HAS BEEN REMOVED TO PROTECT
CONFIDENTIALITY**

*This study has been approved by City University (ethical approval reference number
'PSYETH(UPTD) 11/12 097') and South Central – XXXX X REC*

1st July 2012

INVITATION TO PARTICIPATE IN A STUDY

***Project Title: An investigation on the experience of group treatment for obesity and
attachment style as a predictor of intervention outcome: A mixed methodology study***

I work with XXXXX and I would like to invite you to participate in a research project that I am undertaking. The project aims to understand whether taking part in the XXXX weight management group affects people's levels of anxiety and depression and their BMI. The questionnaire that I ask you to complete today is the Attachment Style Questionnaire because I am interested in whether people's attachment styles affect these measures. Later on in the project, I would like to explore how people experience being in a group and how this experience may differ between people.

I would be very grateful if you could complete and return the questionnaire I give you today to the group facilitator next week.

I will be asking anyone who is enrolled on the XXXXX groups from July 2012 to May 2013 if they would be able to complete these questionnaires. I am hoping that I will be able to have the completed questionnaires from 100 people in total.

When the XXXXX groups have finished, I will contact 7 people who have indicated interest to take part in the second part of this study. This involves meeting up with me at the premises where the XXXXX group has taken place so that I can ask some questions about the group experience.

Please see the enclosed information sheet for more details.

This study is ethically approved by City University London and South Central – XXXX X REC NHS Research Committee. The research project will contribute to my qualification to become a counselling psychologist, which I am in training for at City University, London.

If you have any questions about this project or would like any more information about taking part in my study, please contact me. (My contact details are on the next page).

If you would like to participate, please complete the attached questionnaires and consent form.

Yours sincerely,

Jenny Astley (Researcher for the project/Trainee Counselling Psychologist)

Mobile: XXXXXX **Email:** XXXXXX

Supervisor's contact details:

Dr Pavlos Fillipopoulos, Programme Director of Counselling Psychology

Telephone: XXXXXXXX

Email: XXXXXX

Postal Address: XXXXXXXX

Appendix B: Participant Information Sheet

THE NUS TRUST LOGO HAS BEEN REMOVED TO PROTECT CONFIDENTIALITY

This study has been approved by City University (ethical approval reference number 'PSYETH(UPTD) 11/12 097') and South Central – XXXX X REC

PARTICIPANT INFORMATION SHEET

Project Title: An investigation on the experience of group treatment for obesity and attachment style as a predictor of intervention outcome: A mixed methodology study

This information sheet gives further details about the project you are being asked to participate in. If you have any questions, please do not hesitate to ask me.

Invitation

I would like to invite you to participate in my research project which is being conducted as part of the educational requirements for a doctorate in counselling psychology. Participation is voluntary. If you do not want to take part, it will not compromise your experience with XXXXX. Please read the following information which explains about the project and what participation involves so that you can decide if you would like to take part. If you decide to take part, you will be asked to sign a consent form.

Why is this study being done?

This study is for my doctoral research thesis in counselling psychology. The project aims to understand whether taking part in the XXXXX weight management group affects people's levels of anxiety and depression and their BMI and whether these changes are different according to people's attachment styles. It also aims to explore how people experience being in a group and how this may differ between people.

Why are you being asked to participate?

I am asking anyone who is enrolled on the XXXXX groups for the months of July 2012 to May 2013 if they would be able to complete these questionnaires. I am hoping for completed questionnaires from 100 people. I will also be inviting 7 people who have completed the XXXXX group to ask if they might be willing to meet up with me at the XXXXX venue so that I can ask some questions about the group experience.

Do I have to take part?

You do not have to take part. If you do decide to take part, you may withdraw participation at any point without having to give reason. Your care with XXXXX will not be affected.

What will I have to do if I decide to take part?

If you decide to participate, I will ask you to complete a questionnaire about your experiences in forming close relationships along with a questionnaire that measures anxiety and depression. This information will be made anonymous, so that the data I

collect cannot be linked with your name.

The second part of this study involves meeting up with me at a convenient time on the premises that the XXXXX groups took place around XXXXX so that I can ask some questions about the group experience. The interview would last for approximately one hour.

I will have some questions to ask, but it will generally be an open conversation about the group experience. This conversation will be audio recorded so that I can transcribe the information in order to do the analysis part of the project. Afterwards, the audio recording will be destroyed. When I transcribe the recordings, they will become anonymous, as I will assign a number (rather than someone's name) to the transcriptions.

Will my taking part in the study remain confidential?

When I have completed the transcriptions, it would not be possible for anyone to have any identifying information for people who have taken part. When I write up my study, it will only be anonymous quotations that might be used from the conversations. The findings in the project will talk about the main themes that were commonly talked about in the conversations with different people who have completed the XXXXX programme.

If you agree to take part in the study, the data may be used in future ethically approved research. All data will remain anonymous.

What will happen if I decide I don't want to carry on with the study?

Even if you decide to take part in the study, you may withdraw at any time without giving reason and your XXXXX experience will not be compromised.

Researcher's contact details:

Jenny Astley (Researcher for the project/Trainee Counselling Psychologist)

Mobile: XXXXX **Email:** XXXXX

Supervisor's contact details: **Dr Pavlos Fillipopoulos**, Programme Director of Counselling Psychology

Telephone: XXXXX **Email:** XXXXX

Postal Address: XXXXXXX

Comments, concerns or observations procedure: This project has been approved by the Research and Ethics Committee of the Department of Psychology of City University London, project approval number: **PSYETH(UPTD) 11/12 097**. If you have any comments, concerns or observations about the conduct of the study or your experiences as a participant, please contact the Secretary to the Committee Mr XXXX, quoting the above project approval number: **Telephone:** XXXXX **Email:** XXXX
Postal Address: XXXX

THANK YOU FOR YOUR TIME

Appendix C: Consent Form 1

**THE NUS TRUST LOGO HAS BEEN REMOVED TO PROTECT
CONFIDENTIALITY**

*This study has been approved by City University (ethical approval reference number
'PSYETH(UPTD) 11/12 097') and South Central – XXXX X REC*

CONSENT FORM 1

***Project Title: An investigation on the experience of group treatment for obesity and
attachment style as a predictor of intervention outcome: A mixed methodology study***

Please
initial box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to ask any questions I have about the study. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving reason, and that this will not affect my experience with XXXX. ☐
3. I understand that any information I give will be stored as data for this project and I give my consent for the storage of this data. I have been informed that my data will remain anonymous. ☐
4. I give my consent to any data I provide may be used in future ethically approved research. I understand that this data will remain anonymous. ☐
5. I agree to take part in the above study. ☐

Please tick this box if you would also like to take part in the interview part of this study about your group experience. ☐

If you would like to have access to the research report please either contact the researcher directly via e-mail/telephone (details overleaf) or provide an e-mail address you would like it to be sent to:

Participant: Please print name

Date

Signature

Researcher: Jenny Astley

Date

Signature

Researcher's contact details: Jenny Astley (Researcher for the project/Trainee Counselling Psychologist)

Mobile: XXXXX

Email: XXXXX

Postal Address: XXXXX

Supervisor's contact details:

Dr Pavlos Fillipopoulos, Programme Director of Counselling Psychology

Telephone: XXXXX

Email: XXXXXXXX

Postal Address: City University, Northampton Square, London, EC1V 0HB.

Comments, concerns or observations procedure:

This project has been approved by the Research and Ethics Committee of the Department of Psychology of City University London, project approval number:

PSYETH(UPTD) 11/12 097.

If you have any comments, concerns or observations about the conduct of the study or your experiences as a participant, please contact the Secretary to the Committee Mr XXXXX, quoting the above project approval number:

Telephone: XXXXX; **Email:** XXXXX

Postal Address: XXXXXXX

Appendix D: Debrief Information Sheet

**THE NUS TRUST LOGO HAS BEEN REMOVED TO PROTECT
CONFIDENTIALITY**

*This study has been approved by City University (ethical approval reference number
'PSYETH(UPTD) 11/12 097') and South Central – XXXX X REC*

PARTICIPANT DEBRIEF INFORMATION SHEET

***Project Title: An investigation on the experience of group treatment for obesity and
attachment style as a predictor of intervention outcome: A mixed methodology study***

If taking part in this study has caused you distress and you would like to talk about it some more with a professional, there is a service in XXXXX called XXXXX and it is run by qualified psychologists and therapists. It is an NHS service, and their number is: XXXXXX. They accept self-referrals, which means you can call them up yourself and say you would like to see a therapist to talk about any issues you would like to. You can also email them at XXXXX.

It is also possible to make an appointment with your GP to raise any concern you may have.

Thank you for taking the time to partake in this research interview.

Yours sincerely,

Jenny Astley (Researcher for the project/Trainee Counselling Psychologist)

Mobile: XXXXXX **Email:** XXXXXX

Supervisor's contact details: **Dr Pavlos Fillipopoulos**, Programme Director of Counselling Psychology **Telephone:** XXXX **Email:** XXXXX **Postal Address:** XXXXX

Comments, concerns or observations procedure:

This project has been approved by the Research and Ethics Committee of the Department of Psychology of City University London, project approval number: **PSYETH(UPTD) 11/12 097**. If you have any comments, concerns or observations about the conduct of the study or your experiences as a participant, please contact the Secretary to the Committee Mr XXXXX, quoting the above project approval number:

Telephone: XXXXX; **Email:** XXXXXX

Postal Address: XXXXX

Appendix E: Group Treatment Protocol

Session	Topic
1	Introduction
2	Building Motivation and SMART Goal-Setting
3	Portion Sizes and Planned Eating
4	Increasing Physical Activity
5	Healthy Eating and Self-Monitoring
6	Linking Thoughts, Feelings & Behaviour, and Breaking Habits
7	Understanding Food Labels and Reducing Fats
8	Eating Out and Mindful Eating
9	Identifying and Managing Emotional Eating
10	Tackling Snacking and Managing Plateaus
11	Building Social Support and Relapse Prevention
12	Weight Maintenance
9 Monthly Masterclass Review Sessions	

Appendix F: The ASQ

Attachment Style Questionnaire - Feeney, J. A., Noller, P., & Hanrahan, M. (1994)

Please tick ONE box to show how much you agree with each of the following statements:

1. Overall, I am a worthwhile person.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

2. I am easier to get to know than most people.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

3. I feel confident that people will be there for me when I need them.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

4. I prefer to depend on myself rather than other people.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

5. I prefer to keep to myself.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

6. To ask for help is to admit that you're a failure.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

7. People's worth should be judged by what they achieve.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

8. Achieving things is more important than building relationships.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

9. Doing your best is more important than getting on with others.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

10. If you've got a job to do, you should do it no matter who gets hurt.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

11. It's important to me that others like me.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

12. It's important to me to avoid doing things that others won't like.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

13. I find it hard to make a decision unless I know what other people think.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

14. My relationships with others are generally superficial.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

15. Sometimes I think I am no good at all.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

16. I find it hard to trust other people.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

17. I find it difficult to depend on others.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

18. I find that others are reluctant to get as close as I would like.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

19. I find it relatively easy to get close to other people.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

20. I find it easy to trust others.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

21. I feel comfortable depending on other people.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

22. I worry that others won't care about me as much as I care about them.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

23. I worry about people getting too close.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

24. I worry that I won't measure up to other people.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

25. I have mixed feelings about being close to others.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

26. While I want to get close to others, I feel uneasy about it.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

27. I wonder why people would want to be involved with me.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

28. It's very important to me to have a close relationship.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

29. I worry a lot about my relationships.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

30. I wonder how I would cope without someone to love me.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

31. I feel confident about relating to others.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

32. I often feel left out or alone.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

33. I often worry that I do not really fit in with other people.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

34. Other people have their own problems so I don't bother them with mine.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

35. When I talk over my problems with others, I generally feel ashamed or foolish.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

36. I am too busy with other activities to put much time into relationships.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

37. If something is bothering me, others are generally aware and concerned.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

38. I am confident that other people will like and respect me.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

39. I get frustrated when others are not available when I need them.

☐	☐	☐	☐	☐	☐
totally	strongly	slightly	slightly	strongly	totally
disagree	disagree	disagree	agree	agree	agree

40. Other people often disappoint me.

☐	-----	☐	-----	☐	-----	☐	-----	☐
totally		strongly		slightly		slightly		strongly
disagree		disagree		disagree		agree		agree

THANK YOU FOR YOUR TIME

Attachment Style Questionnaire - Feeney, J. A., Noller, P., & Hanrahan, M. (1994)

Appendix G: Interview Schedule

This study has been approved by City University (ethical approval reference number ‘PSYETH(UPTD) 11/12 097’) and South Central – XXXX X REC

Project Title: An investigation on the experience of group treatment for obesity and attachment style as a predictor of intervention outcome: A mixed methodology study

The intention behind the interview schedule is to keep the questions as openly explorative as possible. Before the interviews begin, each participant will be asked to reflect on their personal experience in the group, rather than what they think might be the entire group’s experience. The following vague questions will be covered in depth:

- 1) ‘What was your group experience like?’
- 2) ‘What was it like being with others in the group?’
- 3) ‘How important to you was social support from other group members?’

Appendix H: Consent Form 2

**THE NUS TRUST LOGO HAS BEEN REMOVED TO PROTECT
CONFIDENTIALITY**

*This study has been approved by City University (ethical approval reference number
'PSYETH(UPTD) 11/12 097') and South Central – XXXX X REC*

CONSENT FORM 2

***Project Title: An investigation on the experience of group treatment for obesity
and attachment style as a predictor of intervention outcome: A mixed
methodology study***

Please
initial box

1. I confirm that I understand the purpose of the above study. I have had the opportunity to ask any questions I have had about the study. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving reason, and that this will not affect my experience with XXXX. ☐
3. I understand that if I participate in this interview with the researcher about my XXXX experience it will be audio recorded and I give my consent for this. ☐
4. I give consent for my personal quotes to be used in the project write-up and I know that my name will NOT be linked to these quotations. ☐
5. I give my consent to any data I provide may be used in future ethically approved research. I understand that this data will remain anonymous. ☐
6. I understand that any information I give will be stored as data for this project and I give my consent for the storage of this data. ☐
7. I have been informed that once my interview has been transcribed, the audio will be destroyed and my transcript will remain anonymous. ☐
8. I agree to take part in the above study. ☐

Participant: Please print name

Date

Signature

Researcher: Jenny Astley

Date

Signature

Researcher's contact details: Jenny Astley (Researcher for the project/Trainee Counselling Psychologist)

Mobile: XXXX

Email: XXXXX

Supervisor's contact details:

Dr Pavlos Fillipopoulos, Programme Director of Counselling Psychology

Telephone: XXXX

Email: XXXX

Postal Address: XXXX

Comments, concerns or observations procedure:

This project has been approved by the Research and Ethics Committee of the Department of Psychology of City University London, project approval number: **PSYETH(UPTD) 11/12 097**.

If you have any comments, concerns or observations about the conduct of the study or your experiences as a participant, please contact the Secretary to the Committee Mr XXXXX, quoting the above project approval number:

Telephone: XXXX; **Email:** XXXX

Postal Address: XXXXX

Appendix I: An illustration of the steps followed with an extract from a transcript

An extract from Frances's interview:

Frances: I mean, I don't think I've actually learnt a lot new during this 12 weeks because I've been to slimming clubs before where I've been given most of the information.

Interviewer: mhm.

Frances: Um, but it has been approached from a slightly different angle with the psychological aspect. This time, uum, and I think, I think I have to respect the person running the group as a professional for it to work...and I belonged to slimming clubs for a while and I had one person who was a college lecturer in her daytime job and I really felt enthused by what she did and enthusiastic to slim and then I moved and the person who took over it was what I call a typical housewife and I felt I knew more than her....and it didn't work.

Interviewer: mm.

Frances: (laughter) and the second time I didn't slim.

Notes made in the margin:

- Not learned a lot new
- Disappointment
- This group approached from a different angle to previous experiences
- Psychological aspect new
- 'Looking down on' tone of voice
- It's important for Frances that the people running the group are educated
- Respect for professionalism

The notes in the margin contained “descriptive”, “linguistic” and “conceptual” comments.

The notes became instances of themes in Frances’s table of emergent themes:

Theme	Page/line	Quotes
Need to respect the facilitator for being educated	7/8	I have to respect the person running the group as a professional for it to work.
	7/14–7/17	I had one person who was a college lecturer in her daytime job and I really felt enthused by what she did and enthusiastic to slim and then I moved and the person who took over it was what I call a typical housewife and I felt I knew more than her....and it didn’t work.
	7/18	And the second time I didn’t slim.
Didn’t learn a lot new	7/1–7/3	I don’t think I’ve actually learnt a lot new during this 12 weeks because I’ve been to slimming clubs before where I’ve been given most of the information.
Different approach to other slimming clubs	7/5	It has been approached from a slightly different angle with the psychological aspect.

Appendix J: Letter of Confirmation

**THE NUS TRUST LOGO HAS BEEN REMOVED TO PROTECT
CONFIDENTIALITY**

*This study has been approved by City University (ethical approval reference number
'PSYETH(UPTD) 11/12 097') and South Central – XXXX X REC*

Participant's name
Address line 1
Address line 2
Address line 3
Postcode

8th October 2012

Dear XXXX,

It was a pleasure to speak to you on Friday and I am very grateful to you for taking part in my research project.

I just wanted to confirm the details of our meeting:

Date: Friday 26th October

Time: 6pm

Place: XXXXX

I will ask for your consent for our discussion to be recorded (so that I can type up what is said to analyse the data). As soon as I have typed up our conversation I will destroy the audio recording and your name will not be linked to anything in the research. I imagine our discussion will be about 1 hour and I will have a few questions to ask you about the experience of being in a group during XXXX.

If you have any questions or any concerns, please do give me a ring or send me an email (my details are below).

I look forward to seeing you on the 26th.

Yours sincerely,

Jenny Astley (Researcher for the project/Trainee Counselling Psychologist)

Mobile: XXXXX

Email: XXXXX

Appendix K: An example of some Master List themes

I will miss it when we're not there anymore (Lucy)

I wish it could go on forever (Susan)

Francis: 18/18 'I would like the contact to continue beyond the year'

Lynette: 2/17–2/21 'Although they're still going to be there for you it's different because ...I need to ring them up but I can't talk to them face-to-face or discuss and come up with ideas'

3/12 'At least you know oh I didn't do very well this week but I've got to go Monday, I can sort it out'

Susan: 2/1 'I was quite sad that it was ending'

2/2 'I wish it would go on forever'

2/4 'I just would have loved it to have gone on'

2/18 (The course information) 'was really getting into my head'

2/18 'I loved it'

Joe: 2/4 'I'm not happy' (it's ending)

3/16 'We can come to the weighing sessions, which are weekly...but it's just a weighing session and then we're off'

3/20 'But we actually like to sit down and have a bit of a natter'

Lucy: 4/10 'I will miss...it'

31/5 'If you could maybe do it on a rolling programme, so you have your 12 week course and then maybe continue to weigh and have discussions, because there's always something you can talk about 'cause someone's going to bring something up aren't they?'

31/12 'I'd be happy to pay to come to this course because it's different from (other weight loss group)'

I'd quite happily go back through it again (Susan)

Nicola: 6/7 'I wanted to do it again'

Lynette: 41/1 'I'd go again, if I was offered a group session'

41/2 'It's made me realise that actually it does work'

41/10 'If I didn't lose and they needed to readdress so I started from scratch, I wouldn't be scared to go again'

41/18 'They wouldn't be like so obviously you failed then'

42/2 'They wouldn't judge me that oh she didn't lose weight so she's had to come back again'

42/3 'They would say right we need to re-cap what we did last time to see where we could tweak it to help you'

Susan: 2/19 'I'd quite happily go back through it again'

36/19 'I'd go through it again and again and again to have it put into my head. To have a little snippet of information'

It's been my motivation (Lynette)

Francis: 6/6 '[I'll miss] the spur it gives you...the feeling of 'I've got to do something for next week...the motivation'

Lynette: 1/14 'It's been my motivation'

1/14 'It's almost as if I need to go to the course because I'm having a meeting'

27/5–27/20 '(Will miss) the motivation'

27/21 'It's just missing the regular motivation to come here. That's all I'll really miss'

2/10 'That worries me to a degree because then my structure, my back-up isn't there anymore because on a Monday night I'm not going to the meeting'

2/16 'Because if you've got the structure there it's easier'

3/6, 3/6, 3/9 (Meeting physically weekly) is the real help 'the structure and the back-up'

27/5–27/20 '(Will miss) the structure'

Susan: 2/1 'I do like the structure of the once a week'

Joe: 26/13 'That's where I go to get my inspiration'

30/22 'The actual thing itself has been the main drive, the thing that keeps us going'

31/1 (The regular meeting)

31/18 'Weekly makes a big difference. Support'

Lucy: 1/19 'It's like 'What are we going to do?''

4/10 'I will miss...the fact that it's there and you can ask questions and get reassurance'

Will I lapse and get back to my old ways? (Lynette)

Francis: 19/12 'I shall slip back if I don't'

19/17 'But if I know it's continuing...there's a reason where, if I do slip, I've got a target to get back'

36/3 'I'm not sure that I'll be able to succeed without support of some sort'

Lynette: 1/14 'If it's not weekly will I lapse and get back to my old ways?'

1/15 'Because there's not the motivation that I need'

1/17 'But if I haven't got that every week, my motivation has gone'

1/18 'Cause at least then there's something for me to look forward to'

2/14–2/16 'So that's a bit daunting for me'

2/21 'I'm on my own and I've got to do it for myself'

3/1 'And that frightens me'

3/13 'If that stops, you haven't got that anymore, so it's like what do I do now?'

Susan: 2/5 'I work better under pressure'

Joe: 2/6 'We, as a group have found that we do better with the support'

2/2 'The weeks that we weren't here, lots of people put weight back on'

31/9 'Once you stop going, the weight goes back on'