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THE UNIVERSITY OF ALBERTA

CHANGE AND THE OVERWEIGHT GAME

by

DEVON JOY MARK

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE

DEGREE OF DOCTOR OF PHILOSOPHY

IN

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FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled "Change and the Overweight Game", submitted by Devon Joy Mark in partial fulfilment of the requirements for the degree of Doctor of Philosophy in Counselling Psychology.

Supervisor

Robert J. Fischer

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Date May 28, 1979.

To Allen

who charted unexplored territory with me.

ABSTRACT

This study was carried out to demonstrate the process of second-order change, expanding on information in this area, and to investigate the impact of second-order interventions on the attitudes and behaviors of individuals caught in the Dieting Game Without End. This Game was described as the repeated cycle of using self-restraint solutions to control eating, losing control over eating, and renewing self-control solutions. The attempted solutions were assumed to maintain the control/loss-of-control cycle.

In January, 1978, 14 volunteers who fit the pattern of the Dieting Game Without End were obtained for both the Treatment and Promise-of-Treatment Groups. They were selected from 47 respondents to an advertisement accompanying the Program Guide of a Continuing Education Centre.

The focus of the 12-week Treatment Program was on interrupting the problem-maintaining-solutions through the use of second-order interventions in order to affect processes related to the presenting problem. The immediate goal was not to focus on weight loss, or the first-order goal. In order to upset their old pattern of letting themselves gain before trying to lose, participants were encouraged to try to gain between 15 and 25 pounds before they let themselves lose.

Verbal (tapescripts of spontaneous comments and therapy interaction; phone calls) and written (questionnaire) self-report information was collected weekly from each individual in the Treatment Group. These weekly self-reports and the 2-month questionnaire served as process markers in relation to the presenting problem and formed the

basis for the 13 Treatment Case Studies. These data were evaluated according to whether there was a shift from the Dieting Game Without End to a second set of behaviors and attitudes in which control of eating was no longer an issue.

In relation to the directions to gain weight, participants generally followed two patterns: eight tried to follow the directions; five resisted. Within each pattern there was range of reactions which illustrated various combinations of the logical levels of outcome, the second-order process level and the first-order weight goal level.

The written self-report (questionnaire) data collected from the Promise-of-Treatment Group were evaluated and showed no shifts in the Dieting Game. Promising treatment, in this instance, did not appear to be a form of paradoxical treatment.

A number of difficulties related to the implementation of the second-order change model were discussed. Success appeared to be related to following the gain instructions and trust in the therapy relationship. Failure appeared to be related to difficulties conceptualizing the problem and interventions.

Implications to the area of second-order change were suggested. First, in examining the success of second-order change, it is important to consider the logical levels of outcome, the second-order process level, and the first-order goal level. Second, before making definite statements about success, it is important to observe outcome at both levels over a period of time. Finally, on the basis of initial conditions, it is very difficult to predict outcome from the use of second-order approaches.

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To my parents, thank you for the encouragement you have given me throughout the course of my education.

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CHAPTER I

INTRODUCTION

The purposes of this thesis are (1) to demonstrate and describe the process of second-order change, thus expanding on information and knowledge in this area, and (2) to investigate the impact of second-order interventions with a group of overweight individuals who have persistently failed to lose weight or maintain a weight loss through self-restraint solutions.

Conceptual Framework for the Thesis Problem

Assumptions about how problems are created and how they are resolved, whether explicit or implicit, are the foundation of every therapy approach. For example, if it is assumed that problems are created in early childhood through deficiencies in need gratification by parents, problem resolution tends to be past-directed with an emphasis on understanding or reliving early experiences in order to change present behavior. If it is assumed that problems are a product of certain reinforcement contingencies in the environment, problem resolution may center around altering these contingencies to produce more adaptive behaviors. In the change approach suggested by Watzlawick, Weakland, and Fisch (1974) it is assumed that problems are created by attempting the wrong type or wrong logical level of solution in order to

resolve a difficulty. Problem resolution centers around determining the attempted solutions which are creating and maintaining the problem and intervening in ways which block or interrupt these problem-maintaining-solutions, thus facilitating a shift in the problem. This shift is termed a second-order change.

In brief, this change approach deals with both persistence and change. Watzlawick et al. consider two types of change: first-order change and second-order change. First-order change is discussed primarily in relation to stability and persistence in a system, and problem formation and maintenance. First-order change involves interaction patterns where the attempted change actions, usually of a logical, common-sense nature, leave the basic pattern or structure of the system unchanged even though observable behaviors may be quite different (Watzlawick et al., 1974). Second-order change is discussed primarily in relation to problem resolution where continued, logically applied behaviors fail to bring about the expected resolution. This type of change is considered to be a shift in the structure of the system or the rules governing the system. Second-order change is analogous to sudden shifts which occur in resolving paradoxes and in creative movements; it is similar to the "lightning flash" which enables problem components to be seen in a new way that for the first time permits its solution (Kuhn, 1970). This type of change appears abrupt and unexpected in contrast to the logical, common-sense qualities of first-order change.

To illustrate, Watzlawick et al. (1974) give the example of the familiar nine-dot problem.

The task is to join the nine dots using four straight unbroken lines. Most individuals assume the problem must be solved within the framework of the square or, in other words, within a limited set of choices. This is considered an example of first-order change. That is, no matter how many variations on the pattern of trying to join the dots within the square are attempted, the problem cannot be solved. The problem is solved only by moving outside the framework of the square (see page 9 for the solution). This shift in the assumptions or premises about what the problem is and how it is to be solved is an example of a second-order change. The difficulty in solving the problem was not with the nature of the problem per se but with the assumptions that were made about problem resolution. The attempted solutions are the problem. Continuing these wrong types of solutions repeatedly creates a Game Without End. A Game Without End is defined as a system which may run through any number of internal changes without changing the structure or pattern of the system (Watzlawick et al., 1974, chap. 2). Once in operation a Game Without End, like the nine-dot problem, can only be solved through change actions which step outside the system or outside the framework of the game. These change actions are called second-order change interventions. As mentioned, these strategies, directed at blocking and interrupting the problem maintaining solutions, often lead to second-order change, or a shift in the system.

The following interaction pattern illustrates a Game Without End involving two individuals taking opposing positions which maintain the

game. The first individual persistently criticizes himself for being worthless, for not being able to do anything well, and for always ending up back in the same losing spot. The second individual(s) reacts to this self-criticism in a common-sense way by encouraging the person to pick out the things he does well, by pointing out his strengths, and so forth. At this point, the first individual may become defensive and try to convince the second otherwise. While this type of strategy may work for a while, when the individual once more encounters a difficult situation, the old fears and doubts arise. Renewed efforts are made to convince him he is worthwhile and has strengths in areas in which others do not. He may then redouble his efforts to convince people that he really is worthless.

The basic pattern of the individual feeling worthless and others trying to convince him otherwise continues. Common-sense solutions, intended to build him up, may create the illusion of change for a period of time but in the long run, nothing has changed. In other words, these solutions have led to first-order change. To interrupt this vicious circle of difficulties and solutions, interventions may be directed at the problem-maintaining-solutions of positive suggestions and encouragement. An example of one such strategy is to agree with the individual's down feelings, reflecting surprise that he is not feeling worse in view of all the problems he has. Another strategy is not only to agree with the individual but perhaps to even point out a few other negative features that the individual has not mentioned. Paradoxically, when these unusual strategies are attempted, the individual often starts defending himself, claiming that he isn't really that bad and he does indeed have his good points. The Game Without End has been interrupted.

The Problem

The second-order change approach has been used successfully, i.e., the established goals of treatment were reached for a wide range of problems, in clinical practice at the Brief Therapy Center in Palo Alto, California (Watzlawick et al., 1974; Weakland, Fisch, Watzlawick, & Bodin, 1974). There are also some reported failures. Watzlawick et al. indicate that the failures were related to incorrect conceptualization of the problem and solutions, to unrealistic or inappropriate goals, or to unsuccessful attempts to motivate clients to follow instructions. Even so, there remain unanswered questions about the conditions under which second-order change strategies succeed or fail. When and under what conditions do second-order interventions lead to a shift in the problem system? When do they have no impact? How can the shift from one system to another be identified? Is it possible to work with a group of unrelated individuals who have each attempted to solve a difficulty through similar types of problem-maintaining solutions?

The main intent of this thesis is to investigate the boundaries of the effectiveness of the second-order approach to change by demonstrating and describing the change process, thus expanding on information relating to the process. To do this the condition of being overweight and using self-restraint measures to control eating and weight was chosen to illustrate, first, a particular Game Without End, and second, what processes occur when second-order interventions are used to interrupt problem-maintaining solutions. Thus the second intent is to show how second-order approaches affect the attitudes and behavior of individuals caught in the Dieting Game Without End.

The Dieting Game Without End

Overweight was considered to be a relevant problem area to deal with for two reasons. First, in spite of the prevalence of overweight and obesity in North America and its acknowledged dangers to physical and emotional health (Bruch, 1973; Garrow, 1975; Gordon & Kanner, 1973; Hirsch, 1975; Oscancova & Hejda, 1975), the overweight condition is remarkably resistant to successful treatment (Bruch, 1973; Craddock, 1973; Kiell, 1973; Stunkard & McLaren-Hume, 1959; Stuart & Davis, 1972). While most current dietary, self-help, medical and psychological treatments assist some individuals to lose weight and maintain the weight reduction, often the lost weight is regained. Sometimes the weight is regained almost immediately and sometimes it is regained after a period of years (Bruch, 1973; Craddock, 1973; Hall & Hall, 1974; Stunkard & McLaren-Hume, 1959). The issue is not so much weight loss as weight maintenance and alteration of this pattern of losing and gaining. The second reason for investigating this problem is that the repeated cycle of losing and gaining fits the pattern of a Game Without End.

As mentioned previously the way treatment is approached depends largely on the particular set of beliefs or assumptions held about the nature of the problem. Therapists from various orientations make different assumptions about conditions leading to and maintaining the overweight problem. However, in spite of their differences, what most therapists have in common is that they approach change by trying to make patients behave differently. They assume that weight control can be influenced primarily through willpower or through efforts that will enhance the person's capacity to behave differently and avoid overeating. This is true whether the therapist prescribes diet control, exercise,

self-help groups, behavior modification, or dynamic psychotherapy (Ingram, 1976). Thus, there is often a cycle of using restraints to control eating and weight, then losing control over eating, and renewing similar self-control efforts. A few hypnotherapists approach change from another direction. Instead of trying to make the person behave differently, they encourage and utilize current behaviors, including resistance and relapses, to facilitate change and subsequent weight loss (Brodie, 1964; Erickson, 1960, 1970; Hanley, 1967). This approach is consistent with the second-order approach to change.

In this thesis the repeated cycle of using restraints to control eating in an attempt to lose weight, losing control over eating, and renewing self-control solutions, is called the Dieting Game Without End. The attempted solutions--the common-sense, willpower types of solutions--are assumed to maintain the control/loss-of-control cycle and the continual preoccupation with food and weight. Following this assumption, problem resolution must be directed at these solutions rather than towards characteristic weight loss goals.

As mentioned, the second intent of this thesis is to show how second-order change interventions affect the attitudes and behaviors of the participants, that is, their process in relation to their problem with eating. The immediate goal is <u>not</u> to focus on weight loss. The position taken is that the use of the second-order approach with an overweight group can not be evaluated simply in terms of weight. Changes in attitudes towards food and weight, changes in body-image, and in other life areas such as increased autonomy and improved interpersonal relationships are often judged to be fully as important

as weight loss or maintenance (Bruch, 1973; Buchanan, 1973; Ingram, 1976; Rand & Stunkard, 1977). Evidence of these other changes in attitudes and behavior can be observed or obtained through participants' self-report.

That is, there are two different logical levels of outcome--the second-order or process level and the first-order goal level. In the case of overweight, the first-order goal level is weight loss. However, there are behavioral changes relating to both first-order and second-order differences. When looking at behavioral change, it is therefore important to consider the context of the change. Whereas first-order change is obvious and directly related to the expressed problem, the second-order behavior changes are often less predictable, more surprising, and may or may not also include the first-order difference. Thus, success may, but does not necessarily, involve both logical levels.

More specifically, the second goal of this thesis is to facilitate a shift from the Dieting Game Without End, in which eating and weight are experienced as out of control and self-restraint methods are the attempted solutions, to a pattern in which control of eating is no longer an issue or if it becomes an issue, self-restraint solutions are no longer attempted. Instead of following prescribed diets to attempt to control eating it is possible that participants may have a more expanded set of choices available in relation to their eating behavior. For example, participants may be able to eat what they desire and still experience control over their eating.

Research Questions

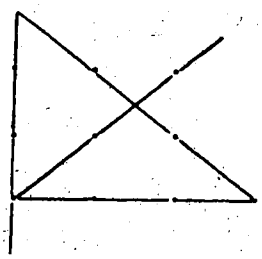
1. What is the effect of using second-order change approaches with a group of individuals caught in the Dieting Game Without End? Can second-order change interventions bring about changes in attitudes and behaviors in relation to eating?

2. Will the verbal and written self-reports of the individuals who follow the symptom prescription to gain weight show evidence consistent with second-order change?

3. Will the verbal and written self-reports of individuals who resist the directions and refuse to gain weight show evidence consistent with second-order change? Will these individuals continue to maintain their excess weight or will they lose weight?

4. Over the 12-week treatment period, will the self-report information from individuals who have been promised treatment show evidence of second-order change?

Solution to the 9-dot problem.



CHAPTER 2

LITERATURE REVIEW

The Change Model of Watzlawick, Weakland, and Fisch

First-order and Second-order Change

The change model of Watzlawick, Weakland and Fisch (1974) deals with both persistence and change. How problems are created and persist as well as how problems are changed are discussed in terms of interaction systems and two types of change. First-order change is related to persistence and continuity in a particular system--an individual behavior system, a family, a business organization, or a political system. Second-order change is related to shifts in the pattern of a system, in its organization and structure.

First-order change. First-order change is related to persistence and continuity of the current system. In theory, the given system remains unchanged with first-order change conditions even though the behaviors surrounding an issue may look very different. To clarify ideas about first-order change and the types of change which occur within a given system, Watzlawick et al. (1974) used the Theory of Groups from the field of mathematical logic as an analogy. This theory is concerned with relationships between members and groups. Numbers, objects, concepts or events can be drawn together into a group as long as they have one common characteristic (Watzlawick et al., 1974, chap. 1).

Group theory illustrates that members of a group can be combined in many different ways which make no difference in terms of actual membership in the group. One example given by these authors is that if the members of the group are hours, as indicated by the integers 1 through 12 on the face of a clock, any combination of two or more members is always a member of the group (Watzlawick et al., 1974, p. 3). Thus first-order changes are considered to be changes from state to state within the group or system in question. Even though the member may appear very different, it remains a member of the same group.

In terms of human behavior, this first type of change is thus considered to be a change in which one behavior is substituted for another within a given way of behaving, within the same set of choices. It is a change from state to state within the same system. For example, a person having a dream may experience many different behaviors in his dream while the dream state itself remains unchanged. Similarly when driving a car with a gear-shift, first-order change occurs when speed is increased by pressing on the accelerator within a given gear range (Watzlawick et al., 1974). In human behavior,

> a pattern frequently observed is that involving two partners, e.g., two spouses, who for one reason or another maintain a certain emotional distance between each other. In this system it does not matter if either tries to establish more contact, for every advance by one partner is predictably and observably followed by a withdrawal of the other, so that the overall pattern is at all times preserved. (Watzlawick et al., 1974, p. 16)

Thus many varieties of change make no overall difference: "Things may be 'as different as day and night' and the change from the one to the other appear to be extreme and ultimate, and yet, paradoxically, in the wider context...nothing may have changed at all" (Watzlawick et al.,

1974, p. 19). From a pragmatic perspective, some issues escalate into problems or Games Without End, when first-order changes are attempted. For example, when a solution fails, it may be tried again with even more effort, or a solution which appears different may be chosen from the same set of alternatives. Ways in which first-order changes lead to persistence and worsening of problems will be discussed in the forthcoming section on Problem Formation.

Second-order change. Second-order change is related to conditions which change the system. Change of this type often appears "unpredictable, abrupt, illogical, etc. (when viewed) from within the system...But seen from outside the system, it merely amounts to a change of the premises governing the system as a whole" (Watzlawick et al., 1974, p. 24). Second-order change occurs from stepping outside the current system; second-order change occurs when there is revision of the system from which choices are to be made. Second-order change conditions lead to new attitudes or behaviors in which the original problem is no longer an issue. This type of change has occurred when an individual has made a shift in his process or way of behaving. In the dream example, second-order change occurs when the dreamer wakes up; that is, he changes to another system. When driving, second-order change occurs when gears are shifted to increase speed; that is, a different system is now in operation or there has been a change to another state.

Differences in first- and second-order change. One important difference between first-order change and second-order change is that they exist on different logical levels. This is crucial to understanding the paradox that is created if the logical structure of the differences is not recognized. In other words, in a discussion about change, if

person A is talking about first-order change and person B is talking about second-order change, and this is not a recognized point, an impasse is created. Two different logical levels have been mixed and a paradoxical situation has been created. Thus in terms of change issues, the first question must be "what type of change is being discussed?", otherwise the discussion becomes meaningless.

To clarify the difference between the two types of change, to describe how both types of change can lead to Games Without End, and to describe the paradoxical nature of second-order change interventions, the Theory of Logical Types, (taken from the field of mathematical logic), was used as an analogy. The Theory of Logical Types deals with hierarchies in levels of abstraction or logical types and with the paradox and confusion that occur when member (part of the total) and class (the total) are mixed or when members from one class are included as members in another class. First, the Theory of Logical Types states that no class can be a member of itself; that is, class is of a higher logical type than its members. For example, the class of chairs is not itself a chair; the class of cats is not a real cat. The class of chairs and the class of nonchairs are of a different logical type than the members, or the actual chairs and nonchairs. The class of cats and the class of noncats are of a different logical type than live cats and the actual members of the class of noncats, say dogs. Second, a class cannot be considered to be one of those items which are correctly classified as its nonmembers. Third, if the above rules are broken and these logical levels are not kept separate, paradox and confusion occurs. For example, to include the class of chairs as a member of the class of nonchairs leads to a paradox in which chairs become nonchairs (Bateson, 1972).

Difficulties in keeping logical types separate and thereby avoiding paradox are inherent in the nature of our language. One word may label both the class and the member. Only context may give clues about how the word is to be understood. For example, the words "concept" and "method" are at various times used to denote both the class level as well as the member level (Watzlawick, et al., 1974). With concrete objects, where classes have commonly agreed upon external or objective characteristics, mixing logical types may seem very unlikely. However, with abstract ideas and events class membership becomes less consistent. The more abstract the class in question, the more difficulties arise in keeping class and member separate because classes are formed through the meaning attributed to the concept or event. That is, classes are formed through values and judgements. As abstraction increases the chance of mixing logical levels and creating a paradoxical situation increases. Therefore, with the concept of change, it is important to stress that first-order and second-order change are of different logical types. Second-order change involves looking at problems from a different logical level than first-order change does. Attempting solutions involving changes of the wrong logical type leads to the creation of a paradoxical situation or a Game Without End (Watzlawick et al., 1974).

Problem Formation and Problem Maintenance

When difficulties are mishandled they become problems through the attempted solutions. These attempted solutions then serve to maintain the problem. A difficulty-solution Game Without End or a problem has been formed. The distinction between difficulties and problems is as follows:

> Difficulties...mean an undesirable state of affairs which either can be resolved through some common-sense action...or, more frequently we shall mean an undesirable but usually quite common life situation for which there exists no known solution and which--at least for the time being--must simply be lived with. (Watzlawick et al., 1974, p. 38)

> ...problems (refer to) impasses, deadlocks, knots, etc., which are created and maintained through the mishandling of difficulties. (Watzlawick et al., 1974, p. 39)

According to Watzlawick et al. (1974), there are three ways problems develop. In all three ways the attempted solutions are viewed as the problem; that is, the attempted solutions either maintain or create the problem. The three ways are:

1. The attempted solution is denying a problem is a problem.

2. The attempted solution is directed at changing a difficulty which is unchangeable or nonexistent. "Action is taken when it should not be" (Watzlawick et al., 1974, p. 39). For example, if the utopian idea is held that life should always be pleasant, unrealistic attempts may be made to eradicate the generation gap or the normal discomforts and difficulties that occur with normal developmental sequences as adolescence, marriage, parenthood or retirement. On the other hand, some individuals hold the belief that the absence of difficulty, or gains made with ease are themselves problems. In both types of utopias, normal difficulties and pleasures in life are defined as abnormalities (Watzlawick et al., 1974, p. 54). If the wrong type of action is taken a difficulty becomes a problem.

3. The attempted solution is of the wrong logical type. The first way an error in logical typing may occur is through attempting a first-order change in a situation requiring second-order solutions. Consider two classes of behavior, controlled and spontaneous. When

willpower is applied to resolve an issue involving spontaneous behavior, a paradoxical situation is created. Insomnia, impotence, feeling sadness and anxiety, and blushing, are everyday occurrences or difficulties. Attempting a "try harder" solution, a first-order or common-sense solution, in these instances usually makes it worse. For example, the harder one tries to sleep or to avoid feeling anxious, the more the sleeplessness and anxiety increases. The initial difficulties are not the problem. The solutions of exerting willpower and trying harder are the problem; they have been applied to areas which require spontaneity in order for change to occur.

A second way in which error in logical typing leads to problem formation is attempting a second-order change in a situation requiring first-order change. This occurs primarily in areas where an outside source makes a demand for a spontaneous change or an attitude change (Watzlawick et al., 1974). For example, parents may demand that a child not only apologize but mean it. This example becomes clearer by considering the classic paradox "be spontaneous." On the class level, the message is that behavior should not be governed by rules, it should be spontaneous. On the member level, this injunction comes from the class of rule-bound behavior. The behavior cannot be spontaneous because it has been demanded. The paradox created is that to obey and be spontaneous is to disobey because it is following the directive or demand for spontaneous behavior. Once a "be spontaneous" rule is given to areas of behavior which require spontaneity for change to occur, the initial difficulty and subsequent solutions form a Game Without End (Watzlawick et al., 1974).

In summary, in the change framework of Watzlawick, Weakland and

Fisch (1974), problems are created through misapplied solutions. These attempted solutions create and maintain the problem situation. A Game Without End occurs. The attempted solutions are the problem. Problem resolution requires interventions that focus on the solutions rather than on the problem.

Problem Resolution

Similar to second-order change, second-order interventions often seem absurd, especially when viewed from within the system of first-order, common-sense change. Second-order interventions are not logical or common-sensical; they have paradoxical qualities.

First, in attempting problem resolution from the perspective of second-order change, action is directed to what is considered the solution in the first-order change system and not to the problem itself. To interrupt the problem or Game Without End, the attempted solutions are discovered and interventions are made in relation to what has been attempted or in relation to how the issue has been handled to this point. One area in which the attempted solutions are clearly the problem, rather than the initial difficulty, is in that class of behavior in which the person encounters feelings of loss of control. The attempted solutions have usually involved some counterproductive assertion of willpower. If the fear is loss of control when speaking in front of a group, typically there is something the person concerned cannot help doing (like blushing or trembling) or something he would like to do but cannot (such as keeping his voice firm)(Watzlawick et al., 1974). As in the trying-to-sleep paradox, attempting solutions of exerting more control, applying willpower, or trying harder only make things worse. The second-order interventions are directed towards undermining these

solutions. For instance they might include asking him to advertise his difficulty or to try to tremble. Doing so interrupts or blocks the problem maintaining solutions of trying to control the behavior.

Second, the example illustrates the paradoxical quality of second-order change interventions. When carried out, the interventions lead to change in unexpected and paradoxical ways. Thus symptoms, having developed by creating paradoxical situations, are approached in an equally paradoxical fashion in order to resolve them. In the trying-to-sleep paradox, the paradoxical approach is to ask the individual to force himself to stay awake (Watzlawick et al., 1974). This is an example of symptom prescription.

> Symptom prescription--or, in the wider, non-clinical sense, second-order change through paradox--is undoubtedly the most powerful and most elegant form of problem resolution known to us. (Watzlawick et al., 1974, p. 114)

A third principle of second-order change interventions is that the situation is dealt with in the here-and-now. There is no search for explanations of the problem which lie in the past. Viewed from the framework of second-order change such a search for causes may simply block solving the problem and hence become part of the problem-maintaining solution. It is not important to find out the reasons which led up to a particular Game Without End. What is important is to intervene in the current situation in ways which will shift the interaction system and begin the change process.

The fourth principle of second-order change techniques is that their use "lifts the situation out of the paradox-engendering trap created by the self-reflexiveness of the attempted solutions and places it in a different frame" (Watzlawick et al., 1974, p. 83). Reframing is defined as follows:

> To reframe, then, means to change the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and place it in another frame which fits the "facts" of the same concrete situation equally well or even better, and thereby changes its entire meaning.
>
> (reframing means) changing the emphasis from one class membership of an object to another, equally valid class membership or especially introducing such a new class membership into the conceptualization of all concerned. (Watzlawick et al., 1974, pp. 95, 98)

Watzlawick et al. (1974) present the examples of how Tom Sawyer reframes the drudgery of whitewashing a fence into a pleasure for which other boys must pay and of how a salesman's bad stammer was reframed from being a handicap to being an unusual advantage in an area where salesmen are disliked for slick and clever sales talk. "Reframing...<u>teaches a different game</u>, thereby making the old one obsolete" (Watzlawick et al., 1974, p. 104). Another example of reframing is to consider resistance to change as a necessary prerequisite for change. By reframing in such a way, when resistance does occur, the client is encouraged to resist as part of the healing process. Milton Erickson commonly reframes resistance in this way. From the second-order change perspective it is also crucial to reframe a client's improvement; instead of reacting with encouragement, as common-sense would suggest, it is important to reframe the change as being temporary, transient, and so forth. "Incipient change requires a special kind of handling, and the message "Go slow!" is the paradoxical intervention of choice" (Watzlawick et al., 1974, p. 135).

To reframe effectively, it is important to carry out second-order change interventions within the language framework of the client. This is also important in motivating clients to carry out instructions. That is, if the interventions are consistent with the client's view of the world, he is more likely to accept and carry out the instructions

(Watzlawick et al., 1974, chap. 9). Relating to the client in his own conceptual framework decreases resistance to change--he is not busy disagreeing with terminology--and increases the client's feeling of being accepted and understood with his particular difficulties. As Watzlawick (1978) states: "We search for premises and, having found them, utilize them as the vehicle of change" (p. 141). Therefore, if the client's belief is that understanding and discussion are necessary before change will occur, this belief is not challenged. Rather, interventions are structured to agree with the client's world view and at the same time interrupt the problem maintaining solutions.

In summary, just as problems are often paradoxical in nature, problem resolution from the second-order change framework has paradoxical qualities. Since second-order change occurs on a different logical level than first-order change, second-order change tends to appear illogical and nonsensical. However, this is true only when viewed from the framework of first-order change. When viewed from "outside the system, it merely amounts to a change of the premises...governing the system as a whole...it is a simple change from one set of premises to another of the same logical type" (Watzlawick et al., 1974, pp. 24, 26). That is, there has been a shift from one system to another.

Evaluation on the Second-order Change Approach

Assessing treatment through the use of second-order interventions involved systematically comparing what treatment proposed to do and its observable results. The treatment aim was to change the patient's behavior in order to resolve the main presenting complaint (Weakland, Fisch, Watzlawick, & Bodin, 1974). Evaluation was based on answers to the questions: Has behavior changed as planned? Has the complaint been

relieved? During the 3-month follow-up interview the patient was asked (1) whether the specified treatment goal had been reached, (2) the current status of the main complaint, (3) whether any further therapy had been sought since termination, (4) whether any improvements had occurred in areas not specifically dealt with in treatment, and (5) if any new problems had appeared (Weakland et al., 1974). Of the first 97 cases treated at the Brief Therapy Center the presenting problem was completely resolved in 40% of the cases. Significant but incomplete improvement occurred in another 32% and 28% showed little or no relief of the presenting complaint (Weakland et al., 1974, p. 164).

Other Paradoxical Approaches to Change

Paradoxical qualities of both the second-order process of change and certain techniques were documented in the previous sections. The use of paradox in therapy, in particular, symptom prescription, is not new. While this tactic was not given the label "prescribing the symptom" until the early fifties when Bateson coined the term during his work on a project, "Family Therapy in Schizophrenia" (Watzlawick, Beavin, & Jackson, 1967, p. 240), Raskin and Klein (1976) note that the use of similar tactics by psychiatrists in the 1800's was documented by Gerz (1966). In the psychological literature, encouraging symptomatic behavior was first discussed in the 1920's when Dunlap introduced the concept of "negative suggestion" or "negative practice." Since that time, although the labels and rationales for interventions which encourage symptomatic behavior have been widely divergent, there have been numerous accounts of paradoxical strategies. Beginning with Dunlap, a behaviorist,

therapists who have used paradoxical strategies will be discussed in this next section.

Behavior Therapy

Dunlap, an experimental psychologist who conceptualized problem formation and resolution in terms of behaviorist learning theory, was one of the first to report the use of encouraging symptomatic behavior. Calling this tactic "negative practice", he instructed patients to engage in symptomatic behavior under prescribed conditions. Often accompanied by other tactics, negative practice was applied to clinical problems ranging from nail biting and eneuresis through stammering and sexual perversions (Dunlap, 1928, 1930; as cited by Raskin & Klein, 1976). While the intent of negative practice was to produce a behavioral shift in symptoms, Dunlap acknowledged that changes in attitude, such as motivation to stop engaging in the habit and pride and pleasure in symptom removal, accompanied the behavior change. That is, the patient shifted from feeling his symptom was involuntary and out of control to feeling the symptom was within his control. While apparently basing the rationale for its use and effectiveness on principles derived from learning theory, the idea behind the intervention was sometimes unclear. Dunlap stated:

> The general principle of negative practice is that of making an effort to do the things that one has been making an effort not to do, instead of making an effort to avoid the things that one has been doing....The principle involved might be formulated as bringing under voluntary control responses that have been involuntary....This is merely a description of the results of negative practice and is not an explanation. (Dunlap, 1946, p. 194)

More recently, a number of therapists using a learning theory rationale have used strategies which fit a paradoxical description. For example, the behaviorist techniques of flooding and massed practice could also be described as examples of symptom prescription. Yates

(1958) instructed his patient to practice a tic in order to get rid of it. Success was explained in terms of Hullian reactive inhibition. Humphrey and Rachman (1965) reported a case in which a young boy was encouraged to tear newspapers into fine strips for periods of 20 minutes at a time. This was done to extinguish the motor compulsion of chewing, biting and tearing materials. Ayllon (1963) encouraged hoarding behaviors in psychiatric patients in order to control these behaviors and Wooden (1963) advocated practicing headbanging in order to extinguish it. Similar to Dunlap, the problem was considered to be resolved once the symptomatic behavior had been removed. Just as symptom formation was explained in terms of learning theory, symptom resolution was also explained in terms of reactive inhibition, extinction, and satiation. However, Raskin and Klein (1976) comment:

> Much more than extinction, however, may be involved in the success of this and other methods. Both "massed practice" and "implosion", whatever their roots in learning theory, can also be seen as exercizes (sic) in courage and in self-control. (p. 549)

Logotherapy

About the same time Dunlap was reporting the use of "negative practice", the logotherapist Viktor Frankl was using a technique he called "paradoxical intention" in the treatment of obsessive-compulsive and phobic conditions (Frankl, 1960). Regardless of the etiology of a symptom, Frankl viewed the development of phobias and obsessive-compulsive neuroses as partly due to the increase in anxiety and compulsions which occurred through efforts to avoid or fight them. This struggle led to a strengthening of the symptom. To remove the symptom, Frankl recommended engaging in the behavior the patient feared, thus replacing the avoidance response with the intentional effort to engage in

the symptomatic behavior. While the goal of using paradoxical intention seemed to be the relief of the symptoms, what was more important in obtaining improvement was that the patient change his attitude towards the symptoms and his neurosis. Frankl (1960) stated that the purpose of paradoxical intention was "to enable the patient to develop a sense of detachment toward his neurosis by laughing at it" (p. 523). That is, paradoxical intention capitalizes on the specifically human capacity to detach oneself from the world and oneself. Hence, variations in the degree of impact of paradoxical interventions may be related to individual differences in the degree to which individuals can apply this ability for detachment.

Frankl (1960) stated that paradoxical intention was particularly useful in phobic cases with an underlying anticipatory anxiety mechanism. He cited successful treatment with cases such as excessive sweating, trembling, attacks of palpitation and fears of collapse, anxiety in relation to heart palpitation, counting compulsions, stuttering, and washing compulsions. While simple symptom removal may seem very superficial, Frankl warned that changes do occur at a deeper level whenever paradoxical intention is applied.

> The humoristic formulations of its method are based on a restoration of basic trust in Being (Urvertrauen zum Dasein, 12, p. 41). What transpires is essentially more than a change of behavior patterns, rather, it is an existential reorientation. (Frankl, 1960, p. 530)

As well as numerous case reports, there have been a few research studies on paradoxical intention. Solyom and colleagues investigated the effectiveness of paradoxical intention in the abolition of specific obsessional thoughts. Using the subject as his own control, the patient was asked to deliberately increase one obsessive thought and to do

nothing with another obsessive or control thought. For five of the 10 patients in the sample, the target thought decreased or stopped. The presenting problem was unchanged for three; two did not apply the technique as directed. The improvement rate of 50% was similar to the outcome of other procedures attempting to treat obsessions (Solyom, Garza-Perez, Ledwidge, & Solyom, 1972).

Raskin and Klein (1976) cite several other studies on paradoxical intention. Saslow (1971), working with obsessional symptoms and other neurotic and psychotic disturbances, emphasized the effects of scheduling the symptom as important in his success with the approach. However, as other parts of the treatment were conditioning to mastery, the use of implosive techniques, desensitization, satiation and contact with a significant other, it was difficult to evaluate the efficacy of paradoxical intention. Gerz (1966) used paradoxical intention, as well as drugs and a variety of verbal-therapeutic dyadic interventions with about three fourths of his phobic patients and two thirds of his obsessive and pseudoneurotic schizophrenic patients (total N=51). He reported either recovery or considerable improvement in close to 90% of those he treated.

Directive Therapy

Through documenting much of Milton Erickson's clinical work, Haley (1963, 1967, 1973) developed a comprehensive description of directive therapy. This included a systematic view of psychotherapy as a whole as well as symptom prescription. From a viewpoint which emphasized power and control as major factors in relationships, Haley attributed all success in therapy, regardless of orientation, to the resolution of various paradoxes posed in terms of the therapy relationship. Crucial to understanding his position is the assumption that symptomatic behaviors

are paradoxical ways of attempting to gain control of the definition of a relationship. Successful therapy was described as a "process whereby a therapist maintains control of what kind of relationship he will have with a patient" (Haley, 1963, p. 19). Thus, the therapist's task was to pose paradoxes to circumvent the client's use of symptomatic behavior to control the relationship. Change occurred through this interpersonal situation which forced the patient to respond differently; that is, the therapist trapped the client in a series of paradoxes which enforced a change. Haley described the basic therapeutic paradox as the simultaneous definition of the relationship as (1) a relationship designed to remove the symptom and (2) a relationship in which the symptomatic behavior is encouraged. The therapist, to different degrees according to orientation, directed the patient to do those things he could voluntarily do, and at the same time, communicated an expectation of involuntary, spontaneous change of the behavior experienced as the symptom.

Symptom prescription, therefore, is just one instance of the therapeutic use of paradox. This process of providing a "punishing ordeal" continued until the patient changed. That is, therapy was successful when the symptom was abandoned and was no longer used to attempt to control the relationship. Further, the patient now related to people in changed ways, showing greater flexibility in his interpersonal strategies. Haley (1963, 1967, 1973) cited hundreds of examples of the directive therapy approach to problems from insomnia and enuresis to more complex marital problems.

Other Psychological Approaches

Paradox is also an important concept stressed by a number of "third force" or "humanistic" therapists. In order for clients to

"experience their process or more of the whole self", Gestalt therapists asked clients to exaggerate symptoms and to fully experience their current, "here-and-now" ways of being, or their awareness continuum (Beisser, 1971; Perls, 1969; Perls, Hefferline, & Goodman, 1951). Rogers (1951) discussed the paradoxical aspects of change in terms of unexpected change that occurs with self-acceptance.

To deal with patient resistance or patient-induced impasses, such as distracting away from inner experience, chronic lateness, and distancing from personal contact, all of which were perceived as blocking the therapeutic process, Kopp (1978) described the use of three basic paradoxical instructions. These were: (1) "Continue to do exactly what you are doing"; (2) "Do even more of what you are already doing"; and (3) "Know that what you are doing means the exact opposite of what you believe it means" (p. 132). As well, Kopp (1977) described the use of paradox to help a woman improve her plans to commit suicide. The result was that she chose to live.

Utilizing concepts from several therapy areas, Grinder and Bandler (1976) described the use of a therapeutic double bind to work with a woman whose symptom was that she could not say "no." Similar to Gestalt therapists, they encouraged clients to "play the more fully expressed polarity" in order to increase awareness of the less fully expressed parts of themselves. Thus the client's choices of "being" were increased.

While the psychiatric approach is not clear, Raskin (as cited in the work by Raskin & Klein, 1976) described a technique he termed "symptom redefinition." A nonpsychotic, mild to moderately depressed patient was encouraged to experience depressive feelings and was told of

the importance in learning to experience and live with depressive affect. The patient began to see depression as a valuable experience. Raskin and Klein view such redefinition of the symptom as involving a cognitive restructuring and a change of attitude toward the events and feelings experienced as problems or symptoms.

Summary

There is no consistent label or rationale for the paradoxical strategies which appear in the literature. Furthermore, the goals to be attained through their use vary widely from symptom removal, symptom removal with existential reorientation, abandoning the symptom as a power tactic within an interpersonal relationship and developing more flexible interpersonal strategies, to experiencing more fully whatever feelings occur in life.

At the present time, this author views the second-order change approach as the most comprehensive model. It offers a framework for describing the part paradox plays, not only in problem resolution but also in problem formation. The behaviorists, including Dunlap, used negative practice or massed practice as simply one intervention style in their repertoire of approaches. Frankl, while attempting to integrate paradoxical intention and the logotherapy approach, still used it primarily as a style to be used with symptoms regardless of their etiology. Most therapists discussed in "Other Psychological Approaches" did not integrate paradoxical interventions and their particular model; however, those who described the paradoxical qualities of the change process (Beisser, 1971; Perls, 1969; Rogers, 1951; Kopp, 1978) appeared to operate from the assumption that change occurs through paradoxical maneuvers. Haley offered a more elaborate description of the paradoxical

qualities of the therapeutic relationship as well as symptom formation and symptom resolution. In common with the second-order change model, his therapy approach utilized the client's behavior, including resistance; dealt with here-and-now behaviors instead of dwelling on the past, on gaining insight or understanding; and set out directions for specific change actions.

There are some crucial differences between the change model and Haley's view of directive therapy. The major difference is in the area of symptom formation. Haley views symptoms as paradoxical maneuvers to gain control over the definition of a relationship. From the change model, problem formation is viewed as mishandling a difficulty through attempting the wrong type of solution. This latter view offers at least three ways for conceptualizing problem formation, thus has more alternatives for examining the problem situation. For example, assuming that symptoms may have in fact developed as a power tactic in a relationship, to view problem formation only in these terms seems limited. The original relationship in which the symptom developed may not be present. Even though it could be argued that behavior tactics carry over to subsequent relationships, it is also plausible that in the current situation, this communicative value of the symptom is no longer its primary function. That is, the symptom may now exist independently of its original power or control function. It is possible that the symptom continues simply because the solutions attempted to resolve it are the logical, common-sense measures to take. Beliefs that reasonable types of measures will lead to problem resolution are typically held by others in an individual's social support system as well. Hence, the individual may persist in applying the wrong type of solution to rid himself of a

problem or symptom. As well as offering more alternatives for conceptualizing both problem formation and hence problem resolution, the second-order change model also has increased practical value for this author. Because it offers a way of conceptualizing how individuals, apart from their interpersonal systems, maintain their problems, it provides a viable framework for treating a group of unrelated individuals with a common problem.

Current Treatments for Overweight and Obesity

In the following sections some of the current treatments for overweight and obesity are discussed. First, however, some attention will be given to the terms, "overweight" and "obesity." Then, dietary, self-help and medical methods will be overviewed. Following that, two popular approaches to weight control, the behaviorist and the psychoanalytic, will be discussed. Other psychological approaches including hypnosis and a variety of psychotherapeutic methods, some of them undefined, will also be reviewed. Finally, because of the importance of his approach to this thesis, the work of Milton Erickson will be examined in more detail.

Definitions of Overweight and Obesity

Generally, body weight that is at least 10% beyond the norm because of fatty tissue is regarded as obesity while overweight refers to any increase in body weight over a statistically determined average (Bray, 1976; Craddock, 1973). Using these guidelines it is possible for athletes to be classified as overweight because of the weight of muscle and bone, and for some people with excess adipose (fatty) tissue to be classified as within normal weight limits. Thus more refined methods,

such as densitometry (measurement of volume and weight through submersion in a tank of water), skin-fold measurement at various sites of the body, and height-weight ratios have been used to assess the degree of fatty tissue independent of height (Womersley & Durnin, 1977). In spite of these more refined methods intended to distinguish between overweight and obesity and to establish more precise weight goals for individuals, height-weight tables are the guides most commonly used by practitioners, probably because of their convenience and practicality.

Kiell (1973) concludes that a generally acceptable definition of obesity does not exist at the present time. This lack becomes even more evident in clinical areas where obesity, its etiology and current dynamics are defined in terms of certain theoretical constructs. The proliferation of views and treatments has led at least one researcher to define obesity as a "disease of theories" (Kroger, 1970). Most approaches to weight control, including dietary, self-help, medical, psychoanalytic, behavioral, and hypnotic methods have all been successful, at least with some individuals. Effecting a measurable loss, however, is only one aspect in the control of body weight. Weight maintenance or the alteration in the cycle of losses and gains is the more important issue and will be discussed in the following sections.

Dietary Treatment

Dietary treatment has been the conventional treatment for obesity and is probably still the most popular approach taken by most individuals who want to lose weight. Based on laws of thermodynamics, the key to weight loss is to reduce energy intake and increase energy output. Typically this is attempted by following a low-calorie diet of some form, with or without accompanying support from a physician or nutritionist.

However, the long range effectiveness of following such a diet to lose and maintain weight varies widely. Craddock (1973), summarizing the results from Western European and American literature, stated:

> Apart from the Roumanian series and the special case of the New York Anti-coronary Club, somewhere between 10 and 40 per cent of patients may have lost weight by the end of the first year, but the proportion of successes diminishes with the length of follow-up and by the end of five years...only between 1 and 13 per cent of patients have maintained some weight loss. (p. 128)

In a 5-year follow up survey of his own dietary treatment of 79 adults, originally all 10% over ideal weight, Craddock (1969) observed 1/3 were successful (showed a loss of at least 10% of the initial weight) or partly successful (showed a loss of at least 5% of the initial weight), 1/3 relapsed after having been successful or partly successful and the remaining 1/3 had failed completely. However only six patients lost enough weight to reach within 10% of the desirable upper weight. After 10 years there was an increase in the number of patients in the successful and partly successful categories, which this physician attributed to his "increasing experience in handling the problems of overweight" (Craddock, 1973, p. 136). He stressed the importance of doing regular, long-term follow-up, stating that while many relapses came fairly soon after the initial weight loss, six in his study relapsed after 2 or 3 years, one after 4 years, and one relapsed 6 years after the initial successful weight loss. In a 2-year follow-up these cases would have been falsely classified as successes. As well, several of his patients could have been classified as successful or partly successful if his survey had happened to coincide with the period following a spell of successful dieting.

As cited in the review by Leon (1976), Glennon (1966) reported a

follow-up, ranging from 12 to over 24 months, of persons who had been hospitalized and placed on an 800-1220-calorie reducing diet. At follow-up only 23% had been able to achieve and maintain a 20-pound weight loss and only 6% a 40-pound weight loss. Alley, Narduzzi, Robbins, Weir, Saben, and Danowski (1968; cited by Leon, 1976) evaluated a weight reduction program with 50 subjects, ages 6-17, who were placed on a 1,000-calorie-per-day diet on an outpatient basis. Over a period of 1-5 years 28% of the group were successful weight losers (defined as a 5 to 66 pound loss). However 82% of the total group remained above the 90th percentile for body weight at follow-up. Sohar and Sneh (1973; as cited by Leon, 1976) found that the majority of persons had regained the weight they had previously lost at the time of the 14-year follow-up.

In summary, while following a diet to lose weight seems to be the most popular means of weight control, often when weight is lost it is regained, either soon after the initial loss or in the following years. However there is a wide variation in the results, often related to the type of supervision associated with the diet (Craddock, 1973). Some of the best results of dietary treatment were reported by Craddock (1973). After 10 years 47.8% of the patients in his survey were considered successful or partly successful.

Self-help Organizations

There are a variety of self-help organizations designed to help the obese and overweight person to reduce. Two of the most popular are Take Off Pounds Sensibly (TOPS), a volunteer organization, and Weight Watchers, the world's largest commercial weight loss group.

Take Off Pounds Sensibly. TOPS enrolls over 300,000 members, predominantly women, in 12,000 chapters in all parts of Canada and the

United States (Stunkard, 1975). Each chapter of approximately 25 to 30 people meets weekly to be weighed and to spend time discussing weight-control issues. Members consult their doctors for diet counselling; however, each chapter can make decisions about how weight loss is approached. The basic approach to change is one of social pressure where each member's loss or gain is announced to the group and either praised or punished. Since overeating and overweight are viewed as evidence of defective emotional control, control over eating is a central virtue. This theme is reinforced in weekly slogans and songs. Motivation includes praise for losing, being named "Queen" for losing the most weight in a particular week or period of competition, regional and national conferences where awards are given, and admission to the Keep Off Pounds Sensibly (KOPS) group once the goal weight is reached. As well there is a newsletter including diet tips and successes which is sent to TOPS members.

Chapters vary widely in their success at facilitating weight reduction. Difficulties in assessing treatment include high dropout rates. However, a number of reports have been published. Wagonfeld and Wolowitz (1968) studied three TOPS groups and a non-obese control group. They found that nearly 50% of new members dropped out within 6 months. Of those remaining over 6 months, 80% showed "some" weight loss as long as they were members. Stunkard, Levine, and Fox (1970) studied 22 chapters and reported the average weight loss to be 15 pounds with 28% losing more than 20 pounds. In the five most effective chapters 50% lost more than 20 pounds with 62% of the most effective chapter losing 20 pounds or more. These authors concluded that the average results

compared favorably with those achieved by medical management and that the results of the most effective chapters ranked with the very best results in the medical literature.

To determine what factors accounted for the varying effectiveness among the chapters, a resurvey was done 2 years later (Garb & Stunkard, 1974). While the mean weight loss of 14.2 pounds across all chapters was similar, the chapters did not seem to maintain the same level of effectiveness. As well there were high attrition rates associated, not with losing more weight, but with the loss of lesser amounts of weight. This high dropout rate made the comparison with physician treated patients less favorable. Garb and Stunkard concluded that a small percentage of persons who join TOPS lose a substantial amount of weight and most find that TOPS is a relatively ineffective method of weight control.

To examine whether professionals could assist TOPS groups to become more effective, Levitz and Stunkard (1974) introduced behavior modification techniques to already existing chapters. During the 3-month period of active treatment the two behavior modification approaches produced significantly lower attrition rates and significantly greater weight losses (a mean loss of 4.2 and 1.9 pounds, respectively) than either the nutrition education or control groups. At the 9-month follow-up, for subjects who remained in each group, the differences between treatment methods was even greater, favoring the professionally led behavior modification group. However, attrition rates for <u>new</u> members at the follow-up were highest for the behavior modification group.

In summary, TOPS chapters do not seem to have any general effectiveness. Weight losses and maintenance vary widely among individual

members (Garb & Stunkard, 1974).

Weight Watchers. Weight Watchers, the world's largest weight-control organization, offers a three-part dietary "program" for weight reduction and for maintenance (Nidetch, 1972). Weekly instructional modules, based on behavior modification principles, have been introduced in the last few years as part of each meeting. Members attend weekly advisory meetings led by a supervisor who has experienced being overweight and who has reached his or her goal weight. Social pressure is part of the weekly meetings. Those who have lost weight are applauded; those who have gained are counseled to renew their efforts to "stay on program" for the coming week. The dietary program is nutritionally sound, offering a large selection of common foods. Basically there is a positive approach of advising what must be eaten rather than the negative approach of what must be avoided. Once members reach their goal weight and follow a maintenance program for about 8 weeks during which time they learn to deal with problem foods, they are eligible to become Lifetime Members. Motivation to maintain this goal weight is not paying a fee as long as they weigh-in once a month and stay within 2 pounds of goal. While there are no reports on attrition rates and few published studies about Weight Watchers, when people are able to follow the program and keep up the recommended contact with the organization, the results are impressive. In a British survey reported by Bender and Bender (1976), the records of a selected group of 215 members who had successfully lost surplus weight and had become lecturers were followed up for periods of 1 to 6 years. They reported:

> Altogether 121 subjects (56.3%) maintained goal weights within ±2.3 kg. of goal; 79 subjects (36.7%) maintained within ±4.5 kg ....39 subjects (18.8%) had maintained constant weight for more

> than four years, 22 subjects (10.6%) for three to four years, 65 subjects (3.14%) for two to three years, 58 subjects (28.5%) for one to two years, and 23 subjects (11.1%) for periods up to one year. (p. 60)

Craddock (1973) reported that only 15 to 20% of members in the United States attain their goal weight. Whether or not the introduction of behavior modification principles reduced the attrition rate and increased the percentage of members reaching goal weight is not known.

In summary it is difficult to assess the effectiveness of Weight Watchers as there are few published reports. However it appears that when members lose weight and become lecturers they tend to be very successful.

Medical Treatments

Medical treatments include pharmacological, long term fasting, and surgical methods. These will be briefly overviewed.

Pharmacological methods. There is some evidence that treatment with thyroid hormones which increase oxygen consumption and protein catabolism facilitates weight loss. Bray (1975) reported a study, consistent with others in this area, in which the group on triiodothyronine, a 1320-calorie diet, and mercurial diuretics lost significantly more weight than the group on the diet alone or the group using the diet and diuretic. Amphetamine related drugs have also been used alone or in combination with some type of calorie reduced diet to assist patients in their weight loss efforts. In a study using fenfluramine and phentermine (Steel, Munro, & Duncan, 1973) patients were followed for 36 weeks. As well as medication, a 1000-calorie diet was prescribed. Average weight loss was 12 kilograms. However the rate of weight loss was nil by the end of the study. Anorectic drugs do appear to make it easier for patients

to follow a low energy diet for a while (James, 1976); however, the treatment of obesity based on medications alone is seldom successful as weight is typically regained once previous eating habits resume (Asher, 1975). As well, because of the problem of addiction, the use of amphetamine-based drugs is no longer approved for general treatment of obesity (Edison, 1971).

Long-term fasting. Long-term fasting requires close medical supervision and frequently hospitalization. There is no doubt that large weight losses are obtained. Five recent studies of total starvation cited by James (1976) report mean losses of 17, 19, 28, 18.3, and 47 kilograms. The average duration of the fasts were 42, 89, 83, 47, and 121 days, respectively, with a range from 4 to 249 days. Craddock (1973) stated that being hospitalized and following a low-calorie diet (800 calories per day) or complete starvation may be the only way for superobese patients (100 to 150 pounds of excess fat) to break out of their old patterns. Maintenance of weight loss seems to occur more often with those patients who have had the motivation to starve to within 20% of their ideal weight (Craddock, 1973). However, Drenick (1975) reported that even in prolonged fasting there is often a rapid return to original weight once well-established eating patterns are resumed. In addition, there are occasional deaths during or immediately following total long-term starvation (James, 1976); therefore, it is important to weigh the benefits and potential dangers before this more extreme approach is attempted. As a result of her review of 17 studies on therapeutic starvation, Leon (1976) concluded: "The equivocal weight maintenance results and the number of serious physical complications associated with prolonged starvation suggest that this technique should be used only in

extreme situations" (p. 572).

Surgical methods. The main surgical methods which have been used to treat obesity are intestinal bypass surgery, in which a portion of the small intestine is bypassed, and dental splinting, in which the patient's teeth are wired together, allowing him to speak and drink but not eat. Attempts have been made to destroy the hypothalamic feeding centre, either by irradiation or by stereotactic surgery; however, this method is not in general use (James, 1976).

Dental splinting has produced weight losses comparable to those occurring by complete starvation (James, 1976) but at this point there has been little evaluation of its practicability, general acceptance, and long-term effects. Intestinal bypass surgery has been studied over a longer period of time and earlier methods have been refined (James, 1976). Such surgery is done only with massively obese patients, at least 100 pounds above or double their ideal weight, who are "severely impaired" in their social functioning, and whose physician considers the excess weight damaging to the individual's physical health (Bray, 1977; Salmon, 1975). Potential benefits are weight loss, improved psychosocial functioning and improvement in morbid-risk factors (Bray, 1977). A progressive decline in weight occurs over a period of 1 to 2 years before patients restabilize their weight, "not necessarily within the 'normal' range" (James, 1976, p. 62).

Salmon (1975) reported that of 137 patients, mostly women, most weight loss was complete within 2 years. Weight loss seemed to occur for two reasons: a decrease in food intake and malabsorption of ingested calories (Bray, 1977). However, James (1976) mentioned that some clinical impressions are that food intake is often reduced in attempts to minimize

troublesome diarrhea, one of the main complications from this type of surgery. As well there are other complications such as malnutrition, electrolyte imbalances, liver disease, anemia, syndromes of bacterial overgrowth, renal failure and arthritis. The surgery is reversed in less than 10% of the patients (Bray, 1977). Occasionally there are deaths; the operative mortality reported is about 2-7% in studies done with fairly large groups of patients (James, 1976). Bray (1977) noted that the enthusiasm for this procedure as a treatment for obesity has declined somewhat since its mortality rate exceeds that of all other forms of treatment for obesity. It has been suggested that this procedure be discontinued or used with caution only in cases of intractable massive obesity (Welch, 1973; cited by Leon, 1976).

In summary, some obese patients have been helped to lose weight through the use of drugs, long-term fasting, and surgery. However these methods are recommended for use only in very special cases and are not relevant treatments for the majority of individuals interested in weight control.

Psychoanalytic Approaches

Psychoanalysis is not a treatment for overweight and obesity per se. Rather, problems with weight regulation are treated indirectly when patients with emotional and neurotic problems enter treatment because of other difficulties in their lives (Bruch, 1973; Ingram, 1976; Rand & Stunkard, 1977). Ingram (1976) stated that patients who attempt to enter psychoanalysis with the chief complaint of being overweight and who do not show evidence of "neurotic distortion and self-alienation or other destructive effects of unconscious conflict" (p. 228) should not be accepted for psychoanalytic treatment. Similarly Bruch (1973) stated

that only a small percentage of fat people probably need analytic treatment.

While obesity is generally viewed as a symptom of other problems arising during early development and subsequent failures in areas of interpersonal functioning, there are many different theories of obesity and treatment in the psychoanalytic area. Efforts at validating the various psychodynamic views through the empirical model of research have been hindered by difficulties in defining psychological characteristics of the obese in contrast to the non-obese. This point was illustrated by Hagen (1976) when he stated:

> Miller (1974, p. 7) reminds us, 'the research shows that obese subjects do (Conrad, 1970) and don't (Abramson, 1971) exhibit psychogenic hunger. Eating does (Conrad, 1970) and doesn't (Schachter, 1971) reduce anxiety....The obese do (Stunkard, 1957) and don't (Stuart and Davis, 1972) risk symptom substitution as a result of dieting'. In addition, the obese are (Schachter, Goldman and Gordon, 1968) and aren't (Singh, 1973) more responsive to internal cues. (p. 3)

Results of psychoanalytic approaches. In the following reports successful outcome was evaluated not only in terms of weight loss and stability but also in terms of resolution of other difficulties in life. The results were most often reported as case studies intended to illustrate particular theoretical issues (Bruch, 1973; Garma, 1968; Rosenthal, 1963) or to simply report the results of a particular therapist's work (Buchanan, 1973; Hoff & Winick, 1961; Ingram, 1976). One recent survey study examined the effectiveness of a variety of psychoanalytic approaches with obese patients (Rand & Stunkard, 1977).

Holt and Winick (1961) reported on a psychoanalytic therapy group for six middle-aged obese women considered "seriously ill." The therapist's particular analytic approach was not clearly presented; the

general approach was to make it clear that the members could discuss anything that occurred to them, including dreams, daydreams, body sensations, and fantasies. After the analyst became aware of the dynamic functions served by the patients' overweight, he restructured the goal of the group to be weight maintenance and acceptance rather than weight loss. In terms of improved emotional well-being and level of adaptation, the group was evaluated as successful. At a 30-month follow-up three patients had lost 5 pounds or more. The average loss for the group was 4.3 pounds.

Rosenthal (1963) included a brief case study of treatment with an obese woman in her examination of the association between a variety of neurotic conditions and the fear of death. For this woman, the loss of weight was identified with dying, and overeating, which counteracted her hidden death fear, was equated with health and life. Once this insight occurred the patient lost "considerable" weight without going on a specific diet.

Garma (1968) reported the changes in psychosomatic pathology which occurred in the case of a homosexual, obese since childhood. The progression through obesity, migraines, peptic ulcer, and myocardial infarction was related to his genital conflicts and various phases of psychosexual development. The cause of his obesity was viewed as masochistic oral-digestive regression and oedipal castration anxieties. Little information about the outcome of his analysis was presented in terms of weight or resolution of other conflicts, although it was mentioned that the patient was no longer impotent.

One of the most comprehensive psychoanalytic approaches to obesity and its treatment has been presented by Bruch, a leading authority on

eating disorders (Bruch, 1973, 1975, 1976). During the course of nearly 40 years of work, Bruch treated patients suffering from developmental or childhood obesity. Finding that obese patients were not responsive to traditional psychoanalysis, she developed a fact-finding, non-interpretative approach which focused on the patient's "failure in self-experience, on the defective tools and concepts for organizing and expressing needs, and on the bewilderment when dealing with others" (Bruch, 1976, p. 271). Allowing patients to lead the way in an active examination of their development, she attempted to make it possible for the patient to make discoveries about his abilities and resources on his own. Therapy attempted to repair the conceptual defects and distortions; to repair the underlying sense of incompetence, isolation and dissatisfaction; and to help patients develop a constructive life in which eating was not used as a remedy for other difficulties (Bruch, 1973, 1976). While the main focus on the resolution of inner and interpersonal conflicts, Bruch stressed that it is important that the patient does not assume that the fat will just melt away with the resolution of conflicts, but that reducing is difficult regardless of what understanding has been reached. After a period of analysis, when the patient has developed better self-awareness and no longer indulges in overly optimistic fantasies that reducing will solve all his problems, the overweight issue is usually dealt with through some form of diet but preferably by means of a more total reducing program including changes in social activities and exercise (Bruch, 1973). She cautioned that dieting without dealing with the underlying dynamics can lead to depression and emotional disturbance in the group she has treated.

Bruch (1973) reported numerous case studies, some with follow-up

of 35 years, on the development and treatment of developmental obesity. In contrast to the often expressed view that developmental obesity condemns an individual to obesity in later life, she has found that many of the obese children she had treated became slender adults and raised normal weight children. She stressed the complexities of these cases and pointed out the difficulty in drawing general conclusions about background and the factors contributing to serious disturbance in personality development. Even with a successful treatment, defined as having progressed in terms of improvement in daily living as well as in weight stability, patients were not free of their weight problem; Bruch (1973) stated that former patients "owed their slim or slightly plump figures to 'eternal vigilance' about what they ate" (p. 378).

Buchanan (1973) reported the results of a 5-year psychoanalytic study of obesity. Initial therapeutic goals were "to try to have the patient put his eating behaviour into some emotional context in his current life" (p. 34). Utilizing Horney's framework, attempts were also made to relate obesity to "predominant neurotic trends" and the ways compliant, detached, and aggressive persons used their obesity as solutions to internal conflicts. The three criteria used to measure treatment success were (1) loss of weight with alteration of the weight loss-gain curve, (2) control of the eating compulsion, and (3) evidence of healthy growth in relationship to oneself and others. While the 5-year period was considered an insufficient amount of time to determine whether the weight curve was permanently altered, three of the seven obese patients met all three criteria for success. A fourth patient was on a plateau for 4 years and then went from 56% overweight to 39% overweight. Two patients who were close to normal weight but who had an

eating compulsion were successful in terms of the latter two criteria. The remaining three patients made few changes; those changes that did occur were mainly in the third category. Buchanan noted that the most remarkable changes were in terms of the third category. Although doubtful that the eating compulsion would ever be completely eradicated, especially during periods of stress, he noted that the periods of compulsive eating became less frequent, more short-lived, and tended to be corrected by periods of dieting.

Ingram (1976), also using Horney's description of personality types, reported on a psychoanalytic approach to obesity. Through exploring unconscious forces the patient may be able to rid himself of compulsive attitudes and behavior. When helpful to the patient in discovering unconscious motivation or in developing the analytic relationship, behavioral approaches, self-help groups, and dietary regimes were used. With a shift from self-effacing solutions to positive expansive trends, (for example, when reduced alienation from feelings of jealousy and anger was achieved), weight reduction was attained by some patients for "an indefinite period" of time (p. 233). Both the analysis and weight reduction were considered important to the emergence of this expansive trend. No individual information was presented.

Rand and Stunkard (1977) reported a survey study done to explore the effectiveness of psychoanalysis in treating two problems specific to obesity: overweight and disparagement of body image. Information about 84 obese and 63 normal-weight patients, matched for age, education, and socioeconomic status was contributed by 72 psychoanalysts of various analytic orientations (Freud, Horney, Sullivan, Rado and others). The majority (60%) of both obese and control patients had sought treatment

for depression and anxiety; only 6% presented obesity as the chief complaint. The lack of control over patient selection and the number of analytic orientations were not considered a "serious" source of bias. "Of the 67 patients on whom weight-loss-data was (sic) available, 28% lost more than 20 lbs and 9% lost more than 40 lbs" (p. 470). These figures compared favorably with results reviewed by Stunkard and McLaren-Hume (1959) which showed that about 25% of the patients lost more than 20 pounds and no more than 5% lost more than 40 pounds. The intensity of body-image disparagement was also reduced significantly. This change was considered the most outstanding aspect of treatment as body-image disparagement is considered extremely resistant to change even after long periods of successful weight loss. There was no relationship between weight change and the change in body-image disparagement.

Summary. There are a variety of psychoanalytic approaches that treat obesity indirectly as a symptom of a neurotic disorder. The patients treated are considered to have a great variety of emotional disturbance in addition to being obese. Often they have been the failures of conventional approaches. The most common principle of treatment is that interpretation can lead to uncovering motives for overeating and for continued fatness, thus allowing the person to control and change his problematic eating patterns (Buchanan, 1973; Ingram, 1976; Rubin, 1973).

One of the leading authorities, Hilde Bruch (1973) advocates a noninterpretative, fact-finding approach. Outcome is evaluated not only in terms of weight loss and stability but in terms of more effective or satisfying interpersonal relationships (Bruch, 1973; Buchanan, 1973; Ingram, 1976) and reduction of body-image disparagement (Bruch, 1973;

Rand & Stunkard, 1977). As well, the patient's acceptance of a higher body weight than that which cultural stereotypes of thinness may dictate is viewed as successful because thinness is no longer seen as the solution to all the patient's problems, and less energy goes into weight control and food related concerns (Bruch, 1973; Ingram, 1976).

Even when psychoanalysis is considered successful in terms of improvements in daily living, weight control itself is often approached through dieting or other willpower methods that enhance the capacity to avoid overeating (Bruch, 1973; Buchanan, 1973; Ingram, 1976). However, with a successful analysis, weight reduction and control are tackled more easily. While efforts at evaluating the psychoanalytic approaches to the treatment of obesity are hindered by the prevalence of numerous different approaches, the fact that success is evaluated in a number of different ways independent of weight, and the fact that results are often presented in terms of case studies, there is evidence that psychoanalytic approaches compare favorably with other current treatments (Rand & Stunkard, 1977).

Behavioral Approaches

Behavioral approaches are currently the most popular in the psychological and medical literature on the treatment of overweight and obesity. According to Foreyt, Scott, and Gotto (1976) there are two reasons for this popularity. First, traditional approaches to weight control usually were ineffective (Stunkard & McLaren-Hume, 1959). The conclusion of the Cornell Conference on Therapy (1958) was that "most obese patients will not remain in treatment. Of those who do remain in treatment, most will not lose significant poundage, and of those who do lose weight, most will regain it promptly (p. 87)" (cited by Stuart,

1975, p. 367). In light of these poor results, the behavioral approaches offered new promising techniques in which treatment conditions could be more explicitly specified.

Second, weight change in pounds offered an excellent dependent variable to test theoretical issues of learning theory and the outcome of psychotherapy (Foreyt et al., 1976; Stunkard, 1975). After Stuart (1967) reported that eight women, treated with a program based on restructuring the environment relevant to eating, all lost over 25 pounds, an explosion of research occurred on the behavioral control of obesity.

Behaviorists acknowledge that different types of obesity result from some combination of the following etiological factors: hypothalamic, endocrinological, or genetic disorders, inactivity, dietary abnormalities, or drug effects. However, they address themselves to the eating abnormalities and exercise insufficiencies found in all cases of obesity (Stuart, 1975). That is, overweight is viewed primarily as a function of poor food-related and exercise-related habits which are learned in ways similar to other behavior and which consequently can be modified using principles of learning theory.

Results of behavioral approaches. The general method used involves the control of the antecedents and/or consequences of eating behavior through classical conditioning techniques or the use of instrumental or operant conditioning (Foreyt & Frohwirth, 1977; Stuart & Davis, 1972). The first type of behavioral procedure, evolving from the classical conditioning paradigm, attempts to create conditioned aversion responses to certain classes of food or overeating through a wide variety of techniques in which a noxious, aversive unconditioned stimulus is paired with the target or conditioned stimulus. Electric shock, chemical

nauseants, foul odors, and images of unpleasant scenes have served as unconditioned stimuli paired with actual stimulus objects (food), photographs of food, the individual engaging in the problem behavior, or the individual imagining both food and the problem behavior. The second, more popular type of behavioral approach, evolving from the operant conditioning paradigm, involves control over stimulus conditions surrounding eating; self-monitoring of weight, activity, and food intake; and behavioral programming such as contingency contracts, token economies, self-rewards and self-punishments.

Abramson (1973, 1977), Hall and Hall (1974), Leon (1976), and Stuart (1975) report numerous studies using behavioral approaches to weight control. Abramson (1973) reviewed 40 case reports and experimental studies. The studies were categorized as aversive conditioning, covert sensitization, coverant conditioning, therapist-controlled reinforcement, and self-control of eating. While there was little empirical evidence to indicate that aversive procedures were an effective treatment for obesity, there was some indication that they may be useful when combined with other procedures. There were some favorable outcomes with covert sensitization; however, the weight losses reported were small. The greatest loss was an average of 11.7 pounds. Generally losses averaged between 4 and 5 pounds. Several coverant conditioning studies also yielded discouraging results. While therapist-controlled reinforcement in institutional settings produced significant weight loss, outpatient treatment showed questionable results. For example, when the target behavior was weight loss instead of actual eating behaviors, outpatient subjects sometimes used extreme measures such as vomiting or taking laxatives or diuretics to promote weight loss. Abramson concluded

that self-control procedures in which specific skills were taught to control eating behavior showed most promise. Problems noted in this review were inadequate methodology, diverse criteria for determining improvement so that direct comparisons between studies were impossible, different methods for dealing with attrition, frequent failure to provide follow-ups, and the use of select samples (that is, the majority of studies used moderately overweight college females). As well, results of studies reporting statistical significance were not necessarily clinically significant.

Hall and Hall (1974) examined 33 studies on the behavioral treatment of obesity with respect to outcome and adequacy of design. Studies were divided into Experimenter-Managed and Self-Managed approaches. In their evaluation, they considered sex of the subjects, incidence of premature termination, and various characteristics of the sample population. Studies employing Experimenter-Managed procedures produced relatively rapid weight loss when the techniques were successful, particularly when aversive stimuli were not used. Self-Management procedures produced greater weight losses than those obtained under no-treatment conditions. The findings were still "promising" when behavioral treatments were compared with other treatments or attention-placebo conditions. However, they noted that after termination of treatment, clients tended to stabilize their weight rather than continue weight loss as might be expected with self-management approaches. A particularly relevant observation was that in those studies with follow-up periods of 12 weeks or less, the differences between experimental and control groups were no longer significant.

Of the 19 experimental studies reviewed, only <u>one</u> of them was

sufficiently well designed to allow the conclusion that it was, in fact, the behavior modification techniques that led to the weight loss and not simply attention, situational expectations, or a particular therapist. Hall and Hall also experienced difficulties when attempting to make direct comparisons of the results of the studies due to sample differences, the use of different measures for assessing initial weight status and weight change, and variable premature termination rates ranging from 0 to 83%. Other problems noted were the lack of attention-placebo conditions, the lack of adequate follow-up, and the failure to include more than one experimenter or to assign experimenters in such a way that experimenter effects could be assessed. Because of the large inter-subject variability in response to programs, they pointed out the value of individual subject research designs. Their conclusion was that the most promising theoretical combination of techniques was using Experimenter-Managed procedures early in treatment to produce relatively rapid weight loss while at the same time teaching Self-Management procedures to maintain or continue weight loss following treatment.

Stuart (1975) examined the results of clinical and experimental studies from 1964 to 1973. Similar to Abramson (1973), he observed that when studies had used aversive conditioning techniques a relatively large percentage of subjects withdrew from treatment, there was a rapid weight loss among those who remained, and a slight loss, if any, occurred after the end of treatment. In contrast, with operant studies involving the reprogramming of the environment, most subjects had small but regular weight loss during treatment and either maintained or continued the loss at follow-up. However, he noted that "despite the large number of studies, few definitive intervention programs have been crystallized, and none of

these have been thoroughly validated" (Stuart, 1975, p. 373). In his view this was due to the development of disparate traditions in the behavioral area, one stressing self-control and the other employing situational control, and as the result of "glaring methodological errors" in the design and execution of the studies.

Leon (1976) reviewed 33 behavioral studies, including those using self-control techniques such as behavioral management and stimulus control, therapist-provided rewards in a controlled environment, contingency contracting, self-reward and self-monitoring, aversive procedures, covert sensitization, and coverant control. She concluded that aversive conditioning and covert sensitization procedures, while they have produced substantial weight loss in a number of studies, were not the most efficient ones for bringing about weight reduction, particularly since weight loss was often not maintained. Therapist-provided reinforcement resulted in substantial weight loss by institutionalized subjects (30 to 102 pounds). Contingency contracting studies showed mixed effectiveness in producing weight loss. The most effective programs were those behavioral management and environmental control procedures which taught direct modification of eating patterns. While these latter procedures were more effective in weight maintenance than those producing the best results reported in the medical literature, Leon noted that the weight losses generally were not very large when examined in terms of average losses for a treatment. Other shortcomings noted were follow-up periods of less than 13 weeks, using overweight college females as subjects, and high attrition rates. She recommended that weight maintenance rather than initial weight reduction be used as a criterion of success in any type of program.

In his second review, Abramson (1977) surveyed recent developments in the behavioral treatment of obesity. Since the earlier review there had been a proliferation of studies. Over twice as many studies were reported in the last 4 years as compared with the previous 11 years. No new studies of aversive therapy had been published. Three studies of covert sensitization yielded discouraging results. The few studies on the effects of therapist controlled reinforcement indicated that this technique can promote weight loss while the contingencies are still in effect. Hence, when the therapist controls the total environment, therapist controlled reinforcement is very effective; however, on an outpatient basis weight is often regained.

Since the 1973 review the bulk of the behavioral research has been devoted to variants on self-control procedures. Methods that have been studied include self-monitoring, self-reward and self-punishment, exercise, coverant conditioning, and stimulus control. Findings suggest that self-monitoring of daily calorie intake, premonitoring instead of postmonitoring, self-rewards for habit change instead of self-reward for weight loss, and programs including exercise lead to superior outcomes. While the complex self-control procedures were still the most consistently successful approaches, there was conflicting evidence and it was not possible to draw any firm conclusions regarding the relative merits of the various specific techniques. As well, two studies conducted on simple self-control, requiring that the participant count every mouthful of food and every swallow of caloric liquid, suggested that simple self-control was as effective as complex self-control.

Abramson noted several improvements in the behavioral research literature since his 1973 review. Studies which included follow-up

data of 1 year were increasing. Several recent outcome studies reported the effects of treatment on clinical populations instead of the usual moderately overweight college female sample (Currey, Malcom, Riddle, & Schachte, 1977; Ferguson, 1976; Musante, 1976; Weisenberg & Fray, 1974). Methodological shortcomings such as the lack of agreed upon measures for assessing treatment effects and differing methods for dealing with patient attrition were still prevalent. Other unresolved issues regarding self-control studies were the wide range of response to treatment (even in the most effective programs there were participants who did not lose weight) and the considerable variation in effectiveness among therapists using the same techniques. While this type of variation was attributed to a variety of non-specific factors independent of the treatment, there was no research which explored these variables.

Summary. While the results of aversion therapy with obesity have generally been poor (Abramson, 1973; Leon, 1976; Stuart, 1975), the outcome of the operant approaches has been promising. Behavioral treatments involving complex self-control procedures have generally been superior to no treatment, attention-placebo, and other treatment conditions during the reported short-term follow-up period (Abramson, 1973; Hall & Hall, 1974; Leon, 1976; Stuart, 1975). Weight losses of about 1 to 2 pounds per week with mean weight losses in the range of 8 to 10 pounds for groups of individuals treated with such self-control procedures are common (Foreyt & Frohwirth, 1977). According to Ferguson (1976) the most systematic studies of the variables involved in weight loss and maintenance, combining a group and behavioral approach, indicate that over 50% of the participants lost more than 20 pounds and 80% either maintained their lower weight or lost more weight in the

following 2 years. The most helpful approach seems to involve some combination of (1) self-control techniques for habit change; (2) therapist reinforcement techniques; (3) nutritional information; and (4) a regular exercise program (Foreyt et al., 1976; Stuart & Davis, 1972).

There are still many unanswered questions that require investigation. For example, it is not known which components of complex behavioral self-control programs are necessary and which are superfluous or detrimental (Abramson, 1977; Hall & Hall, 1974; Stuart, 1975). Variables predicting treatment success have yet to be isolated (Abramson, 1977; Leon, 1976; McReynolds & Paulsen, 1976; Stuart, 1975; Weiss, 1977). Little information exists about the wide range of individual responses to treatment (Abramson, 1977; Weiss, 1977). Relevant patient and therapist variables such as the motivation and expectancy of the clients and the interpersonal skill and expectancy of the therapist have often not been included in the research. As well, weight maintenance is no less a problem with behavioral treatments than with more traditional diet or exercise therapy (McReynolds & Paulsen, 1976).

While there have been improvements in the recent behavioral research, there are still major problems including:

(1) failure to report attrition data;

(2) lack of standards for reporting initial and final weight status and lack of standards for statistical analyses;

(3) failure to report follow-up of an adequate period of time, preferably 2 to 5 years;

(4) inability to generalize results as most studies have been done with college subjects or hospitalized psychotic subjects;

(5) failure to collect data on wide-ranging effects of treatment such as symptom substitution or adverse side effects;

(6) difficulties with experimental design (Abramson, 1977; Foreyt, 1978; Hall & Hall, 1974; Jeffrey, 1976; Stuart, 1975).

It is important to point out that in spite of these limitations the behaviorists are attempting to systematically explore and evaluate their approaches to weight control. Hence they offer extensive critiquing of the research which has been done and recommendations for improvement of both the programs and the research.

Hypnotic Approaches

Hypnotherapists have no common view on obesity and its treatment other than the fact that some form of trance is induced and various types of suggestions are given. In the individual or group treatment of obesity, hypnosis may be used either as the primary method (Hanley, 1967; Stanton, 1975, 1976; Wollman, 1962), or in combination with psychoanalysis or psychotherapy (Wick, Sigman, & Kline, 1971; Hanley, 1967), in combination with behavioral approaches (Kroger, 1970; Miller, 1976; Tilker & Meyer, 1972), or in conjunction with diets or fasts (Brodie, 1964; Clawson, 1964; Kroger, 1970), and exercise (Brodie, 1964; Miller, 1976). Erickson's treatment of obese patients (Erickson, 1960, 1970) is given special attention in this review, as his utilization of patterns of patient behavior and his emphasis on using the patient's language to facilitate change are important concepts in the second-order approach to problem resolution.

Results of hypnotic approaches. Wollman (1962) used group hypnosis. Positive suggestions intended to "direct the appetite by auto-suggestion

to the proper food limitations" (p. 179) were given. A three sentence "grace", emphasizing that the patient would eat only enough to satisfy his hunger, was to be repeated before each meal. At no time was it ever suggested that food would be unpleasant or distasteful. Techniques were individualized for each patient. The greatest loss was 47 pounds in 2 months. The overall average was a 30-pound loss over 3 months. No individual or follow-up information was presented on the 450 cases treated.

Hanley (1967) treated patients through both individual and group hypnosis. They were given positive suggestions about the pleasure of eating, being satisfied with smaller amounts of food, and having the desired body weight. Hanley dealt with the relapse and discouragement which usually followed the initial weight loss in ways suggested by Milton Erickson; that is, he accepted and utilized patient behavior patterns, explaining the relapse as expected and as being an important part of the learning process, and congratulating the patient on having relapsed so quickly and so well. Depending on the degree of personality disturbance he also used psychotherapy with hypnotherapy. Weight losses for a group of "six to eight" women averaged 2 to 3 pounds a week. The greatest loss was 70 pounds in 6 months. Patients also reported changes in their outlook on life as well as many other unexpected improvements in other aspects of their lives. No specific weight loss or follow-up information was reported.

Stanton (1975, 1976) also used hypnosis as the primary method of treatment. Emphasis was placed upon the importance of the therapist-patient relationship and, in particular, on fostering a positive expectation that the treatment would be successful. Aspects of the hypnotic

process used were (1) direct positive suggestions relating to the amount and type of food eaten; (2) ego-enhancing suggestions to help patients live their lives more pleasantly; and (3) mental imagery to establish a desired goal weight. Daily auto-hypnosis to reinforce suggestions was recommended. In his first report all 10 cases were successful both in achievement of their desired weight and maintenance of this weight over a 2-year period. Weight losses ranged from 8 to 40 pounds with a mean loss of 22 pounds. The weight loss process was reported as occurring without any real effort. All patients treated reported one or more of the following: "(1) gains in their ability to relax, (2) increased confidence, independence and energy, and (3) enhanced powers of concentration and memory" (Stanton, 1975, p. 95).

Stanton (1976) used a taped presentation of his approach in one of two treatment conditions. Patients either paid the usual fee for therapy or received treatment free. After the 8-week period, weight loss recorded under the fee-paying condition was significantly greater than that under the non-fee paying condition. The mean loss for the fee-paying group was 19.19 pounds with a range of 14 to 30 pounds and a standard deviation of 5.7 pounds. The mean loss for the free treatment group was 11.1 pounds with a range of 1 to 20 pounds and a standard deviation of 7.05 pounds. As in his previous article, Stanton emphasized that patient expectancy about the success of treatment is an important variable in the success of treatment. He hypothesized that patients who pay for treatment had a greater success because patients expect to pay for services, viewing free help as having little value.

Wick, Sigman, and Kline (1971), used a psychotherapeutic approach, hypnoanalysis, in the treatment of a superobese woman. This case was

intended to illustrate the type of obese individual who requires psychotherapy as the primary mode of treatment before a direct attempt at weight management and control can be made. After a year there was no weight reduction, although there was some indication that the patient had gained a greater understanding of some of her problems.

In their pilot investigation of an educational program based on constructs of hypnotic intervention, the cognitive control of motivated behavior was emphasized. "Self knowledge was the keynote; 'willpower' was de-emphasized; 'why' was stressed" (p. 252). During the first 7 weeks the mean individual weight loss of a group of 16 housewives was 10.2 pounds. Following termination of the group, weight gains which wiped out most of the losses occurred. The investigators concluded that continuous involvement in this type of therapeutic education was necessary not only to achieve weight loss but also to maintain it.

Although Kroger (1970) treated eating associated anxieties with Wolpe's reciprocal inhibition procedures under hypnosis in the second phase of his comprehensive treatment program, aversive techniques were the most common behavioral methods used with hypnosis. The first part of Kroger's approach involved a 1000-to-1350-calorie diet, a thyroid pill if the patient weighed over 200 pounds, and training to develop responses of satiation or aversion to specific types of food by recalling disgusting thoughts, feelings, and smells. He stated that patients cannot "will" themselves to lose weight--that the harder they try, the less they will accomplish. Nevertheless he had patients set deadlines for monthly weight losses and buy clothes one to two sizes too small because "one then tries much harder." When failure occurred he advocated a non-condemnatory attitude combined with encouragement. A "high

percentage" of his patients were able to maintain their weight loss effectively for years. About 50% relapsed and required periodic treatment. No actual weight data or other treatment information were presented.

Tilker and Meyer (1972) used hypnotic procedures with a female college student to facilitate the use of covert sensitization procedures which had become aversive. During a trance, trials of covert sensitization were repeated and post-hypnotic suggestions were given for daily self-induction of similar trials. Weight loss was 18 pounds after 15 sessions and 16 pounds at the 9-month follow-up.

Miller (1976) reported the use of hypnoaversion aimed at diet and weight control when other procedures had failed. As well as attempting to create strong aversions to high calorie foods, Miller gave patients suggestions to increase physical, recreational and work activities. No treatment information was presented.

Brodie (1964) and Clawson (1964) also used suggestions about low-calorie diets and exercise in combination with hypnosis. Brodie (1964) viewed obesity as the result of faulty habits of eating and as an addiction to food. Hypnosis was used as the technique to induce rapport with the therapist, to increase motivation to learn new eating habits, and as the method of communication to convey ideas and suggestions. By hypnotic techniques and actual trance induction, patients were encouraged to become gourmets--to enjoy food to the fullest. As well, decreasing intake of foods with starch and sugar, 2-day fasts, exercise, slow deep breathing, and daily autohypnosis were suggested. To reduce guilt about overeating on special occasions, Brodie complimented patients about the learning they had achieved by doing so. No weight data for

other actual treatment information were presented.

Clawson (1964) reported that several hundred cases of obesity had been treated with hypnosis, a 900 to 1000 calorie diet, and appetite suppressants. Self-hypnosis was used daily. Most patients lost weight "regularly"; weight losses were as great as 75 to 100 pounds. No information about the particular hypnotic techniques and messages used or of individual weight losses or follow-up was given.

Reports by Milton Erickson. Erickson (1960, 1970) stressed that centering on individual personality needs, attitudes, and experiences, whether reasonable or unreasonable from the therapist's point of view, is crucial to adequate communication of ideas and understandings during hypnotherapy. He utilized long-established behavior patterns and resistance to change to help patients attain their goals. Erickson (1960) reported the course of treatment with a superobese 21-year-old woman. His treatment emphasized the importance of using language related to a patient's conceptual and need framework even when messages sound objectively unkind and brutal. For example, the patient described herself as a "plain, fat slob. Nobody would ever look at me except with disgust" (p. 83). In order to establish rapport, Erickson communicated with her in terms of the only understanding she had of intercommunication, that of brutality. To convince her that he understood her and recognized her problem, he confirmed the fact she was not simply a plain, fat disgusting slob, but the "fattest, homeliest, most horrible bucket of lard" he had ever seen. Various other comments to the effect that she was a hideous mess were made with the intent of convincing her of his sincerity. Still phrasing his directions within her framework of understanding, she was told to go into a trance.

Certain facts about her parents and earlier life were obtained. In this and subsequent sessions, she was given homework assignments during the trance state intended to increase her experience in areas of fashion and cosmetology. Within 6 months she begged to be allowed to do something about herself. In another year she weighed 150 pounds, a loss of about 100 pounds, and had enrolled in University. Upon completion of university she weighed 140 pounds, was engaged to be married, and had a good job. This weight was maintained for at least 15 years.

Three other cases of obesity which Erickson (1970) treated with hypnosis again illustrate the importance of centering on the individual personality needs and attitudes of the patients as well as on the long-established behavior patterns. In each case he utilized the patient's behavior. "One patient's pleasure in eating was intensified at the expense of quantity, a change of sequence of behavioral reactions led to success for the second, and a certain willfulness of desire to defeat the self was employed to frustrate the self doubly and thus achieve the desired goal" (p. 116). The first woman patient, in one session, was systematically taught time distortion so that small portions of food would lead to feeling satiated. After 9 months of following a diet and eating her meals in this state of time distortion, the woman easily lost 120 of her 240 pounds, and though she ate less, she enjoyed her food more. With the second patient Erickson utilized her repeated pattern of stopping reducing by advocating a process of gaining. A change of sequence in this losing-gaining pattern was implemented by having the woman gain between 15 and 25 pounds before she began losing. When she was finally allowed to reduce, she eventually reached her goal of 125 pounds with none of the previous obsessive weighing. At the time of the

report her weight had been maintained for at least 9 months. Finally, in the third case, the woman's persistent overeating was used as a means of losing weight. During trances she was instructed to carefully and willingly overeat to support lower weights. Thus, directing the patient to continue to overeat was used to help her gain control over her self-defeating behavior. After 6 months of treatment she had reached 190 pounds, a loss of 80 pounds.

Summary. Most of the studies reviewed reported success in terms of weight loss. As well, a number reported positive changes in other aspects of the patients' lives (Erickson, 1960; Hanley, 1967; Stanton, 1975; Wick, Sigman, & Kline, 1971). However, these studies are difficult to evaluate as most of them included no specific information about weight losses and maintenance (Brodie, 1964; Clawson, 1964; Hanley, 1967; Kroger, 1970; Miller, 1976; Wollman, 1962). Other than some form of trance induction, they reported no consistent hynotherapeutic approach to weight control. Some utilized only positive suggestions about food and weight control (Brodie, 1964; Hanley, 1967; Stanton, 1975, 1976; Wollman, 1962). Others utilized aversive conditioning in relation to certain foods (Kroger, 1970; Miller, 1976; Tilker & Meyer, 1972). Erickson, and some other therapists used the patients' resistance and relapses (Brodie, 1964; Hanley, 1967). Miller (1976) acknowledged that outcome was affected by the therapist's ability to deal with resistance. Kroger (1970) advocated a non-condemnatory attitude and encouragement when patients failed. The others did not mention their approach to resistance and relapse. These differences, together with the variety of methods and techniques used in combination with trances, add to the difficulty of assessing the effectiveness of hypnosis in the treatment of obesity.

Erickson's reports on the treatment of four obese women (Erickson, 1960, 1970) received special consideration in the review because of the importance of his methods to the development of the second-order approach to change.

Other Psychological Approaches

Other than the psychoanalytic and behavioral approaches, no psychological system has an organized body of theory or research on overweight and obesity. However, psychologists of various persuasions do mention overweight or obesity in theoretical discussions or in terms of particular case reports.

Two approaches in which the problem of overweight has been cited to illustrate theoretical points are transactional analysis and bioenergetic analysis. Jongeward and Scott (1976, chap. 10) stressed the importance of being aware of Parent, Adult, and Child Ego States so that the Adult Ego State could intervene to make decisions to change eating habits based on current awareness. Lowen (1975, chap. 2) mentioned the case of a "big, fat, unshapely" young man who could not overcome these handicaps by dieting or running. Fatness was viewed as the expression of his inner conflicts and the manifestation of the part of him which identified with being more a baby than a man. Through an emphasis on basic functions of breathing, moving, feeling, self-expression and sexuality, the individual was freed from restrictions and conflicts and was helped to move towards a lower body weight. Neither of these two reports included information about specific outcomes.

A variety of undefined psychotherapeutic approaches were used to facilitate weight loss in the following case studies. Crisp and Stonehill (1970a, 1970b) presented specific weight loss and follow-up information

on the treatment of seven severely obese patients through hospitalization on a psychiatric ward, dietary restriction, and psychotherapy, variously described as "group", "weekly", or "supportive." Some patients also received antidepressants, anorectic drugs, and electric-shock aversion therapy. Outcome was evaluated in terms of weight loss and improved psychiatric status, including clinical judgements in all cases and changes on two self-rating questionnaires for three cases. Seven patients were hospitalized from 4 months to 1 year and lost 84, 86, 42, 84, 77, 42, and 87 pounds, respectively. At follow-up, one woman had regained the lost weight and eventually committed suicide. Two patients had regained all the lost weight and more, two had regained half or more of the loss, one had regained 14 pounds, and one had regained 7 pounds. Patients were described as "socially isolated and generally unchanged"; "cheerful and confident"; "somewhat socially isolated"; "more sociable and content"; and as "having fewer neurotic symptoms."

Rowland (1968) treated six hyperobese adults with both psychotherapy and total starvation. A variety of emotional reactions to fasting was discussed. Weight losses ranged from 30 to 100 pounds at the end of fasting and up to a total of 150 pounds for two subjects who lost weight as outpatients.

Schonfeld (1964) reported little information about method or outcome of treatment with three obese adolescent boys who had severe body-image disturbances and problems with sexual identification. For one, "his adaptations were somewhat improved", as a result of supportive therapy. A second, first seen at 14 years of age, "still refused psychotherapy, dietary management for the obesity, or plastic surgery for the pendulous breasts" (p. 498) when he was seen at 23 years of age.

Studies by Slawson (1965), Mees and Keutzer (1967), Kornhaber (1968), Shumway and Powers (1973) and London and Schreiber (1966), all cited by Leon (1976), approached weight reduction through groups. The techniques used were insight psychotherapy, emotional support, and task orientation to weight reduction. Slawson (1965) reported on an insight-oriented psychotherapy group for obese women which had been active for a 2-year period. Weight changes were minimal. Mees and Kuetzer (1967) demonstrated that short-term group psychotherapy which focused on problems in adhering to a diet, as well as on personal issues, resulted in some degree of weight loss in obese women. Through discussion of diet problems in an emotionally supportive atmosphere, successful weight reduction occurred in a group of seven women (Kornhaber, 1968). Shumway and Powers (1973) described a supportive group approach to weight reduction but presented no specific weight change information. London and Schreiber (1966) reported a significantly greater weight loss over a 6-month period for persons in group discussion sessions providing support and pressure to diet than for those receiving a combination amphetamine-tranquilizer drug. Mean losses were 16.1 and 10.0 pounds, respectively.

Summary. The literature on the use of psychotherapy to treat obesity suggests that there is a wide range of individual response to treatment. Difficulties in evaluating the individual and group approaches reviewed here include the lack of specific weight-loss and follow-up information as well as the fact that descriptions of the particular therapeutic approaches are poor or not present at all.

Conclusions about Current Approaches to Weight Control

Within each of the current approaches to weight control, whether it is a dietary, medical, psychoanalytic, behavioral, hypnotic, or other psychological treatment, there are some individuals who are successful in terms of weight loss and weight maintenance. However, there is a wide range of response to each type of treatment and sometimes within a particular study or case report. Successful outcome is assessed in a variety of ways ranging from weight loss or weight maintenance to resolution of inner conflicts and subsequent improvement in interpersonal relationships and reduction of body-image disparagement. At times acceptance of a higher body weight is considered more successful than continuing to be preoccupied with cultural stereotypes of thinness (Bruch, 1973; Ingram, 1976). Several hynotherapists noted that with successful weight loss there were improvements in other areas that were not the focus of treatment (Erickson, 1960; Hanley, 1967; Stanton, 1975). However, there is general agreement that weight maintenance and not weight loss is the real issue as weight is often regained either almost immediately or within several years. Therefore, in assessing weight maintenance a follow-up of 2 to 5 years and preferably longer is recommended before any definitive conclusions can be made about the success of treatment (Buchanan, 1973; Bruch, 1973; Craddock, 1973; Foreyt et al., 1976; Stuart, 1975).

The behavioral approaches, particularly those involving complex self-control techniques, are currently the most popular of the psycological methods and have shown promising results, at least with respect to short-term follow-up; however, because of problems of subject

selection, long-term follow-up, attrition rates, and numerous methodological difficulties (Abramson, 1977; Foreyt, 1978; Hall & Hall, 1974; Jeffrey, 1976; Stuart, 1975) generalizations about their long-range effectiveness across diverse populations would be unwarranted. However, these problems are just as common in other areas. Just as psychological data are often absent in studies dealing with dietary control or mechanical treatment of obesity, physiological data are not included in most psychological studies. Thus it is not possible to determine whether the weight gainers, weight maintainers, and weight losers can in fact be differentiated along physiological lines (Stuart, 1975).

There is a wide variation in the assumptions about the etiology and treatment of overweight among psychological systems, as well as a wide variety of treatment approaches within each orientation. What most treatments have in common is the assumption that weight control can be influenced primarily through willpower or through efforts that enhance the capacity to avoid overeating. That belief seems to prevail whether the approach is diet control, exercise, self-help groups, behavior modification or dynamic psychotherapy (Ingram, 1976). As well, some hypnotherapists also use self-restraint methods as part of their treatment package. Thus, weight loss and maintenance are typically attempted through the common-sense solutions of dieting and willpower or some weight reduction program involving diets and exercise. A few hypnotherapists, particularly Erickson, do not advocate such self-control approaches but instead utilize the patient's behavior, including his resistance and relapses, to facilitate change in self-defeating behavior patterns and to subsequently bring about weight loss and maintenance (Brodie, 1964; Erickson, 1960, 1970; Hanley, 1967). As the main problem

facing all the treatment approaches seems to be weight maintenance, methods which deal with resistance and relapses may prove to be the most effective in dealing with the recurrent pattern of losing and then regaining which is so common to the overweight condition.

Delayed Treatment: A Paradoxical Intervention?

One of the most negative views of the effectiveness of counselling and therapy was put forth by Eysenck (1952). After examining a number of survey studies he concluded that two-thirds of people seeking help improved regardless of whether or not they received therapy. In view of this spontaneous remission rate he argued that there was no evidence to show that psychotherapy was effective. This article supported the belief that some individuals mysteriously improve without therapy through some undefinable, unresearchable process called spontaneous remission.

Since that time there have been numerous replies to the article. The "myth of spontaneous remission" has been thoroughly refuted, particularly by Kiesler (1966) and Bergin (1971). In addition to discussing Eysenck's methodological errors, Bergin proposed that one explanation for people improving without therapy was that outside of the therapy situation they received therapeutic contacts with others. That is, therapy is simply a special case of phenomena occurring in every day life. This view is consistent with that of Watzlawick et al. (1974) who observed that some of the most ingenious problem solvers are not therapists but individuals working as policemen, bar tenders, and writers. Studying the same area, Subotnik (1972) attributed observations of "spontaneous remissions" to the disappearance of external stress, the unreliability of assessment techniques, unvalidated clinical

judgements and cyclical changes in the severity of problems.

There may be another explanation for the recovery of individuals without therapy, particularly those individuals who are promised treatment at a later point in time. Promising treatment may be a special case of allowing and encouraging the problem behavior. In trusting that the expert will eventually help them, individuals may give up or relax the solutions which they are using in attempts to solve their problems. Giving up the problem-maintaining solutions may allow the individual to continue his problem behavior but in a new and different way. Being more relaxed about the problem (even though it still exists) may allow shifts in the pattern of a system and lead to resolution of the problem.

In terms of the problem illustrated by the Dieting Game Without End, it may be that when promised treatment, individuals caught in such a control, loss-of-control game will relax their self-control solutions of dieting and willpwer, thus causing a shift in the game. It is possible that individuals will initially gain weight as a reaction to the relaxation of controls and restrictions but will subsequently maintain or lose weight without following a diet. That is, when there is no longer a pattern of controlled deprivation followed by out-of-control period of indulgence where weight is often regained, the amount of food eaten over time may be reduced.

CHAPTER 3

METHODOLOGY

Rationale for the Case Study Approach

The character of case studies tends to be as varied as their purposes and their supporting theoretical rationales. Niele and Liebert (1973) state that the case study approach to research has been used in each of the following ways:

> (1) as a prototypical example used to illustrate some form of behavior, (2) to demonstrate important methods or procedures, (3) to provide a detailed account of a rare or unusual phenomenon, and (4) to disconfirm allegedly universal aspects of a particular theoretical proposition. (p. 144)

Cases, generally selected to illustrate a particular point or theory, are not intended to be representative. For example, Neale and Liebert note that the phenomenon of "multiple personality" was illustrated through the observation and description of a patient in psychotherapy, "Eve White", who displayed three distinct personalities. To demonstrate a particular therapeutic technique, these authors (as cited by Neale & Liebert, 1973) reported detailed information about the treatment of a mute psychotic woman through a combination of reinforcement and imitative learning procedures.

The investigator using the case study approach typically does not maintain tight control over the independent variable. In order not to miss critical new information, he remains open to new discoveries which occur during the course of the investigation. "The very

lack of control that characterizes case studies and permits things to 'vary as they will' also increases the method's potential for revealing new and perhaps important findings" (Neale & Liebert, 1973, p. 147). Piaget used an unstructured case study method with his own children, permitting situations to wander considerably, in order to get as much information as possible about the quality of children's thinking.

Finally, the case method is often flexible with respect to the choice of dependent variables. Sometimes structured techniques, such as standardized personality tests, are used for data collection. However, often a range of measures which fits the particular purposes of the study or provides additional descriptive information (for example, videotaping) is collected to allow for the discovery of unsuspected findings.

In terms of the current study, the case study method was chosen for a number of reasons. First, in exploring and developing any new area, a descriptive, idiographic approach, often precedes and provides clues and ideas for future types of inquiry (Neale & Liebert, 1973, chap. 8). Thus, the case study method is suited to exploring this relatively new area of second-order change.

Second, because it is an excellent method for examining behaviors of individuals, a case study approach would allow for a description of the unique as well as general factors in the change process. It is often by investigating the unusual reactions of "extreme cases", in contrast to the common or normative ones, that

advances in an area occur (Pondy & Olson, 1977).

Third, the case method allows flexibility in the types of measures which are collected. This was important because it was assumed that the impact of second-order interventions depends on their effect on the receiver and not on the intent or motivation of the sender. As well, there are many aspects of the change process which are unknown. Feedback from the participants was thus particularly important. What were the individuals' perceptions of the interventions? What interventions connected with them? This method would incorporate the collection of results based on the verbal (tapescripts of spontaneous comments and therapy interaction; phone calls) and written (questionnaire) self-reports of the participants about their reactions to the interventions, about their experience of change, and about their perceptions of the treatment program and the process of problem resolution.

Finally, the Treatment Program was intended to be interactional in nature. While some interventions were planned ahead of time, the plan was to allow for spontaneous interventions and for the process to emerge throughout the 12 weeks on the basis of exchanges between the therapist and the individuals, both in individual sessions and in the group. It is extremely difficult to define and operationalize such interactions in the concrete behavioral terms often specified as necessary for experimental design. That is, while the classical empirical methods are suitable to investigation of clearly defined states or entities within a closed system, they are

not appropriate to the investigation of processes occurring in an open system. When information is continually being exchanged among a variety of subsystems, it is not possible to isolate clearly defined concrete variables. Abeles (1976) summarizes this issue:

> With interactional systems and the concepts that explain them, there are no isolates, and etiology is not interpreted in terms of lineal cause-and-effect determinism (Von Bertalanffy, 1966, 1968a, 1968b; Scheflen, 1963, 1966, 1968; Watzlawick, Beavin, and Jackson, 1967). This suggests a more appropriate approach to research would be provided by some model other than that embodied by the experimental method. (p. 138)

Plan of the Study

Two groups of overweight individuals were selected. The first received group treatment by second-order change methods. The second received promise of future treatment in order to indicate whether shifts in the problem occurred over the treatment period as a result of the promise or other identifiable factors. The first group, the Treatment Group, met for 1-1/2 to 2 hours once a week for 12 weeks. A 2-month follow-up was done in order to assess longer range effects of the Treatment Program. The Promise-of-Treatment Group began after the end of the 12 weeks and followed a similar format as the first group; however, the results of treatment for this group are not part of this thesis.

The Participants

The Problem Condition

Using ideas from the second-order change framework, it is

hypothesized that while there may have been physiological, dietary, and family factors involved in gaining excess weight, that problems with controlling eating and weight and the subsequent self-restraint solutions are a Game Without End. This Dieting Game Without End may have originally developed in a number of ways. First, concern about weight may have developed as a means of denying a problem in another area of life. Focusing on eating and overweight as the problem may have in fact been the solution to coping with unpleasant feelings or dealing with some family difficulty which was denied. A second way the Dieting Game Without End may have developed is through taking action to eradicate normal day-to-day weight fluctuations. Thus, a problem may have been created through defining a normal life difficulty, a gain of 2 to 5 pounds, as an abnormality and taking action when it should not have been. The third way a problem may have been created is through attempting change solutions of the wrong logical type. That is, first-order change solutions may have been attempted when second-order solutions were required for problem resolution.

This last alternative was chosen for the framework of this study for two reasons. From the second-order view, the origins of the problem eating and the overweight condition are not the issue; rather, the issue is: What solutions are maintaining the current difficulties with eating and weight control? Second, this description fits the pattern that many overweight individuals demonstrate; that is, they are unable to control eating and weight through first-order, self-restraint solutions.

The assumptions governing the game appear to be: (1) If I control my eating and lose weight, I will be getting what I want. (2) To control eating and lose weight I need to deprive myself of what I want. (3) New and more deprivations or more self-restraint, will lead to better control and getting what I want. These ideas about the way to lose weight and get the individual what he wants may also be reinforced by friends, family, physicians, and popular literature.

However, loss-of-control of eating fits the description of a symptom--a behavior experienced as being outside the individual's control. As such, symptoms belong to the class of behavior defined as spontaneous. The attempted solutions, variations on the same set of first-order self-restraint actions, belong to the class of behavior defined as controlled. Attempting to change a situation belonging to the class of spontaneous behaviors through control, first-order solutions creates a paradoxical situation or a Game Without End.

The deprivation solutions, regardless of whether they include following a prescribed diet, simply using willpower, counting calories, skipping meals, reducing activity to lower appetite, or increasing activity to burn off calories, are simply variations within the same pattern or group of behaviors. Even though the repeated diets or other self-control measures may appear very different, they are still included within this set of choices. Such self-restraint measures, attempted in order to get the person what he wants in terms of control, weight loss, and maintenance, have the opposite effect of getting the person what he wants. They tend to increase preoccupation with all food-related areas instead of diminishing concern; instead of leading to control, they tend to make control over eating more of an issue; they often do not lead

to weight loss or if they do, weight is typically regained. Individuals trapped in this game repeatedly use variations on the same type of control solutions to get what they want; they are repeatedly disappointed when these solutions do not bring about the desired changes, control over eating or weight maintenance. The solutions have become the problem.

Not being able to control eating, lose weight and get what is desired, and the subsequent self-restraint solutions, form a self-reflexive Game Without End. This Dieting Game Without End is maintained by the very solutions attempted to get the individual what he wants. From the second-order change perspective, interventions must be designed to interrupt these problem-maintaining-solutions. The expectation is that by blocking the use of these solutions, there might be a change in both attitudes and behaviors surrounding eating and weight control. That is, there might be a change in the rules governing weight control. For example, there might no longer be the need for self-deprivation (giving up what is wanted) to get what is wanted. With reduced self-deprivation there may be less preoccupation with food-related areas; eating, control of eating, and weight control may no longer be issues in that individual's life. Accompanying these changes in attitude and food patterns, there may be increased control over eating and eventual weight loss and maintenance.

Criteria for Selection

The group chosen involved individuals who (1) experienced eating and weight as out of control (that is, eating was symptomatic) and (2) had repeatedly failed to control their eating, and hence lose weight and keep it off, through self-restraint solutions such as willpower and dieting. An arbitrary amount, 20 pounds overweight according to height-

weight standards (Nidetch, 1972), was chosen to ensure that individuals who applied for the weight control program would have some excess weight, and to screen out normal weight people who wanted to be even thinner or who were continually preoccupied with food. In addition, candidates were to be at least 18 years old and willing to sign a release for the researcher to contact their family physician to rule out drug-related and metabolic or other physical reasons for weight fluctuations.

The Volunteers

Eight female and six male volunteers from Edmonton, Alberta, and surrounding suburbs were obtained for the Treatment Group. Ages ranged from 28 to 56 years. The Promise-of-Treatment Group consisted of seven women and seven men, ranging in age from 19 to 72 years. These two groups were selected from 47 respondents (32 women and 15 men) to an advertisement (see Appendix A, Part 1.1) accompanying the Program Guide of the Continuing Education Centre of the Edmonton Public School Board. These Program Guides were routinely mailed to members of the community who had phoned and asked to be on the permanent mailing list. When one of these advertisements was received by a local radio station, the weight control project was announced once. (Seventeen people were registered as a result of this announcement.)

As the registration forms were received, names were placed on a list. These individuals were called using a standard phone call (see Appendix A, Part 1.2). If the phone was not answered the next name on the list was called. Individuals meeting the criteria for the study were accepted into the Treatment Group first. Once the Treatment Group was filled, individuals meeting the criteria were asked to take part in the second group and send the researcher the requested information by mail.

Following these phone conversations, "regret cards" (see Appendix A, Part 1.3), were sent to individuals who had not been accepted for either group; "reminder cards" (see Appendix A, Part 1.4) noting the time and location of the first group, were sent to the Treatment Group; and the Screening Questionnaire, research permission requests, and six weight record cards plus stamped self-addressed envelopes and a letter repeating the phone directions were mailed to the Promise-of-Treatment Group. Subsequent phone calls were made to remind individuals who were late sending in their weight record cards. At the end of March, the April Questionnaire and a letter requesting the completion of the questionnaire and the return of the final weight card was mailed. (See Appendix A, Parts 2.1 and 2.2, for copies of the letters.)

Thirteen individuals attended most of the Treatment Group sessions and returned the 2-month follow-up questionnaire. One woman dropped out after Week Two, reporting a time conflict. With two exceptions (Cases 7 and 12) the 13 participants met the selection criteria at the beginning of the Treatment Program.

Eleven people from the Promise-of-Treatment Group returned all or most of the requested information. Two women and one man dropped out. One woman decided to join Weight Watchers; another was moving to Ontario; the man did not return the April Questionnaire as he was away on a holiday. With two exceptions (Cases 17 and 24) the description of the problem and solutions was consistent with the Dieting Game Without End. (See Appendix C for data on the Promise-of-Treatment Group.)

The Therapist

The therapist was a female Ph.D. student who had used second-order change techniques in individual and group counselling.

The Questionnaires

Self-report questionnaires, based on the steps to formulate second-order change interventions (Watzlawick et al., 1974), were used to collect information from both the Treatment and Promise-of-Treatment Groups. Descriptions of the Screening Questionnaire, administered in January; the Homework Questionnaire, administered weekly to the Treatment Group; the April Questionnaire, administered to both groups after the 12-week treatment period; and the June Questionnaire, the 2-month follow-up for the Treatment Group, follow.

1. The Screening Questionnaire. This questionnaire was intended to gather initial information about the problem systems of both the Treatment and the Promise-of-Treatment Groups, assessing whether the description of the problem and solutions met the selection criteria. As well questions were asked about goals in terms of weight and control over eating. (See Appendix A, Part 3.1.)

2. The Homework Questionnaire. The intent of this questionnaire was to monitor weekly changes of individuals in the Treatment Group and to get feedback about the impact of the therapist's directions. Individuals were asked to report the homework directions they thought to be important, thoughts and feelings about these directions, and thoughts and feelings surrounding incidents involving food throughout the week. (See Appendix A, Part 3.2.)

3. The April Questionnaire. The intent of this questionnaire was to assess whether there had been any changes in the problem system, the Dieting Game Without End, in the previous 12 weeks. Changes in the problem and in the solutions to eating and weight control; in other patterns not related to eating such as sleep, work, and activity; and in

goals for weight and control over eating were assessed (see Appendix A, Part 3.3). The two forms of this questionnaire were identical except for page five. Participants in the Treatment Group were asked to describe what single aspect of the program was most and least helpful. Participants in the Promise-of-Treatment Group were asked whether they were planning to attend the weight control group beginning April 24, 1978. (See Appendix A, Part 3.4, for the contrasting questions.)

4. The June Questionnaire. The intent of this questionnaire was to determine whether shifts in the problem system continued once the Treatment Program was completed, and whether any new changes, including new problems, emerged during the subsequent 2 months. Like the April Questionnaire, information about current problems with eating and weight control, current solutions, changes in eating patterns, changes in thoughts and/or feelings about food and weight control, changes in other life patterns, and about feelings of control over eating were obtained. Current weight was also reported on this questionnaire. (See Appendix A, Parts 3.5 and 3.6 for the accompanying letter and the questionnaire.)

Description of the Treatment Program

The Structure

Twelve weekly treatment sessions lasting approximately 2 hours each were held. The Treatment Group met in the Conference Room of the Student Personnel Services at Victoria High School in Edmonton. Individual weigh-ins were completed in an adjacent Medical Room on a balance beam scale. The discussions in the Conference Room and during the individual weigh-ins were tape-recorded, and typewritten transcripts were made.

With few exceptions each session followed a similar structure. First the Homework Questionnaire was filled out (exception: Week One). Second, small groups of three to four were formed to discuss the success individuals had had in following the directions during the past week or to discuss some other concern with eating and weight control (exceptions: Weeks One, Eight, and Twelve). Third, one member of the small group, the "scribe", reported a summary of the discussion to the large group and the therapist responded to issues and questions arising out of these reports. Fourth, individuals were weighed in the Medical Room and individual interventions were given (exception: Week Two).

Exceptions to the above structure were as follows. Week One. After the program purposes had been overviewed, the January Questionnaire was filled out. Then permission was obtained to use information about the participants in research (see Appendix A, Part 4.1) and to contact family physicians to rule out physical or metabolic and drug-related reasons for weight gains and losses (see Appendix A, Part 4.2), using a negative return form (Ley, Bradshaw, Kincey, Couper-Smartt, & Wilson, 1974) (see Appendix A, Part 4.3). As well, a sheet entitled, "Agreement to be a Co-researcher" (see Appendix A, Part 4.4) which detailed what was expected from participants and asked for a commitment to attend whether or not they could follow the directions, was signed. Week Two. Weights were taken first because when the directions were given at the end of the session, people were asked to leave quietly without talking to anyone. Week Eight. Due to the size of the group there was no subgrouping. Week Twelve. There was no subgrouping due to the extra time needed for the April Questionnaire.

Second-order Change Interventions

The purpose of the program was to bring about second-order change in the participants in relation to their problem with eating and weight control.

Second-order change was operationally defined as making a shift from the Dieting Game Without End in which (1) eating and weight are experienced as out of control and (2) the attempted solutions to control eating and weight are willpower and trying to diet, to a second set of behaviors in which control of eating is no longer an issue or if it becomes an issue, the loss of control is not handled by attempting more control. More specifically, there should be a change from reporting, verbally and on questionnaires, that eating feels as if it is sometimes out-of-control or uncontrollable, to reporting that eating feels as if it is under control or that out-of-control times are not handled by attempting more control. Other reported changes would include those that indicate participants have a more expanded set of choices to control eating and weight, such as eating what is desired instead of following a restricted diet.

To accomplish these purposes interventions based on principles of second-order change were used. Definitions of these interventions follow.

(1) Prescribing the symptom, suggested by numerous authors (Haley, 1963, 1973; Watzlawick et al., 1967, 1974), is defined as encouraging the individual to do the specific thing that is to be eliminated or changed.

Prescribing the symptom was operationally defined as (a) encouraging the overweight participants to gain 15 to 25 pounds before they let

themselves lose weight; (b) encouraging participants who begin gaining to gain even more; (c) encouraging the participants to plan a certain time, place, and menu for overeating or bingeing; (d) encouraging a relapse when individuals have lost some weight and are concerned that their old habits may return; (e) encouraging all participants to relapse and try to gain 3 to 5 pounds whenever they need to do so in order to maintain their control over eating; and (f) encouraging individuals to eat at certain problem times when their eating tends to get out of control.

(2) Restraining, a term suggested by Rohrbaugh, Tennen, Press, White, Raskin, and Pickering (1977), parallels the "go slow" or "resist change" directives used by Watzlawick et al. (1974). In order to allow the desired change to occur, change may be discouraged (soft restraining) or denied (hard restraining). For example, when improvement occurs an individual is encouraged to go slow. When resistance is encountered, the dangers of improvement are emphasized (utilizing resistance).

Restraining is operationally defined as (a) encouraging individuals who begin to lose weight, not to lose too fast, not to press, but to go slow; (b) emphasizing to those resisting by not gaining weight that they are individuals with whom this approach will probably also fail so it is best that they do not follow the directions; (c) telling an individual that losing weight is probably an impossible goal so that learning to live with the excess weight is likely the most that can be expected.

(3) Reframing is defined as follows:

> To reframe...means to change the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the "facts" of the same concrete situation equally well or even better, and thereby changes its entire meaning. (Watzlawick et al., 1974, p. 95)

Reframing was operationally defined as giving the eating and weight problem a different meaning through (a) redefining gaining weight as being in control, and redefining losing weight as the out-of-control part of the losing-gaining cycle; (b) redefining resistance as a normal and expected difficulty that some people have and therefore encouraging the individual not to try to follow the directions; and (c) redefining things usually done in order to lose weight, like eating breakfast and exercising, as ways of helping to gain weight and thus gain control over eating.

The Treatment Process

While the interventions for Week One and Two were planned prior to the beginning of the Treatment Group, the plans for subsequent interventions arose out of the group interactions and individual sessions, the therapist's impressions of the type of interventions needed to deal with change and resistance to change, and the therapist's consultation with colleagues. Even though directions were sometimes prepared in advance, the plan was to wait to give the direction until it had relevance to the group or individual, to react to the spontaneous moment. As well as the general plan for responding to those complying with instructions and those resisting instructions, some directions for individuals were also planned ahead of time and followed or changed on the basis of current contact. The specific directions given to individuals are provided in Appendix B.

In the following section, directions and other messages considered to be as important to the process of second-order change are summarized. Group interactions are also reported at times because the Treatment Program was interactional in nature and to some degree evolved throughout

the 12 weeks according to the processes of both the therapist and the participants. As there were specific directions given on Weeks One, Two, and Twelve, those directions will be reported in more detail.

Week One. The expressed purposes of the program were to help participants to gain control over eating and to change their eating habits and patterns. Participants hoping to focus on weight loss per se were referred to Weight Watchers.

The intent of the messages given in Week One was to "hook" the participants and set them up for the directions of Week Two. Participants were given a general overview of the program without specific directions in order to create an atmosphere of suspense and to increase their interest and curiosity about the program.

Messages considered important to the "hooking" were:

(1) Pointing out the frustration of the cycle of trying to lose and then letting yourself gain.

(2) Emphasizing the difficulty of the treatment approach--"I want to make it clear that it may work for you and it may not. Even people it does work for find it difficult to follow. In fact anybody would find it difficult to follow."

(3) Emphasizing that the program focused on changing patterns around eating and getting control over eating in rather unusual and different ways.

(4) Stating that the most important message would be given the following week, with the final twist, "I don't want you thinking about that until then."

As well certain messages were given to build up expectations about what might happen in the future if the program turned out to be successful

for them. First, the importance of eventually developing an individual success pattern was mentioned. "What I tend to believe is the most successful kind of program is one you develop yourselves, not as a group but individually." This was important so the therapist would be able to reframe individual variations in responding to the directions as being consistent with the intent of the approach. Second, to stress the idea of individual success patterns, participants were told that sometimes they would get an instruction that everybody was to try to follow and at other times they would get individual directions as the therapist got to know them better. Third, participants were given a set for possible changes in other life patterns. They were told that sometimes when the approach is successful and their eating patterns change, other patterns in their life also change and that this could be an upsetting experience: "That's very normal with this approach." This technique also made it possible for the therapist to reframe feelings of distress with changes in eating patterns or other life patterns as normal responses associated with a success pattern.

Finally, certain behaviors which could easily be carried out such as attending sessions, providing program feedback, and monitoring their weight (rather than changing behavior or following the difficult directions), were requested. Those not able to meet these requirements were discouraged from returning the following week. The importance of their roles as co-researchers in discovering more about this approach and helping others with similar problems with eating and weight control was stressed.

Week Two. To lay more groundwork for the weight-gain directions, the group was reminded that the most important directions would be given

at the end of the evening. Then participants were divided into groups of three to discuss (1) the problems they had with eating and weight control and (2) the solutions they had attempted to control their eating and weight. The therapist then summarized the reports given to the total group by the "scribes", emphasizing the similarities in the attempted solutions. The frustration of the cycle of trying to lose and then letting themselves gain was stressed.

Then the intent of the directions was stated as helping participants "get to a place where you can allow yourself to lose weight, where you let yourself lose weight rather than forcing yourself to lose weight, rather than having to lose weight." To emphasize the difference between trying to do something and allowing or letting something happen, metaphors or examples from the areas of sleeping, swallowing pills, and remembering names were given. It was emphasized that trying often led to failure whereas letting often led to success. Having this extra wait during these various activities served to build up more curiosity and suspense in the group.

Several messages requiring the participants' verbal agreement were given to increase the likelihood that they would try to follow the final instructions to be given later in the evening. Participants were requested to agree to not ask questions, to not discuss the directions for 24 hours, to leave quietly without talking to each other and to not talk to each other the following week until after the Homework Questionnaires were completed. An example of these directions follows.

> This is the most difficult part of the evening. Shortly I'm going to give you the important instruction. Now when I do I want you to do certain things. First I don't want you to ask me any questions. Second I don't want you to talk to each other or to

myself. I want you to put on your coats and leave quietly. Number three, I don't want you talking to anyone about the instructions for at least 24 hours. Now, I think I'm being clear but I want somebody to give me a check to make sure.

Finally, the symptom prescription, "try to gain weight", was given.

> Again it's kind of startling and if some of you are prone to shock you might want to hold onto your chairs. I'm going to ask you to do what is easy for you to do instead of what's hard for you to do. Instead of having you work against yourself and try to change your self-defeating behaviors, I'm going to try to work with your self-defeating behaviors.
>
> Now what I want you to do is try to gain between 15 and 25 pounds. Some of you will need to gain less than that and some of you will need to gain more than that. You can gain it as quickly or as slowly as you wish. The important thing is to begin right away.
>
> I'll see you next week. Thank you for coming. Good night.

Weeks Three and Four. After the completion of the Homework Questionnaire, the group was subgrouped and asked to discuss the success they had had in following the directions. The intent was to give a positive reframing to the experience of gaining weight. To set the groundwork for making comparisons between the gaining and the losing patterns, participants were asked to set goals for how much weight they would try to gain (Week Three). Further similarities between the patterns of gaining and losing, including the resistance to changing food habits and the difficulties in both gaining and losing weight, were pointed out both weeks. As well, during each session, the intent of the directions (instead of losing being followed by gaining, gaining will be followed by losing) was stressed. Week Four, to lay the ground work for asking people to buy big clothes, the group was asked: "How many people have ever bought clothes anywhere from a size to a couple of sizes too small and intended to grow into those clothes? I'd like to know how many people have done that as a motivator...How many people's closets are full of clothes that don't fit because they're too small?"

Week Five. Week Five's directions and messages were given largely as responses to comments and questions from the group. For example, one group reported about the difficulties of gaining: "All members of our group expressed the desire to go back on a diet and lose weight...we all felt that we have been afraid to put on weight for varying periods of time....But trying to gain weight is another thing. It's a darn sight harder than losing weight in our opinion." The similarity between the difficulty of gaining and the difficulty of losing weight, between the desire to stop gaining and the desire to stop losing after a period of time, was again mentioned. The intent of the gain directions as aides in shifting old patterns, getting control over eating, and getting to a place where "you let yourself lose" was emphasized. As well, in response to comments about difficulties, the prediction of what would happen in terms of food choices once a person achieved control was stated.

> The intent of the directions is to get you to a place where you have control over your eating. It's to shift your old pattern of trying to lose and letting yourself gain into one where you try to gain until you get to a place where you let yourself lose. Instead of gaining following losing, losing follows gaining. And the more control that you get over your eating, the more you'll find you can eat what you want to eat. That is, instead of following a prescribed diet of what's fattening and what's not fattening, and feeling guilty if you don't follow that diet and feeling really deprived if you do follow that diet, you move into a place where you can eat what you want.

When one group expressed apprehension about clothes fitting, the planned message about buying "big clothes" was given.

> I can hear the impatience for people to change and go off gaining weight and I...again draw the parallel between people who have been on a losing diet for a month and are getting really impatient to have something they want to eat. I also heard that people are getting concerned their clothes aren't fitting. Now if you're getting uncomfortable in your clothes, what I want you to do is go out and buy an attractive outfit that's at least two sizes too big for you.

Before weigh-ins, the intention of the directions was repeated and the therapist responded to other concerns and questions.

Week Six. First the Homework Questionnaires were completed. Then an issue brought up in Week Five, the participants' concern about not having enough time to gain 15 pounds before the end of the sessions, was dealt with. The therapist offered continued contact--further meetings or phone calls--with members who did not feel they had adequate direction by the end of the Treatment Group. This seemed to allay concerns about being left "high, dry, and fat."

In the small groups participants were to discuss what had happened over the past week, whether there was food that they had wanted that they had not yet let themselves have, and if there was a time when they had wanted to eat when they had not yet let themselves eat.

After the reports, the following planned directions about eating bigger breakfasts to help gain weight were given. (People on diets are often encouraged to eat breakfast in order to lose weight. This was considered a reframing message; that is, eating breakfast was not associated with depriving themselves).

> For people who are having difficulty gaining the weight that they need to gain, I'd suggest that you attempt to eat a breakfast.... ham or bacon, plus eggs, toast and butter and jam, fruit juice or fruit, coffee the way you really like it. And of course some dessert!....Now if there are some of you who can't follow that outline because of religious preferences, make up your equivalent.

Weeks Seven to Eleven. Basically the same pattern was followed each of these weeks. The focus was on the success participants were having following the directions, the control they were experiencing, and on ways to improve by eating more of what they wanted. As well, in relation to group comments, similarities between the patterns of losing

and gaining were emphasized. Variations on this pattern follow. Week Seven participants were asked to write down how their families or friends were reacting to their attempts to gain weight. As well, the participants were directed to eat balanced lunches, including "proteins, grains and fat, vegetables if you like them" if they were having difficulty gaining weight. Weeks Nine, Ten, and Eleven, to change the routine which was becoming boring to some people, the subgroups were given a choice to discuss something other than the changes related to eating. Week Nine, the following suggestion, intended to reframe doing exercise, often prescribed as part of a deprivation pattern for dieter, was given. "Sometimes just getting out and walking or doing something more active does stimulate your appetite a bit more (and help you to gain weight and hence, control over your eating)." Week Ten directions were given to two members (Cases 1 and 8) in relation to concerns about interaction with their sons and food. Week Eleven, participants were reminded that they could arrange continued contact with the therapist if they felt they needed to after completion of the 12 weeks.

Week Twelve. The Homework Questionnaire was completed. Then the April Questionnaire was handed out with the directions to, "respond as clearly and directly as you can right now. Don't be concerned about your spelling or the way you express yourself. What's most important is the message that you get across." Participants were reminded of the two subsequent questionnaires they would be receiving in June and October. They were thanked for their time and the work they had done. Then the directions for "letting themselves lose", for maintaining control, and for handling out-of-control times were given to the whole group.

The directions for maintaining control and for handling out-of-control times were designed respectively as directions to have a relapse and as a positive reframing of gaining weight. "Overeating to let yourself lose..." was designed to be a message aimed at resistance to the losing process; that is, the idea was given that losing could occur without deprivation. The therapist gave a soft restraining message by expressing doubt that people who had not gained weight or who had not reached their goal would be able to let themselves lose. The directions given follow.

> I said at the beginning that some of you would need to gain a bit less and some of you would need to gain a bit more in order to gain control. Now some of you've been able to do that and some of you haven't been able to. The point that I want to make very clear is that in spite of the fact that most of you have said you gained weight very easily, most of you have had great difficulty doing that. Some of you haven't been able to, even though you've been encouraged to do that steadily for eleven weeks. I think it's really important to make that clear.
>
> Now I don't know if people who haven't reached their goal have control. But nevertheless I'd like to give everybody the directions for letting themselves lose. I'm not sure that people who haven't been able to reach their goal will be able to let themselves lose either but if you want to make a decision to let yourself into a losing pattern at this point in time I think that's an appropriate choice to make....
>
> Now the instructions for letting yourself lose are to continue to overeat to let yourself lose no more than you've been able to gain in a week. It's important to overeat to lose very slowly....I want you to overeat to continue losing very slowly.
>
> One thing that's extremely important is that you eat food that you want to eat. It's very important that you don't set yourself up in a pattern of depriving yourself of certain types of food. It's very important that you don't get into a pattern of depriving yourself and then feeling guilty if you eat what you're not supposed to.
>
> The last thing that's very important for continued maintenance is that every four to eight weeks, now this is pretty individual,..., you deliberately regain two to five pounds. Do that whenever you need to in order to ensure your maintenance of control....The other thing that's important is that if you get to a place where

you feel it's very important to try to lose weight, at that point it's probably important for you to try to gain some weight until you can get to a place where you can let yourself lose again.

After a number of questions from the group the weigh-ins were done. During these individual sessions, further checks were done on the clarity of the directions.

Evaluation Criteria for the Case Study Data

The verbal (tapescripts of spontaneous comments and therapy interaction; phone calls) and written (questionnaires) self-report information was evaluated at the end of the 12-week program and at the 2-month follow-up for evidence of second-order change in terms of the following criteria.

Success. Participants were considered successful illustrations of second-order change if self-reports indicated that (a) their eating was under control while eating what they desired instead of attempting to follow a prescribed diet, (b) they had no current difficulties with eating and weight control, and (c) the changes in attitudes and eating behaviors appeared to be connected with the treatment interventions. That is, there was a shift from an out-of-control, passive orientation to eating to a more active process in which individuals took more personal responsibility for control of eating and in which a more expanded set of choices for control of eating was available (if control did become an issue).

Partial success. Participants were considered partially successful in terms of second-order change if self-reports indicated that

(a) if difficulties were present (including feeling eating was out of control), these difficulties were being handled through strategies learned in the program, (b) attitudes and behaviors surrounding eating and weight control had changed, and (c) changes appeared to be connected with the treatment program.

Failure. Participants were considered failures if self-reports indicated that (a) difficulties with eating and weight control were present, (b) these difficulties were being handled through self-restraint solutions such as attempting to follow a diet, (c) attitudes and behaviors towards eating and weight control remained similar to that at the beginning of the program, and (d) there was little or no relationship between their current state and the treatment interventions.

CHAPTER 4

RESULTS

Over the treatment period data were collected from the participants in the form of verbal (tapescripts of spontaneous comments and therapy interaction) and written (questionnaire) self-reports. These weekly self-reports and the 2-month follow-up (written questionnaire and phone call if requested) served as process markers or as indicators of change in the pattern or process in relation to the presenting problem. It is this information which forms the basis for the 13 case studies which appear in Appendix B. Data extracted from these case studies form the results of the study. These data were evaluated according to the criteria which were set out in Chapter 3.

Written self-report data (questionnaires) were collected from the Promise-of-Treatment Group twice during the treatment period (see Appendix C). Excerpts from these data and bi-monthly weight reports were used to answer questions about the relationship between delayed treatment and paradox.

Case Study Data

The individual reactions and outcomes for the 13 participants after 12 weeks of the Treatment Program and at the 2-month follow-up were somewhat different. In relation to the directions to gain weight,

participants generally followed two basic patterns: eight tried to follow the directions to gain weight; five resisted the gain directions most of the time. The verbal and written self-reports of some individuals in both patterns showed evidence considered to illustrate second-order change. However, within each pattern there was a range of reactions, from no or little change in the original problem and the context surrounding eating and weight control, to dramatic change in attitudes, patterns of eating, and in sense of control over eating. As well as facilitating some of the expected changes, such as increased feelings of control without dieting and using self-restraint solutions, there were some unexpected changes in both attitudes toward eating and weight control and in other areas apparently affected by these changes.

Before presenting the case study data, a brief summary of the main interventions given to the total group is presented to give the results more clarity. The reader is reminded that all of these messages and interventions occurred within a particular context and that there were often preliminary messages given to prepare for the following statements. (See Chapter 3 for the complete interventions given.)

Week Two. At the end of the evening a symptom prescription to gain weight was given.

Week Three. The group was asked to set goals for how much weight they would try to gain.

Week Five. Directions to buy clothes at least two sizes too big (to grow into) were given.

Week Six. Directions to eat bigger breakfasts, including a dessert, were given to help those who were having difficulty gaining.

Week Twelve. Directions for "overeating to let yourself lose..." and for maintaining control over eating by trying to gain 3 to 5 pounds as necessary were given (planned relapse).

Case I: Mrs. T.

At the beginning of the Treatment Program, Mrs. T's description of her problem and solutions was consistent with the Dieting Game Without End. Through trying to gain weight (9 1/2 pounds), there was a clear change from a passive to an active orientation to eating and weight control. "I felt I am the one in control, not a diet book, a doctor, etc." She not only experienced a change in her sense of control over eating, her whole attitude to her problem changed.

> My whole life is just turned upside down, it really is. It's fantastic! If I don't lose weight, I'm still happy....I think that I'll never be a failure again because...when I do eat it will be because I decide to start eating and when you make that decision then you're not a failure. 'You can't be a failure really because you're still in control.

Mrs. T. attributed these changes to "facing food, trying to gain weight, and removing guilt feelings."

She also experienced changes in other areas of her life, both intrapersonal and interpersonal. She accepted her size and her fatness; her energy level increased; she took up new hobbies; she got up more easily in the morning; her body temperature increased; she began to smell food again. Mrs. T.'s relationship with her 12-year-old son improved, especially on eating related issues. She gave him choices about after-school snacks instead of telling him that he could not possibly be hungry. He stopped snacking as he had before. Therefore, at the end of the 12 weeks Mrs. T. was assessed to be successful in terms of illustrating second-order change.

Two months later the changes in both her original problem and in other areas were still present. She was continuing to explore previously forbidden foods, eating what she wanted, when she wanted. She felt her eating was under control and continued to feel relaxed about food and her weight. Mrs. T.'s eating pattern consisted of three meals a day with no snacking. She attended banquets and entertained without the struggles which previously occurred. Since she was not preoccupied with food all the time, she was directing her energy to other things. Mrs. T. was still not concerned with weight loss. Yet her attitude or perception of her weight had continued to change. She was feeling less self-conscious about her size and was wearing shorts, something she had not done previously. During the requested follow-up phone call, she readily agreed with the therapist that she may need to gain a bit more since there were a lot of foods she had not explored yet. Being overweight was simply not a problem for her anymore. "Whether I'm skinny or not, it doesn't really matter, I'm going to look after me." Once again Mrs. T. was evaluated as a success in terms of illustrating second-order change.

Case 2: Mr. M.

Mr. M.'s description of his problem and solutions was consistent with the Dieting Game Without End. Throughout the program he attempted to gain weight, reaching his 15-pound goal weight by Week Eleven. His sense of control over his eating increased; he experienced no cravings or guilt in relation to food; he was eating a good breakfast and was no longer snacking. "Removal of the food taboo and the associated guilt feelings about food diminished its importance." Finding that he did not balloon up overnight, he found that he could pick and choose his food

better.

> I don't have the urge to get to the bottom of a dish of peanuts, etc.--I eat when and what I want without feeling a compulsion to pig out on junk foods. Have little desire to eat at other than meal times. I have also found that certain foods that I thought were great weight putter-onners (sic) don't seem to have that effect in a balanced diet.

Having lost 5 1/2 pounds between Weeks Eleven and Twelve, he thought his present problem with weight control was remembering to "eat enough to keep the weight from disappearing too rapidly." As well as changes in his eating habits, Mr. M. reported he was sleeping better and had stopped watching television, previously an excuse to eat. He thought he was slightly more active than he had been before.

While considered a success at the end of the program, Mr. M. was evaluated as partially successful at the 2-month follow-up. After a loss of 10 pounds he experienced his eating as out of control. He had stopped eating breakfast, something that had been an important part of his control pattern. However, he was implementing the second-order approach learned in the program and was deliberately overeating to regain control of his eating. He was planning to begin eating breakfast again. Mr. M. was still pleased with his new attitudes towards food yet he was disappointed that he had not lost weight more quickly and that overeating the second time was not helping him regain control as dramatically as it had during the program. Thus, while there were still some attitude changes and he was utilizing some second-order change techniques, the context of his eating was still in a similar frame to that at the beginning of the program.

Case 3: Mrs. V.

Mrs. V.'s description of her problem and attempted solutions

was consistent with the Dieting Game Without End. Initially she quickly lost 8 pounds, in part due to illness. However, by Week Three, Mrs. V. began trying to gain weight. As well as being encouraged to try to gain she was given symptom prescriptions to eat particularly when she was depressed, a peak time of overeating.

During the course of the program Mrs. V. reported relief from guilt about eating, feeling good for the rest of the day if she ate breakfast, that food had lost most of its appeal, that she was throwing away her children's leftovers (instead of eating them), and that watching television advertisements for food did not turn her on anymore. These changes were attributed to "having to gain this extra weight" (17 1/4 pounds). Mrs. V. became increasingly self-conscious about her size throughout the program. However, because she was so heavy any weight increase was difficult for the therapist to see. Mrs. V. also reported feeling very tired, sluggish, and short-tempered. Beginning Week Five she said she had chest pains; at this point she weight 6-1/2 pounds less than Week One.

Mrs. V. had difficulty bringing on her depression on the agreed-upon days; however, when the depressions did "happen" upon her, she was praised and encouraged to try hard to stay depressed. By Weeks Eleven and Twelve she did not want "to head for the fridge" when she was depressed. "I just didn't feel like eating." As well as reaching her gain goal, Mrs. V. reported she had control over food. "It's not like it used to be where I had to have it." The instructions to let herself lose and to maintain control by trying to regain weight made "sense" to her. Mrs. V. was assessed to be successful in terms of illustrating second-order change.

At the 2-month follow-up there were no indications of these changes in the presenting problem. Appearing to have relapsed completely, she was considered a failure at this time. Mrs. V. was now attempting to control her eating by keeping busy and not eating breakfast; she reported that she was very depressed. However, while she sounded depressed on the follow-up questionnaire, she did not seem so during the follow-up phone call. She was getting out more. During the conversation she decided she would start eating breakfast again. Mrs. V. related the incident precipitating the change back to her old patterns. She had met Mr. O. (Case 6) in the supermarket. After learning he had lost about 25 pounds in contrast to her 10 pounds, she felt like a failure. She began omitting breakfasts, hoping to lose more quickly. Mrs. V. then regained about 5 1/4 pounds in an out-of-control fashion and became very depressed. During this phone call, the therapist attempted to respond to her current process, encouraging and reframing it when possible. For example, within the frame of the importance to her of staying fat, Mrs. V. was encouraged not to eat breakfast and not to get control over her eating. In relation to her future process, her words seem most appropriate. "Only thing I can say is time will tell."

Case 4: Mr. B.

Mr. B.'s problem and solutions were consistent with the Dieting Game Without End. Throughout the 10 weeks he tried to gain weight, he managed to gain 10 pounds. He often expressed how difficult a task that was. At one point he reacted to eggs and broke out in boil-like welts.

By the end of the program there were changes consistent with the operational definition of second-order change. He felt his eating was

under control while eating what he desired. Mr. B. had also stopped feeling guilty about eating, no longer worried about the amount of food he ate, and had a more relaxed attitude towards food. He had discarded his previous belief that he only had to look at food to gain weight and had lost his fear of gaining weight. "I have learned not to be frightened of food and to tackle a greater variety of them....I find that on occasions I can do quite well with smaller amounts." He reported his eating had slowed down and that he felt no cravings for food. These changes were attributed to the direct experience of gaining weight.

While he felt more alert and productive at work and was sleeping better, Mr. B. was very uncomfortable moving about. As well, he was no longer so concerned about his children's eating habits--"I don't force them to eat and I don't stop them from eating."

Although Mr. B. was considered to be successful in terms of illustrating second-order change at the end of 12 weeks, he was assessed as a partial success at the 2-month follow-up. Some of the shifts in the problem were still evident. He was not using willpower or diets to lose weight and he was still eating what he wanted. When his eating did get out of control he tried to regain control by "not worrying about what I eat." However, after losing 8 1/2 pounds he had reached a plateau and began feeling out of control and disappointed that he had not lost as quickly as he had hoped. Jibes from family and friends about his apparent failure seemed to accentuate this concern. Yet by the time he was given his requested follow-up phone call, he was implementing second-order change techniques. He had regained control over his eating by deliberately overeating and gaining about 6 pounds. He

was letting himself lose once again. He was still concerned that he was heavier than he wanted to be; however, he stated, "I've been heavy 30 years; I can wait another year." Thus, in spite of some current difficulties with eating and weight control, there was evidence of change in his attitudes and behaviors consistent with the partial success category.

Case 5: Mrs. E.

Mrs. E.'s problem and solutions were consistent with the Dieting Game Without End. Although she initially had mixed feelings about doing so, Mrs. E. attempted to gain weight throughout the program. With a great deal of difficulty she eventually gained 11 3/4 pounds. By the end of the program there were changes consistent with the success category of second-order change. Mrs. E. felt her eating was under control. Her eating patterns had changed so that she now ate breakfast and lunch instead of skipping them. She carefully prepared "small nutritious snacks", finding that she ate less when she did so. At the beginning of the program she had written, "one slice of bread, a half tablespoon of corn, rice or potatoes means a gain of weight." In contrast, she stated, "I don't have to starve to lose weight. Knowing I can have anything, I have lost my cravings for foods or food in general." As well, Mrs. E. no longer believed she simply had to look at dessert to gain weight and now found many things too sweet.

Mrs. E. thought she was more active, was sleeping less, and was more awake in the mornings. She had stopped insisting her children clean their plates as she had done previously; she allowed small portions of dessert even if the main course had not been completely finished. However, Mrs. E. was very irritable because she had not reached her

gain goal.

At the 2-month follow-up, some indications of the changes in the presenting problem were still evident. She experienced her new eating habits and attitudes towards food as a "new-found freedom." Although there were times when her eating was out of control she felt she had met her control goal. However, she was discouraged about her slow loss--5 pounds. She had hoped she would have lost more quickly. As requested, a follow-up phone call was given. Going slow, trying to gain weight to get control, finding out what's missing at breakfast, and experimenting with her eating patterns were emphasized. Mrs. E. was evaluated as a partial success--while there were some changes the presenting problem was not totally resolved.

Case 6: Mr. O.

Mr. O.'s problem and solutions were consistent with the Dieting Game Without End. He tried to gain weight, reaching his gain goal by Week Seven and losing 9 1/2 pounds by Week Ten. When he returned the April Questionnaire by mail, there was some question about the changes which had occurred. He reported that his eating was out of control sometimes and that to get control he stood in front of the mirror and thought how unattractive he looked.

He stated that his present problem was "trying to eat properly and fill up as well as lose weight." However, he reported his attitude to food had changed. He attributed this attitude change to finding he could eat anything he wanted and still not gain a great amount in a short period of time.

As he had missed the final session he was telephoned to remind him about the follow-up questionnaires and to give him the directions for

maintaining control (the planned relapse). During this phone conversation he stated, "Maybe I didn't understand the questions. Since last session I haven't had the problem of losing control. I eat what I feel like eating; that's all. I think I have control." Talking to him, it also sounded as if he did understand the directions for letting himself lose and for maintaining control. He stated he was not eating as much but seemed more satisfied with what he did eat. Mr. O. was reminded to eat what he wanted and not get to get into a pattern of depriving himself. He replied, "Right, if you deprive yourself, then you end up really wanting it and you get out of control again." Since Week Ten he had lost a further 9 1/2 pounds; he was 4 1/2 pounds lighter than Week One. The discrepancies between his written and verbal self-report may have been related to the fact that he completed the questionnaire at work where he was being constantly interrupted (questionnaire postscript). However, because his reports were inconsistent Mr. O. was evaluated as a partial success.

Two months later Mr. O. reported changes which were clearly consistent with the success category of second-order change. He felt he had control over his eating and that he had met his goal for control. He was not following a diet and continued to eat starchy foods in moderaton. Occasionally he ate extra food when he had a few beers. Mr. O. felt he could eat enough to lose weight without feeling hungry; he had lost a further 15 pounds and was 19 1/2 pounds less than Week One. At this point his attitude towards himself as well as towards weight control seemed to have changed. "I feel that if I want to eat anything I can. I know I can lose it just as fast as putting it on...I believe I was a compulsive eater before, now I still enjoy eating but do not

need to pig out."

Case 7: Mrs. J.

While Mrs. J.'s eating problem and solutions were consistent with the Dieting Game Without End, she did not meet the 20-pound selection criterion. Initially Mrs. J. resisted the directions to gain weight. Then for approximately 5 weeks she tried to gain. Throughout this time symptom prescriptions aimed at her eating-guilt and eating-depression patterns were given. Although she gained 8 1/4 pounds she did not experience control over her eating. Week Nine she decided to rejoin Weight Watchers for the third time in the past 14 months. However, she wanted to continue attending the Treatment Program, commenting that she was finally confronting her problem and facing food instead of running away from it.

By the end of the program there were some changes in her presenting problem. Mrs. J. was more aware that she could eat all kinds of food, that she did not really have a different type of metabolism, and that she used to eat without considering it as "really eating." She was allowing herself desserts when dining out, finding that when she did so she did not come home and binge. Mrs. J. reported "a more relaxed attitude toward food and I enjoy my food more when I do indulge." As well, she was more patient with her daughter's eating, not pushing her to eat if she did not want to.

However, Mrs. J. still felt her eating was out of control. Although she was once again having difficulty following Weight Watchers, she had been attempting this self-restraint approach. She described her current weight control problem: "Every time I feel successful about weight loss or that I'm getting my eating habits under control I start

eating a lot. This triggers guilt and I eat more." In terms of second-order change Mrs. J. was assessed to be a failure.

Two months later there were a few changes. She was still feeling less guilty about the food she ate and she realized she could eat fattening food like other people do. However, the changes were still not consistent with second-order change. Her eating did not feel under control. While she had lost 10 3/4 pounds, she had done so through a program of increased activity and reduced calories. She was still afraid she would go off the "deep end" with some foods and was still impatient to lose weight.

Case 8. Mrs. Y.

Mrs. Y.'s description of her problem and solutions fit the pattern of the Dieting Game Without End. Throughout the program, Mrs. Y. tried to gain weight.

Gaining was extremely difficult and at her peak she was only 2 1/4 pounds above her starting weight. Her difficulty was reframed as being a failure with gaining weight.

At the end of the program there were some changes consistent with a shift in the problem. However, there were some discrepancies between her verbal and written reports. Verbally she reported that her eating was under control, that she did not crave foods the way she used to, that at times she was satisfied with smaller amounts, that she was not snacking, that she was not continually tasting as she cooked, and that she could bake cakes and cookies without eating them. Contrary to these comments, Mrs. Y. reported on the questionnaire that she felt her eating was out of control sometimes when she was upset and nervous. Another conflicting report was that while she said she was eating everything she

had ever craved, she wrote she was avoiding sweets and chocolates. Mrs. Y. still felt she had a weight control problem. "I was to gain 15 to 20 pounds and somehow I just don't seem to be able to do it." Mrs. Y. also reported that while she was getting up more easily and earlier, that she was less energetic and crankier. Unexpectedly, Mrs. Y. decided to keep trying to gain weight. She was evaluated as a partial success at this time due to the discrepancies in her verbal and written self-report and the fact that she was going to continue gaining.

Contact was maintained through monthly phone calls. By the time of the second call, changes were more consistent. She was eating what she wanted, was pleased with her 5-pound gain, had lost her craving for sweets, and had run out of foods to explore. Nevertheless, she wanted to continue gaining. By the time the 2-month follow-up was returned, Mrs. Y. reported that her eating was in control, that she had met her control goal, and that she was still not snacking. After gaining 6 to 7 pounds in total, she had let herself lose this weight, eating what she wanted, when she wanted. "I'm on my way now. I'll relax and my weight will come off." While an important factor in these changes may have been starting an evening job, Mrs. Y. was now viewed as a successful illustration of second-order change in terms of the control she experienced over eating while eating what she desired.

Case 9: Mr. A.

Mr. A.'s description of his eating problem and solutions fit the pattern of the Dieting Game Without End. Throughout the program he followed a resistance pattern. "I can win. I'll defeat your purpose. I think I can come out positive for myself on that. I can lose some weight without gaining the 15 pounds first." When his reported success

with losing was doubted (he was too heavy to be weighed), he challenged, "You were wrong. I'm still on it." When Mr. A. missed several sessions, he was called and asked to attend and give his feedback. By the time he returned the April Questionnaire by mail (he missed Week Twelve as well), he reported his eating was under control and that he had continued to lose slightly due to "resisting the research programmed (sic) instructions." The most helpful intervention was reported as "telling me I wouldn't get anywhere." (See Appendix for the hard restraining message given to him Week Seven.) Mr. A. was assessed as partially successful because "eating too much" was still reported as a problem.

However, as his resistance also carried over into completing questionnaires, at the 2-month follow-up it was difficult to determine if any further changes, including a report of "slight loss", were related to the treatment interventions. As before, Mr. A. answered the questionnaire as briefly as possible. While he reported he had no current difficulties with eating and weight control and that his eating was out of control only twice a month, he stated that he had not met his control goal. Mr. A. stated he had cut down on food because of high food prices. Because there was no evidence of changes connected with the second-order change approach Mr. A. was evaluated to fit the failure category.

Case 10: Mrs. I.

Mrs. I.'s problem and solutions fit the pattern of the Dieting Game Without End. She followed a resistance pattern throughout the program.

> During the course of the week if I felt like eating something which I knew I shouldn't I'd think of your instructions which would allow me to, but when it really came down to it, I wouldn't bother as I couldn't follow the directions....You have the opportunity to eat whatever you desire and in whatever quantities but it just didn't seem to matter that much. It just wasn't important anymore.

Her resistance included a period (Weeks Seven to Ten) of trying to regain 2 pounds to prove to the therapist she did have control over her eating. "I'll prove it to you that I have (control)." "Go slow" and other soft restraining messages such as "I'm doubtful" were frequent individual messages given to her.

In spite of her efforts to prove to the therapist she did have control over eating, it was difficult to attribute the changes in her eating (no snacking and eating three meals a day) and her weight loss (11 3/4 pounds) to the program. She thought these changes had occurred because her initial loss encouraged her to try not to gain. When she felt her eating was out of control, she gave herself a "mental talking to--try to substitute some other activity." She cut down on eating dessert, ice cream, candy bars, etc., to control her weight. Her present problem was "learning to eat lesser quantities and avoiding to 'excess' foods which tend to lead to weight gains." However, she did find it helpful to have no definite "don't do this or that." As well Mrs. I, stated that "each individual decided what she would do and how she would go about it." In terms of this movement from a passive mode where eating was out of control and solutions were sought in the experts to a more active mode where control appeared to be her responsibility, Mrs. I. was evaluated as a partial success.

At the 2-month follow-up Mrs. I. reported she had met her control goal even though her eating was out of control occasionally. While she

still used control measures to lose weight (a total of 18 pounds), she did not follow a totally restricted diet. At times she allowed herself "some foods which could never be part of a diet" or something "junky--I won't want anything like that for quite some time." She stated, "The program...has made me aware that with a little persistence I can control my weight gain." Because she appeared to have a more relaxed, yet more responsible attitude towards weight control, and because she reported no current difficulties with eating and weight control, Mrs. I. was once more evaluated as a partial success.

Case II: Mrs. K.

Mrs. K.'s problem and solutions were consistent with the Dieting Game Without End. Missing Week Two through unexpected business, she was given the gain instructions during an individual session on Week Three. While she initially gained and made a number of small losses and gains throughout the 12 weeks, she predominantly resisted the directions. Week Seven she wrote, "This (gaining weight) is not really suitable to my needs....I have gained control of my eating habits. There is no particular food I crave anymore. It's like having your cake, but not wanting it!" From that point a pattern of proving to the therapist that the approach had helped her to get control became evident. "Food is not the center of my life anymore like it used to be. Like it's because you're saying "eat" and I say, "Oh, no, I don't want to eat." She insisted her whole outlook had changed. "I was always struggling with myself and now I'm not struggling with myself." At one point she gained almost 3 pounds to prove to the therapist that she could in fact gain easily.

At the end of the program this resistance pattern seemed firmly

entrenched. She stated she had complete control over her eating--"I feel I've got it beat...if I don't I'll have to phone you up and you just say 'eat'!" Whereas before she used to "just keep on eating until I felt satisfied, now I'm eating slowly and find I am satisfied on a smaller amount of food." She thought the most helpful part of the program was the "go ahead signal to eat all and everything I desired. This made me want to put my brakes on every time and cut down." However, in spite of her insistence during the sessions that she had control over her eating, Mrs. K. reported that she felt her eating was out of control at times. In terms of changes in her eating pattern, she wrote, "after discovering how quickly I gain weight on certain foods and the larger amounts--I can now minimize the amounts and cut out junk foods and desserts entirely." At this time she weighed 1 pound less than she had at Week One. While there did appear to be changes in her attitudes and behaviors in relation to eating and weight control, there were discrepancies between her verbal and written self-reports about the control she experienced over eating. As well, she was to some extent following a self-restraint approach by eliminating certain foods from her diet. Therefore, Mrs. K. was assessed to be a partial success in terms of illustrating second-order change.

Two months later Mrs. K. was evaluated as a failure. She had lost 9 pounds by "trying not to overeat." Her eating was still out of control at times, thus she did not feel she had met her goal to "never be tempted to overeat." The program was still a reminder to her about how "quickly and painlessly" she could gain weight. Putting on weight was a reminder to her "of what foods help me to gain weight" and that "I must learn good eating habits once and for all and stick with them."

Thus her problem sounded similar to that existing at the beginning of the program.

Case 12: Mr. H.

Mr. H.'s description of his eating problem and solutions was inconsistent with the Dieting Game Without End. He did not feel his eating was out of control; he had made only one major attempt to control his weight and this had been successful for 5 years before he slowly regained. He was allowed to continue on the basis that the program was exploratory in nature and that his presence might contribute important information. However, as the therapist's initial impression (that the approach would not work for him) may have influenced his pattern from the beginning through her reactions and expectancies, it is impossible to know whether these inconsistencies had anything to do with his reaction to the directions. As well, his attendance became irregular.

Nevertheless, the gain weight directions did have some effect on him. Week Three he wrote, "It just made me more conscious all week about food intake." Week Ten his report stated, "I still feel uneasy about your directive to gain 15 to 25 pounds. So I keep trying to stay on a weight loss regime." He also commented, "I think that I've got the control, like you've been talking about." However, he attributed his 6-pound loss at the end of the program to his "desire to lose weight." While there was some evidence of changes in his presenting problem--he did not have a current eating problem and he was not putting a time limit on his loss--it was difficult to associate the changes to the second-order change interventions. He was therefore evaluated as a failure.

After 2 months there was little evidence of a change in the

presenting problem. While he stated he had no current difficulties and that his eating was still under control, he had not met his control goal nor had he lost further weight following basic Weight Watchers. Mr. H. commented, "Food intake and weight control still remains a problem to overcome." He was indeed "going slow."

Case 13: Mr. R.

Mr. R.'s eating problem and solutions fit the selection criteria. The gain directions had some initial impact. "Everytime I grabbed something, I'd think of 15 to 20 pounds and get upset....I used to have a Big Mac and fries and a shake and I ordered a Quarter Pounder and a Coke." However, they had no apparent lasting impact. For the first half of the program he vacillated, neither following the directions nor actively resisting them through losing weight. A variety of directions aimed at encouraging his current process was given. At the end of the program, he was given a "hard restraining" message. At this time he experienced no changes in his sense of control over eating, his eating patterns, his attitudes to eating and weight control, or in any other life patterns. His weight remained approximately the same, a loss of 2 1/2 pounds. He was evaluated as a failure.

Two months later there was no evidence of change in the presenting problem. He had lost 11 pounds by "cutting down"; eating too much was still a problem. He experienced his eating as out of control most of the time. This difficulty was handled by trying not to eat so much.

Summary

Pattern one. At the end of the 12-week Treatment Program, the verbal and written reports of five of the eight who gained weight were evaluated as successful illustrations of second-order change (see

Table I, p. 119). These five reported their eating was under control; they were eating what they desired rather than following a self-restraint pattern. Two in this group were viewed as partial successes because of discrepancies between their verbal and written reports about the control they experienced. One was viewed as a failure; there was no increase in sense of control over eating and some self-restraint solutions were still being attempted.

In addition to the increased feelings of control over eating without dieting, there were some unexpected changes in attitudes and behaviors surrounding eating. All eight in this group reported reduced feelings of guilt about eating and reduced cravings for food. Seven reported that they were more at ease with food or less frightened to eat formerly taboo foods. Five, including one from the failure category, reported an increased awareness of the amount of food that had to be eaten to gain, hence a change in the belief that "just looking" at food led to gaining. Other reports included being satisfied eating less, eating more slowly, taking more care and time in preparing food, not continually tasting during food preparation, throwing away children's leftovers instead of eating them, not being tempted by food advertisements on T.V. or in magazines, not feeling pressured to lose within a certain length of time, increased acceptance of fatness, and increased self-consciousness of fatness. All experienced varying degrees of discomfort with the extra weight.

Four individuals (Cases 1, 4, 5, and 7) became more relaxed about their children's eating, not forcing them to eat, not withholding food, or generally not interfering with the child's food choices. Sleep improved for three (Cases 1, 2, and 4). Two women slept less (Cases 5

and 8). Three experienced a decrease in energy accompanied by increased irritability (Cases 3, 7, and 8); however, four experienced an increase in energy or alertness for at least half of the program (Cases 1, 2, 4, and 5). Near the end of the program, two of these four experienced a drop in energy (Cases 1 and 2). One man (Case 2) stopped watching television as much as it was no longer an excuse to eat; he thought he was slightly more active. One woman (Case 1) decreased her smoking which had previously accompanied her snacks, started to smell food again, started new hobbies, and experienced an increase in her body temperature. One man (Case 4) stated he was more accurate and productive in his work.

Weight gains (assessed in terms of the difference between lowest* and highest weekly weights) in order of case presentations were: (1) 9 1/2, (2) 15, (3) 17 1/4, (4) 10, (5) 11 3/4, (6) 14 1/2, (7) 8 1/4, and (8) 4 1/2 pounds. Two (Cases 2 and 6) began losing this gained weight by the end of the treatment program (5 1/2 and 19 pounds, respectively).

After 2 months three were assessed to be successful illustrations of second-order change (see Table 1). All three (Cases 1, 6, and 8) felt their eating was under control, that they were still eating what they wanted when they wanted, and that they had no current difficulties with eating and weight control. Three others in this group (Cases 2, 4, and 5) were viewed as partial successes in illustrating second-order change. While there seemed to be some resolution of the presenting problem, eating was not experienced as under control. However, Cases 2

*Lowest weekly weight and Week One's weight were not always the same; some lost weight during the time they were trying to gain.

and 4 were implementing some alternative strategies for weight control--gaining weight to get control--and Case 5 experienced her new eating habits and attitudes towards food as a "new-found freedom." The last two in this group, (Cases 3 and 7), were considered failures. The presenting complaint had not been relieved nor had weight loss occurred in a different manner; self-restraint was still the means to attempt to control eating.

Weight changes (assessed in terms of the difference between Week Twelve and the 2-month follow-up) in order of case presentations were: (1) +2 1/2, (2) *-2 1/4, (3) -4 3/4, (4) *-2 1/2, (5) -5, (6) -15, (7) -10 3/4, and (8) *-3/4 pounds. (*These figures do not reflect the fact that after losing weight, Cases 2 and 4 were deliberately trying to gain weight to get control, or the fact that Case 8 had deliberately gained, then lost 7 pounds after the end of the program.) Weight changes (assessed in terms of the difference between lowest weekly week and the 2-month follow-up) were: (1) +12, (2) +7 1/2, (3) +12 3/4, (4) +7 1/2, (5) +6 3/4, (6) -19 1/2, (7) -2 1/2, and (8) +2 1/2 pounds.

Pattern two. At the end of the 12-week Treatment Program, the verbal and written self-reports of the five in the group who resisted the weight gain interventions showed no evidence consistent with the success category of second-order change (see Table 1). Three individuals were evaluated as partial successes. There were some changes in attitude towards food and weight control; the presenting problem appeared to be resolved to some extent. The remaining two were viewed as failures in terms of limited or no evidence of change in the presenting problem. Other changes noted by members of this group were decreased snacking, eating more slowly, not putting a time limit on

losing, and reduced cravings for food.

Table 1

Evaluation of Cases in Terms of Second-order Change

Pattern	Week Twelve			2-month Follow-up		
	Success	Partial Success	Failure	Success	Partial Success	Failure
One	1 2 3 4 5	6 8	7	1 6 8	2 4 5	3 7
Two		9 10 11	12 13		10	9 11 12 13

Note. Pattern One refers to those eight who attempted to follow the gain directions. Pattern Two refers to those five who resisted the gain directions.

At the 2-month follow-up, only one member of this group was considered partially successful (see Table 1). The rest of this group were considered failures in terms of either resolution of the presenting complaint or lack of evidence that any change occurred in connection with

the second-order approach.

At the end of the 12 weeks, weight losses, in order of case presentations were: (9) "slight loss" (too heavy to be weighed), (10) 11 3/4, (11) 1; (12) 6, and (13) 2 1/2 pounds. Weight change (assessed in terms of the difference between Week Twelve and the 2-month follow-up) in order of cases were: (9) "slight loss", (10) -6 1/4 (total, -18), (11) -9 (total, -10), (12) 0 (total, -6), and (13) -11 (total, -13 1/2 pounds.

Data from the Promise-of-Treatment Group

At the end of the 12-week promise-of-treatment period, two of the 11 individuals in the Promise-of-Treatment Group reported changes in relation to eating patterns and in thoughts and/or feelings about eating and weight control. One woman (Case 18) had met her control goal and was not "pigging out and eating the whole package and was trying not to feel guilty if I take one piece of something." However, she reported her eating was not under control. The way she handled out-of-control times was stated as follows: "usually eat--except when I know in exactly so many days I have to 'weigh-in' at Weight Watchers. I tend to have more control and get busy doing something else that will take my mind off food." She was still avoiding certain foods in order to control her weight. She was assessed to show no indications of change in the Dieting Game Without End. She was still using self-restraint methods to attempt to control her eating. One man (Case 14) reported that his eating pattern had changed due to his resolve to stick to Weight Watchers. "The problem is that I can slide back into old habits

with shocking ease." He reported that his eating was out of control at times and "I don't handle them very well." Over the 12-week promise-of-treatment period, he lost 19 pounds. Even so, his pattern was still consistent with the Dieting Game Without End. Another man (Case 20) also lost weight (12 pounds); one man (Case 15) and one woman (Case 21) gained weight (6 and 4 pounds, respectively). There was no evidence that these changes were different from previous loss-gain cycles. Therefore, over the 12-week promise-of-treatment period there was no evidence consistent with resolution of the Dieting Game Without End. Promising treatment, in this instance, did not appear to be a form of paradoxical treatment.

CHAPTER 5

DISCUSSION

While the study was not intended to be a strictly defined experiment following the rules of prediction and control, some factors related to the investigation of second-order change merit attention. Following this section of limitations, there will be a discussion of information relevant to the research questions. The main implications of the results to the area of second-order change will be the next topic. Finally the author's plans for future research will be presented.

Limitations

Difficulties Related to Implementation of the Second-order Change Model

(1) The conceptualizations of the problem, the solutions, and the intended second-order change interventions represent only one set of possibilities which are consistent with the second-order change framework. The results associated with an alternate set of choices, still consistent with the second-order change framework, is not known.

(2) Typically, therapists at the Brief Therapy Centre, define both the problem and the therapy goals in a face-to-face interview. This allows time and opportunity for clarification of issues, solutions, and what in fact would be an acceptable degree of improvement. In this study the problem and the solutions were conceptualized ahead of time.

Individuals were then selected to meet predetermined criteria related to this particular conceptualization. Goals were not explored jointly. As well, the goals were prescribed. Weight goals or control over eating were the only alternatives. Hence there were some Utopian sounding goals in terms of weight loss and control over eating set by the participants which may represent still another problem. For example, Cases 5 and 7 initially wanted to lose about 30 pounds in 12 weeks. Case 1 set an initial goal of losing control over her eating only once a year. As such, these goals may represent unrealistic or inappropriate process markers.

(3) Watzlawick et al. (1974) stress the importance of framing interventions in terms of the individual's conceptual framework or viewpoint. Although there were more individualized interventions given during weigh-ins, an individual approach did not occur most of the time. The main interventions given to the entire group, such as during Weeks One, Two, and Twelve, were prepared ahead of time and phrased in general terms rather than in the conceptual framework of any one particular individual. While such interventions appeared to connect with some individuals, other participants were undoubtedly missed. As well, the group approach did not allow for variations in the timing of interventions.

(4) Therapists using the Brief Therapy approach often utilize other members of the interaction system to facilitate change. As predetermined by the study design, there was no access to other parts of the interaction system, such as the family. Yet other parts of the system may have been supporting the Dieting Game Without End either directly through coercing "try harder" behavior patterns or indirectly

through supporting the set of beliefs and assumptions about dieting being the only solution to weight control. The impact of these other systems upon the therapy process is open for speculation.

Difficulties Related to the Questionnaires

(1) The questionnaires required that subjects express themselves in writing. Some of the participants were not able to do this comfortably (Case 13) and sometimes there were discrepancies between verbal and written self-reports (Cases 6, 8, 11).

If, as suggested by Watzlawick (1978), therapeutic change does occur through interventions which connect with the patient's right hemisphere (that part of the brain which conceives and expresses world-image in terms of nonverbal, nonlinear patterns), then to ask for information in terms of rational, logical, verbal, left hemisphere responses may miss the impact interventions are having. That is, even when change interventions connected and changes occurred, participants may not have been able to verbally report or write about this impact. Examining this rational, verbal information for evidence about the effect of the interventions misses the whole realm of affective responses, the laughs, blushes and flashes of confusion or anger which are possible indicators that interventions were connecting with right hemisphere patterns.

(2) Some of the terminology of the questionnaires was not clear. For example, what was meant by eating "being out of control" or "uncontrollable"? What did this mean in terms of specific behaviors? Hence, when examining follow-up questionnaires for evidence that there had been changes in control over eating, beyond a subjective report, it was not possible to determine whether this "control" was evident by changes in eating patterns. Did reports of being out of control mean

similar or different behaviors at different points in time? Was sense of control simply associated with an attitude change in which the same out-of-control behaviors were now perceived as being in-control? As such discrepancies may exist, specific interpretations are in large part speculative.

The Success and Failure of Second-order Change Interventions

Following the Interventions and Success

The group who followed the instructions was judged more successful than the group who resisted. Those who followed the instructions encountered their fears about food and weight gain in an active, experiential way. When there was encouragement to eat what they wanted, previously forbidden foods were not so attractive. They experienced reduced guilt and fear about eating. Some became aware of how much they had been eating without actually "counting it" and how much food really had to be eaten to gain weight. The sheer difficulty of gaining weight surprised most who tried to gain. There was a sense of mastery over eating.

Those who resisted also reported that when they had permission and encouragement to eat, they did not want to eat as much. They attempted to convince the therapist that they were not depriving themselves, that they were in fact eating what they wanted, when they wanted, and that they had their eating under control. However, these participants were evaluated as partially successful because they retained a more restricted set of choices in relation to weight control. Since the directions to eat and gain weight tended to increase feelings of

willpower, self-restraint measures were still attempted to control eating and weight. The thought of eating what they really wanted or gaining weight still seemed to be frightening risks. They relinquished the presenting complaints of lack of control over eating in order to prove to the therapist that they did have control, that the therapist was wrong, and that they could lose without gaining weight. Thus, the context of the control was different; control was maintained in a different manner or in a different frame from the control which occurred through trying to gain weight.

Because many of the reported changes with this latter group occurred through resisting the therapist and not through actively experiencing changes in eating behaviors and attitudes, to a certain extent participants were still in a passive, dependent, or reactive mode. They had not stepped outside the boundaries of their past behavior. Hence, once the week-to-week contact stopped, the changes, apparently maintained through this dependency on the therapist, dropped off.

Trust in the Therapy Relationship and Success

There does seem to be a relationship between success or partial success and the therapist's perception that the participants trusted her and expected that this approach might be of some value where others had failed. These perceptions were based on the verbal support given to gaining during the group, the enthusiasm expressed over changes in attitudes and eating patterns, and a general ease of contact between the therapist and participant.

Perhaps a system of mutual trust and expectancy of positive

change occurred through nonverbal communication and similarity of world views. With some of the participants it was easier for the therapist to understand the particular world images and realities and utilize this understanding to facilitate change. Such a system is mutually rewarding and thus perpetuates itself, increasing the feelings of trust that the suggested approach would work. That is, success may be related to the therapist communicating to the client an accurate understanding of the problem (from the client's point of view), to the creation of positive expectancies about change, and to the client's belief that the therapist possesses tools or techniques to alleviate the presenting problem.

Difficulties Conceptualizing the Problem and Failure

Similar to the observations of Watzlawick et al. (1974), in this study there did seem to be a relationship between failure to illustrate second-order change (Cases 3, 7, 9, 11, 12 and 13) and difficulties conceptualizing the problem and interventions. For example, due to initial perceptions and the fact that he though he had his eating under control, the therapist thought that Case 12 did not meet the initial selection criteria. Of course this could have become a self-fulfilling prophecy; however, it is also possible the problem was incorrectly conceptualized. For example, he reported he had controlled his eating for 5 years before slowly regaining. Perhaps control was simply the wrong issue to deal with in terms of his eating problem and an alternative second-order approach might have been more effective. With Cases 3, 7, 9, and 13, the therapist changed the original conceptualization of the problem or put the problem in a different frame from simply gaining control over eating.

For both Cases 3 and 7 there appeared to be connections between out-of-control eating and times of depression. Losing weight seemed to be viewed as the solutions to other difficulties in life. While eating was the presenting problem, and as such, needed to be accepted as the lever for change in terms of accepting the participant's reality, it seems possible that the attempts to deal with the depression-eating cycle were simply inappropriate. It might have been more appropriate to deal only with the depression with reference to the family system. In relation to Case 9, a man who was too heavy to be weighed on the balance scale, it seems unlikely that repeatedly failing to control his eating through self-restraint was the problem-maintaining solution. Again, it is only speculation, however, family problems may have been a factor as he stated at one time that he had put on the extra weight since his marriage and jokingly mentioned that perhaps he should leave his wife.

> The thing is that I gained all this weight over the last 6 to 7 years. You know, before that, I had absolutely no problem. So I don't know.....Maybe I should run away from my wife....I don't know, just, my lifestyle changed then sort of, found a different pattern than what it used to be. I used to be on the go all the time, now I'm slowed down more.

Case 13 was having difficulties in most every area of his life--his relationships, his work, and his current living arrangements. His weight problem seemed to be a minor part of what appeared to be a failure pattern connecting all life areas which had persisted for some time. Conceiving of his weight problem as being perpetuated by trying to diet did not seem fruitful. However, the therapist was not able to successfully reconceptualize his problem and therefore, never did get around to prescribing new alternative ways to fail.

These difficulties in conceptualization of the problem and interventions were not as apparent with Case II. While the therapist did have some difficulty dealing with this woman's resistance, at the end of the program she seemed to be experiencing some changes in attitudes and behaviors in relation to eating. Yet, 2 months later, there were no apparent changes. Although her reasons for failure to maintain these changes is unclear, they may have related to the perceptual difficulties observed during the treatment program (see Appendix B).

Implications

While the findings from this study are specific to the particular group, therapist, and set of second-order change interventions, they have expanded the author's understanding of the area of second-order change. First, in examining the success of second-order change, the importance of considering the logical levels of outcome, the second-order process level and the first-order goal level, is much clearer. Second, the importance of observing outcome at both levels over a period of time (such as through repeated follow-up), before making definite statements about success or failure, is evident. Third, on the basis of initial conditions or dimensions, outcome from the use of second-order approaches is very difficult, if not impossible, to predict. These three areas will now be discussed in further depth.

The Importance of the Two Logical Levels of Outcome

In this study there were a number of combinations of the two logical levels of outcome, the process level and the goal

level (weight loss). First, there was one woman who changed both her perceptions about food and weight and her eating patterns and as yet had not lost weight (Case 1). Second, there were some who had changed their attitudes towards their problem, their attitudes about ways of controlling weight, their eating patterns, and who had also lost varying amounts of weight (Cases 2, 4, 5, 6, 8, and 10). Finally, there were some (Cases 3, 7, 9, 11, 12, and 13) who did not change their perceptions about food and weight control and who maintained similar eating patterns even though they lost weight. That is, they lost weight through trying to restrict food intake and struggling with times when their eating was experienced as out of control. These individuals still appeared to be caught in the restricted framework of the Dieting Game Without End.

Thus weight loss itself does not necessarily make any difference to the process. Weight loss does not change the system. Thinness does not equal happiness, improved relationships, improved self-concept, and so forth. Attitudes and behaviors connected to increased happiness, improved self-concept; and improved relationships tend to be largely independent of weight.

While weight may serve as a useful process marker, weight is not necessarily the problem which is taking up energy. Whether fat or thin, some individuals have the same all-consuming preoccupation with food and weight. Weight is simply the issue. Perception of the weight and assumptions about weight control are the energy consuming problems. However, through a change in perception of weight and eating which appears to affect eating behaviors, weight may be lost as an artifact of this change in process.

Another reason to value both logical levels of outcome is that to view success only in terms of weight loss not only misses much outcome information but also limits the clients' options for experiencing success. That is, if the client's view is that thinness is the source of happiness, and this view is explicitly or implicitly reinforced through the therapist's views, the client may remain locked into a restricted framework where thinness and happiness are one.

In summary, both logical levels of outcome are important; both occur as evidence of effective treatment. Paradoxically, while focusing on concrete behavioral changes is a powerful means to facilitate a shift in the problem system, to focus on outcome only in terms of concrete goals may mean that much outcome information is missed and in the case of weight control, such a focus may mean a perpetuation of a Game Without End.

The Importance of Observing Outcome Over Time

Researchers from various orientations have found that follow-up at different times often produces vastly different results in terms of both weight changes and in other life processes. In this study changes in attitudes towards food and weight control, in eating behaviors, and in weight occurred with varying degrees of speed. Some assessed to be successful after 12 weeks were no longer as successful at 2 months. In contrast, some who appeared partially successful at 12 weeks, were evaluated as successes at 2 months. The implication this has to the area of second-order change is that the 10 sessions advocated by therapists at the Brief Therapy Centre are too short to draw any definite conclusions about the impact of interventions with problems of a cyclical nature such as overweight. However, if the concrete goals were defined,

not in terms of weight change, but rather in terms of smaller changes in eating habits and patterns, some evaluation of effectiveness could be made at the end of 10 weeks. As well, smaller behavioral changes are more consistent with the intent of the brief therapy approach: "our treatment was not intended to achieve final solutions, but an initial breakthrough on which they themselves can build further" (Weakland et al., 1974, p. 162).

The Unpredictable Nature of Outcome

Under apparently similar conditions, individuals who fit the description of a common Game Without End, the Dieting Game, reacted in a variety of ways to the second-order change interventions. While some of the attitude and behavioral changes were predicted, other things occurred which were not predicted. For example, sometimes there were changes in other life areas, such as relationships with children or energy for work; sometimes there were no changes in these areas. Based on the initial information it was not possible to predict how individuals would react to the interventions. Changes between the end of the 12-week treatment program and the 2-month follow-up were also unpredictable. On the basis of observable behaviors and self-report evidence, it was impossible to predict that "b-intervention" would lead to "b-outcome."

This unpredicability makes more sense when the participants and therapist are viewed as simply parts in a complex network of systems. As well only part of the participants' system, the eating system, was dealt with. While some important parts of the system, the family, for example, were outside the research framework in this study, even if they had been included, unexpected or unknown interactions with yet other parts, might have influenced individuals in a variety of ways

creating further unexpected twists and turns. To make this point clearer the impact of certain therapist conditions and group interactions will be discussed. As well, metabolic processes related to differences in speed and ease of weight gain may have influenced accompanying attitude changes.

The therapist. Of undeterminable importance was the therapist's self-disclosure of her own struggles with weight control and that she had tried a similar approach to getting control over her eating and weight.

The fact that the group was conducted to collect information for a Ph.D. dissertation was communicated to the group during the initial screening and during the first sessions of the Treatment Program. It was made clear that because information was needed for the dissertation, continued attendance and feedback by the group members was the most important aspect of the program whether or not the directions were followed. This had at least two perceived effects, one on the participants and the other on the therapist. For some of the participants, the knowledge that they were part of a research project led them to try to be very helpful. For example, Mr. A. and Mr. B. (Cases 9 and 4) joked that they would produce the desired results if simply told what to do. Both Mr. M. and Mr. B. (Cases 2 and 4) thought that a neat, upwards weight-gain curve was the therapist's goal for the group, and at one point, refrained from taking up jogging or biking in case they would spoil this curve.

The effect on the therapist was that she felt very dependent on the participants and sometimes, out of fear of losing subjects, gave more conservative, possibly less effective interventions. Instead of

actively encouraging a participant to gain or capitalizing on resistance, for example by commenting on the hopelessness of gaining control, interventions such as "If you can't gain, stay the same" or "go slow" were given.

When several individuals reported physical complaints, the therapist also tended to back down from giving interventions, stressing that attendance and feedback were the important behaviors. Some of her fears were compounded in Week Six when Mrs. K. (Case 11) stated that the doctors of the participants would probably not approve of the weight gain. Already concerned about potential medical opposition to the efforts to try to gain weight, scenes of being called before a fat judge and a fat jury to defend the approach became active fantasies. The impact of this fear was that again the therapist backed down from certain interventions.

When the therapist was feeling less fearful and more "gutsy", her risk level was higher. She seemed to respond in a more immediate, spontaneous manner. For example, Mr. A. (Case 9) had been receiving cautious directions intended to encourage resistance--"I want to encourage you to resist my directions"--with little perceived impact. In contrast, when the therapist spontaneously gave a hard restraining message Week Seven, this appeared to have more impact--he reported that this had been the most helpful intervention: ("Well, my hunch is that this approach is going to fail for you too. I think other things have failed for you and I think this is going to fail for you...somehow it seems really important for you to fail at this.") Thus it is speculated that when the therapist stepped outside her regular response system or set of boundaries and took a risk, interventions at these

points had a higher degree of impact on the participants. Perhaps she was more in tune with the participant's world view at these times and produced interventions which connected with the right hemisphere patterns.

The group. Further variation in the two basic patterns of trying to gain or resisting the directions, as well as in individual patterns, appeared to occur as a result of group interactions in and out of the group. Some members of the group, Mrs. T. (Case 1) in particular, seemed to act as group catalysts. She was always very lively, enthusiastically supporting efforts to gain and bubbling forth with all the exciting changes which were occurring in her life while trying to gain.

It does not seem to be a coincidence that individuals who knew each other tended to follow similar patterns. Not only did both Mrs. T. and Mrs. E. (Cases 1 and 5) try to gain, but they supported each other in their efforts to gain and shared their delight in their different attitudes towards food and weight control. Mrs. J. and Mrs. K. (Cases 10 and 11), also friends, both resisted the directions to gain weight. Although they apparently did not know each other earlier, Mrs. V. and Mr. B. (Cases 3 and 4) drove to the sessions together. Both tried to gain weight.

Interaction of participants outside the group also affected individuals. For example, about a month after the end of the program, Mrs. V. (Case 3) reported that she met Mr. O. (Case 6) while shopping. She had lost 10 pounds; however, Mr. O. had lost about 25 pounds. At this point, Mrs. V. said she began feeling like a failure and quickly reverted to her former dieting pattern, regaining most of the lost

weight in an out-of-control fashion.

In terms of the group approach where individuals shared reactions and the success they had had following the directions, some individuals thought the group sharing was helpful, some thought other members did not give each other enough support to follow the directions, and one man thought the group aspect of the program was the least helpful part for him.

Thus the group approach itself had an undetermined degree of influence on the second-order change methods employed.

Metabolic processes. While there was no control over the amount of food actually eaten and no study of metabolic processes, it seems possible that differences in metabolic processes influenced the ease and speed of actual weight gain. For example, in studies on experimental obesity and overfeeding (Apfelbaum, Bostsarron, & Lacatis, 1971; Miller & Mumford, 1964, 1967; Miller, Mumford, & Stock, 1967; Sims, Goldman, Gluck, Horton, Kelleher, & Rowe, 1968; Sims & Horton, 1968), some of the subjects were metabolically more resistant to gaining weight. Several of the studies also showed that there is a large individual variation in the amount which needs to be consumed to gain weight (Mahler, 1972; Miller & Mumford, 1964, 1967; Sims & Horton, 1968; Sims et al., 1968). In terms of calories consumed, the theoretically expected weight gains simply did not occur. Miller and Mumford (1967) state: "It is quite remarkable how some subjects can overeat 8-10,000 excess kilocalories in a week and yet occasionally lose weight" (p. 1215). Thus in the present study differences in metabolic processes may have influenced subjective reactions and attitude changes towards food and gaining weight.

The last word. One of the major implications of these observations and speculations is that it is very difficult, if not impossible, to predict conditions associated with the success and failure of second-order interventions. Answers to questions about the success and failure of second-order approaches do not occur through an examination of the interventions, the clients, or the therapist in isolation. Answers occur through examining not only relationships among these parts but potentially among other parts of the system. Answers lie in the context or in the "pattern which connects." Bateson (1978) states:

> We have been trained to think of patterns, with the exception of music, as fixed affairs. It's easier and lazier that way, but, of course, all nonsense. The truth is that the right way to begin to think about the pattern which connects is to think of it as primarily (whatever that means) a dance of interacting parts, and only secondarily pegged down by various sorts of physical limits and by the limits which organisms impose. (p. 10)

Therefore, while the concrete behaviors present in a situation may serve as process markers, the behaviors are likely linked together in vastly different ways. It is only by perceiving the relationships which exist among the physical limits or by perceiving patterns over time, that patterns which connect become apparent. And the task in prediction would include such a broad perception of patterns as to be nearly impossible. Systems connect through personal, familial, national, and international levels. At this point in time, there are simply not adequate languages or procedures for describing such complex communicating systems and their interactions (Bateson, 1978).

The point is that the therapy situation is indeed representative of an open system. As such, therapy is characterized by principles of open systems. Therefore, while participants may appear similar on some dimensions, they vary widely on others. Participants do not simply

receive information; they initiate their own growth and exchange information with other systems. Similarly, the principle of equifinality holds true. That is, with open systems it is not possible to predict outcome on the basis of initial conditions. It is the nature of the process that determines the "final" state. Hence similar initial conditions can be connected with different results and different initial conditions can be connected with the same results. It is observation of the process over time that is crucial (Watzlawick et al., 1967).

Therefore, just as second-order change interventions are unexpected so is the outcome related to their use. Consistent with the principles of second-order change, each situation must be encountered in the present context. There can be principles but no program. There can be direction but no certainty about the outcome.

Plans for Future Research

The author's plans for future research include incorporating the results from the 6-month follow-up and from the Promise-of-Treatment Group with the results presented in this thesis. As well, further follow-up, at 1 and 2 years, is planned.

Conclusion

The Importance of Context

When the focus of evaluation is on the numbers of participants who either experienced second-order change in relation to the Dieting

Game Without End or who lost over 10 pounds, the results of this study are not impressive. However, in the context that this was a group characterized by long-term, repeated failure, the results take on a more positive note. Within the wider context of specific individuals, for example, Mrs. T. (Case 1) and Mr. O. (Case 6), the approach was very successful at the 2-month follow-up and it would have been difficult to convince them otherwise. Therefore, it is important to define the appropriate context for evaluation. A narrow view distorts evaluation of success.

The Importance of Working Within an Individual Context

As mentioned, in the context of a view which focuses on number of participants who either experienced second-order change or who lost over 10 pounds, a group approach is not an effective way to treat individuals who have repeatedly attempted to lose weight through self-restraint solutions. An individual approach is recommended for a number of reasons.

First, in this study, a number of participants presented weight as their main complaint but depression or family difficulties seemed to be the more important issue. Instead of operating from a set of prescribed problems, solutions, and interventions, an individual approach would allow more exploration and clarification of unique problems and solutions. That is, an individual may present a weight problem but may be in a number of related games without end which appear to be more troublesome in terms of that individual's process. When the therapist taps into the more appropriate problem system, for example, through direct clarificiation of which problem to deal with or through interventions which, while accepting the presenting complaint,

focus indirectly on the significant problem, change is facilitated.

An individual approach would allow access to others, such as friends, family, and work colleagues, if, based on analysis of the problems and solutions, it appeared that these relationships were integral parts of the weight game without end. This seems important in view of the variety of reactions, particularly at the second-order process level, which occurred in this study. Thus, when necessary, other individuals could be influenced through direct contact in treatment with the "identified patient," or through interventions which incorporate the consequences of the client's change for these others.

Third, in this study, those who complied were more successful than the resisters in terms of second-order change. It would seem logical that in implementing the second-order change approach, it is important to change a resistance pattern into a compliance pattern. This is consistent with the hypnotic approach of giving directions which are describing what the client has just done, giving the illusion that the client is always following the directions. Subsequent induction messages, utilizing resistance according to individual patterns, keep individuals in a compliance pattern, moving in the direction suggested by the hypnotist. Such an individual approach to resistance is very difficult in a group, particularly because ways of exhibiting resistance are more highly individual patterns than the pattern of those who comply. Thus, when there are a number of resisters, essentially going in different directions, they are a disruptive influence on the group. However, it may be possible that if the group were composed of compliers only, as assessed by some initial screening,

more impact would occur through a group approach.

Finally, an individual context allows for utilizing the client's world-image and language as a lever for change. While it is possible to give some directions that are appropriate for many in a group, some will be missed. As just discussed, it is particularly difficult to frame directions to deal with resistance in a common language in that resistance patterns are varied.

Confusion Within the Second-order Change Model

In Chapter I, two logical levels of outcome--the second-order process level and the more obvious, first-order goal level--were discussed. The results of this study did not occur in terms of simply one or the other, but in a variety of combinations which went beyond the initial conceptualization. These distinctions of the logical levels of outcome, and the fact that they occur somewhat unpredictably in a variety of combinations, may clarify case reports of unclear outcome in work done at the Brief Therapy Centre. For example, Weakland et al. (1974) state that in a few cases, "achievement of the planned goal and reported relief of the problem have been inversely related--hitting our target of change did not lead to relief, or we somehow got results in spite of missing our target" (p. 164).

In terms of the two logical levels, these mixed cases could be described, first, as those who reached a first-order goal without change at the second-order process level, and second, as those who experienced a second-order process change but had not reached the first-order goal. For example, in this study, the first category (those who hit the goal without relief) would include those who lost weight through self-restraint solutions but still experienced their

eating as out-of-control. The second category (those who showed results while missing the goal) would include those who had changed their process in relation to eating but had not lost an appreciable amount of weight. Similarly, the two logical levels of outcome may be used to describe those clients treated at the Brief Therapy Centre who reached or approached the goal without complete resolution of the presenting problem; it may be that this group was successful at a first-order goal level; but experienced limited change in terms of attitudes or behaviors surrounding the presenting problem.

By limiting the evaluation of the Brief Therapy Model to the assessment of whether concrete, behavioral goals are reached, it appears that important outcome information is missed and that there is a "double-bind" within the model. That is, there seems to be a contradiction between the concept of second-order change and its implementation and evaluation. On the one hand, second-order change is defined as change in the premises governing a system, as change in the process or way of behaving within a system. On the other hand, in order to implement this change, observable, concrete, behaviors which are intended to reflect this change, are decided upon ahead of time. However, what determines results in an open system is the process which occurs over time; therefore, the goals decided upon as appropriate at one point in time may no longer be suitable later on or may not reflect a process change. That is, these predetermined concrete behavioral goals are of a different logical level than the concept of second-order change which emphasizes shifts in the system. What is important to the process of second-order change is not simply the observables but the relationships among these behaviors, the way

these behaviors are connected, or the underlying pattern. "Actual behaviors are only markers or embodiments (evidence) of the underlying structure, which is of a different order of significance" (Sluzki & Ransom, 1976, p. 162). Thus, the concept of second-order change, a process or open systems concept, appears to have been confounded through attempts to implement and evaluate it based on first-order, predetermined behavioral goals. It is not that behavioral changes do not occur with a shift in process; however, the behavioral changes which do occur are unexpected and less predictable than the first-order behavioral goals.

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APPENDIX A

FORMS, LETTERS, AND QUESTIONNAIRES

PART I.I

ADVERTISEMENT FOR RESEARCH PROJECT

ATTENTION: DIET DROPOUTS

IS WEIGHT CONTROL A PROBLEM? IS YOUR EATING CONTINUALLY GETTING OUT OF CONTROL? HAVE YOU REPEATEDLY FAILED TO LOSE WEIGHT THROUGH WILLPOWER AND DIETS, INCLUDING NUTRITIONALLY BALANCED DIETS? WILLING TO RISK SOMETHING NEW? READY FOR A LOOK AT THE SOLUTIONS INSTEAD OF THE PROBLEM?

OVERWEIGHT INDIVIDUALS, OVER 18 YEARS OF AGE, ARE INVITED TO PARTICIPATE IN A RESEARCH PROJECT FOLLOWING A NEW, NON-DIETARY APPROACH TO CONTROLLING WEIGHT.

INDIVIDUALS SHOULD BE AT LEAST 20 POUNDS OVERWEIGHT AND SHOULD HAVE REPEATEDLY FAILED TO LOSE WEIGHT AND KEEP IT OFF. MEDICAL APPROVAL WILL BE NECESSARY TO RULE OUT METABOLIC AND OTHER PHYSIOLOGICAL CONCERNS RELATED TO WEIGHT GAINS AND LOSSES.

BECAUSE THIS IS AN EXPERIMENTAL COURSE, ENROLLMENT WILL BE LIMITED. IF ENROLLMENT WARRANTS THE COURSE WILL BE DIVIDED INTO 2 SECTIONS AND OFFERED AGAIN AT A LATER DATE. PARTICIPANTS WILL BE ASKED TO COMMIT 1 EVENING A WEEK FOR A PERIOD OF 12 WEEKS. THE FIRST SESSION WILL BE A GENERAL INFORMATION AND SCREENING SESSION.

INSTRUCTOR: MS. DEVON MARK (B.SC.N.; M.ED.)

LOCATION: CONTINUING EDUCATION CENTER, 10820-101 STREET, EDMONTON

DATES; JANUARY 30 TO APRIL 17, 1978 DEADLINE FOR REGISTRATION: JANUARY 23, 1978

FEE: THIS SESSION TO BE FREE

P.S. IF YOU CAN'T USE THIS, DO YOU HAVE A FRIEND WHO CAN?

****

REGISTRATION FORM

MAIL TO: MS. DEVON MARK, DEPARTMENT OF EDUCATIONAL PSYCHOLOGY, UNIVERSITY OF ALBERTA, EDMONTON, T6G-2E1

MISS
MRS. _____ _____
MS. FAMILY NAME (PLEASE PRINT) GIVEN NAME
MR.

ADDRESS _____ POSTAL CODE _____

RESIDENCE PHONE _____ BUSINESS PHONE _____

PART 1.2

STANDARD TELEPHONE CALLS

Treatment Group

Hello, this is Devon Mark. Your name has been selected to take part in my weight control research. I'd like to find out more about your commitment to the project and tell you more about the requirements. Are you able to talk now or would you like me to call back?

First, I want to make it clear that this is a research project for my doctoral dissertation. I'm using a different method which has been successful on an individual basis but to my knowledge it hasn't been tried with a group. So, it may work for you and it may not.

To find out whether you are in fact having enough difficulty to participate, I'd like to ask you a few questions. I hope that's alright with you.

1. Are you at least 20 pounds overweight?
2. Have you tried diets to control your weight?
3. Approximately how many diets have you tried to control your eating and your weight?
4. Do you think you have a good knowledge of a proper diet even if you have a hard time following a proper diet?
5. Is controlling your eating a problem from time to time?
6. Do you have trouble controlling your weight?

I'd also like to ask you a few questions about your health to make sure there are no physical reasons why you shouldn't attend.

7. Do you suffer from a heart condition, diabetes, kidney problems, thyroid problems, or some other major health problem?
8. Are you taking any drugs to control your appetite or which affect

affect weight gains and losses?

9. Are you pregnant?

Finally,

1. Would you be willing to give me written permission to contact your doctor with a form letter?

2. Would you also be willing to give me written permission to include anonymous information about yourself in my thesis?

In terms of the group, I want two main things from you. I would like a commitment to attend the 12 meetings and be weighed whether or not you are able to follow the very difficult directions. Would you agree to that? I would also like you to share your reactions to this method by filling out a short weekly questionnaire. Would you agree to do that?

I know I am asking a great deal from you so if you are having doubts about taking part please back out now. For my research purposes I must work with individuals who can meet these requirements. Would you like time to consider your answer?

Promise-of-Treatment Group

Hello, this is Devon Mark. I received your application for my weight control research. Because there were so many applicants the January to April group filled up very quickly. Would you be interested in taking part in the research group beginning in April?

(If the answer was "no", the applicant was thanked. If the answer was "yes", the nine questions on the previous page were asked.)

What I want from people taking part in the group beginning in April is that they agree to fill in two questionnaires and to keep a record of

of their weight every 2 weeks. Are you willing to do that?

Now, the first questionnaire and six weight cards, along with self-addressed envelopes and directions, will be mailed on January 24. The second questionnaire will be mailed to you at the beginning of April. I'd like you to return the first questionnaire and weight card on January 30. Every two weeks after that I'd like you to mail one of the dated weight cards. Do you have any questions?

Thank you very much for agreeing to take part in the second group.

PART 1.3

REGRET CARD

I am sorry to inform you that both sessions of "Diet Dropouts" are filled at this time. Your name will be kept on file for future groups. Thank you very much for your interest,

Devon J Mark

PART 1.4

REMINDER CARD

Thank you for your interest in my weight control research. As mentioned on the telephone, the first meeting will be held on Monday, January 30. I'm looking forward to meeting you then.

LOCATION: Victoria Composite High School
10210 108 Avenue
Room 115

TIME: 7 p.m.

Devon J Mark

PART 2.1

LETTER SENT WITH THE SCREENING QUESTIONNAIRE

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY
EDUCATION CENTRE—NORTH WING
TELEPHONE (403) 432-5246

FACULTY OF EDUCATION
THE UNIVERSITY OF ALBERTA
EDMONTON, ALBERTA
CANADA T6G 2G5

January 24, 1978

Dear :

Thank you for agreeing to be part of the research project on eating and weight control.

Check the contents of this envelope. You should have received a Screening Questionnaire, a Research Permission sheet, six dated cards to record your weight, one large envelope, and four small envelopes.

Please fill out the Screening Questionnaire, sign the Research Permission sheet, and record your weight of January 30 (morning). Return these to me in the large envelope on January 30.

Please record your weight and mail the card to me on February 13, February 27, March 13, and March 27. A card and envelope is provided for each of these dates.

During the first week of April you will receive a second questionnaire and a large envelope. Please mail this questionnaire and your last weight card to me on April 10.

If you have any questions regarding these directions please contact me at 432-5030.

Sincerely;

PART 2.2

LETTER SENT WITH THE APRIL QUESTIONNAIRE

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY
EDUCATION CENTRE—NORTH WING
TELEPHONE (403) 432-5245

FACULTY OF EDUCATION
THE UNIVERSITY OF ALBERTA
EDMONTON, ALBERTA
CANADA T6G 2G5

April 3, 1978

Dear :

Since January you have been taking part in my research project on eating and weight control. Enclosed with this letter is the April Questionnaire that I said I would be sending to you. Now I would like you to complete the APRIL QUESTIONNAIRE and return it plus your last weight card in the enclosed self-addressed envelope on April 10.

As well I want to find out whether you are interested in continuing in the project by taking part in the weight control group beginning on April 24 and ending on June 26, 1978. (See page 5, question 16, of the APRIL QUESTIONNAIRE)

The first meeting will be held on Monday, April 24, in the Conference Room of the Student Personnel Services, across from the General Office, at Victoria Composite High School, 10820 101 Street. Enter through the main south door. Meetings will be held each Monday evening at 7:00 p.m. and last from one to two hours. I'll be looking forward to meeting you then.

I'd like to thank all of you for returning your questionnaires and weight cards. For those of you choosing not to participate in the weight control group I will be contacting you with regard to the follow-up study I will be doing.

Thank you again for your assistance in my research project.

Sincerely;

PART 3.1

SCREENING QUESTIONNAIRE

SCREENING QUESTIONNAIRE

Miss
Mrs.
Ms.
Mr.

FAMILY NAME (PLEASE PRINT) _____ GIVEN NAME _____

ADDRESS: POSTAL CODE:
PHONE: AGE:
OCCUPATION:

1. Do you sometimes feel that your eating is uncontrollable or out of control?
   Yes ____ No ____

   If yes, please describe how often and under what conditions you feel your eating is out of control.

2. What food or types of food seem to be a major problem for you?

   Give examples of what and how much (approximate number of ounces, cups or slices, etc.) you eat and drink for:

   Breakfast: Time of day:

   Lunch: Time of day:

   Dinner: Time of day:

   In between: Time of day:

3. a. As specifically as possible describe or define your problem with eating and weight control.

   What do you consider your most undesirable eating pattern or what eating behavior stops you from losing weight?

SCREENING QUESTIONNAIRE

3. b. What solutions have you tried to control your eating and lose weight?
I have tried:

i. a nutritionally balanced or proper diet (examples: Canadian Diabetic Diet; Weight Watchers; following Canada's Food Rules or a diet recommended by a hospital weight loss diet):
Yes ____ No ____

If yes, which nutritionally balanced diet did you follow?

_____

For how long did you follow this diet? _____

ii. other types of diets: Yes ____ No ____

If yes, please give the name. _____

iii. diet organizations or groups: Yes ____ No ____

If yes, please give the name. _____

iv. other methods: Yes ____ No ____

Please describe what other methods you have tried.

c. How many times (approximately) have you followed a diet to control your eating or to lose weight? _____

d. For how long have you attempted to control your eating or to lose weight? 1 year ____ 2 years ____ 3-5 years ____ 6-10 years ____ 11-15 years ____ 16 years or more ____

If you have managed to lose weight were you able to keep it off?
Yes ____ No ____

If you answered no, how long did you keep it off before regaining?

_____

Please describe what led to you regaining the weight.

SCREENING QUESTIONNAIRE 3

3. e. How long have you weighed approximately what you weigh now?
_____ weeks _____ months _____ years

As an adult, what is the most you have weighed? _____
the least? _____
What would you like to weigh? _____

4. The focus of these sessions will be on changing your patterns (habits) of eating and on getting control over your eating. What you eat or how much you eat will not be the focus.

What specifically would have to happen (or stop happening) in order for you to feel this program has been successful? That is, what would be an acceptable degree of imporvement to you in terms of:

a. control over your eating. Check the closest answer.

i. I would never lose control over my eating _____

ii. I would lose control only once a week _____ twice a week _____
once a month _____ twice a month _____ once every 2 months _____
once every 6 months _____ once a year _____
your answer _____

iii. If I lost control of my eating, it would be only for that particular day or evening and not continue for days _____

iv. I've been discouraged so many times, I don't want to set a goal regarding control over my eating. _____

b. your weight.

i. I would have lost _____ pounds.

ii. How much do you want to weigh

2 months after these sessions stop? _____
6 months after these sessions stop? _____
9 months after these sessions stop? _____

iii. I don't want to set a weight loss goal as I have been discouraged so many times. _____

PART 3.2

HOMEWORK QUESTIONNAIRE

HOMEWORK QUESTIONNAIRE

NAME: _____

1. Please write down your homework directions. This is useful information to me so I can see if (1) I am giving directions clearly and (2) if I am giving you directions which are suitable to your particular individual needs.

2. What was your reaction to the above directions?

   I thought _____

   _____

   I felt _____

   _____

   Other remarks: _____

   _____

3. Pick out one specific incident involving food during the week. Try to get a clear picture in your mind. What were you eating? What were you doing? What were you thinking? Describe the situation as clearly as possible.

   What were you feeling?

   Was anyone else involved? Yes _____ No _____ If yes, who _____
   Please describe the involvement or the part of this person or people in the above example.

PART 3.3

APRIL QUESTIONNAIRE

APRIL QUESTIONNAIRE

Miss
Mrs.
Ms. _____ _____
Mr. FAMILY NAME GIVEN NAME

ADDRESS:

POSTAL CODE:

1. Three months ago you registered in a research project on weight control. Have you followed a weight control program or diet during the past three months?
Yes_____ No _____

If yes, please describe what program or diet you followed.

2. Do you sometimes feel that your eating is uncontrollable or out of control?
Yes _____ No _____

If yes, please describe how you handle the times when you feel your eating is out of control.

If yes, please describe how often and under what conditions your eating is out of control.

3. Do you avoid (not eat) any particular fodds in order to control your weight?
Yes _____ No _____

If yes, please list the food(s) you avoid.

4. As specifically as possible describe or define your present problem with eating and weight control.

What eating behavior stops you from weighing what you would like to?

5. Is your eating pattern (what you eat, when you eat) the same, or almost the same as it was three months ago? Yes _____ No _____

APRIL QUESTIONNAIRE

If your answer to question 5 was no, please describe how your eating pattern is different than three months ago.

If there has been a change in your eating pattern in the past three months please describe in as much detail as you can what led to the change.

6. Since January have you experienced any changes in terms of your thoughts and/or feelings about food and eating and weight control? Yes _____ No _____

If yes, please describe these changes in your thoughts and/or feelings in as much detail as you can.

If there were changes in your thoughts and/or feelings about food and eating and weight control, please describe what led to the changes.

7. Have you experienced any changes in other parts or patterns of your life, for example, sleeping, activity, sickness, work, or play, during the past three months? Yes _____ No _____

If yes, please describe the changes.

APRIL QUESTIONNAIRE

Please describe what led to the change(s).

8. The SCREENING QUESTIONNAIRE, filled out in January, asked you to set goals in terms of control over your eating and in terms of your weight. According to that questionnaire you responded as follows:

   a. in terms of control over your eating your goal was:

      i. I would never lose control over my eating. _____

      ii. I would lose control only once a week _____ twice a week _____ once a month _____ twice a month _____ once every 2 months _____ once every 6 months _____ once a year _____ your answer _____

      iii. If I lost control of my eating, it would be only for that particular day or evening and not continue for days. _____

      iv. I've been discouraged so many times, I don't want to set a goal regarding control over my eating. _____

   b. in terms of your weight your goal was:

      i. I would weigh _____ at the end of the sessions.

      ii. I would weigh _____ 2 months after the sessions end.

      iii. I would weigh _____ 6 months after the sessions end.

      iv. I would weigh _____ 9 months after the sessions end.

      v. I don't want to set a weight goal as I have been discouraged so many times. _____

9. In the past three months have you met your goal in terms of control over your eating? Yes _____ No _____

   If yes, describe what helped you reach your goal.

10. Did the goals you set in January change during the period from January to April? Yes _____ No _____

    If yes, please state the way(s) in which you changed your goal(s).

APRIL QUESTIONNAIRE

11. Did you meet your revised or new goal(s)? Yes _____ No _____

If yes, describe what helped you reach your new or revised goal(s).

12. Please give your present goals in relation to:

a. control over your eating. (Check the closest answer)

i. the same as I answered in January _____

OR

ii. I would never lose control over my eating. _____

iii. I would lose control only once a week _____ twice a week _____
once a month _____ twice a month _____ once every 2 months _____
once every 6 months _____ once a year _____
your answer _____

iv. If I lost control of my eating, it would be only for that particular day or evening and not continue for days. _____

v. I've been discouraged so many times, I don't want to set a goal regarding control over my eating. _____

b. your weight.

i. the same as I answered in January _____

OR

ii. I want to weigh _____ at the end of the sessions.

iii. I want to weigh _____ 2 months after the sessions end.

iv. I want to weigh _____ 6 months after the sessions end.

v. I want to weigh _____ 9 months after the sessions end.

vi. I don't want to set a weight goal as I have been discouraged so many times. _____

13. What reaction(s) have your family and friends had to your being part of this research project on weight control over the past three months?

APRIL QUESTIONNAIRE

5

14. What reaction(s) have you had to being part of this research project on weight control?

15. For the past three months you have had your weight taken and recorded regularly. Did this have any effect on your eating habits? Yes _____ No _____

If yes, please check the closest answer:

i. I tended to eat less than usual. _____
ii. I tended to eat more than usual. _____
iii. I didn't change my eating habits in any way. _____
iv. I _____
YOUR OWN ANSWER

16. What aspect of the program was most helpful to you?

17. What aspect of the program was least helpful to you?

PART 3.4

CONTRASTING QUESTIONS ON APRIL QUESTIONNAIRE

APRIL QUESTIONNAIRE

5

14. What reaction(s) have you had to being part of this research project on weight control?

15. For the past three months you have regularly recorded your weight. Did this have any effect on your eating habits? Yes _____ No _____

If yes, please check the closest answer:

i. I tended to eat less than usual. _____
ii. I tended to eat more than usual. _____
iii. I didn't change my eating habits in any way. _____
iv. I _____
YOUR OWN ANSWER

16. Are you interested in continuing in this research project by taking part in the weight control group beginning on April 24 and ending on June 26, 1978?
Yes _____ No _____

If yes, the first meeting will be held on April 24 in the Conference Room of the Student Personnel Services, across from the General Office, at Victoria Composite High School, 10820 101 Street. Enter through the main south door. Time: 7:00 p.m. Meetings will be held once a week.

If no, thank you very much for filling out the questionnaires and sending in your weight cards. Since this is a continuing research project I would like to contact you with regard to the follow-up study I will be doing. Thanks again.

PART #3.5

LETTER SENT WITH THE JUNE QUESTIONNAIRE

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY
EDUCATION CENTRE—NORTH WING
TELEPHONE (403) 432-5246

FACULTY OF EDUCATION
THE UNIVERSITY OF ALBERTA
EDMONTON, ALBERTA
CANADA T6G 2G5

June 12, 1978

Dear ;

This is the questionnaire I said I would be sending two months after the end of the sessions.

Please answer the questions according to your present habits or patterns and what has happened for you since the end of the program, April 17. Don't worry about spelling and grammar. Just let me know in your own words what has happened.

I would like you to answer the questionnaire as soon as possible. Then on Monday, June 19, please weigh yourself without your shoes on and mail the questionnaire in the enclosed self-addressed envelope.

Thank you once again for your help. Remember to go slow. I'll be in touch in October. Hope to see you at that time for our six month party.

Sincerely;

PART 3.6

JUNE QUESTIONNAIRE

JUNE QUESTIONNAIRE

Miss
Mrs.
Ms.
Mr.

_____ FAMILY NAME

_____ GIVEN NAME

ADDRESS:

POSTAL CODE:

Please answer the following questions according to your present patterns or habits and what has happened for you since the end of the program, April 17.

1. What is your weight on Monday, June 19, without your shoes on? _____ pounds
   _____ kilograms

2. Have you followed a weight control program or diet during the past two months (April 17 to June 19)? Yes _____ No _____

   If yes, please describe what program or diet you followed.

3. Do you feel that you have met your goal in terms of control over your eating? Yes _____ No _____

   If no, please write down your goal for control over your eating.

4. Has your eating pattern (what you eat, when you eat, how much you eat) changed since the end of the program, April 17? Yes _____ No _____

   a. If yes, please describe how your eating pattern is different than at the end of the program.

   b. Please describe in as much detail as you can what led to the change(s) in your eating pattern over the past two months.

JUNE QUESTIONNAIRE

5. Do you sometimes feel that your eating is uncontrollable or out of control? Yes _____ No _____

   a. If yes, please describe how you handle the times when you feel your eating is out of control. What do you do?

   b. If yes, if your eating does get out of control sometimes, please check which one(s) of the following statements is closest to your pattern.

      i. My eating gets out of control every day. _____
      ii. My eating gets out of control two or three times a week. _____
      iii. My eating gets out of control once a week. _____
      iv. My eating gets out of control twice a month. _____
      v. My eating gets out of control once a month. _____
      vi. When my eating gets out of control it is only for that particular day or evening and does not continue for the next day. _____

6. Have you experienced any changes in your thoughts and/or feelings about food and weight control over the past two months? Yes _____ No _____

   a. If yes, please describe the changes in your thoughts and/or feelings since the end of the program.

   b. If yes, please describe what led to the changes in your thoughts or feelings.

7. Have you experienced any changes in other parts or patterns of your life, for example, sleeping, family relationships, activity or sickness during the past two months? Yes _____ No _____

   a. If yes, please describe the change(s).

JUNE QUESTIONNAIRE

b. If yes, please describe what led to the change(s) in other parts or patterns of your life.

8. Have you any difficulties with eating and weight control at the present time?
Yes _____ No _____

a. If yes, please describe your present difficulties.

b. If yes, please describe how you are handling your present difficulties.

9. Would you like a phone call to discuss your progress or regress with eating and weight control? Yes _____ No _____

Present phone number at home: at work:

10. If you have other comments in relation to your eating habits, weight control, your experience in the weight program, or ...., please write them here.

PART 4.1

RESEARCH PERMISSION

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY
EDUCATION CENTRE—NORTH WING
TELEPHONE (403) 432-5245

FACULTY OF EDUCATION
THE UNIVERSITY OF ALBERTA
EDMONTON, ALBERTA
CANADA T6G 2G5

RESEARCH PERMISSION

I understand that all information obtained by participating in this program will be kept confidential in accordance with good research ethics. Nothing which will personally identify me will be included in any verbal or written statements.

I give my permission that Devon Mark can use anonymous information obtained during this program for research purposes, including her dissertation and subsequent research articles.

_____
SIGNATURE

_____
DATE

PART 4.2

PERMISSION TO CONTACT PHYSICIAN

PERMISSION TO CONTACT PHYSICIAN

I authorize you, Devon Mark, to contact my family physician

NAME OF PHYSICIAN: _____

ADDRESS: _____
(PLEASE PRINT)

using a form letter. I understand that this is to ensure that there is no metabolic or physiological reasons for my weight gains and losses. That is, if I, _____, am:
NAME (PLEASE PRINT)

1. suffering from a condition that might cause weight gain (e.g. congestive heart failure; renal oedema; endocrine diseases such as diabetes mellitus, thyroid dysfunction or Cushing's disease);

2. receiving drugs such as appetite suppressants, corticosteroids, thyroid-active drugs, diuretics, etc.;

3. pregnant;

4. suffering from some other physical condition that affects weight gains and losses;

5. suffering from diverticulitis, gout, tuberculosis, Addison's disease, ulcerative colitis, or regional ileitis;

I understand the physician will return the form letter to me.

If the form letter is not returned I understand I can continue to participate in the program. If the form letter is returned, I understand I will not continue to participate.

_____
SIGNATURE

* * * * *

I authorize Dr. _____ to release information to Devon Mark in the event he recommends against my participation in the weight control program.

_____
SIGNATURE

PART 4.3

LETTER SENT TO PHYSICIANS

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY
EDUCATION CENTRE—NORTH WING
TELEPHONE (403) 432-5246

FACULTY OF EDUCATION
THE UNIVERSITY OF ALBERTA
EDMONTON, ALBERTA
CANADA T6G 2G5

January 31, 1978

Dear Dr. :

Your patient, _____, is intending to participate in a research project in relation to eating and weight control. The focus is on changing patterns (habits) of eating and gaining control over eating instead of changing what is eaten to lose weight.

Regarding your patient's health it is important to exclude individuals who have some metabolic or other physiological reason for their weight condition or their inability to successfully lose weight. Please notify me immediately by returning this letter in the enclosed self-addressed envelope if your patient is:

1. Suffering from a condition that might cause weight gain (e.g. congestive heart failure; renal oedema; endocrine diseases such as diabetes mellitus, thyroid dysfunction or Cushing's disease);

2. Receiving drugs such as appetite suppressants, corticosteroids, thyroid-active drugs, diuretics, etc.;

3. Pregnant;

4. Suffering from some other physical condition that affects weight gains and losses;

5. Suffering from a condition which contraindicates weight loss such as diverticulitis, gout, tuberculosis, Addison's disease, ulcerative colitis, and regional ileitis.

If this letter is not returned to me within 7 days I will assume that there is no medical reason why your patient should not participate in a non-dietary weight control program.

If you wish further information about the program please contact me at 432-5030 Mondays and Wednesdays 9:00 am - 12:00 Noon; Tuesdays 9:00 am - 12:00 Noon and 2:00 - 4:00 pm. My research supervisor, Dr. Harvey Zingle, may be contacted at 432-3745.

Sincerely,

Ms. Devon Mark
Ph.D. Candidate

DM/lsm
Enclosure

PART 4.4

AGREEMENT TO BE A CO-RESEARCHER

AGREEMENT TO BE A CO-RESEARCHER

If accepted into this program, I agree to fulfill the following requirements. I agree to:

1. attend sessions and be weighed whether or not I am able to follow the difficult directions;

2. complete 4 questionnaires on my eating and weight problems, solutions I have attempted to lose weight, and my eating and weight goals. (This will be done during Week 1 and Week 12, (then) 2 months and 6 months after the completion of the program);

3. complete weekly questionnaires about my attitudes and feelings to eating and the effect of the program.

_____

SIGNATURE

APPENDIX B

TREATMENT-CASE STUDIES

Treatment Case Studies

Case 1: Mrs. T.

Mrs. T., age 43, attended 11 of the 12 sessions, missing one week for an Easter holiday. The therapist's initial impressions were very positive. Mrs. T. had a bubbliness, that together with very direct eye contact, made her stand out among the 14 people attending on the first night.

Description of the initial problem. Mrs. T.'s description of her problem with eating and weight control and her attempted solutions was consistent with the Dieting Game Without End. She felt her eating was uncontrollable or out of control two or three times a week. She reported that she had always been heavy. At 16 she weighed 170 pounds, and after crash dieting weighed 127 to 135 pounds from 17 to 21 years of age. Currently Mrs. T. weighed 175 3/4 pounds, 33 pounds above the goal weight for a woman of medium build, 5 feet 6 inches tall (Metropolitan, 1972).

To control her eating and weight Mrs. T. deprived herself of many foods and tried a number of self-restraint solutions such as the Canadian Diabetic Diet, Dr. Atkins' Diet, and a 900-to-1200-calorie-a-day diet. These attempts had occurred about 20 times over 16 years or more. On "real strict" diets she had lost but then regained.

Mrs. T's control goal was to lose control once a year and only for a particular day or evening, not for days. She wanted to weigh 166 pounds at the end of the sessions, and 2 and 6 months later, she wanted to weigh 156 and 146 pounds respectively.

Interventions. Other than the group messages and interventions, the main instructions given to Mrs. T. were to try harder to gain weight, to explore more types of food to help her gain, and to go slowly in making shifts in other areas of her life.

Reaction to the interventions. Mrs. T. was initially "stunned" when she heard the directions to try to gain 15 to 25 pounds. She quickly began to experience this direction in a very positive fashion; she felt relieved she didn't have to worry about what she ate. She believed that attacking the weight problem in this manner would relieve the constant pressure and put her problem back into perspective. Mrs. T. saw the process of gaining weight as an opportunity "to learn what you need to learn about yourself." During the first week of following the instructions to gain weight she found that she really enjoyed eating anything she wanted to -- "I never tasted food before or enjoyed it." It was always, "I shouldn't be eating this." Her enthusiasm is expressed in the following interchange which occurred in the group discussion.

> Mrs. T.: I had a beautiful week. And I did so much of everything else too. Things I've wanted to do for a long time and didn't do. I had a great week.
> T.: You're really beaming.
> Mrs. T.: (laughs) I had a fantastic week, just from eating what I wanted to eat. It was wonderful. I really felt good about it.

In spite of her initial enthusiasm to try to follow the directions, there was some conflict about doing so according to her weekly homework questionnaire. This seemed to have disappeared by the fifth session. While trying to gain weight, she lost for the first two weeks although she reported eating chocolate bars, mashed

potatoes and gravy, "really hard core stuff." Mrs. T. reported she was also eating more slowly and spending more time in the kitchen instead of dashing in and out to avoid the temptation of food. After the first week she lost weight. She was very surprised and left talking excitedly about having her first cream pie in 25 years. When she failed to gain the second week, she felt pretty discouraged, and at another level was amazed that she could be eating so steadily and not gaining. Since she was also experiencing shifts in her energy patterns during these weeks, she thought she was probably just burning up her extra food.

After three weeks of trying to gain (Week Five) Mrs. T. was able to put on 3 pounds. She reduced activities like jogging because they "represented a caloric expenditure that wasn't consistent" with her gain goal. By Week Six Mrs. T. was feeling more in control -- "I felt I am the <u>one</u> in control, not a diet book, a doctor, etc." While even more determined to gain weight, once more she lost a pound and a half in spite of her efforts. "I couldn't lose a pound and a half for the life of you before... I've got to stop doing all I'm doing," she laughed.

The following weeks she continued exploring different types of previously taboo foods. She was feeling more comfortable with gaining and felt that she had almost complete mastery of her eating habits. Her continuous eating had nearly stopped and she found that she actually wanted to snack on fruit. During Week Seven's group discussion the extent of the changes she was experiencing became very apparent. "Oh, my whole life is just turned upside down, it really is. It's fantastic! If I don't lose weight, I'm still happy. At

least I'll be fat and happy. Always before I was fat and miserable (laughs)."

Week Eight, in spite of efforts to gain weight which included sleeping more, cutting down on her exercise, and eating ten chocolate bars a week, Mrs. T. lost 1/2 pound. She thought she did better at gaining when she was somewhat active so she planned to begin her morning exercise program again. At this time she noticed that she had gone through a cycle in her eating and was going back to foods she missed when she was first trying to gain. Once more she saw this as part of learning about herself: "I can see why it's important to take enough time...to learn what you need to learn about yourself."

Upon her return from her Easter holiday, Mrs. T. expressed confidence that she could "conquer" her food problem. "What I have really learned is that this problem is no mountain..., it's just like learning a chapter in a book or mastering an exam or whatever, I can do it. I've got that confidence I never had before." During the holiday she had continued to explore new foods (buffalo roast, Vienna coffee, and Yorkshire pudding) previously avoided because of the calories. Breakfast was becoming more enjoyable. She was now eating 4 slices of toast and jam, plus an egg or two, juice, and coffee. With a gain of only 3/4 pound over the past two weeks, Mrs. T. was becoming increasingly impatient with herself, but as before, at another level, she seemed pleasantly surprised by her increased energy. When asked for suggestions to help her gain, she was encouraged to put in an extra effort during the coming week, including trying to get in extra snacks after supper and eating cookies, pasteries, and

cake instead of fruit.

By allotting herself so many buns, donuts, sandwiches, date rolls, and chocolate bars each day, Mrs. T. was able to gain 2 1/4 pounds (Week Eleven). Although following this regime was a struggle, she felt more optimistic and experienced a greater sense of control. Still continuing to enjoy new foods, she had a pork roast for the first time in 15 years.

Consistent with her tendency to view the weight gaining as a learning process, Mrs. T. spent part of the last week analyzing and writing about what had happened to her over the past 12 weeks. During the final weigh-in she presented the therapist with a two-page typewritten summary of the changes which had occurred for her, entitled "A Look Through the Chocolate Bar." She had decided during the week that she wanted to let herself lose. Even though she hadn't reached her 15-pound goal, she believed the time she had spent trying to gain had been a learning experience. She also experienced a change in that she wasn't putting limits on herself in terms of losing.

Changes in self-image. Most of the changes in her self-image seemed to center around an increasing awareness and acceptance of her size. Week Three she stated, "I'm fat and it's about time I realized it (laughs) or recognized and said it I guess." With gains of as little as 1/4 pound or 3 pounds Mrs. T. felt increasingly fat and was more aware of her stomach touching her legs when she sat down. These reactions occurred when she was only 1 1/2 pounds heavier than the first weigh-in. With a gain of 2 1/4 pounds she experienced herself as having a big stomach, "I never had a stomach before." By Week Ten

she had started wearing bigger clothes all the time. She thought this gave her greater freedom to eat and try to gain. These changes seemed very important to Mrs. T.'s process. Admitting that she was fat and not just overweight seemed to give her a self-acceptance and self-confidence to master her problem.

Changes in energy. While Mrs. T. experienced an increase in her energy level for most of the program, it was very low for the last session. Along with examples of the changed energy pattern in many everyday areas of her life (housework, community league, church, new hobbies) it was also apparent in her behavior in the group. She was cheerful, supportive, and literally, sparkled.

Changes in other areas. During Week Six Mrs. T. stated that a whole world had opened up for her. She had started to smell food again. Before she had tried not to smell because she would be tempted to eat. She was now planning meals and taking time to cook them. Before she used her microwave oven so she wouldn't be in the kitchen for very long and be tempted by food. She started reading recipes instead of wishing magazines didn't have them. She was no longer experiencing panic during her weekly shopping, and she was buying less and examining quality more although the frequency of her shopping trips had increased. Her smoking had decreased because she wasn't snacking, an activity that had always been followed by a cigarette. Week Ten Mrs. T. said she noticed a change in her body temperature. Before she was always cold at night, sleeping with "my heating pad and my dog and my husband...trying to keep me warm...now I'm warm... It's just something terrific." She was also enjoying her rest more

now that she wasn't cold. As well, she woke up "bright and early and cheery" instead of being in a fog.

Family reactions and changes. In spite of wondering if it would work Mrs. T.'s family gave her full support, wishing her well on the program. Her husband was pleased with the meals she was cooking and felt good about the class because she felt good. Her twin girls, age 10, were very pleased that she always had some "goodies" around.

Her one concern about her family was the way she was interacting with her 12-year-old son. She noticed that she had the same attitude about his eating as she used to have about her own. Mrs. T. made many comments to him about not eating or about eating something other than he wanted. The effect on him was discussed; she thought that it was similar to her response when someone told her not to have something, that is, she would go and eat more. Mrs. T. was asked to keep a record of her comments about his eating for a week.

During Week Eleven's group discussion she gave some examples. "So after school he came in. 'What's to eat?' and I say, 'You aren't hungry are you? You had a big lunch.' Anyway, he digs around and finds something to eat." By Thursday she said she couldn't stand herself anymore so "I changed my attitude toward him and...when he came in and said 'What's to eat?', I listed 12 different things that he could eat. He said, 'None of it sounds good' and walked out the door (she laughs). So obviously it was my attitude towards his eating that made him come in and eat and so far he hasn't eaten like he did." Furthermore, Mrs. T. thought that because she was now able to allow her son to eat and to give him choices, she was now

freer to eat and gain more easily.

Week Twelve Mrs. T. reported that her problem with her son seemed to have disappeared. "He seems to be just a different boy. I make sure he gets a little dessert, I make an attractive lunch for him,..., make it really nice for him. He eats a better breakfast and he's not searching and prancing in the kitchen any longer."

Description of the problem after 12 weeks. Changes consistent with shifts in the Dieting Game Without End and in other areas were apparent. Mrs. T. reported that she did not feel as if her eating was uncontrollable or out of control. Her eating pattern had changed in that she was eating what she wanted when she wanted, and was having breakfast. Mrs. T. reported that "facing food, trying to gain weight, and removing guilt feelings" had led to these changes. Changes in her thoughts and feelings about food and weight control, also attributed to trying to gain weight, were: "I like food now; I'm not afraid to eat--I know it takes a lot of food to gain one pound; I enjoy cooking; I read recipies; I'm at ease with food." Mrs. T. reported that trying to gain weight had led to the other changes in her life such as being warm, taking up new hobbies, getting up easily in the morning, and being happy. "I do a lot more and I'm much less tired... Time is not so important. I know I will win so what's the rush."

During the 10 weeks she was encouraged to gain weight Mrs. T. was able to gain 9 pounds. Her final weight was 183 1/2 pounds. Mrs. T. changed her weight and control goals. Her new goals for 2 and 6 months after the end of the sessions were 165 and 150 pounds,

respectively. Her new control goal, "I would never lose control over my eating," may sound Utopian; however, it reflected the increase in her control and confidence. "I think that I'll never be a failure again because...when I do eat it will be because I decide to start eating and when you make that decision then you're not a failure. You can't be a failure really because you're still in control."

Description of the problem at the 2-month follow-up. The shifts in the original problem and in other life areas continued. Mrs. T. felt she had met her goal in terms of control over her eating; her eating did not feel out of control. Eating three meals a day with no snacking was attributed to the fact that she was not "uptight about food or about my weight." She had attended end-of-the-year banquets, previously "avoided or struggled through," even eating the desserts.

Mrs. T. thought that her energy, very low at the end of the program, had picked up. As well, it seemed to her that she was able to absorb more of her studies (registered accountant) with less effort. During the requrested follow-up phone call, Mrs. T. reported that she wasn't feeling self-conscious about her size anymore and was even wearing shorts. She wasn't weighing herself as frequently. If she had a craving she ate what she wanted. "I don't eat all the kitchen before eating the chocolate bar I want." Mrs. T. had also been doing a lot of baking. Basically she was feeling "really good and really confident" until she looked at her 2 1/2 pound gain. Then she started wondering if she was on the right track. Her meal habits were discussed. Suggestions were given that she seemed to be missing

something at breakfast and that as she hadn't reached her gain goal, she might try to gain some more. Mrs. T. quickly agreed that she needed to gain a "bit more." She was also given a "go slow" message. The shift in the Dieting Game Without End and in other areas in her life seems best summed up in her words, "Whether I'm skinny or not, it doesn't really matter, I'm going to look after me...I don't see my being overweight as a big problem anymore; I am not thinking about food all the time--I can now direct my energies to other things."

Case 2: Mr. M.

Mr. M., age 38, attended 11 sessions. One of these was an individual session to take the place of the missed second meeting in which the instructions to try to gain were given. Initially Mr. M. did not stand out in the group; however, his sense of humor and his goals to change his eating patterns (rather than simply lose weight) set him apart by Week Three.

Description of the initial problem. Mr. M.'s problem-solution pattern was consistent with the Dieting Game Without End. He reported that snacking and desserts were a daily problem.

To control his eating and weight Mr. M. had tried Weight Watchers for 3 months and also the Dr. Atkins' Diet. He had made three major efforts to get control over his eating and lose weight over the past 6 to 10 years. However, he was able to maintain the loss for only a month before regaining--"I felt so good about the weight, I felt I deserved a reward--eating." Mr. M. tended to use an all-or-nothing approach, treating his first failure "as negating the value of the program" and thus giving up. At 216 1/2 pounds,

Mr. M. was 77 1/2 pounds above the goal weight for medium-framed men, 5 feet 4 inches tall (Nidetch, 1972).

Mr. M.'s control goal was: "If I lost control of my eating, it would be only for that particular day or evening and not continue for days." He wanted to weigh 201 at the end of the sessions. Two and 6 months later he wanted to weigh 195 and 190 pounds, respectively.

Interventions. Mr. M. was not present Week Two when the gain interventions were given; he received these in an individual session. Because he began to have difficulty snacking and was not gaining very much (Weeks Six and Seven) he was asked to "try to shift your eating into bigger meals" in order to gain. Then, in Week Ten, because he had gained a total of only 2 pounds in the last three weeks, he was asked to start snacking again "if you could tolerate it." The instructions to let himself lose weight were given to him individually in Week Eleven, once he had reached his 15-pound-gain goal.

Reaction to the interventions. Mr. M.'s initial reaction to the gain directions was that "someone was playing games with my head" and that perhaps he was part of the control group as he had received the directions in an individual session. Nevertheless, Mr. M. gained 3 3/4 pounds during the following week. "This burden of guilt you always carry on top of your head disappeared." As well, he thought that gaining weight might be the way of breaking out of the cycle of losing weight, rewarding yourself by eating, getting depressed and starting over again.

After the second week of trying to gain (Week Four), he continued to feel skeptical about gaining the weight; however, he

stated "although it seems somewhat counter-intuitive, I've decided I'm willing to try it." As well as relief from guilt, he experienced relief from other people's reprimands to diet.

By Week Five, Mr. M. felt he had reached a saturation point with food. He wrote, "It has become a chore to eat and I don't know if I can continue trying to gain for much longer. I feel that fifteen pounds is probably out of the question and possibly I need more limited goals--or a periodic break. (The sacrifice/reward cycle in reverse?)." In spite of gaining 7 1/4 pounds since Week One, Mr. M. was feeling quite energetic.

Mr. M. took a break from eating at the beginning of the next week, and similar to a losing diet, gave it a "big push Friday, Saturday and Sunday, trying to catch up." Although he was having difficulties, Mr. M. was beginning to feel "cautiously optimistic" as he noticed his feeling towards foods changing. For example, he was finding snacking more difficult. "It's incredible really,... I look around and there's nothing, there's absolutely nothing, I want to eat" (laughing). He was beginning to feel the same way about milkshakes as he used to feel about fish on Weight Watchers. Because he had gained only half a pound, he was encouraged to experiment with larger breakfasts, even when he had to get up earlier and make his own. To relieve some of his difficulties with snacking he was asked to shift the extra eating into his main meals.

To his disappointment and disbelief, following the directions to gain by eating larger meals lead to a loss of 3/4 pound.

> Mr. M.: I had good vibes about this week that I was going the right direction; I was enthusiastic, eating big breakfast, hating them (laughing).

T.: Suffering (laughing).
Mr. M.: (laughing) I mean when you're suffering you know you've got to be doing good, right?
T.: (laughing) Well, I would suggest that you continue to suffer.

He was encouraged to continue with the big breakfasts and experiment more with his lunches and suppers. By now Mr. M. felt that he was more aware of the extra weight burden; he felt more irritable and less energetic. Still he thought he was making "progress in terms of my attitudes to food. I think my goal is now attainable."

Missing Week Eight due to business, he was able to gain 3 pounds between Weeks Seven and Nine by really concentrating on eating at mealtime and not snacking. The directions now seemed to make more sense to him in view of his increasing awareness of changes in attitudes to food and his new eating habits. "It's amazing the change in my outlook..., I haven't been snacking and it's becoming obvious to me now that that was kind of the biggest part of my problem... a bedtime snack is a pain in the behind." His physical discomfort with his bulkiness continued to increase.

When Mr. M. lost a pound during the following week, he was instructed to start snacking again to help him reach his goal. As he was feeling more optimistic about actually reaching it, Mr. M. thought that he could put in the extra effort.

Between Weeks Ten and Eleven, Mr. M. was able to gain 6 pounds to reach his 15-pound gain goal. He was feeling good about having done so except for the extra stress it had put on his body. He thought he had an increased sense of control just in the past few weeks. "I've got a feel now for the type of things that will put

weight on me... It would seem to me that by subtracting those things it'll start to slide off." While he noted that there was a definite change in his attitude towards food, Mr. M. was concerned about it lasting. Instructions for letting himself lose weight were given. Mr. M. left appearing very elated.

During the Week Twelve group discussion, Mr. M. received the instructions for maintenance of control as well as a repetition of the directions to lose. In the previous week, he had lost 5 1/4 pounds--"The weight slides off with no effort--completely in control!!" During weigh-in, he was told that he was going too fast and cautioned to go much slower. He thought his present problem with weight control was remembering to "eat enough to keep the weight from disappearing too rapidly." Mr. M. found the directions for maintaining control a key piece of information that removed the one remaining doubt he had. He said that when he lost control he planned to take a sack of cookies and go to bed.

Changes in energy. Mr. M. experienced an initial increase in his energy during the first three weeks of trying to gain. By Week Seven, though his total gain was approximately the same, 7 pounds, he felt more irritable and less energetic. He thought the feelings were similar to those when he was trying to lose weight and was getting fed-up with dieting. As well he had sprained his ankle two weeks previously and was probably more aware of the extra weight he was carrying.

Changes in other areas. Mr. M. thought he was slightly more active than he used to be. He found that eating a more substantial breakfast changed his attitude towards work. He was sleeping extremely

well, something he thought might be related to excluding evening snacks. Mr. M. stated the most significant change in his patterns was that he wasn't watching television anymore; he thought that watching it had previously been an excuse for eating.

Family reactions. While his wife was very skeptical of the approach, she supported his efforts. His teenage children, on the other hand, believed that "I have completely spun out." His family remained doubtful but noticed changes in his eating patterns and attitudes.

Description of the problem after 12 weeks. There was evidence of a shift in the Dieting Game Without End as well as changes in other life patterns. Mr. M. reported that he did not feel that his eating was out of control at the present time. He thought his eating pattern was different than at the beginning of the program, writing "I don't have the urge to sneak off and eat a bag of cookies, three Laura Secord puddings and a quart of ice cream--and destroy the evidence. No cravings! No guilt! Am eating better meals and... particularly a larger breakfast." "Removal of the food taboo and the associated guilt feelings about food (which) diminished its importance ...and substantial meals" led to the change.

Changes in his thoughts and feelings about food and weight control, attributed to attempting to gain weight by overeating and finding that he didn't balloon up overnight, were that he found he could pick and choose much better. He wrote:

> I don't have to get to the bottom of a dish of peanuts, etc. --I eat when and what I want without feeling a compulsion to pig out on junk foods. Have little desire to eat at other than meal times. I have also found that certain foods that I thought were great weight putter-onners [sic] don't seem to

have that effect in a balanced diet. Eg.: I can lose weight and consume carbohydrates.

Changes in other areas were increased energy for work, improvements in sleeping, and cutting out television, previously an excuse to eat.

During the 9 weeks when Mr. M. was encouraged to gain weight, he was able to reach his gain goal of 15 pounds. He lost 5 1/4 pounds during the last week. His weight on Week Twelve was 226 1/4 pounds. Mr. M. changed his weight goals. His new goal for 2 and 6 months after the end of the sessions were 200 and 180 pounds, respectively.

Description of the problem at the 2-month follow-up. Changes in the Dieting Game Without End continued. At this time Mr. M. weighed 224 pounds and was overeating to regain control, having lost control at 221 pounds. He was also planning to re-establish the pattern of eating larger breakfasts. Mr. M. was disappointed that his efforts to regain control at this time were less successful than during the program. His goal was to establish a gradual losing pattern that he could live with on a day-to-day basis, stating that he was seeking "not necessarily a dramatic loss." During the follow-up phone conversation he was given support for deliberately gaining weight, that is, deliberately having a relapse, and was encouraged to "go slow," and to begin eating breakfasts again.

Case 3: Mrs. V.

Mrs. V., age 28, attended at least part of all 12 sessions. Mrs. V. stood out from the rest of the group the first night because of her size.

Description of the initial problem. Mrs. V.'s description of her problem and solutions were consistent with the Dieting Game Without End. She reported that her eating was out of control, especially when she was depressed or when her children "got on her nerves." Her main problem with weight control was "the frustration of not losing it fast enough...and snacking."

Mrs. V. reported she had been continually trying to follow a diet to control her weight for 16 years or more. She had tried Weight Watchers and a hospital weight loss diet as well as acupuncture --"I lost 21 pounds in 21 days, but was not allowed to eat anything, just drink water." Mrs. V. had been able to keep weight off "for a time" but regained because of her "tendency to eat more." She had never reached a weight goal she had set.

Mrs. V.'s control goal was: "If I lost control of my eating, it would be only for that particular day or evening and not continue for days." While she eventually wanted to weigh 160 pounds, she didn't want to set any weight loss goals as she had been discouraged so many times. At 258 1/2 pounds, Mrs. V. was 126 1/2 pounds above the goal weight for medium-framed women 5 feet, 2 inches tall (Nidetch, 1972).

Interventions. As well as the group messages and interventions (see Chapter 3), Mrs. V. received symptom prescriptions to eat particularly when she was depressed, already a peak time of overeating, to help her gain weight. For example:

Mrs. V: a couple of days I felt very depressed...
T.: You might try to gain weight by eating more than you usually do when you're depressed...
Mrs. V: As a rule when I'm depressed I eat right away; I head for the fridge.

T.: Well, keep it up and see if you can put on some weight by eating when you're feeling that way.

Each week she gained she was praised and encouraged to gain for the next week.

Reaction to the interventions. Mrs. V.'s initial reaction to the gain instructions were those of shock. "I thought, 'Are you crazy?'; we came to lose weight not gain it. I also thought you might be trying reverse psychology." Although she thought she would try to gain if it would eventually help her, Mrs. V. came down with the "flu" and continued to lose weight as food "was one thing I didn't want."

By Week Three Mrs. V. was feeling better and thought she would try to gain. Week Four she was feeling relief from guilt but she was still worried about losing what she had gained (2 1/4 pounds). Mrs. V.'s ambivalence continued during the following week. She was finding it difficult to gain and agreed with the members of her small group that "we have been afraid to put on weight for varying periods of time...we were frightened [that] if we relaxed the diets when we were dieting we would gain. But trying to gain weight is another thing; it's a darn sight harder than losing weight in our opinion." As the following weigh-in exchange shows, she was very surprised when she had not gained between Weeks Four and Five.

Mrs. V.: I know I gained. I just feel it.
T.: Sorry lady.
Mrs. V.: Oh, you're kidding! What I ate!...I ate pie and ice cream and cake and ice cream and bread and potatoes. Oh, I lost...Oh, boy! (laughs)

She had stopped snacking when she watched soap operas which may have accounted for the loss. Mrs. V. was encouraged to experiment with

eating a breakfast, a lunch, and a supper to cut down on feeling bloated. During the discussion she mentioned that previously most of her weight gain had been through the day by snacking, particularly when she was feeling depressed. This led to the symptom prescription, as noted, to help herself gain by trying to eat more when she was feeling depressed.

Mrs. V. also mentioned that she was experiencing pains in her chest. She used to have similar pains when she was working, but she thought these were related to gaining weight. The therapist suspected the pains were related to anxiety, as Mrs. V. was 6 1/2 pounds lighter than Week One and had recently gained only 2 1/4 pounds. Nevertheless the therapist experienced some fear that her hunch was wrong.

While food had lost most of its appeal by Week Six, Mrs. V. still found she had a craving for a banana split. She had not been depressed during the previous week, so during weigh-in time she was given the following directive to try to relapse.

T.: What I'd like you to do is in this next week try to bring on your depressed feelings again.
Mrs. V.: You're kidding!
T.: No, I'd like you to try to bring on your depression again...and at those times,... try to eat to help you gain.

Week Seven, Mrs. V. reported she was accepting the program more and having more faith in it. She thought that this was the reason she had been gaining steadily. In contrast to her previous pattern, she was now eating breakfast. Doing so, she found her grumpiness decreased. Still she reported feeling very tired and irritable. She had been able to bring on her depression for about ten minutes and had then made herself a peanut butter and honey sandwich.

By Week Eight, Mrs. V. didn't know how much longer she could continue "I feel awful," she reported. She was now 4 1/2 pounds above her Week One weight. She had noticed that, "I even throw the kids stuff in the garbage now (laughs)...and my cravings for food, I have no cravings. I'll be sitting watching T.V. and they will be advertising something good...it doesn't even turn me on anymore." Mrs. V. had been able to bring on feelings of depression by watching soap operas on T.V. For the following week she was asked to try to bring the depression on by herself, without the soap operas, on a day we decided on ahead of time. The following exchange occurred.

Mrs. V.: Make sure the kids are in bed (laughs). O.K. I'll try that...I like to be by myself, you know, without the kids around...It makes it nicer...it's a treat. That's when I relax when the kids are in bed.

T.: Which are you going to pick?

Mrs. V.: I'll pick Thursday because Friday, my mom and dad are leaving for Hawaii. I'll pick Thursday or Friday. I'll pick Friday, the day they leave.

While Mrs. V. was not able to bring on her depression, Week Nine she was still feeling "awful." She continued to have a pain in her chest. Although she was 15 1/2 pounds above her Week Three weight, the therapist was doubtful she had established control over eating. Therefore, to test her control Mrs. V. was directed to overeat to either gain 2 pounds or overeat to lose 2 pounds, "We'll be able to tell from there what direction to go in." The plan was that if she did let herself lose, then directions to continue to let herself lose would be given. Mrs. V. was also going to try to bring on her depression on Thursday.

Mrs. V. did not bring on her depression on the decided upon day. "It started on Friday and it's been with me ever since," she

stated. She was encouraged to "keep it with you a few more days. Really try hard to keep it with you." Mrs. V. continued to feel tired, sluggish, and short-tempered. As she had lost only 1/2 pound, she was asked to overeat to gain 2 pounds.

During the Week Eleven weigh-in Mrs. V. reported she had been able to keep her depression until Friday. She stated, "But this last time when I did get depressed I didn't want to head for the fridge. I just didn't feel like eating." However, she had gained only 1 of the requested 2 pounds. In spite of her continued difficulty with the directions she was determined to try to follow them. She was directed to bring on the depression and overeating once again on Wednesday, a day that she chose, and to try to gain another 1-1 1/2 pounds.

Mrs. V. found the last week "pretty good." She had been able to gain 1 1/4 pounds. In relation to her depressed feelings she related, "It wasn't Wednesday, it was Tuesday (laughs) so I did like you said. I went and I got out to the fridge and uh, I didn't want it." During the weigh-in, Mrs. V. commented that the instructions to let herself lose and to maintain control through trying to regain "made sense." She sounded pleased with her sense of control.

> I didn't know I could have control over food. Maybe the odd time I'll still, you know, if I see the kids eating a chocolate or something, I might want it, but when it comes down to having it I don't want it. It's not like it used to be where I had to have it and after I ate one I wanted more ...I find as long as I eat breakfast I'm O.K. the rest of the day.

Changes in self-image. Mrs. V. became increasingly self-conscious about her size throughout the program. For example, during the opening discussion in Week Eight, she giggled, "If I get any bigger

I won't be able to fit in this chair." This seemed to be related to an increase in awareness rather than size per se as at this point she was only 4 1/2 pounds heavier than on the first night and this amount was indistinguishable to the therapist. Several other times she mentioned feeling embarrassed about going out shopping and having other people see how big she was; she said this had not bothered her before.

Changes in energy. From Week Seven to the end of the program Mrs. V. reported she felt tired and sluggish.

Changes in other areas. Mrs. V. found she was more short-tempered and that her children seemed to get on her nerves more often.

Family reactions. While some of her family, including her mother, thought she was crazy to attempt such an approach to weight control, Mrs. V.'s husband solidly supported her. "As a matter of fact, he is the one who convinced me not to give up on it. I told him if he wants a 10-ton elephant walking around the house, I'll go through with it. He told me it is for my own good." Week Six she reported he was also giving her some "coaching"--" 'Come on', he says. 'You can do it'."

Description of the problem after 12 weeks. At the end of the Program there were some shifts in the initial problem. Mrs. V. thought her eating was under control. Her eating pattern was different than at the beginning of the program. "I never ate breakfast. I now eat breakfast, have a small dinner, and then eat whatever I cook for the family for supper. My snacking is cut down. In fact, I may snack maybe only once or twice a week, depending on how I'm feeling." She attributed these changes to "having to gain this extra weight."

However she viewed her present problem as: "I still like the odd piece of pie or cake." Eating still appeared to be unacceptable at times. Nevertheless her reported attitude towards food and weight control had changed. Since she did not have "to feel guilty about eating something normally avoided on a diet,..., food just does not turn me on like it used to. It's there, and if I want it, I don't have a guilty feeling if I eat it." She thought some of the changes were related to gaining weight; Mrs. V. also reported that gaining weight was also the least helpful part of the program. While there were several areas where her answers seemed contradictory, most evidence indicated that there were changes in the problem.

Week Twelve, Mrs. V weighed 267 3/4 pounds, a gain of 17 1/4 pounds since Week Three or 9 1/4 pounds since Week One. In contrast to the beginning of the program, she did set weight goals. Mrs. V. wanted to have lost 20 and 50 pounds at the 2 and 6 month follow-up.

Description of the problem at the 2-month follow-up. All indications that there had been changes in the initial problem seemed to have disappeared at the follow-up. She had stopped eating breakfast, hoping to lose faster, but instead had ended up eating more later in the day. (She weighed 4 3/4 pounds less than Week Twelve.) She was handling times when she felt her eating was out of control by trying to keep busy, Mrs. V. reported that she was more grouchy and less patient with her children, that her back ached all the time, that she was making up excuses not to go out with friends, that she was losing sleep because she could not get comfortable in bed, that her posture was worse and that she was not interested in sex. "My

attitude towards life and myself are getting worse... It's a losing battle for me, and I've just sort of given up, not caring whether I live or die... I guess I expect a miracle and I really know the only way I'll lose weight is if I really try hard." In short, on the follow-up questionnaire Mrs. V. appeared to be very depressed. As well she felt she had a psychological problem stemming from her past. "It's all in my head, and if my attitude could be changed, I'm sure my eating habits could be changed too... I do know one thing, I really want to lose weight. Maybe I'm just scared of the change it would make in me." One positive note was that on the occasional days when she ate breakfast she was fine for the rest of the day.

During the follow-up phone call, Mrs. V. did not sound as depressed as anticipated from reading the questionnaire. She had had a good weekend, going out one evening with her husband. That morning she had been shopping with a neighbor and was planning to go out for supper with a friend and their children the next day. She related that after the end of the program she had lost 10 pounds. However, while shopping she met Mr. O who had lost about 25 pounds. She then felt like she wasn't doing well and gained it all back. Mrs. V. was told that if anything the 10-pound loss in 1 month was too fast. It was implied that anybody could lose weight but that a slow approach was more effective in the long term. The directions for letting herself lose and maintaining control were reviewed and the ideas of going slow and gaining weight to test or maintain control were reinforced.

As much as possible the therapist intended to encourage and reframe Mrs. V.'s current process. Her hopelessness was commented on

in a strictly reflective way, "sounds like you're feeling pretty hopeless." Her search into her past for the solution to her problem was encouraged as a means of giving her something to do. "Probably you should spend a lot of time thinking about your past. I don't think you'll find your solution there but it'll give you something to do." It was acknowledged that the program was probably not what she needed. Her feelings of being out of control were framed as important to staying fat. "It also sounds like it's important for you not to get control over your eating. Like it's more important to continue in this pattern of trying to use willpower and staying fat... I guess the directions to help you get control weren't what you needed. I guess it's more important to stay fat." Mrs. V. quickly denied that it was important to stay fat; however, she acknowledged her fear about getting thin. For the first time she also mentioned she wanted to lose at least 100 pounds. During the conversation Mrs. V. decided she would start eating breakfast again, only later in the morning in order to reduce feelings of nausea. Finally, the importance of keeping her fat self-image, no matter how much she might lose, was stressed.

Case 4: Mr. B.

Mr. B., age 38, attended 11 sessions. Mr. B. stood out in the group because of his accent. As well, he arrived early for the sessions every week.

Description of the initial problem. Mr. B.'s description of his eating and weight problem and his attempted solutions were consistent with the Dieting Game Without End. His eating was out of

control "virtually every meal time, especially at lunch when I eat out... late evening snacks when watching T.V." He described his problem as "basically everything I like I should not eat...I only need to look at food to gain weight!" He thought that liking food stopped him from losing weight.

Over the last 16 years Mr. B. had tried to follow diets about 10 times. For example, he had followed a doctor's diet and the grapefruit diet. He had been able to keep weight off for only 3 months before regaining; he though this was due to the "difficulty in keeping to types of food required for diets."

At 218 1/2 pounds, Mr. B. was 52 1/2 pounds above his goal weight (Nidetch, 1972). His control goal was to lose control only twice a week and only for a particular day or evening, not for days. He wanted to weigh 198 pounds at the end of the sessions, and 185 pounds 2 and 6 months later.

Interventions. As well as the group messages cited in Chapter 3, each week he was encouraged to gain weight, praised if he had, and asked to gain more. Sometimes suggestions for exploring previously avoided foods were given. As well, because his wife began "giving away some of his food to the kids," he was given a direction to enlist her help in gaining weight by having her remind him not to eat so much. The intent was that this message would reframe her actions as being helpful instead of a hindrance.

Reaction to the interventions. Mr. B.'s main overall reaction was to attempt to follow the directions. His initial reaction to the gain directions was: "has Devon gone mad, but maybe there is a

reason to it--someway, somehow." He felt "dumfounded, speechless," but decided to "give it a go," looking forward to some "good big meals." (He gained 2 1/2 pounds the following week).

Week Four he reported that he was not feeling guilty about eating and was happy that his family was "not making any remark to me about not eating any item." Still somewhat amazed at the directions, he continued to gain slightly (3/4 pound). His rationale was "that by doing so I would learn to control my weight on the premise that you have to walk before you can run, fall before you walk, sink before you swim, gain weight before you lose weight." Mr. B. remarked that "one had to do the opposite before achieving the actual goal."

While he had expected to gain about 4 pounds by Week Five, to his disappointment, Mr. B. was able to gain only 1 1/4 pounds. During the weigh-in he expressed the fear that "time's running out on me" and that he wouldn't have enough time to gain the weight. To gain weight he was exploring different foods like lasagna. He was feeling very satisfied after his meals and was beginning to wonder about his previous belief that he had only to look at food to gain weight. During the group discussion he stated, "I think I've done better at work these past few weeks...more involved, more alert."

Mr. B. continued to have difficulty gaining weight. Between weeks Five and Six he gained only 1 pound to make his total gain 5 1/2 pounds. This was particularly disappointing to him as he was feeling fat and had changed to his biggest pair of trousers. Mr. B. thought that he was taking more time to eat instead of just gulping

food down. He also though he was having a reaction to certain foods --he was breaking out in boil-like welts. In the past these had occurred when he ate too many eggs or dairy products. Mr. B. was told that while the gaining was important to get control, "it's most important that you take care of your body."

By Week Seven the welts had completely disappeared--he had stopped eating eggs. Although he had gained another 2 1/4 pounds, he thought the "easy going weekends" were slowing him down. He continued to feel more alert but was uncomfortable moving due to the increased weight. Mr. B. thought the increased energy was due to better eating patterns. He was getting a better night's sleep. However, his wife had begun telling him not to eat so much, and on one occasion gave away some of his Sunday breakfast to his children. He was given the following directions.

T.: ...ask her to help you gain weight by reminding you not to eat.
Mr. B.: O.K. So when she reminds me not to eat, that's my cue to go and eat.
T.: That's right.
Mr. B.: O.K. It's been working that way. I've had a kind of reaction against it for the last 2 or 3 days. She said, 'Don't eat all that!' And I'll go and get another helping. (laughs) I guess she's annoyed but so what. It's my life, not hers.
T.: Well, it's important for you to enlist her help and do that by asking her to help you gain weight by reminding you not to eat.
Mr. B: I'll do that.

Mr. B. missed Week Eight. He telephoned to ask if the directions were the same. In relation to the direction of Week Seven, Mr. B. reported that enlisting his wife's help to gain weight was not helping. This was not pursued further.

Week Nine he had lost 3 1/4 pounds due to illness. While in the small group he reported discouragement at not gaining more weight, during the weigh-in he said, "I'm not discouraged. It's just that it's a lot harder than I thought to gain weight. And I always thought if I just ate an extra slice of bread that I would be up a pound, you know." Mr. B. continued to explore different types of food and tried to eat three meals a day. He thought his body was adjusting itself, making it harder to gain weight than it had been initially. Mr. B. was finding normal tasks more difficult and was afraid to start jogging or bicycling in case it might cause him to lose weight and ruin the research information. He was encouraged to try some activity to decrease feeling boggy and increase his appetite so he could eat more.

Week Ten Mr. B. had gained 3 3/4 pounds. "I haven't overfed myself or eaten too much. I just had what I wanted and like everybody else I've gone off the snacks. I'm fully satisfied with the meals.". Mr. B.'s general discomfort with his extra weight (8 1/4 pounds) continued. He reported that during the previous Saturday breakfast with his family, "not one person took exception to the amount I ate. There was lots for everyone and I really enjoyed it."

Mr. B. reported a mixed reaction to gaining weight Week Eleven. While talking with three other members of the group, he stated, "I feel great,..., I feel better in myself than I have for months... The only feeling I've got is that I wish I had put weight on faster, I thought it would be a lot easier... I have no cravings for any food now." Shortly afterward he commented, "I'm beginning to wonder

if it's all worthwhile." His weigh-in report was also mixed.

> I think it's basically what my mind's thinking at the time. I eat the same amount every week... I think I'm controlling it myself to some extent. I just don't think I can fully accept to gain 15 pounds, basically, It's uh, I feel so uncomfortable now,... if I just walk to the bus I'm out of breath... but I feel better in myself, I'm sleeping better, getting up easy, going to work fresh; I'm more alert at work, I'm making less mistakes, and uh, I think it's suiting me, I think. (laughs)...I'm trying to do something yet my subconscious is stopping me, somehow, because my body seems to be controlling the weight. It's just resisting.

Mr. B. also noted that getting praise for gaining weight seemed to stop his gain the following week.

During Week Twelve's weigh-in the directions were checked. "In other words don't really concern myself with my weight, just eat what I want to eat. Think losing." Mr. B. commented that he was no longer afraid of gaining weight. "My mother always said, 'Oh, don't eat that, it'll put weight on'...the same with my wife...always spoiled it for me. Now I just don't bother, just eat what I want, when I want, and how I want,...so I'm content." However, Mr. B. was disappointed because he had hoped to have lost some weight by this time.

Family reactions. Mr. B.'s wife didn't agree with his attempts to gain weight and thought it "was all crazy." Week Seven he reported that she had taken some of his Sunday breakfast and given it to the children; however, Week Ten "not one person took exception to the amount I ate" at a Saturday breakfast.

Description of the problem after 12 weeks. Changes consistent with shifts in the Dieting Game Without End and in other areas were apparent. His eating felt as if it was under control. His present problem was described as: "having been asked to gain 15 to 20 pounds ...it is extremely hard to do so, even though I have taken off all

restraints on the foods I eat." He thought his eating pattern was different--"Now I don't worry about the type of food or the amount of it I eat. I also enjoy a breakfast and a fair sized lunch." These changes, and changes in his attitudes about food, were attributed to the direct experience of gaining weight. "I have learned not to be frightened of food and to tackle a greater variety of them. Also I have a more relaxed attitude to food. I find that on occasions I can do quite well with smaller amounts." He was no longer afraid that extra helpings of food would send his weight rocketing upwards.

Mr. B. gained 10 pounds over the treatment course. His current weight was 228 1/2 pounds. His new goals for 2 and 6 months later were 200 and 190 pounds, respectively.

Changes in energy. Mr. B. reported increased alertness in the mornings and while at work but experienced shortness of breath when he moved.

Changes in other areas. He found that he was sleeping better and dreaming less, and that he was more accurate and productive at work. However he didn't feel like playing with his children as much as "I'm out of breath earlier." Mr. B. stated, "Just taking this course and eating more food has to some extent taken away anxieties whether conscious or unconscious."

Mr. B. made a shift in his reaction to his children. Before the tendency was to tell them that if they didn't eat the meal "don't ask for something later on. [Now] we give way on that; if you sort of feel like a hamburger you can have it... I don't bother whether they eat, I don't force them to eat and I don't stop them from eating."

Description of the problem at the 2-month follow-up. Some of the shifts in the original problem, particularly not using willpower and control solutions, were still present. However Mr. B. was getting a "bit concerned" about his weight and experienced out-of-control periods two or three times a week. After the end of the program he had lost 1 to 2 pounds a week and then reached a plateau where he began to feel fat. By the time he was given his requested follow-up phone call, he had regained control by gaining from 220 to 226 pounds and was currently letting himself lose. He was still concerned that he was not as light as he had hoped. Mr. B. was supported in his efforts to gain weight when he felt out of control; the importance of going slow and eating what he wanted was also stressed. Mr. B. sounded as if he was still willing to try the treatment approach. "I've been heavy 30 years; I can wait another year."

Case 5: Mrs. E.

Mrs. E., age 49, attended 12 sessions. The therapist was initially impressed by Mrs. E. saying that she had gained 10 pounds following the Weight Watchers diet and that she couldn't eat the smallest amount of carbohydrates without gaining weight.

Description of the initial problem system. Mrs. E.'s description of her eating and weight problem and her attempted solutions was consistent with the Dieting Game Without End. She felt that her eating was out of control especially after "long periods of dieting and not losing any weight." Chocolate was a major problem food for her. Her main problem was that "any diet other than starvation helps to stabilize my weight, but one slice of bread, a half tablespoon of

corn, rice, or potatoes means a gain of weight." Other problems were "preparing meals for the family, not being able to eat what I want, and not losing any weight after weeks of dieting."

To control her eating and weight, Mrs. E. had tried liquid diets for 3 days at a time, small amounts of food at regular meal times, Dr. Atkins' Diet, and had attended Weight Watchers for 3 1/2 to 4 months. She had been trying to lose weight for 6 to 10 years, managing to keep weight off for approximately 2 to 3 days before regaining.

Mrs. E. set her control goal as losing control only once a week and only for that particular day or evening, not for days. She wanted to weigh 150 pounds at the end of the sessions. Her weight goals were 150 and 130 pounds, 2 and 6 months after the end of the sessions. At 180 pounds she was 38 pounds above her goal weight (Nidetch, 1972).

Interventions. Mrs. E. was present when all the group interventions and messages were given. Mrs. E. was encouraged to try harder to gain weight (Weeks Three to Five) and praised for gaining (Weeks Six, Seven, Nine). Sometimes the encouragement to gain was as follows: "Well, see what you can do in the next week...I know that it's really been tough with you...see what you can do. Not everybody can succeed in gaining" (Week Eight). Suggestions that might help her gain were given in Week Ten, although she was "basically on your own" as the therapist was perplexed about Mrs. E.'s slow progress with gaining. Week Five, her difficulty in gaining was reframed as being a failure with gaining weight.

Reaction to the interventions. While initially Mrs. E. felt "mixed feelings and misgivings," her main reaction was to try to follow the gain instructions. She began exploring different foods, allowing herself cookies at coffee break for the first time in a long time. Mrs. E. found she didn't want to gorge. That is, because she was told she could have as much of any type of food as she wanted, food seemed to lose its appeal.

> I ate what I wanted but because I could have it...I would have a small amount of it rather than eat a lot of it whereas before, "Aw, well, I'm going to eat some. I might as well eat a lot and get my fill," and even eat it to the point where you really don't want it, you know. Whereas this way you just ate a little and were satisfied. The rest could wait in the cupboard because you could have it later on if you wanted it or another day if you wanted it. You didn't have to eat it all.

Mrs. E. was worried about how she would lose weight after she'd gained; however, she noted that usually there's a gain before a loss anyway and that perhaps by gaining deliberately she wouldn't acquire the usual frustration and anxiety about the gain which typically led to going off her diet.

During the following week (Week Four to Five), her concern about eventually losing weight persisted. However, Mrs. E. felt "relieved to eat more freely." She was exploring a variety of foods--apple sauce with sugar, chocolate bars, candy, potatoes with sour cream, potatoes with gravy, home-baked muffins, pies, and cake. She had also unfrozen the remainder of her Christmas baking. In spite of the extra food, she lost 3/4 pound. She commented, "I used to look at dessert and I gained weight." Mrs. E.'s concern with her slow gain was reframed:

Mrs. E.: I'm trying...I eat, eat, eat. I take food to work and it's just nauseating to eat it and I eat it.
T.: Yeah, I guess you'll be a failure with gaining weight.
Mrs. E.: Pardon?
T.: I guess you'll be a failure with gaining weight.
Mrs. E.: (laughs) I'm a fat dropout!

By Week Six, Mrs. E. reported feeling depressed about not gaining more. "I'll never make it. How will I ever lose what I have if I don't gain?" She was increasingly turned off food, feeling sick of it. However, she had begun eating a breakfast of an egg and 2 slices of toast and taking a bit of lunch to work. At this point Mrs. E. reported she was having headaches; she was told to take a break from eating to get rid of her headaches if she needed to.

Mrs. E.'s concern that she would never "make it" persisted throughout the following weeks. Week Seven she still had headaches and nausea "in response to the force-feeding"; she was feeling "crabby" and wasn't sleeping her usual 4 to 5 hours. Having gained 7 1/4 pounds left her with some feeling of success. During the small group discussion she commented that she had no craving for food and "could think of things such as chocolate, etc. in the same terms she thought about inanimate objects such as a pen or a pencil." She noted the changes in her eating habits: "I used to go without breakfast and lunch and I'd eat supper, and then from supper on it would be snack time 'til bedtime; and now I eat breakfast, a bit of lunch and supper and I think, 'Oh, I'll get this all ready for my snack,' and I rarely eat the snack." Although she had gained weight, there were no changes in the way her clothes fit her. She was reminded of Week Five's direction to buy big clothes to grow into.

Week Eight Mrs. E. reported further changes in her eating. Instead of "gobbling" a whole bag of candies, she had given some to her children. She found that white chocolate which she used to think was "great" was "terrible junk." Although she continued to eat breakfast and lunch, there were some difficulties: "I've found with eating lunch, I can't eat a big supper." One of her solutions was to add a fourth meal, "a proper little lunch," instead of cookies, later on in the evening when working late. Having lost a pound and a quarter, Mrs. E. had a "strange feeling" she'd reached a level where she didn't have to eat so much, where she was eating what she wanted, knowing she could have more. While the therapist thought that Mrs. E. might have reached the point where she could let herself lose weight, she was encouraged to gain more. If she lost again, then directions for losing would be given.

Mrs. E. gained 3 1/4 pounds so she was praised for the gain. She reported feeling "no need to eat and no cravings," including no desire to eat marshmallow Easter eggs, a rare happening.

Week Ten, Mrs. E. continued to try hard to gain in spite of feeling discouraged. Coming home from a holiday, she refused offers of sandwiches--"I said, 'Nope, we're going to eat junk food, so I can gain weight. We're going to eat, eat, eat, eat, on our way home'." Mrs. E. reported that she was now eating her vegetables and meat, and then forcing herself to eat dessert, including a little ice cream which she didn't like. While she was still feeling nauseated from trying to gain, she seemed pleased that she "could eat or leave it alone, even favorite foods" and that she was developing better

eating habits, eating three meals a day and small nutritious snacks instead of junk food.

The following week (Week Ten to Eleven) seemed to be one of Mrs. E.'s worst. She was very depressed and angry at herself for not having gained more even though she was eating potatoes and second helpings. Nevertheless, Mrs. E. continued to feel that she had "learned something about food itself" and to feel pleased that she had developed a different eating pattern. "I find that I still enjoy a roast pork sandwich, but instead of wanting two or three, a half is enough to satisfy hunger and desire. There is no craving for it but it is still tasty." She had also bought herself bigger pants and a blouse in pink--"It makes me feel big."

Week Twelve she had gained 3 1/4 pounds by adding chocolate twice a day. Mrs. E. had decided that even though she had not been able to gain the full 15 pounds, she was going to start losing. Her plan was to take it a week at a time, eating what she wanted and reviewing her progress at the end of each week. She decided that if she ate only what she wanted, cutting out the extras, she'd lose. While she was pleased to look forward to losing, she was still very angry at not being able to gain more weight. She planned to regain weight from time to time to help maintain control.

Family reactions. Her family was very interested at first until she "lost weight instead of gaining. Then indifference settled in. As I got crabbier and crabbier, they all decided maybe I deserved to be fat." However, they thought that if it would help they would go along with her.

Description of the problem after 12 weeks. Changes consistent with a shift in the Dieting Game Without End and in other life patterns were present, Mrs. E. reported that her eating felt under control. She reported no current problem with eating and weight control, commenting that "I think before this program it was the belief that I had to starve to lose weight." Her eating pattern had changed. "I eat a good breakfast (cereal, eggs, toast, and orange juice) and lunch (sandwich, fruit and cookies or cake). I eat less at night. I could easily go without at night as I eat solely to gain right now." She thought that "eating all this food in trying to gain, and I didn't gain," led to the following attitude changes: "I don't have to starve to lose weight. Knowing I can have anything, I have lost my cravings for foods or food in general."

During the 10 weeks she had been encouraged to gain she had gained 11 3/4 pounds. Her final weight was 190 1/4 pounds. Her goal weights for 2 and 6 months after the end of the sessions remained the same, 150 and 130 pounds, respectively.

Mrs. E. thought that although she was more active at home and work, she was much more irritable due to not being able to gain the 15 pounds. As well, she was sleeping less. "I used to work to about two in the morning and get up at seven and now I work 'til four and get up at six...It's just I'm wide awake at six o'clock. I used to get up at seven, go downstairs and start the breakfast and go back upstairs and lay down for 15 minutes and I don't even do that anymore. I'm wide awake."

Mrs. E. reported that her attitude towards her children's eating had changed. She stopped insisting that her children clean

their plates like she used to and allowed small portions of dessert even if the main course had not been completely finished.

Description of the problem at the 2-month follow-up. Two months later some of the shifts in the original problem were still apparent. Mrs. E. was still eating a breakfast, lunch, and supper, preparing snacks very selectively. She still felt she could lose weight without starving. Knowing she could have what she wanted and learning how much food was really needed to gain, had led to a "new-found freedom." While she reported she had met her control goal, there were times her eating was out of control. She did not state how she handled these times. Although she had lost 5 pounds, Mrs. E. was discouraged because she wasn't losing faster.

During the follow-up phone conversation she reported that whereas before she couldn't find anything sweet enough, she now found many things too sweet. Often it she took cake for lunch she would bring it back home. To emphasize the importance of breakfast, Mrs. E.'s eating pattern was reviewed and she was given a suggestion that there was something missing at breakfast. She was encouraged to go slow and to try to gain when she felt downhearted. Her discouragement was reframed as indicating one of the normal pattern shifts accompanying changes in eating patterns which had been discussed at the beginning of the program. In spite of her discouragement, Mrs. E. was not thinking in terms of losing by diets. "It's a new-found freedom. Even though people look at me kind of funny I feel good about the way I'm thinking."

Case 6: Mr. O.

Mr. O., age 36, attended eight sessions. Initially Mr. O. seemed to "fade into the background" in the group, perhaps because of his quietness.

Description of the initial problem. Mr. O.'s description of his problem and solutions were consistent with the Dieting Game Without End. He felt that his eating was out of control sometimes and that he was an "impulsive eater." All types of food were a problem for him. "Eating for no reason" was stated as his most undesirable eating pattern.

To control his eating and lose weight, Mr. O. had tried Weight Watchers for 6 to 8 months, Dr. Atkins' Diet, and eating one meal per day. These attempts had occurred "numerous times" for 16 years or more.

At 238 1/2 pounds, Mr. O. was 84 1/2 pounds above the goal weight for medium-framed men 5 feet, 7 1/2 inches tall. He set no weight goals. His control goal was to lose control only for a particular day or evening and not for days.

Interventions. Mr. O. missed the instructions given Weeks Six (eat bigger breakfasts), Nine, Eleven, and Twelve (overeat to let yourself lose, and maintain control by trying to regain). Week Six, by telephone, he received the encouragement to gain and to eat bigger breakfasts to help the gain. During Week Seven's weigh-in, he was encouraged "Not to slack off this next week" and was given a symptom prescription to "try to bring back your depression about feeling fat." This last direction was intended to help him get

control over his down feelings through prescribing what he was already doing. During Week Eight, as he had lost so much weight, he was initially given instructions to let himself lose weight. When he sounded doubtful whether he would be successful following that direction, he was asked to gain 5 pounds. The directions for letting himself lose weight were given again in Week Ten, and again on the telephone on April 27 (Week 13). The directions for maintenance were also given on the phone.

Reaction to the interventions. While Mr. O. eventually attempted to gain weight, his initial reaction to the gain instructions was "I must be in the wrong group." He didn't go "overboard" the first week; he did experience relief at not having to worry about what he ate when he felt hungry. Mr. O. commented, "Isn't it like the old thing, what you can't have, you want. So now you can have all you can have so you don't want it."

Week Four, although he continued to have mixed feelings about gaining, Mr. O. had gained 3 1/2 pounds by eating foods he normally avoided. He was feeling physically uncomfortable, particularly when wearing a tie.

By Week Five, having gained 6 pounds, Mr. O. was feeling miserable, uncomfortable, and very overweight. His former sweet tooth was gone--"I'm just turned right off." He wasn't gaining as fast as he thought he would and wanted to lower his gain goal.

Mr. O.: So it's got to be at least 15 pounds, hey?
T.: That's right.
Mr. O.: (laughs) Oh, you're a hard task master.
T.: (laughs) I sure am.

The following statement, made to the group, indicates that the purpose

of the program seened to be clearer to him. "The idea of the program is...to learn how to put on weight. If you learn how to put it on, then you can learn how to take it off...without going on a diet... just through your eating...You just do whatever you want. You can eat whatever you want, but you...set your own limits."

Although Mr. O. had gained 14 1/2 pounds by Week Seven, he was encouraged not to "slack off" during the next week so he would reach the 15-pound goal. He was also given instructions to have a relapse of feeling depressed about his fatness to help him get control over feeling down. (This was not followed up and is considered to have been ineffective.)

By Week Eight Mr. O. was fed up with eating. During the group discussion he stated:

> Most of the time I force myself to eat...and I'd just rather ...eat it in moderation now...like there's all those candy stuff in the backroom, cookies, very seldom I'll have any... I think I should have one but I don't feel like eating one ...I used to sit down and eat two, three plates and...now I don't. I have one plate...I can't eat anymore.

He had also stopped snacking. Just as he had suspected, Mr. O. had lost weight--11 1/2 pounds! He had not intentionally cut out food but felt that he just couldn't eat anymore. This following segment of the weigh-in session describes Mr. O's attempts to prepare for attending.

> I've been trying so hard to put on this weight and...I just get to the point where I can't eat anymore. I would have probably even lost more but I went out and had a, you know, a few beers just so I could have some weight (laughs)...for lunch,..., I went to the Gas Pump and I had, you know, the regular meal there, and they put on a big meal..., there were buns and that, and I couldn't even eat buns. I would normally go and have, you know, a bun and somebody else's bun,..., but you know, there were four buns there when we sat down,..., and there were four buns there when we left...I knew I had to come

here tonight and I knew I had to eat lots and yet I just couldn't.

Mr. O. thought that part of the reason he had lost so much had to do with the fact that aside from managing his business during the day, he was extremely busy setting up a company in the evening. As it seemed important to stay with his process, Mr. O. was given the directions to begin letting himself lose--"continue to overeat and lose no more than you've been able to gain in a week." While his initial reaction was positive, "I guess I've been doing it right now for this last week," he was concerned that continuing to do so on his holiday would be tough. Because of this reaction, the therapist changed the directions to trying to gain 5 pounds over the next 2 weeks.

On his return he had gained 2 pounds. "You know, I just relaxed and ate everything. I dranks lots of beer, just totally relaxed." Directions to let himself lose very slowly by continuing to overeat were repeated.

Mr. O. missed the following 2 weeks. An April Questionnaire was mailed to him.

Description of the problem after 13 weeks. After the questionnaire had been returned Mr. O. was telephoned to remind him about the two remaining follow-up questionnaires and to give him the directions for maintaining control by trying to gain. While there were discrepancies between his responses on the questionnaire and on the telephone, there did seem to be a shift in the original problem in terms of increased feelings of control and subsequent weight loss through eating what he desired. Whereas on the questionnaire he agreed that his eating was out of control sometimes, on the phone he

stated, "Maybe I didn't understand the questions. Since last session I haven't had the problem of losing control. I eat what I feel like eating, that's all. I think I have control." Talking to him, it also sounded as if he did understand the directions for letting himself lose and for maintaining control. Yet on the questionnaire he said he stood in front of the mirror and thought about how unattractive he looked in order to get control. Nevertheless, Mr. O. was thinking very positively about losing. Since Week Ten he had lost 9 1/2 pounds; he was 4 1/2 pounds lighter than Week One.

There were other discrepancies in terms of his present problem with weight control and how his eating pattern was different. On the questionnaire he stated that his present problem was "trying to eat properly and fill up, as well as lose weight." "Junk foods and overeating" were stated as stopping him from losing weight. Yet on the phone he said he did have bread and potatoes sometimes, "but if they aren't there it's O.K. But I have just a bit. Before I'd almost fill my plate with potatoes but I don't do that anymore. I have a bit and I also have other things I want." He stated he was not eating as much and feeling more satisfied. He had stopped eating as much sugar and candy. On the questionnaire he attributed his attitude change to finding he could eat anything he wanted and still not gain a great amount in a short period of time. Weighing himself every day also led to the change in his eating pattern. Perhaps a postscript on the questionnaire explains some of the discrepancy between his questionnaire and the telephone conversation as well as a number of unanswered questions. "Please excuse the mess, as at work and constantly interrupted." Mr. O. was reminded to eat what he wanted

and not to get into a pattern of depriving himself. He replied, "Right, if you deprive yourself, then you end up really wanting it and you get out of control again."

In contrast to the beginning of the program, Mr. O. did set weight goals. He wanted to weigh 180 pounds 6 months after the end of the sessions, losing about 1 to 2 pounds a week. His control goal was to lose control only once a week.

Mr. O. noticed no changes in other patterns of his life.

Description of the problem at the 2-month follow-up. Changes consistent with a shift in the Dieting Game Without End still seemed apparent. He felt he had control over his eating and that he had met his goal for control. He was not eating constantly and continued to eat starchy foods in moderation. Occasionally he ate extra food when he had a few beers. He attributed these changes to the realization "that the food is there, I don't have to eat it unless I am hungry." At this point he felt he could eat enough to lose weight without feeling hungry. At 219 pounds Mr. O. had lost 15 pounds since Week 13 without following a restricted diet. He wasn't worrying about gaining weight. "I feel that if I want to eat anything, I can. I know I can lose it just as fast as putting it on." While he still wanted to be "skinny right now!," he thought that it would take time to take the weight off. Perhaps the change is most evident in his changed perception of himself--"I believe I was a compulsive eater before, now I still enjoy eating but do not need to pig out."

Case 7: Mrs. J.

Mrs. J., age 28, attended 10 complete sessions. What impressed the therapist initially was that Mrs. J. did not look heavy enough to meet the selection criteria. This was discussed with her during the Week One weigh-in. At 143 3/4 pounds Mrs. J. was 16 3/4 pounds above the goal weight for small-framed women of her height. Although this did not meet the 20-pound criterion she was allowed to continue as her problem and solutions met the other criteria set out.

Description of the initial problem. Mrs. J.'s description of her eating problem and solutions were consistent with the Dieting Game Without End. Mrs. J. felt her eating was out of control "when I plan to start a diet and eat a small amount of forbidden food. This makes me feel I've blown it so I go all out. This may happen several days in a row. I also seem to eat if I'm feeling bored or restless, even if I'm not hungry." Problem foods were breads, carbohydrates, fats, and peanut butter. Her major problem was: "I almost always feel guilty about the food I have eaten." Mrs. J. thought that "stuffing myself when I feel I have eaten something I shouldn't have" stopped her from losing weight.

To control her eating and lose weight, Mrs. J. had tried the Canadian Diabetic Diet, Weight Watchers, following Canada's Food Rules and a diet recommended by a hospital at "one time or another." Weight Watchers was successful for 7 months. She had also tried Dr. Atkins' Diet for 1 week. Over the past 6 to 10 years she had tried to follow a diet to lose weight approximately 10 times. She had kept weight off for a period of time. "I lost 20 pounds in 1973

and kept off 15 of it for a year. In the next 2 years I gained 6 pounds. I became pregnant in 1976 and still have not gone back to my pre-pregnancy weight."

Mrs. J. set her control goal as losing control only for that particular day or evening and not for days. Her weight goals were 117 pounds at the 2- and 6-month follow-up.

Interventions. Mrs. J. was present for most of the group instructions, missing Weeks Eight and Nine. Individual symptom prescriptions intended to help her get control over her depressed feelings and her guilt about eating, both typically accompanied by eating and gaining, were given through the later half of the program. In Week Eleven she was asked to gain some weight again if she felt as if her weight or eating were getting out of control (anticipating and prescribing a relapse).

Reactions to the interventions. Mrs. J. initially resisted the gain instructions--"it was reverse psychology and it wouldn't work for me. I felt disappointed because I was expecting something different." When she tried to better manage her eating habits she slipped back to her old pattern. The directions did have some impact. She thought she didn't feel as guilty about eating what she wanted. She agreed with other members that "if you feel guilty you just go on and on, but this way we reached a point where we did seem to feel full and wanted to stop on our own." When Mrs. J. resisted the directions, stating she was as heavy as she'd let herself be, she was told "if you can't follow the directions of gaining, see if you can stay the same."

In Weeks Four and Five, Mrs. J. began following the directions. To help her get control over her guilt feelings which were usually accompanied by eating and gaining weight, Mrs. J. was given a symptom prescription to eat at times when she was feeling guilty to help her gain.

Although Mrs. J. thought the directions, making a special effort to eat at times when she was feeling guilty about her weight and eating, would be easy because she was already doing that, she was still worried about gaining and then losing weight." By this time, Week Five, she had gained 5 1/4 pounds, was getting tired of food, and was feeling less energetic. "I can hardly wait so I can get up in the morning and have a boiled egg and just not feel so bloated." Eating as much as she wanted was "not as much fun as you thought." When she stated that she wasn't feeling guilty about eating she was encouraged to "try to bring on the guilt again".

T.: What I want you to try for the next week is to increase the number of times you feel guilty about eating and I'd like you to do that by eating more often and eating more.

Mrs. J.: Well last week you told me to eat whenever I felt guilty and I did that and it just got to the stage where I didn't feel guilty anymore...and I just ate so it was kind of nice in a way to get rid of that, that kind of inner, really guilty feeling.

T.: A week isn't very long...and what I would suggest is that you try to bring on the guilt again and try to increase the amount of guilt you feel about eating by eating more frequently and more often. Like I really want you to get fed up with feeling guilty.

Week Six Mrs. J. felt more listless and irritable; however, she continued to report that she wasn't feeling guilty. Instead she was feeling depressed about the way she looked, particularly towards the end of the week. At those times she thought she ate more. "A

further symptom prescription, aimed at increasing her control of her depression and eating was given.

> T.: What I want you to do this next week is to see if you can arrange to be depressed starting on, um, Thursday morning, Friday morning,
> Mrs. J.: Yeah
> T.: and see if you can maintain that until you come to the group Monday night. See if you can eat more at those times to help bring up your weight. You are doing very well...you're well on your way to your goal weight.

Mrs. J.'s awareness of her eating habits also increased. She noted that previously she thought she had "some sort of special metabolism."

> Another thing that I find amazing is that I, we really fool ourselves so much. Like we all say, "Oh, if I look at dessert I'll gain weight." And when I see how much I've eaten, and only gained 2 pounds, which isn't that terribly much you know, in a week, it's very surprising. It's really sort of a revelation to me how much I kidded myself...you know the non-admitted calories that I must have been consuming and not really admitting to myself.

Week Seven Mrs. J. reported that her depression wasn't as serious although she had been feeling "low" on Friday. She was still eating anything she wanted, but found she was eating less. "I guess it's not a food craving like it used to be." Feelings of low energy and irritability persisted. To her amazement Mrs. J. lost 3 pounds; she thought part of this must have been fluid loss as she had been eating pie and gourmet meals during the week. Mrs. J. was advised "to try harder this next week and see if you can bring on the depressed or low feelings, Thursday, Friday, and see if you can maintain that until group time...and maybe having gone down can help you feel a little low." She laughed.

Week Eight Mrs. J. attended for about 15 minutes as she didn't have a babysitter. She wrote that she couldn't stand eating the way she had been for much longer. In spite of her efforts to gain, eating "especially at the times when I was to bring on depression," she went up 1 pound only. She had not been able to feel depressed for longer than a day. She was again given a symptom prescription to bring on her depression on a day of her choice.

Mrs. J. missed Week Nine, Easter Monday.

During Week Ten's group discussion Mrs. J. commented she was finally confronting her problem and facing food instead of running away from it. Once more she noted that she was more aware of old habits, such as standing and snacking, which had previously been discounted as "not really eating." As a consequence of feeling "absolutely depressed and frustrated," particularly on the day she decided to bring on her depression, Mrs. J. had decided to rejoin Weight Watchers for the third time in the past 14 months. However, she still wanted to attend the Treatment Group. While the therapist expressed concern that following Weight Watchers might lead to guilt feelings again (whoops, so much for suggesting a self-fulfilling pattern), she also said she was glad Mrs. J. had made a decision that felt good to her. At this point Mrs. J. felt confident Weight Watchers would work for her. She was given further encouragement to bring on her depression, still with the intent of increasing her control over it. She accepted the directions with some enthusiasm and laughter.

T.: I'm going to have you have a depressed day this next week.

Mrs. J.: (laughs) What day? I'll tell you the best days for my depressed days, that are most common, are Friday, Saturday. Thursday, Friday, Saturday, any of those days are really good for me.
T.: Which is your choice?
Mrs. J.: Probably Saturday. Yes I'm going out for supper on Saturday...maybe Sunday would be better then because I'll have eaten...it might come easier on Sunday.
T.: O.K. and see if you can do it really well. You did it really well this last time.
Mrs. J.: Oh, yeah. I did it with a vengeance I'll tell you (laughs).
T.: Well, it sounds like you had a good blue day coming to you.
Mrs. J.: Yeah, yes, I think so, I think so.
T.: I think you'd earned one.
Mrs. J.: (laughing) Yeah, that's right. Too happy!

Week Eleven Mrs. J. expressed further mixed feelings about gaining weight. She appreciated what she had learned about her matabolism and eating but was disappointed that she wasn't "svelte and lovely" by this time. While the previous week proved to be upsetting to her as she had not followed the Weight Watchers Program --"all of a sudden I was eating...like I was a zombie or something, I was eating something I wasn't supposed to," she did think there had been a "definite" difference. She thought she had some control --she hadn't binged after going out to supper and having a dessert. She had also given herself permission to eat what she wanted instead of fighting and trying to stop herself when she had done something that felt out of control. On her initiative, she was again given instructions to bring on her depression. Laughing, she picked out a "good" day.

Mrs. J.: So what kind of instructions? Pick another day?
T.: Yep. I'd like you to pick a day to really have a blue funk on.
Mrs. J.: (laughing) Oh, O.K. Alright. A really bad one. Probably towards the weekend again would be good because that's usually my time. Thursday, Friday.

Around in there. Saturday's not too bad and Sunday, it's hard for me then, because we're busy...

T.: So Thursday. And I want you to be so depressed that you're not going to be able to get your work done for the day and that potentially you have to go back to bed.

Mrs. J.: If I want, yeah, O.K. Yeah.

Mrs. J. was also given instructions to have a relapse and try to gain if her eating got out of control.

Week Twelve Mrs. J. was feeling happier eating what she wanted even though she didn't lose. The following exchange about her depression occurred during the weigh-in.

T.: Were you able to bring on your depression that day?

Mrs. J.: It was Friday, wasn't it? I'm pretty sure. I was thinking that but I almost forgot...But I couldn't bring it on to the extent of not getting anything done, but I did.

T.: But you were kind of lazy about it...

Mrs. J.: Yeah, well, I had people over for dinner so I couldn't sit, you know, and feel really depressed, you know, but I was.

T.: Well you have more excuses for not being depressed than I've heard in a long time.

Mrs. J.: Me? (laughs heartily) Oh, I was depressed but I guess not enough.

She was reminded that if she chose to, she could let herself into a losing pattern (see Week Twelve's group directions) and could regain weight when she needed to do so to get control over her eating.

Family reactions. When her husband and mother found out about the program "their reaction was surprised silence." She wrote, "My family and friends have been mildly curious and interested in this method of weight control but nothing more" (Week Twelve). However during the final weigh-in Mrs. J. mentioned one thing that was "getting her down." Her mother was attending a Weight Loss Clinic, losing about 10 pounds a week, and giving her a daily call about her losses.

Mrs. J. was feeling the indirect message in these calls was "you should do this too."

Description of the problem after 12 weeks. There was some evidence of shifts in the initial problem and in other life patterns; however, the changes were not consistent with the operational definitions of second-order change. Mrs. J. did not feel she had control over her eating. She described her current weight control problem: "Every time I feel successful about weight loss or that I'm getting my eating habits under control I start eating a lot. This triggers guilt and I eat more." Still Mrs. J. thought she had a more relaxed attitude towards her 14-month old daughter's eating. Instead of feeling her daughter had to eat something, she did not push her to eat if she did not want it--"She's not going to starve to death."

Changes in her attitudes, attributed to "the fact that I didn't gain weight as quickly as I thought I would," were as follows: "I now see that I was kidding myself thing I couldn't eat all kinds of food. It is much more difficult to gain weight than I imagined. I also saw how much food I consumed by picking and not really admitting I ate it." Mrs. J. also wrote that she had a "more relaxed attitude toward food and I enjoy my food more when I do indulge." She realized "that I wasn't overeating as much as I was punishing myself for, and there was really no need to feel guilty all the time." She thought that there had been a change in her eating patterns as a result of sitting down and enjoying her meals rather than standing and picking at food.

During the first seven weeks she was encouraged to gain, Mrs. J. both resisted and followed the gain directions. Week Nine she

was 8 1/4 pounds above her lowest weight (Week Three). She revised her weight goals. She wanted to weigh 130-135 pounds and 123 pounds, in 2 and 6 months, respectively. This latter goal seems to reflect some relaxation about her weight in contrast to her earlier 117 pound goal.

Description of the problem at the 2 month follow-up. There were a few changes in the initial problem. She was feeling less guilty about the food she ate, and she realized, because gaining weight had been so difficult, that she could eat fattening foods like other people do and that she could eat one piece of cake "without feeling I should eat the whole thing." While Mrs. J. had lost 10 3/4 pounds, she had followed an activity program and reduced-calorie diet. (She had again dropped out of Weight Watchers.) She was still worried that she would go "over the deep end" with some foods and she was still impatient to lose weight. She was evaluated as a failure in terms of illustrating second-order change.

Case 8: Mrs. Y.

Mrs. Y., age 44, attended 11 sessions. She did not initially stand out in the group.

Description of the initial problem. Mrs. Y.'s description of her eating and weight problem and her attempted solutions was consistent with the Dieting Game Without End. She felt her eating was out of control, especially when she was nervous. Sweets and after dinner snacks while watching T.V. were major problems. Her main problem was "too much spare time and always near the fridge."

For over 16 years, she had frequently followed a diet to control her eating or to lose weight. She had tried the Canadian Diabetic

call) she was praised for the weight she had gained. The control she was getting was emphasized in all three calls. During the last call, the directions for letting herself lose and for maintaining control by trying to regain were reviewed.

Reaction to the Interventions. Mrs. Y.'s initial reaction to the gain instructions was "that something had gone wrong. I felt cross if to be putting on more weight" [sic]. However the directions seemed to have had an impact. During Week Three's weigh-in she said she didn't crave food anymore, "It's psychological I guess."

By Week Four Mrs. Y. had decided to gain weight. However, she lost weight even though she was eating ice cream and toast before bed and generally stuffing herself. This loss was reframed as "failing at gaining" as follows.

T.: You lost...
Mrs. Y.: Gall darn it. And I ate like a pig all week. I give up.
T.: Well, maybe you're a failure with this approach.
Mrs. Y.: I don't know.
T.: Maybe you're a failure at gaining weight.
Mrs. Y.: But how can I be! I've gained it before.
T.: Well, I'm not sure (laughing).
Mrs. Y.: (laughing) Because, you know, I wouldn't be here if I hadn't gained it before...I've been fat as long as I can remember...
T.: Well, give it another try this week.

Week Six, in spite of feeling stuffed all the time and less energetic, Mrs. Y. had been able to show a gain of 4 1/4 pounds. Because she thought the extra weight was causing her sciatica to bother her, she was assured that even if she couldn't follow the gain directions, what was most important was that she attend and give her feedback.

Diet for 3 months and a grapefruit diet. Once she kept weight off for 2 months before regaining due to being "upset, nervous, and not keeping busy enough."

At 190 3/4 pounds she was 44 3/4 pounds above the goal weight for medium-framed women of her height (Nidetch, 1972). Her 6 month goal was 165 to 170 pounds. She wanted to lose control of her eating no more than twice a month and when she did, she didn't want it to continue for more than that particular day or evening.

Interventions. Mrs. Y. was present when all group interventions were given with the exception of Week Five (buy bigger clothes to grow into). The theme of the individual instructions was to encourage her to gain, sometimes offering ideas about what might help her gain, including going for walks to improve her appetite so she could eat more. The therapist, "stumped" and bewildered at Mrs. Y.'s difficulties in gaining weight, reframed this as being a "failure with gaining weight." Week Ten Mrs. Y. received the same direction as Mrs. T. (Case 1). She was asked to keep a record of each time she asked her son not to eat or made some other comment about his eating. As she did not remember to bring it in, she was asked to keep a record for a second week.

Mrs. Y. was phoned at monthly intervals three times after the end of the Treatment Group as she had decided Week Twelve she wanted to continue trying to gain. Support was given to her efforts to gain weight in April and May. In May she was also asked to have a relapse and try to eat some more chocolate bars to discover whether her craving for them had really gone away. In June (the follow-up

Week Seven, although she was feeling less energetic and more irritable, she found it easier to get up in the morning. When she had lost 3 1/2 pounds her eating patterns were discussed. Suggestions to help her gain were made.

Mrs. Y. laughed in response to being told, "Well you certainly are a failure at this gaining weight!"

With the directions to eat a smaller breakfast and a big lunch, Mrs. Y. thought she "would really be able to put on weight." However, to her frustration, she had stayed the same. "What else can I do? I mean, I've got so I'm sick of eating. My two sandwiches at noon, I force those down, and don't snack, I haven't snacked since last week." She found that nothing appealed to her anymore; meals she'd looked forward to simply didn't taste like she'd anticipated. Her difficulty was again reframed--"Well, maybe you'll just have to accept the fact you're going to be a weight gain loser...you're definitely a failure at gaining." Walking was suggested to stimulate her appetite so she could eat more.

Mrs. Y. continued to try to gain. She commented Week Nine, "I'm satisfied with just a little bit; I don't snack anymore...I don't want to eat anymore like I used to." Because of her difficulties she began to wonder if "something up here (pointed to head) triggers me from not doing it." The message that she was "really a failure at gaining weight" was reinforced. She laughed, and asked for further suggestions to help her gain.

Week Ten proved to be more successful for Mrs. Y. although she hadn't gained the 5 pounds she had hoped for. When she expressed

concern that she was running out of time, she was reminded that the important "thing is to try to get control over your eating by gaining, and it looks like you're doing that."

Mrs. Y. was amazed when she had lost weight Week Eleven. Some of the changes which were occurring are mentioned during this weigh-in exchange.

Mrs. Y.: Why? When I keep trying so hard...I've been even eatin' breakfast when I get up...at seven and I eat breakfast again at nine...and I make desserts every night which I normally don't do.
T.: Well, you've got me stumped.
Mrs. Y.: ...I don't know what I can do to eat anymore. I can't eat after supper anymore, I just can't... before we go to bed...I used to pick up a piece of cake...Now I can't...It just turns me off. I can make a cake now, or cookies, and I'll never touch them, that isn't the way I used to be...it tastes funny, if you can believe that...And when I cooked before I used to always be tasting, which I don't do anymore...I don't know what to do anymore.
T.: You are a failure.
Mrs. Y.: I don't know, I believe you're right, because I've eaten everything I've craved for years.

Week Twelve Mrs. Y. was still very discouraged about gaining weight. Although she was given the directions to let herself lose Mrs. Y. decided she would try to gain more weight to reach her gain goal. Because she decided to continue her efforts to gain, the therapist kept in touch with Mrs. Y. by phone.

Family reactions. Mrs. Y.'s husband thought "This is a goofy way to lose weight" and that she had "to be nuts to be continuing!" Week Twelve she wrote, "They can't figure out why I have to put on weight in order to be able to lose it!"

One unanticipated effect of her involvement in the program was that her 17-year old son "gained his 20 pounds...and he started at

the same time as we did. So you've got to tell me how to lose it for his sake!" (Week Eleven). She had also expressed concern about her interaction with her son and the issue of food. Like Mrs. T., she was given directions to keep a record of each time she asked her son not to eat. When she forgot the record, she was asked to repeat this task a second week. She was directed not to stop bugging him, but to help him gain weight by reminding him not to eat. A similar direction was given Week Twelve when she again forgot her record sheet.

Description of the problem after 12 weeks. At the end of the program there was some evidence of a shift in the Dieting Game Without End. However, her written report was sometimes at odds with her verbal report.

Contrary to her comments during weigh-ins and the group, Mrs. Y. wrote that she felt her eating was out of control sometimes when she was upset and nervous. Another conflicting report was that while she said she was eating everyting she'd ever craved, she wrote she was avoiding sweets and chocolates to control her weight. (See May 23 phone call).

However, Mrs. Y. did report she wasn't eating after supper anymore, that she could make cakes and cookies without eating them, and that she wasn't tasting continually as she cooked. Her attitude to food and weight control had changed. Due to the loss of fascination for certain foods, "I do not crave the foods I did at one time." Her present problem with weight control was stated as "I was to gain 15 to 20 pounds and somehow I just don't seem to be able to do it."

While her biggest gain had been 4 1/4 pounds, Week Twelve's weight was only 2 pounds above Week One's. Mrs. Y. still wanted to weigh 170 pounds 6 months after the sessions ended.

Other changes Mrs. Y. noticed were that she began getting up earlier in the morning--"Before, I could sleep. If anybody said sleep, I went to bed and slept!"--and that she was less energetic and crankier.

Phone calls. April 25, Mrs. Y. said she'd gained only 1/2 pound. She wondered if it was possible if she was already "there" --at the point where she could let herself lose. The therapist, somewhat concerned about the fact that this lady wasn't following the "rules" and was continuing to try to gain, eagerly seized this statement, hoping to suggest that it was time she let herself lose. "Remember I said some people needed to gain less and some needed to gain more. It's possible you're one who needs to gain less." She was reminded that the whole purpose of gaining was to help her get control. However, it still sounded as if she wanted to try to gain. The plan was to give her the directions for letting herself lose when she was called the next time.

May 23, this plan was upset once again. Mrs. Y. sounded so pleased with her 5-pound gain, that she was praised. A special effort was made to emphasize the control she was getting over her eating. Mrs. Y. stated she was eating what she wanted, not forcing herself or gorging, and was satisfied with less. When she reported she had lost her "terrible craving for sweets...chocolate bars and things like that," she was given a prescription to have a relapse. She

was to try to eat some more chocolate bars to check out for sure whether the craving was gone or whether she was just kidding herself. At this point she was not feeling "so guilty anymore"; she thought there was nothing left to experiment with. Still, she thought she'd try to get up to about 205 pounds.

Description of the problem at the 2-month follow-up. Changes consistent with a shift in the Dieting Game Without End seemed much more apparent. She felt her eating was in control and that she had met her control goal. Mrs. Y. was eating what she wanted, when she wanted, and found she was not snacking anymore. She reported no current difficulties with eating and weight control. Her weight was 192 pounds.

As requested, a follow-up phone call was made. Mrs. Y. said she had gained to 199 pounds, then decided not to gorge herself anymore. Similar to her written report she stated, "If I want something I get it and eat it. I don't worry about what it's going to do to me." Directions were reviewed, particularly the importance of going slow and of trying to gain 3 to 5 pounds to get control at times when she worried about "falling off." Mrs. Y. thought she was "on my way now. I'll relax and my weight will come off."

Case 9: Mr. A.

Mr. A., age 33, attended eight sessions. Mr. A. stood out the first night due to his size as well as comments he made in the group. Initial impressions were that he would resist--"I like to lose weight but I don't want to be pushed into anything I don't really want to do." There was some concern he would not come back as the

balance scale was not big enough to weigh him.

Description of the initial problem. Mr. A.'s description of his eating problem and solutions was consistent with the Dieting Game Without End. He felt his eating was out of control. "Everytime there is something good to eat around and I'm bored! Like watching T.V." "Smoked meats and beer" were a major problem for him. He described his problem as "too much food--too little activity." "Snacking in between" was considered his most undesirable eating pattern.

In his efforts to lose weight, Mr. A. had tried Weight Watchers for 6 weeks and controlling calorie intake. He gave no answer to the number of times he had followed a diet; he responded "off and on" to the length of time he had attempted to control his eating. Mr. A. kept weight off for 1 month before regaining.

Mr. A.'s control goal was to lose control only once a month and only for that particular day or evening, not for days. He weighed over 350 pounds, at least 178 pounds above the goal weight for medium-framed men his height (Nidetch, 1972). He set no weight goals for 2 or 6 months after the sessions ended; 9 months later he wanted to weigh within 10% of 110 kilograms.

Interventions. Mr. A. missed the group interventions Weeks Five, Eight, Nine, and Twelve. Week Three he was encouraged to gain. Beginning in Week Four the therapist began dealing with his resistance pattern. First he was encouraged to resist the directions. Next, in Week Six, he was given an intentionally ambiguous message, "I want to encourage you not to follow my directions." It was intended that this message refer to the gain directions as well as to the

directions for him to resist so that no matter which way he reacted he would be making a shift in his pattern. Week Seven he was given a hard restraining message, in essence pointing out that somehow it seemed important to fail no matter what approach he took to losing weight. This message was followed up by a soft restraining message, "I'm really doubtful," when he reported he was losing weight Weeks Ten and Eleven and during the April 26 phone conversation. Mr. A. was also given the directions for losing and maintaining weight in this conversation.

Reaction to the interventions. Most of the apparent changes seemed to occur through a process of resisting first, the gain directions and second, the hard restraining message that he would fail to lose no matter what approach he took. Although Mr. A.'s initial reaction was surprise, "I'm in the woods. What's the deal?", he gave some verbal compliance to following the directions. By Week Four Mr. A.'s resistance pattern was clearer. When his resistance was encouraged--"I think you are very good at resisting directions and I'd like you to continue resisting directions," he laughed. He reported that he had taken his belt in one notch.

Week Six, Mr. A. still thought he was losing--"I'm still on the same notch but it's getting loose." As planned, his resistance was encouraged, leaving the directions ambiguous enough that he wouldn't know which directions to resist, the ones to gain weight or the directions for him to resist directions. The intent was to capitalize on his resistance pattern whether he lost or gained weight. When told, "I want to encourage you not to follow my

directions," he laughed and stated, "O.K., I'm going to ignore it."

As in previous weeks, Mr. A. responded to Week Seven's Homework Questionnaire very briefly. He acknowledged that he was resisting the directions and stated that he had not shared the "experiment" with his family. During the weigh-in, Mr. A. stated that resisting had lost it's novelty. "It doesn't make any difference anymore." Previous attempted solutions were explored. Then the following hard restraining message was given. "Well, my hunch is that this approach is going to fail for you too. I think other things have failed for you and I think this is going to fail for you. I don't understand myself, but somehow it seems really important for you to fail at this." His immediate reaction was to become more serious. He stated that whether changing lifestyle or eating habits, "I always go in there with a resistance."

When given a further hard restraining message pointing out the importance of staying fat, he seemed to want the therapist to convince him of the benefits of the gaining, ("What would be the next stage after that?") and of sharing more details of the way he thought and more about his problem ("Is there anything you can find in that kind of thinking?"). Each of these reactions was met with a similar hard restraining message, emphasizing the fact that the therapist didn't really understand what was happening with him, but that "somehow it seems really important to stay fat and fail, and I don't want to tamper with that." By the end of the session it seemed like these messages had connected. "I can win. I'll defeat your purpose. I think I can come out positive for myself on that.

I can lose some weight without gaining the 15 pounds first."

When the following two sessions were missed, Mr. A. was called and asked if he would attend to give his feedback for the rest of the sessions. He attended for the first half of Week Ten, filling out the questionnaire, reporting on his weight, and taking part in the small group discussion. When he said he thought he'd "got this thing licked," the therapist expressed doubt at his temporary success. As well he was encouraged not to get his hopes up--"in the past you kind of got your hopes up and then you've had them dashed again."

During Week Eleven's small group discussion, Mr. A. reluctantly acknowledged that he was eating less than he used to and wasn't snacking after suppertime. He attributed these changes to the fact that "there's just nothing good to eat around" and that "I don't have time for snacks. I've hardly been home." When he burst into the Medical Room at his weigh-in time, it was clear that he was hoping to prove that he could reach his goal of losing without following the gain instructions.-

T.:	Hi
Mr. A.:	Hi. You were wrong. I'm still on it.
T.:	Really?
Mr. A.:	Yeah.
T.:	hummpf
Mr. A.:	So far you're wrong.
T.:	So far I am.
Mr. A.:	Yep.
T.:	I think I'm going to end up right.
Mr. A.:	I don't think so.
T.:	You've told me before that you've got into this losing and you lost a lot and then you just go up again.
Mr. A.:	Yeah, but uh, I'm still at it (laughs).
T.:	hummph
Mr. A.:	I might have slipped a little bit, but, in general I'm still on it really good. I'm really, really pleased with myself. (laughs)

T.: Well, I know you've really got your hopes up before and you've been really let down so

Mr. A.: Yeah. I'm still at it though.

T.: I'd really advise you to go really slow.

Mr. A.: Oh yeah, it's a slow process...but it's a steady thing.

T.: Well, maybe, but I guess I'm really still doubtful.

Mr. A.: Well, yeah, right now I'm going pretty good. I think I can keep this up.

T.: I guess we'll see.

Mr. A.: You can tell me anything you like, I'm not going to believe you. (laughs) You see my pants have no rear end in them left anymore. They used to fit tight.

T.: Well, maybe you're right. Maybe I'm wrong.

Mr. A.: Oh yeah, you're wrong on this.

T.: Well, I wouldn't make any bets on that right now.

While plans were made to continue the restraining messages Week Twelve, Mr. A. was absent. The April Questionnaire and a brief note letting him know about the subsequent phone call were mailed.

April 26 phone call. When he was thanked for his feedback and attendance, in keeping with his resistance pattern, he replied, "Oh, I missed the last one, didn't I?" He was reminded of the follow-up questionnaires and given the instructions for losing and maintaining weight, "even though they probably don't fit for you." When he said he was still losing, he was again given a restraining message. In reaction he stated that he still had until the end of the year to get close to his goal. Still expressing doubt, the therapist reminded him that when he started feeling out of control, perhaps around "beer-time" this spring, to try to regain weight. Mr. A. said he would mail the questionnaire soon, that he had it completed but that it kept slipping his mind.

Description of the problem after 13 weeks. There were some changes in the initial problem. Due to "resisting the research

programmed [sic] instructions, I cut down on food intake." He did not feel his eating was out of control. However, "eating in between meals" was reported as stopping him from weighing what he would like and eating "too much" was described as his current problem with eating and weight control. The most helpful part of the program had been "telling me I wouldn't get anywhere"; thus, there was evidence the hard restraining message had indeed connected. Mr. A. reported no other changes.

Description of the problem at the 2-month follow-up. It was difficult to determine whether Mr. A.'s "slight loss" was related to the program interventions or a change in the initial problem. He reported he had cut down on food in general because of high food prices and that his eating was out of control, "I eat more than I have to," about twice a month. However, he reported no current difficulties with eating and weight control.

Case 10: Mrs. I.

Mrs. I., age 40, attended 11 sessions. What impressed the therapist initially was that she was very determined to lose weight, having lost 3 3/4 pounds between Weeks One and Two.

Description of the initial problem. Mrs. I's description of her eating problem and solutions was consistent with the Dieting Game Without End. She felt her eating was out of control "fairly regularly--usually in the evening." Problem foods for her were "desserts, breads and pastries." Her problem was "enjoying foods generally high in calories." "Snacking in the evening while watching T.V." was considered her most undesirable eating pattern.

To solve these problems Mrs. I. had tried following Canada's Food Rules for periods of 2 to 3 weeks and cutting down on amounts. These attempts had occurred six to eight times over the past 3 to 5 years. "Reverting to old eating habits" led to regaining lost weight.

Mrs. I.'s control goal was to lose control only for that particular day or evening, and not for days. She weighed 187 pounds, 37 pounds over the goal weight for medium-framed women her height (Nidetch, 1972). She wanted to have lost 15 pounds by the end of the sessions. No goals were set for the 2- or 6-month follow-up times.

Interventions. Mrs. I. was present when all group interventions were given. The main theme of individual interventions was to go slow in relation to her weight losses. She was asked to have a relapse to test her control in Week Seven. Soft restraining messages were given in relation to the control she said she had.

Reaction to the interventions. Mrs. I. initially rejected gain instructions--"I felt shocked and a little angry as this wasn't what I expected to hear." Yet the direction did appear to have an impact. She wrote, "During the course of the week if I felt like eating something which I knew I shouldn't, I'd think of your instructions which would allow me to, but when it really came down to it, I wouldn't bother as I couldn't follow the directions. I did not wish to gain any weight." As well in the group discussion she stated, "You have the opportunity to eat whatever you desire and in whatever quantities but it just didn't seem to matter that much. It just wasn't important anymore."

Week Four, Mrs. I. remained constant in her reaction to the directions to gain weight and continued "controlling food except on a few occasions." "Go slow" messages were given during the weigh-in. While resisting she seemed concerned about the therapist's approval; she was pleased when her small 3/4 pound loss was praised--"So I did do something right."

Week Five, Mrs. I., still resisting the directions, continued to lose by eating breakfast and lunch, not snacking, walking 12 blocks each day, and using self-control. "I'll want something and I'll wait a while, and then I don't want it again." She found her interest and enjoyment in food seemed to be decreasing. Further "go slow" messages were given in relation to her 2-pound loss.

In spite of the "go slow" directions, Mrs. I. lost 2 pounds Week Six, in part due to a stomach disorder and diarrhea. Directions to try and stay the same weight the following week were given as an alternative to "going slow."

Week Seven, Mrs. I. seemed to be complying with the program objectives at a certain level. For example, she was not so strict with herself, allowing herself an Egg McMuffin for breakfast in place of her usual sensible breakfast. She noted, "I find on the whole I don't have to eat as much as I used to in order to feel 'full'." Having gained 1 pound, directions to have a relapse were given.

T.: O.K. I think that now is a really good time for you to have a relapse.
Mrs. I.: How do you mean?
T.: What I'd like you to do is to gain back 2 pounds, deliberately gain back 2 pounds. That means that you have the control over your gaining, that you

. . . just aren't letting yourself gain.
Mrs. I.: I see what you mean.

Food continued to have less importance to her and her energy increased. "I just feel good."

Determined to have a "slight relapse," Mrs. I. relaxed some of her self-imposed restrictions. She reported, "They all had Big Macs while I ordered an ordinary hamburger. It wasn't as though I wanted a large hamburger and felt I shouldn't have it as I would have felt a few weeks back. Didn't feel that it was necessary." When she had not gained the 2 pounds, she was encouraged once more to try to gain so "you have that sense of control over your gaining."

However, she resisted the directions--"I have tried to gain and have been unsuccessful, so I...revert[ed] to the old pattern [of losing]." She viewed losing weight while visiting relatives as a particularly important test of her control--"if I didn't gain... I had achieved control over my eating." The following exchange illustrates Mrs. I.'s desire to prove to the therapist she did have control.

> Mrs. I.: I'll try next week...
> T.: You better try really hard to put that 2 pounds on.
> Mrs. I.: That's right, because then I'll, then I can prove to both of us, because I think that I have control over my eating now. I think I proved that to myself this weekend. I'll prove it to you next week.

Week Ten she reported that she had tried especially hard to gain on the weekend. However, she gained only 3/4 pound. Further instructions to have a relapse plus a soft-restraining message were given during the weigh-in. Her reaction and the restraining message follow.

Mrs. I.: O.K. I'll give it a try...because really I'm sure if, if some time back, if I had eaten like I did this weekend, I'm sure I would have gained...I could have gained 4 or 5 pounds just over the weekend, without even trying. But when you set out deliberately to do it, it's not that easy.

T.: I don't want you to fool yourself, you know, into thinking you've made it now. I think you've probably thought you've made it before. And in terms of controlling your weight, I think you've probably built up your expectations and your hopes before and you've been let down, and I think you think you have control right now, but I'm still kind of doubtful.

Mrs. I.: (laughs) O.K. I'll prove it to you that I have.

Week Eleven Mrs. I. was absent due to other commitments. True to her resistance pattern, while she reported trying to gain for Week Twelve, she lost a pound and a half. A further restraining message plus directions to relapse in the future to maintain control were given during the weigh-in.

Family reactions. Mrs. I.'s family "found it difficult to believe that we were told to gain 15 pounds before we could start to lose, especially when we weighed more than we wanted to at the outset of the program."

Description of the problem after 12 weeks. There were some shifts in the initial problem. In spite of her efforts to prove to the therapist she did have control over her eating and occasional comments that her sensible eating was related to coming to the sessions (Week Nine), it was difficult to know what changes were connected to the program and not simply to her desire to lose weight. She did find it helpful to have no definite "don't do this or that"; "each individual decided what she would do and how she would go about it."

Mrs. I.'s change in her eating pattern, eating three meals a day and reducing her evening snacks, was attributed to the fact that her initial loss encouraged her to try not to gain. When she felt her eating was out of control, she gave herself a "mental talking to--try to substitute some other activity." She cut down on eating dessert, ice cream, and candy bars to control her weight. Her present problem was "learning to eat lesser quantities and avoiding to 'excess' foods which tend to lead to weight gains." Enjoying eating and not stopping herself from eating too much, stopped her from weighing what she would like to.

Although she was resigned to having to be on alert about her eating, she was not "uptight or discouraged...I'll just have to learn to live with it."

After 12 weeks, Mrs. I. had lost 11 3/4 pounds. Her new goal was 165 pounds 2 months later. Her control goal remained the same.

Aside from changes in her eating Mrs. I. had more energy when she got home from work, slept more soundly and had become more conscious of the need to be more active.

Description of the problem at the 2-month follow-up. Changes in the initial problem were more evident. She felt she had met her control goal even though she lost control about once a week. She had lost a further 6 1/4 pounds without going on a restricted diet. Occasionally she allowed herself "some foods which could never be part of a diet" or something "junky--I won't want anything like that for quite some time." Mrs. I. continued to walk to work every day,

jogged once in a while, and was doing some gardening. She described the effect of the program. "The program, although I didn't follow through and gain the weight we were asked to, has been very beneficial as it has made me aware that with a little persistence I can control my weight gain."

Case II: Mrs. K.

Mrs. K., age 47, attended 11 sessions. The therapist had a number of initial impressions of Mrs. K. First, Mrs. K. had called and made a special request to have her friend Mrs. I. come to the program. This seemed like a fairly assertive action to take. Second, on the first night when heights and weights were being taken, Mrs. K. was very surprised at her height. She insisted that she was as tall as her friend and taller than the therapist when in fact she was about 2 1/2 inches shorter. The therapist thought this was "strange."

Description of the initial problem. Mrs. K.'s description of her eating problem and solutions was consistent with the Dieting Game Without End. She felt her eating was out of control. Starches were a major problem for her. Her problem was stated simply as "overeating." "Overeating" was also considered her most undesirable eating pattern.

Over the past 6 to 10 years she had tried "numerous times" to follow a diet to control her eating and to lose weight. Included in these were Dr. Zak Zabry's diet, Seven Days to Better Eating Habits, and "just using my own common sense." Mrs. K. kept weight off for 6 months before regaining due to "neglecting to watch my amount of

food consumed."

Mrs. K. weighed 180 pounds, 38 pounds above the goal weight for medium-framed women her height. Her weight goals for 2 and 6 months after the end of the sessions were 165 and 160 pounds, respectively. In terms of her control goal, she did not want to continue losing control for more than a particular day or evening.

Interventions. Mrs. K. missed Week Two when the major directions to try to gain weight were given to the group. She was given these directions individually on Week Three. At this time restraining messages were given--she was intentionally discouraged from attending and her success, if she did continue, was doubted. Instead of a week's wait with the directions she was asked to sit alone for 30 minutes. There was no preparation for the directions in terms of discussion of problems and solutions as there was with the total group in Week Two. Weeks Four and Five, Mrs. K. was encouraged to gain and reminded not "to be too upset if you can't follow this approach." This was intended to reframe her resistance as not being a success with gaining weight. This message was repeated Week Six when she did lose some weight. As well, she was asked to "stay the same for the next week." This was an attempt by the therapist to stay one step ahead of her pattern. From Weeks Seven to Twelve restaining messages were given. The main theme of the messages was to "go slow" and to doubt the control she said she had.

Reaction to the interventions. While Mrs. K. eventually resisted the gain directions, she did follow them for about 3 weeks. Her first reactions were astonishment--"You want me to gain." The

gain directions did reduce the guilt she felt while eating. "When I had company and served strawberry shortcake for dessert, I indulged myself. I was not feeling any guilt because the directions were to gain weight." Mrs. K. stated during Week Four's group discussion that she could not allow herself to gain any more weight. Week Five, she continued to be in conflict, writing--"It's a strange way to be in a weight loss programme. I should carry out directions since I failed in the past to keep my maintenance weight." The difference between trying to gain and letting oneself gain didn't seem to make any sense to her. When she had gained only 1/2 pound, she was asked to "put more effort into it this next week...see if you can help yourself gain this week by doing some extra visiting" (a time when she tended to overeat). She was also given a message to reframe her resistance as not succeeding with gaining--"Don't be too upset if you can't follow the directions, not everyone can be successful with this approach."

Week Six her resistance became clearer. She wrote, "I had already proven that by consuming more food I could readily gain weight." She also mentioned during group discussion that she had consulted her doctor about the weight gain; she thought that if other doctors were consulted they would also be concerned. The therapist responded by emphasizing the importance of attending, and giving feedback whether or not she felt she wanted to risk changing her eating patterns in the suggested way. Mrs. K.'s weight loss was reframed as her inability to succeed--"Like I said last week, don't be too upset if you can't follow this approach. I'd like you to

give me your feedback...see if you can stay the same this next week."

The resistance pattern continued Week Seven. She wrote, "This [gaining weight] is not really suitable to my needs as I feel I weigh all I want to weigh. I have gained control of my eating habits. There is no particular food I crave anymore. It's like having your cake, but not wanting it." Mrs. K.'s comments during the small group discussion were consistent with this report; she felt that she had "complete control" of her eating habits. Her weight loss was again reframed as "failing at gaining weight." Restraining messages were given; she was cautioned to go very slowly and her loss was viewed as just temporary.

Week Eight Mrs. K. sounded as if she wanted everyone to move into a resistance pattern. During the group discussion Mrs. K. asked the therapist to give the group a break for the coming Holy Week, a time of fasting in her church. She wanted others to try and find out what would happen if they didn't try to gain. The therapist responded to Mrs. K.'s concerns and fears about gaining weight. As well, Mrs. T. also supported efforts to gain--"If you can gain 15 pounds, you should be able to lose it." While she had written that she felt "quite capable of controlling my eating habits after experiencing the discomfort of added weight," she had not lost any weight. When the therapist once more reframed her not gaining as failing, "the directions are very difficult and not everybody can follow them...my hunch was that you were one person who wouldn't be able to benefit from this approach," she tried to convince the therapist that the approach had been helping.

Mrs. K.: Well, I am benefiting from it because...food is not the center of my life anymore like it used to be. Like it's because you're saying eat and I say "Oh, no, I don't want to eat" (laughs), but you know something is happening...Food doesn't work on me the way it used to...

T.: ...my only concern is that you might be bluffing yourself for a short period of time...

Mrs. K.: ...I've lost my lust for food...it's just because it's something to sustain me now. I must admit I haven't followed your directions, you know,..., but still my attitude is different, my whole outlook is changed... Before all I could say was "Gee, I'd love to eat this but I can't,..., you're supposed to cut down, you're supposed to cut down..." I was always struggling with myself and now I'm not struggling with myself. Well, "Gee, I can eat it," but I don't want it so (laughing) I really feel your program is helping. It's taken all my facination with food away...

T.: Well, let's hope it lasts. I'm kind of doubtful but let's hope it lasts.

Mrs. K.: Oh, I'm not doubtful, (laughs) not yet,..., somehow this time I feel I've got it beat...if I don't I'll have to phone you up and you just say "eat." (I'll say) "no!"

T.: (laughing) Agreed!

Week Nine Mrs. K. continued to report that she was satisfied eating less than she used to and that food had lost it's appeal. "I think it's knowing that you can have it and as much as you want." A clear pattern of proving to the therapist she had control was evident in her written comments--"I had gained control of my eating habits"--and her weigh-in conversation--"Well, this participant gained for you...to prove I can gain 5 pounds in a couple of days." Her 2 1/4 pound gain was praised. (Whoops!) Anticipating her resistance to further attempts to gain, directions intended to reframe a gain or a loss as having control were given. "What I would like you to do this week is to continue overeating and either lose exactly 2 pounds or gain exactly 2 pounds." That is, if she gained 2 that

would be praised, although skeptically, as indicating some control. If she lost 2 pounds she would be given further restaining messages like "it's possible you have control, but I'm doubtful it will last." Mrs. K., of course, jumped at the opportunity to lose 2 pounds.

Week Ten Mrs. K. stated again that she had gained control of her eating habits. During group discussion she commented, "Before we couldn't go by a bowl of peanuts without dipping our hands into them and now we can...it's there but...I can stay away from it." When she had lost 4 pounds instead of 2, this was reframed as being out of control. Further restaining messages were given.

Week Eleven she still insisted she had gained "satisfactory control" of her eating habits. Her 1/4 pound gain was praised as following the "go slow" directions. Additional "go slow" directions were given. Mrs. K. was also pleased that she had had the determination not to be talked out of attending, that the therapist had changed her mind to allow her to attend, and she thought the program had helped her be "diet conscious."

Week Twelve Mrs. K.'s slight weight gain was again praised in the context of "going slow." A final soft restraining message and prescription for a relapse were given during the weigh-in--"I'm still kind of doubtful about whether you do have control...I think it's important for you to do like I've recommended to the others, to regain every 4 to 8 weeks." She laughed, "We'll see what happens in October. I'll be slim and grim!"

Family reactions. Mrs. K.'s husband thought she should be able to lose weight now as she had found out what puts weight on and

what takes weight off.

Description of the problem after 12 weeks. There was some of a shift in the Dieting Game Without End. "When given directions to eat all I want and what I want, food no longer had the appeal it used to." Whereas she used to "just keep on eating until I felt satisfied, now I'm eating slowly and find I am satisfied on a smaller amount of food." Shile she was not avoiding any food entirely she was cutting down on starches and fats. "The quick weight gain when requested to gain weight" was related to changing her eating patterns. "After discovering how quickly I gain weight on certain foods and the larger amounts, I can now minimize the amounts and cut out junk foods and desserts entirely." She thought the most helpful part of the program was the "go ahead signal to eat all and everything I desired. This made me want to put my brakes on every time and cut down." In spite of her insistence during the sessions that she had control over her eating, Mrs. K. reported that she felt her eating was out of control sometimes. Yet she had reached her control goal.

Mrs. K. reported no changes in other areas other than feeling tired more quickly when she gained weight.

During the program Mrs. K. made a number of gains and losses; Week Twelve she weighed 1 pound less than Week One. Her control and weight goals remained the same.

Description of the problem at the 2-month follow-up. While Mrs. K. had lost 9 pounds through "trying not to overeat" it was difficult to attribute this loss to her resistance pattern of trying

to prove she had control. Still, her comments indicated the program had had an impact. Putting on weight made her aware of "what foods help me to gain weight quickly" and "how quickly and painlessly I can do that." Learning this convinced her "I must learn good eating habits once and for all and stick with them." She tried to counter out-of-control times by "short-circuiting myself with the alibi that it will be for this time only. But sure enough another time comes along." Thus she had not reached her control goal--"never to be tempted to overeat." She was evaluated as a failure in terms of illustrating second-order change.

Case 12: Mr. H.

Mr. H., age 56, attended seven sessions. On the first night the therapist's impression was that the program would not be suitable for him. This was based on the fact that he didn't feel his eating was out of control, that he had previously followed Weight Watchers for 5 years with success, that he didn't "look" fat, and that he didn't seem to identify with being a fat person--he made a comment in the group about how gross and disgusting nude fat people were.

Description of the initial problem. Mr. H.'s description of his eating problem and solutions was not consistent with the Dieting Game Without End. While he described his problem as "inability to stay away from eating cashews, peanuts, biscuits," he did not feel that his eating was out of control. "The mid-morning, mid-afternoon and evenings--snacks of the weight-inducing foods" were considered to keep him from losing weight.

As well, over the past 6 to 10 years he had made only one attempt to lose weight, following Weight Watchers for 6 years, thus he did not have a pattern of repeated failures. However, he had slowly regained as "it became bothersome watching food intake on an hourly and daily basis. Also, the last few years I was able to afford to eat 'out' more often."

While reporting that he didn't feel his eating was out of control, he did set a control goal to lose control only twice a month and if he lost control, "it would be only for that particular day or evening and not...for days." He wanted to weigh 170 pounds 2 and 6 months after the end of the sessions. At 190 1/4 pounds, Mr. H., was 36 1/4 pounds above the goal weight for medium-framed men of his height (Nidetch, 1972).

Interventions. Mr. A. missed the group interventions Weeks Five, Seven, Eight, Nine and Eleven. After he had missed the three consecutive sessions he was telephoned and asked if he would attend the remaining sessions to give feedback.

Because of the therapist's doubts about his participation, it was planned to discourage him from following the directions even before they were given. During Week Two's weigh-in (at the beginning of the session) he was told that he wasn't having sufficient problems for this approach to work and that he was one person attending for whom the directions probably would not work. These types of directions were attempts to lay groundwork to deal with his anticipated resistance.

The other individual messages he received were mainly "go slow" messages. For example, Week Three he was told, "I'd really like

you to go slow. You lost 2 pounds and I would just slow it down some." The message that he was the one member who wouldn't be able to follow this approach was stressed again; the emphasis was put on the importance of his feedback. In Week Ten a "soft restraining" message--"I'm doubtful about the control you say you have"--and a prescription for a relapse--"At some point it will be important to let yourself gain weight"--were given.

Reaction to the interventions. As mentioned, Mr. H.'s reaction to the discouragement messages given early Week Two was to reaffirm that he in fact did have problems with his eating. He seemed to consistently resist the gain directions, feeling "revulsion to the whole idea." The directions had a "reverse reaction" on him, increasing his determination to continue losing. He reported, "It just made me more conscious all week about food intake."

However, Mr. H.'s reaction to his other individual directions were unclear. Although he had been given directions to "go slow" in losing, Week Four he wrote, "You again asked us to gain 15 to 25 pounds during the week." During the group discussion he said that he hated to disrupt his losing trend and he didn't try to gain. Mr. H. also said he'd broken out of his problem cycle and was now not pressuring himself to lose. Perhaps the "go slow" message was having an effect at some level and he was simply not able to report the effect to the group. His 1/2 pound gain was praised--"I wanted you to keep going down pretty slow"--and the "go slow" message was repeated.

Week Six he did not write down what his homework directions had been, so it was again unclear what directions were connecting.

The gain directions seemed to be having an impact. During the small group discussion he said he was finding it difficult to gain and had settled into a routine that he felt was helping him lose. As well he felt that he had gained some control over his eating. "I'll eat what I like, but I can control it now, you know, even if I have a bit of dessert...I've been able to cut out all the peanuts and candies and cakes...completely." He was reminded that "your specific homework is to go slow." (The opportunity to be skeptical of his control was missed however).

Even though he had been given specific directions to "go slow," when he returned after a 3 week absence, the gaining directions still seemed to have the most impact. Week Ten, he wrote, "I still feel uneasy about your directive to gain 15 to 25 pounds. So I keep trying to stay on a weight-loss regime." He reported to the group that he was "very, very slowly losing weight" but felt that he had it under control, "with no deadlines, and no specific goals, just taking it easy." As well as being praised for his slow loss (1 pound since Week Six), Mr. H. was given a "soft restraining" message --"at this point I'm still kind of skeptical"--and a "prescription for a relapse" message--"I think...it's going to be important to you to let yourself go up a few pounds." He tried to make sense of the relapse message stating, "I guess this is what you're getting at, to learn to control either way...O.K. I'm beginning to understand now."

According to Week Twelve's homework questionnaire, the "go slow" message had connected--"I was to continue my weight loss

activities on a go-slow basis." He felt, "I could lose the weight, if I could keep my desire to do so, on a steady day-to-day basis." Mr. H. had completely eliminated junk food from his diet--"I don't even have a desire for it anymore." During the weigh-in, he was given support for his individual success pattern and "going slow" was reinforced. Most helpful was the "fact that I'm not looking at 16 weeks or 20 weeks...I just know that I'm going to lose and that's it. And I haven't put a time limit on it." The therapist missed the occasion to give him a soft restraining message when he said, "I think that I've got the control, like you've been talking about."

Description of the problem after 12 weeks. Mr. H. did seem to make some shifts in his problem during the time span of the program. He did not report a present problem with eating and weight control. "I feel I have my eating and weight under control now." He had learned that "it is not necessary to put a time limit to achieve a weight-loss goal." However, to control his weight he was avoiding "cake, candy, peanuts, cookies, fattening foods like smoked meats, butter, sugar, and fried foods."

Whether these changes were connected to the interventions was unclear from his written reports. He attributed his 6-pound weight loss and attaining his control goal to his "desire to lose weight." Considering he saw himself as a "self-starter, self-disciplined," doing so was appropriate to his world view. However, Week Ten, he had written, "I still feel uneasy about your directive to gain 15 to 25 pounds. So I keep trying to stay on a weight loss regime." Week Twelve, he stated, "I think that I've got the control, like you've

been talking about." A major learning was that "it is not necessary to put a time limit to achieve a weight-loss goal." These statements seem to indicate that the directions were having some impact.

Mr. H. made no changes in his control or weight goals at this time. He noted that "feeling lighter" seemed to lead to sleeping better and "being able to get up and go out more often in the evenings."

Description of the problem at the 2-month follow-up. There was little evidence of a shift in the problem at this time. While Mr. H. did not feel his eating was out of control, he did not feel he had met his control goal--to replace junk food with proper food such as fruits and vegetables.

While he reported no current difficulties with eating and weight control, he commented, "food intake and weight control still remains a problem to overcome." His weight had stayed the same even though he had been following "basic" Weight Watchers.

Case 13: Mr. R.

Mr. R., age 28, attended nine complete sessions. He missed most of Week Two when the build-up to the gain directions was given; Week Seven he attended only to fill out the Homework Questionnaire and be weighed; Week Eight he fell asleep and missed the session.

The therapist's impression Week Two, based on the fact that he came approximately an hour and 25 minutes late, was that he would dropout. Later he became one of the most puzzling group members.

Description of the initial problem. Mr. R.'s description of his eating problem and solutions was consistent with the Dieting Game Without End. He felt his eating was out of control occasionally

--"Sometime eating four or five meals a day." His problem was "eating until full." "Fast foods" were a major problem for him.

In efforts to lose weight he had followed a calorie diet and self-control method about three times in the past 3 to 5 years. Mr. A. kept weight off for 6 months before regaining due to "not watching what I eit [sic]."

At 249 1/2 pounds Mr. R. was 87 1/2 pounds above the goal weight for medium-framed men of his height (Nidetch, 1972). He wanted to weigh 230 and 220 pounds at the 2- and 6-month follow-up, respectively. He wanted to lose control only once a month, and only for a particular day or evening, not for days.

Interventions. Mr. R. missed most of Week Two's interventions and all the group interventions in Weeks Seven and Eight. Individual instructions were aimed at encouraging his current process, such as eating particularly when lonely. He was also encouraged to continue being stuck, to avoid making decisions about anything, and to stay the same. The last intervention was part of a "hard restraining message"--"I think one of the only successes the you've known is failing and you're really good at it. And coming from that vantage point, I don't even know why you want to change. You can add this to your list of being successful."

Reaction to the interventions. While Mr. R.'s first reaction to the gain directions was that gaining "wood [sic] be very simple to do," he "felt that I am over weight enough as it is and wood not follow these directions [sic]." The directions still had an impact. He told group members he ate less.

> Everytime I grabbed something to eat I'd think of 15 to 20 pounds and get upset, you know...I used to have a Big Mac, and fries and a shake and I ordered a Quarter Pounder and a coke. It's just, the thought of, no way...I never had any trouble with eating before and I don't enjoy it...I know I'm determined to lose weight and that's all there is to it.

Week Three he was asked to gain and "if you can't I'd like you to stay the same this next week." Following these directions, he seemed to vacillate. He stated, "It just gives me all that much more willpower to say 'No, I don't want it'." Then shortly after he said, "I want to lose it so I don't put it back on and that's why I'll try and follow your instructions because I don't want to put it back on again."

Week Four Mr. R. continued to have mixed reactions. He wrote, "I eight [sic] quite a few chocolat bar [sic] all week long just watching T.V. I want to loose [sic] weigh NOTE [sic] put it on!" Based on information he shared in the group, a symptom prescription, intended to help him get control over his eating, was given--"Try and put your weight on at times when you're feeling lonely." Mr. R. flushed and laughed, "That should be easy. I'll give it a try." As he had also mentioned that he had stopped enjoying food, he was asked to eat the foods he "least enjoyed" for the next week.

Week Five he still seemed stuck between complying with the directions and actively resisting through losing. His fears about gaining 15 to 20 pounds and then having the course end, and the fact that the directions didn't make any sense to him contributed to his ambivalence. The group exploded in laughter after he said, "How could you have control over your eating when you're still gaining?

If someone came up to you, 'Jeez, you look like you're gaining', (what do you say?), 'Yeah, I've got control over my eating?" He was told, "Well, this approach may not work for you. I did say at the very beginning that not everybody is able to make use of this approach and I'm not sure if you're one of the people who's going to make it." By eating the foods he enjoyed the least, "It seems like I didn't eat as much." At this time, Mr. R. was discouraged because he was neither doing what he wanted, nor losing, nor was he following the directions to gain. He was again asked to "eat when you're feeling depressed and kind of lonely."

By Week Six he was getting "sick and tired" of filling out the Homework Questionnaire and talking about food in the small group. He continued to struggle. One day he'd try to put the weight on and then, feeling badly, he wouldn't eat the next day. (The therapist's wish was that he would make up his mind to either resist "properly", that is by losing, or comply!) In order to exaggerate his current process Mr. R. was asked to "stay as stuck as you can." He thought that would be easy and that he'd give it a try.

Because of a curling bonspiel, Mr. R. attended for only about 10 minutes on Week Seven. He filled out the Homework Questionnaire and was weighed. He was still struggling--"I have a very hard time trying to stop eating donuts at coffee time." It was prescribed that he eat at least six donuts; he thought five might do.

Week Nine he had gained 2 pounds and felt very discouraged that he had <u>let</u> it happen. Very frustrated, the therapist missed the opportunity for praising the gain (as he experienced it as "out

of control") and engaged in a power struggle to have him gain weight no matter how he did it.

T.: Well you haven't been trying. You've been letting yourself gain and I'd really like for you to get some control over that, like I think you feel really discouraged when you just let yourself gain.
Mr. R.: Oh, yeah.
T.: Now I want you to take some control and try to put some on.
Mr. R.: It just makes me sick everytime I think about putting on 10 or 15 pounds though and that fights against me everytime I look at something to eat.
T.: O.K. I've got something else that I want you to do, I think it might affect you just the same. I want you to take off 10 pounds by next Monday evening.
Mr. R.: (laughs) Ten pounds by next Monday! See the thing is I'll try that though.

Plans were made to respond in one of two ways depending on whether he succeeded in losing 4 to 5 pounds or whether he failed.

The directions did have the expected effect of increasing his eating--"I've never stuffed myself so much...it started on Friday." Nevertheless, he lost 1 1/4 pounds. The planned "hard restraining" message was given.

T.: It's almost like when I tell you to gain you fail and when I tell you to lose
Mr. R.: you fail.
T.: you fail. And basically I gave you an instruction I thought that you would fail at,
Mr. R.: Is that right?
T.: and you came through with flying colors.
Mr. R.: Yeah, I kind of figured that's why you gave it to me too. But I thought I could do it...3 or 4 anyway.
T.: You seem to set out to fail no matter which way it goes. You seem to be pretty good at doing that.
Mr. R.: (laughs) I won't argue that one. I thought for sure I would have gained.

This message did connect with a process of discouragement that was filling all parts of his life. He wasn't sleeping and thought he was wasting his time and should really be going back to school or

getting a part-time evening job. He was depressed with his current living arrangements; he had stayed at home much of the last few months trying to save money and wanted to move from Edmonton. He could not afford things he enjoyed and had trouble reading and writing. His "stuckness" was encouraged as follows:

T.: Yeah, you're really on a spot...like with your weight you're stuck, with your job, you're stuck. If I had a gold star, I'd give you a gold star for stuckness!

Mr. R.: (laughs) I have to figure it out for myself I guess.

T.: Well,...really try hard to be stuck this next week and don't make any decisions about anything!

Mr. R.: Well, I haven't made any for the last 2 years. I can't see this being any different.

T.: Well, make sure you practice it really hard.

Week Eleven Mr. R. felt in a "completely static" situation. In an attempt to double-bind him into making a decision, he was asked "to make a decision right now, not to make any decisions for this next week." Again he thought that would be easy enough to do.

Mr. R. was not feeling that the directions to avoid decisions were helping. As planned, during Week Twelve's weigh-in, a "hard restraining message" was given.

T.: I'm reluctant to say this but at the same time I'm going to take a shot at it...I think that one of the only successes you've known is failing.

Mr. R.: hm, hm.

T.: And you're really good at it. And coming from that vantage point I don't even know why you want to change. You can kind of add this to another list of being successful.

Mr. R.: And that's it?

T.: I don't know what else to say.

Mr. R.: Well, there's not much else to say I guess...I'll probably be moving in the next month or so, I'll give you a phone call and give you my new address.

Mr. R. left abruptly, not waiting until the rest of the group had finished weigh-ins.

Description of the problem after 12 weeks. At the end of the program there was no evidence of a shift in the Dieting Game Without End. Mr. R. still felt his eating was out of control. His present problem was "I just eat whatever and whenever I want." He reported no change in his eating patterns, his attitudes towards foods and weight control, or in other patterns in his life. Mr. R. felt the program had been helpful in terms of learning that everybody had special problems.

Week Twelve he weighed 247 pounds, a loss of 2 1/2 pounds since Week One. His control and weight goals remained the same.

Description of the problem at the 2-month follow-up. There was no evidence of a shift in the problem. He reported he had lost 11 pounds by "cutting down." His present difficulties were eating too much; this was being handled by trying not to eat so much. During the follow-up phone call, the first thing he said was "I've lost about 20 pounds!" When the therapist responded with "I don't believe it!", he said his loss might be closer to 15 pounds. He was given a further soft-restraining message--"Well, I'm still not convinced." Mr. R. replied, "You will be."

APPENDIX C

PROMISE-OF-TREATMENT GROUP DATA

Promise-of-Treatment Group Data

Case 14: Mr. A., age 23.

January. Mr. A.'s description of his problem and solutions was consistent with the Dieting Game Without End. His eating was out of control particularly when he was "bored or a little bit drunk." Mr. A. described his problem as follows:

> I am more active than a normal individual. I participate in regular exercise most of the time and have been a member of many athletic teams. Yet, I cannot come down to and remain at a reasonable weight for my height. I am a night eater. I consume most of my calories in the evening, which leave me no opportunity to wear it off. Also during periods of lethargy, when I cannot motivate myself to do anything I begin a spiral of high eating and low activity.

For over 16 years Mr. A. had attempted to control his eating with various solutions such as following the diabetic diet, Canada's Food Rules, Dr. Atkin's Diet, fasts, and reduced-calorie diets. He was currently in week three of the Weight Watchers Program. In total, he estimated he had tried between 10 to 20 times to lose weight.

Mr. A.'s control goal was to lose control only for that particular day and not for days. Eventually he wanted to weigh 190 to 200 pounds although he wrote, "I should weigh 180." He now weighed 240 pounds. His weight goals were 190 and 200 pounds at the time of the 2- and 6-month follow-up.

April. Mr. A. returned all the required information except the March 13 weight card. Mr. A. reported changes in his eating pattern and in his activity level. In terms of his eating pattern, he did not eat as many sandwiches when he was "sticking to" the Weight Watchers Diet. The change was attributed to his "resolve to stick to the prescribed diet." He commented, "The problem is that I can slide back into old habits with shocking ease." Mr. A. still

felt that his eating was out of control at times He described his present problem as "eating at night or eating when I am doing nothing." His activity level was lower because he was no longer involved in amateur wrestling. Although he had lost 19 pounds during the Promise-of-Treatment period by following Weight Watchers, the pattern of his problem and solutions was still consistent with the Dieting Game Without End.

Case 15: Mr. F., age 37.

January. Mr. F.'s description of his problem and solutions was consistent with the Dieting Game Without End. He felt his eating was out of control especially during times of inactivity. Liking food, eating between meals, and eating too large a portion at meal times, were described as his undesirable eating patterns.

For over 16 years he had tried 10 to 15 times to lose weight. Mr. F. had tried a form of the Canadian Diabetic Diet for 3 to 4 months and Dr. Atkin's Diet.

Mr. F.'s control goal was to lose control once every 2 months during controlled periods, for example, dining out. At 267 pounds, he eventually wanted to weigh 215 and 220 pounds. He did not set weight goals for the 2- and 6-month follow-up, but wanted to lose 50 pounds "to feel that the program had been successful."

April. Mr. F. returned all the required information except the March 27 weight card. Mr. F. reported that "a desire to be in better physical shape" had led to increased exercise. With the exception that he was not following any diets or weight control programs, there were no other reported changes. He thought his eating pattern was the same. His present problem, similar to his

January problem, was "excessive snacks." Mr. F. still felt that his eating was out of control about three to four times a week. While he had gained 6 pounds over the Promise-of-Treatment period, there was no evidence that this gain was any different than those common to loss-gain cycles of the Dieting Game Without End. His problem appeared to be the same as in January.

Case 16: Mr. J., age 38

January. Mr. J.'s description of his problem and solutions was consistent with the Dieting Game Without End. His eating was out of control "at least once a day, usually during supper and at snack times." His main problem with eating and weight control was that he liked food.

For over 16 years Mr. J. had tried to lose weight approximately 25 to 30 times. He had not been able to maintain a lower weight--"I enjoy eating and I seldom ever ate so much I didn't want more. Would reach approximate goal and in trying to level off for maintenance, I would regain in spurts." Various solutions included the Weight Watchers Diet, Canada's Food Rules, the Royal Alexandra Hospital Diet Program for 6 months, an egg and spinach diet, and exercising.

Mr. J.'s control goal was to lose control only for a particular day or evening and not for days. At 196 1/2 pounds, he wanted to weigh 170 pounds 2- and 6-months after the end of the sessions.

April. Mr. J. returned all the required information. During the 11 weeks that Mr. J. reported his weight, he made a number of small losses and gains. Due to a desire to lose weight, Mr. J. had started an exercise program and limited monitoring of his diet. He

still felt his eating was out of control four to five times a week. He described his problem with eating and weight control as "I like food, particularly sweets (jams, ice cream) and second helpings. I'm always hungry." The pattern of his problem and solutions was still consistent with the Dieting Game Without End.

Case 17: Mr. K., age 54.

January. Mr. K.'s description of his problem and solutions was not consistent with the Dieting Game Without End. On the screening telephone call he had agreed his eating was out of control at times; on the Screening Questionnaire he reported that his eating was not out of control. He described his problem as having "difficulty in resisting second helpings at dinner" and eating during the evening.

Since 1950, Mr. K. had tried 1000- and 1200-calorie diets recommended by his doctor as well as "varying other calorie-restricted diets." He had tried "off and on" to lose weight, never being entirely successful.

Mr. K.'s control goal was to lose control only for a particular day and not for days. At 208 pounds, he eventually wanted to weigh 180 pounds. Weight goals for 2- and 6-months after the sessions ended were 200 and 185 pounds.

April. At this time, Mr. K. reported that his eating was out of control at times, particularly in the evening while reading or watching television. As in January, "too many second helpings and evening eating" were described as his problem with eating and weight control. Mr. K. made one change in terms of his control goal. Now his goal was to never lose control over his eating. Mr. K. reported no further changes.

During the 11 weeks that he reported his weight he stayed within 1 or 2 pounds of his January 30 weight. His problem appeared to be the same as in January.

Case 18: Miss S., age 23.

January. Miss S.'s description of her problem and solutions was consistent with the Dieting Game Without End. She reported that her eating was out of control at least once a week "due to boredom, worry about weight control, general anxiety, and tiredness." Once she sampled one of "anything" she was not able to stop eating. When she overate or had one sweet food she tended to feel guilty and then eat more to suppress her guilt feelings.

Miss S. had tried Weight Watchers "off and on for the last 5 years" and other types of diets such as an 800-to-1000-calories per day diet and a high protein diet. Other attempted solutions were joining a health spa and hypnosis. These attempts had occurred "hundreds" of times in the past 6 to 10 years. She was able to lose weight for a few months before "falling into the same habits of feeling fat and not believing I actually had lost a lot of weight."

Miss S.'s goal for control over her eating was to lose control only for a particular day or evening and not for days. At 170 pounds, she eventually wanted to weigh 130 to 135 pounds. At the 6-month follow-up she wanted to have reached her goal of 130 pounds.

April. Miss S. reported that she had met her control goal. "Not 'pigging out' and eating the whole package and trying not to feel guilty if I take one piece of something so that I go back and sneak more and more and feel guilty" had helped her reach her control goal. "The fact that in summer you wear less" contributed to her

feeling like being more active. Changes in the weather contributed to having difficulties sleeping, fewer headaches, and also increased activity. Yet, her eating problem was consistent with the Dieting Game Without End. Her problem was still not being able to take just one of anything--"I always want to finish the whole package." She reported her eating was out of control at times. On March 29 she had started attending Weight Watchers again. During the 11 weeks she reported her weight, it remained relatively constant.

Case 19: Mrs. M., age 55.

January. Mrs. M.'s description of her problem and solutions was consistent with the Dieting Game Without End. Her eating was out of control. She described her problem as being a "compulsive eater" and "eating before going to bed." Mrs. M. had tried "several" times to control her eating and lose weight. During the last year she had tried the [illegible]ic Diet and taking classes at the General Hospital for [illegible].

[illegible] M. wanted to lose control of her eating no more than two [illegible] week. At 210 pounds, she wanted to weigh 140 pounds. She did not set weight goals because she had been discouraged so many times.

April. Mrs. M. returned all the required information except the February 27 weight card. Her description of her problem and solutions was similar to that recorded on the Screening Questionnaire. Mrs. M. reported her eating was out of control at times; "sweets" and "eating in between meals" were her present problems. To control her weight, she had been trying to eat regular meals. No changes were reported.

There was only one fluctuation, a loss and gain of 6 pounds, over the 11 weeks she reported her weight.

Case 20: Mr. D., age 21.

January. Mr. D.'s description of his problem and solutions was consistent with the Dieting Game Without End. His eating was out of control "when I have nothing to do." This pattern and snacking were his biggest problems.

Over the past 6 to 10 years he had tried to follow diets, including Weight Watchers for 2 weeks and a "juice and meat" diet, "countless" times.

Mr. D. checked two control goals. The first was that he never wanted to lose control of his eating; the second was to lose control once a month. At 360 pounds, he eventually wanted to weigh 180 to 220 pounds. His weight goals at the 2- and 6-month follow-up were 310 and 280 pounds.

April: Mr. D. returned all the required information except the April 10 weight card. Although he did report a loss of 12 pounds, Mr. D. still felt his eating was out of control every 2 to 3 days when he was watching television. His present problem was "I eat too much and drink too much milk." He reported that he had not followed a weight control program or diet during the promise-of-treatment period. Because he had been discouraged so many times, he did not want to set weight goals at this time. His control goal was now to lose control only once a month for a particular day or evening and not for days. While he had lost weight, apparently without following a diet or weight control program, Mr. D. still felt his eating was out of control. His presenting problem was the same at this time.

Case 21: Miss T., age 19.

January. Miss T.'s description of her problem and solutions was consistent with the Dieting Game Without End. Her eating felt as if it was out of control before meals, in the evening, when she had nothing to do, and when she was nervous. "I feel my problem of weight control is not eating proper meals during the day, so I snack all the time." Eating "sweets" and going to "burger places" were also problems.

Over the last year she had tried about six times to lose weight. Her main solution was attempting to follow a balanced diet.

Miss T. wanted to lose control of her eating no more than once a month. At 162 pounds, she eventually wanted to weigh 130 to 140 pounds. At the 2- and 6-month follow-up, she wanted to weigh 152 and 142 pounds, respectively.

April. Miss T. returned all the required information. During the 11 weeks she reported her weight, she gained 4 pounds. Her present problem was similar to that described in January. She felt her eating was out of control about three times a week. "I feel my main problem is I enjoy food too much, if I have nothing to do or feel down, I'll eat." No changes were reported.

Case 22: Mrs. L., age 30.

January. Mrs. L.'s description of her problem and solutions was consistent with the Dieting Game Without End. When sweet foods were available or when she was not busy her eating felt as if it was out of control. Excessive eating and "not burning off enough calories" were reported as her problem with eating. "Gorging on anything,"

whether or not she was hungry, was her biggest problem.

Over the past 6 to 10 years, she had tried to lose weight about seven times. This included following Weight Watchers for 6 months, a hospital dietician's diet, and a two-meal-a-day diet. She was able to maintain a lower weight for 3 months before she started to eat foods that were not on the Weight Watchers Program.

Mrs. L. set her control goal as losing control only for a particular day or evening and not for days. At 172 pounds, she eventually wanted to weigh 120 to 123 pounds. This weight range was her goal for 9 months after the sessions ended.

April. Mrs. L. returned all the required information. During the 11 weeks that she reported her weight, it remained stable. Her current problem was consistent with the Dieting Game Without End. Mrs. L.'s eating was out of control especially when she was not busy or concerned with her weight. She stated that her problem was that "I prefer the more fattening foods...If I do eat these, I can eat quite uncontrollably." Included in her description of her problem was the fact that she did not try to eat more slimming foods. The only change reported in relation to eating and weight control was that she raised her goal weight to 130 pounds. In relation to other changes in her life, Mrs. L. reported that her father had died and that she had been pregnant and miscarried.

Case 23: Mrs. R., age 39.

January. Mrs. R.'s description of her problem and solutions was consistent with the Dieting Game Without End. Her eating was out of control especially when there were baked goods at home. Her

problem was stated as follows: "There is a love of food. At times I will go as far as to steal food from my own kitchen to eat." Starting each day with a big breakfast which always included baked sweets was also a problem.

Over the past 6 to 10 years, Mrs. R. had made about one major attempt each year to lose weight. Her solutions included following the Canadian Diabetic Diet, the Weight Watchers Program, and the diet from the Diet Clinic at the Misercordia Hospital. She regained when she went off the diets.

Her control goal was to lose control no more than twice a month for a particular day or evening and not for days. At 151 pounds, she wanted to weigh 115 pounds. Her weight goals were 120 and 115 pounds at the time of the 2- and 6-month follow-up.

April. All the required information was returned. Mrs. R.'s description of her problem remained unchanged. Her eating was still out of control--"It usually just lasts 2 or 3 days." Her current problem was again described as enjoying food very much--"Even when full I will still be able to have and enjoy any pastries offered to me." Because she had been discouraged so many times, she did not want to set either control or weight goals. She still wanted to weigh 120 pounds. There were no changes in eating patterns or in other areas of her life. Her weight remained stable over the 11 weeks.

Case 24: Mr. S., age 50.

January. Mr. S.'s description of his problems and solutions was not consistent with the Dieting Game Without End. In contrast to his answer during the screening phone call, Mr. S. did not feel

his eating was out of control. "Eat too much" and "like good food" were reported as his problems.

Over a period of 11 to 15 years, Mr. S. had tried Weight Watchers, following Canada's Food Rules, and a diet recommended by a hospital weight loss clinic.

Mr. S. wanted to lose control of his eating no more than once a month. At 244 pounds, he wanted to weigh 200 to 210 pounds. He did not set any other weight goals.

April. Mr. S. returned only the first three weight cards and the two questionnaires. He was telephoned three times to request, first, the return of the Screening Questionnaire and the first weight card; second, the above information and the second weight card; and third, the return of the April Questionnaire and the last weight card.

Mr. S. again reported that his eating was not out of control; his present problem was stated as "weigh more than I want to." No changes were reported. It appeared that the fact that his treatment group would not start until April was not clear to him. He commented, "With diet, suggestions or assistance of any kind I may have felt differently. At present, I feel there has been no advantage whatsoever."