Running a weight control group: experiences of a psychologist and a general practitioner

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SUMMARY. A weight control group is described, led jointly by a general practitioner and a clinical psychologist. Approaches employed included dietary advice, behavioural advice, and group support. Of the original 16 members (including one group leader), seven dropped out at an early stage and the reasons for this are discussed. All members were re-weighed at intervals up to 18 months after the beginning of the six-month intensive period. They were also interviewed by a psychological research worker a year after the start of the group. The results suggest that a combined dietetic and psychological approach to weight control is of value.

Introduction

RECENTLY the general practitioner has been in a better position to make use of the services offered by the psychologist than in the past. The psychologist concerned is often, but not exclusively, a clinical psychologist who, with the establishment of area psychology departments and increasing emphasis on community work, is stepping even more outside the psychiatric hospital which has been his traditional base. The Trethowan Report (DHSS, 1977) recommends closer involvement of clinical psychologists in primary care; other psychologists, including Kincey (1974), argue for a closer liaison between general practice and clinical psychology. Brook and Temperley (1976) discuss the valuable teaching function of psychotherapists working directly in general practice.

Consultations with clinical psychologists in general practice seem to take place in one of three ways. A few health centres have the full-time services of a psychologist, for example, McAllister and Phillip (1975); some have a visiting service where the psychologist may discuss and advise on patients' problems and/or treat them alone or jointly with the general practitioner, which is how we arrange it; but probably most of those who work with psychologists have channels for direct referrals with subsequent communication (Broadhurst, 1977).

Davidson (1977), in the course of a preliminary enquiry into clinical psychology in general practice, showed that 52 per cent of the general practitioner respondents in her sample wanted help from psychologists with obesity (other psychological treatment facilities most wanted were related to addictive problems, phobic disorders, marital problems, and sexual problems).

The dangers and prevalence of obesity have been widely discussed and both general practitioners and psychologists have sought approaches, usually separately within the frameworks of their own disciplines. It is difficult to know how most general practitioners approach the problem. Publications from general practice have often dealt with the use of appetite suppressants, but it is probable that in the 1970s, more than in the 1960s, many general practitioners have used these with increasing reluctance, relying rather on dietary approaches. These, while a necessary component in changing eating habits, are not in themselves sufficient ("You may lead the obese to carrot juice but you cannot make them shrink"). Craddock (1973) is notable for having devoted much time and effort to obesity in general practice, and he has repeatedly indicated the importance of a wide-ranging approach, based on dietetics but also relying on psychological and group factors.

In the literature of psychology most recent work on the subject has appeared in the behaviourally orientated journals, with eating considered as a habit subject to modification by a variety of methods developed by behaviour therapists. Abramson (1977) adequately reviews this literature. Schachter (1971) and others ingeniously demonstrated that fat and thin people react in very different ways to their environment; fat people, they claimed, are more influenced in their eating behaviour by environmental cues, and thin people seem to be more affected by visceral ones. Although some have failed to replicate Schachter's work it seems that his findings are to some extent relevant to fat people's eating habits and may lend support to the theories of Bruch (1974), a psychoanalyst who believes that as a result of indiscriminate food reinforcement in infancy, obese people are unable to differentiate sensations of hunger from other unpleasant internal bodily sensations such as fear or anxiety. 'Self-control' procedures in particular have been found useful in helping patients to reduce the incidence of other self-injurious behaviour such as excessive smoking or drinking. The patient is the main therapist (Stuart, 1967).

It seemed to us that a combination of dietary and behavioural approaches had much to offer. There seemed little point in helping people to modify their eating habits if they were eating all the wrong things. If reduced weight is the main reward (with its many secondary benefits), it is important that weight loss follows quickly a changed eating behaviour. Eating is instantly and powerfully rewarded and for this reason crash or fasting diets are too aversive to work or at least to have any long-term effects; rather than encourage patients to reduce the amount of food eaten on a massive scale, the aim was to help them regulate their calorific intake, by education to increase their awareness of potentially fattening foodstuffs, and to help them gain a greater awareness of the nutritional needs of their bodies.

Objections to treatment of obesity

Of course there are objections to the treatment of obesity in general practice. Bolden (1975) emphasizes that attempts to deal with the problem have been notoriously unsuccessful, and where these have borne fruit the enormous time and effort devoted to what often turns out to be a short-term effect would be better devoted to more 'serious' problems. He also emphasizes the inherited aspects of obesity and the difficulties involved in removing weight after the adipose cells have first been formed in childhood, especially in the first year of life. Clearly, then, if weight reduction programmes are worthless for the average patient in general practice as Bolden suggests, the time of highly qualified staff is wasted on this activity. He makes no reference, however, to behavioural approaches.

The lack of success of such programmes is hardly justification for abandoning them completely but rather a reason to examine the methods used more critically. There is evidence (Craddock, 1973) that although failure rates are considerable, a substantial proportion of obese people are able to lose weight and maintain a significant weight loss.

Method

The practice is based at Langholm (population 2,500), a tweed town in southern Scotland 30 miles east of Dumfries where the psychologist is based. Primary care is provided by three general practitioners working from a small health centre. The psychologist spends one day every two weeks at the health centre where he sees patients referred to him by the general practitioners.

The proposed weight control group was announced by means of a notice in the waiting room of the health centre. Most members of the group had responded to this but a few had been encouraged to attend by their general practitioner when consulting him for disorders associated with obesity. Fifteen ladies attended the first meeting of the group, which like all others took place at the health centre in the evening. Consistent with the experience of other workers, the attrition rate was high and seven members dropped out over the first few sessions; the remainder are considered the core who, allowing for illness or other reasons, attended the majority of group meetings. These were initially weekly and fortnightly, with extra sessions before the difficult over-indulgence periods of Christmas and New Year. In all, 16 group meetings were held. The average age of the attenders was 41, and the mean weight 81 kg (179 lbs). Calculations from the Prudential Assurance Company tables, which take age and weight into consideration, showed the average amount overweight to be 21 kg (47 lbs). Group members calculated their target losses from these tables and thence derived a weekly target loss, usually of 0·5 or 1 kg (1 or 2 lbs).

Means of controlling weight

The process of helping our clients to control their weight can be divided into three main approaches: dietary education, behavioural procedures including environmental management, and group support.

Dietary education

T.K. undertook the greater part of this approach, supplemented by two sessions led by a dietician. Education about such topics as metabolism, basic nutritional requirements, and vitamins was followed by teaching and discussion about the calorific value of a wide range of common foods; literature was distributed such as Marriot-type diet sheets with calorific values, and books and magazines on slimming including Yudkin's publications (Yudkin, 1962). This information was discussed with regard to situations such as ordering a meal in a restaurant, coping with different food demands in the same household, and so on. There were

no absolute restrictions on diet, and each member decided for herself which permanent eating habits she felt able to maintain, with emphasis on dietary exchanges.

Behavioural approach

This approach was largely the province of A.C. who used behavioural advice based on that of Stuart (1971), the aim being to eliminate eating cues. Eating was restricted to the same room and to the same table; appropriate food only was to be available; shopping was to be carried out using a list, and preferably when sated; leftovers were either to be put in a dustbin, or frozen immediately. To decrease the likelihood of overeating, small quantities of food only were to be cooked and served; slow eating was encouraged, utensils being returned to the plate until the mouthful was swallowed in order to focus attention on the act of eating and encourage the experience of control.

Strengthening of cues was carried out by keeping daily records of all food consumed, and weight was recorded twice daily (before breakfast, after evening meal), using the same scales. Appropriate rewards were suggested, contingent on weight loss, for example, buying a valued item of clothing which would fit only when the weight goal was attained.

Weight losers were encouraged to make a list of desirable activities which would be possible or more pleasurable after weight loss and to place this in a prominent position, for example in the kitchen, and to ask relatives and friends to notice and praise weight loss. With the agreement of the group a small financial disincentive to regaining weight was introduced: five pence was forfeited for each point short of the self-determined weekly target.

Group support

Probably one of the most important incentives was the mutual support of the group members. Weigh-in was the important prelude to each session, and loss was recorded graphically, both for the individual members and for the group as a whole. Therapist and group reinforcement for attaining target loss was lavish. Another important influence was the effect of one of the leaders (T.K.) rapidly losing weight with the group. Individual problems were dealt with in general discussion, and therapists were alert for any psychological ill-effect of weight loss.

As a supplement to the other approaches and to encourage maintenance of weight loss, some group relaxation training was carried out by A.C. as an

Table 1. Weights of group members at start, six months, 10 months and 18 months.

Member	Initial weight	Percentage of ideal weight	Six months	10 months	18 to 19 months
	Kg (St lbs)		Kg (St lbs)	Kg (St lbs)	Kg (St lbs)
A	63.6 (10 0)	*125*	57.7 (9 1)	58.6 (9 3)	59.6 (9 5)
B	62.7 (9 12)	*112*	59.1 (9 4)	59.6 (9 5)	54.6 (8 8)
C	84.6 (13 4)	*140*	78.2 (12 4)	76.4 (12 0)	73.2 (11 7)*
D	95.5 (15 0)	*154*	87.7 (13 11)	90.5 (14 3)	95.9 (15 1)
E	94.6 (14 12)	*143*	80.5 (12 9)	81.4 (12 11)	89.1 (14 0)
F	76.6 (11 8)	*112*	70.0 (11 0)	65.0 (10 3)	63.2 (9 13)
G	97.3 (15 4)	*162*	Not known	95.5 (15 0)	96.8 (15 3)
H	82.7 (13 0)	*153*	83.6 (13 2)	80.0 (12 8)	83.2 (13 1)
T.K. (therapist)	72.7 (11 6)	*118*	67.3 (10 8)	66.8 (10 7)	67.7 (10 9)*

*Participants in a continuing weight control group.

Table 2. Weights of group drop-outs at start, 10 months and 18 months.

Member	Initial weight	Percentage of ideal weight	10 months	18 months
	Kg (St lbs)		Kg (St lbs)	Kg (St lbs)
J	72.7 (11 6)	*124*	75.5 (11 12)	75.5 (11 12)
K	80.5 (12 9)	*131*	82.7 (13 0)	79.6 (12 7)
L	69.1 (10 12)	*121*	70.0 (11 0)	70.0 (11 0)
M	64.6 (10 2)	*101*	Not known	63.2 (9 13)
N	81.4 (12 11)	*148*	Not known	95.5 (15 0)
O	76.4 (12 0)	*150*	82.3 (12 13)	86.4 (13 8)
P	86.8 (13 9)	*138*	89.1 (14 0)	80.5 (12 9)

alternative to eating in response to anxiety, and suitable exercises were introduced by T.K.

Regular group meetings were held from October to March, and a review meeting took place in late summer. During the summer, when no regular meetings were being held, members were offered a weekly weigh-in at the health centre at lunchtime. Three or four of the seven adherents usually turned up for this.

Results

Tables 1 and 2 show the weights of the group adherents at the start and at six, 10, and 18 months, and for the drop-outs at the start and at 10 and 18 months.

We have followed Craddock (1973) in his definitions of success, partial success, and failure for the individual group member:

Success: loss of more than 10 per cent of initial body weight.

Partial success: loss of more than five but less than 10 per cent of initial body weight.

Failure: loss of less than five per cent of initial body weight.

Table 3 shows our results in terms of Craddock's criteria. At the end of 10 months, seven of the original group of 16 had achieved success or partial success, all seven being group adherents. At 18 months there were the same numbers of successes and partial successes, but the individuals concerned were different. One drop-out had by her individual effort achieved partial success, and one lady who had regularly attended during the group's life had lapsed from success into partial success. Three members of the original group participated in a subsequent group and by 18 months had lost further weight (Table 1).

Case histories

Patient 1

Mrs E., a part-time mill worker aged 54, has a husband and son who are both overweight. She entered the group at 94·6 kg (14 st 12 lbs) and chose a goal of 76·4 kg (12 st) with weekly weight loss of 0·5 kg (1 lb). She kept a detailed food diary for most of the six months of the group. She is a strong supporter of the town's annual festival of the Common Riding: to be able to sit a horse and be photographed upon it

Table 3. Success, partial success and failure of the group at 10 and 18 months.

	At 10 months			At 18 months		
	Success	Partial success	Failure	Success	Partial success	Failure
Adherents	2	5	2	2	4	3
Drop-outs			7		1	6
Total	2	5	9	2	5	9

was an important incentive to her and during meetings she often referred to this aspiration. During the life of the group she was walking on the hills with her dog, covering several miles daily. She 'paired' with another group member of about the same weight and they often shared both ideas and food. At the end of the six months her weight was 80·5 kg (12 st 9 lbs), a loss of 14·1 kg (31 lbs). Towards the end of the six months she began to complain of hunger pains and a duodenal ulcer was shown on x-ray. She began to have difficulty in refraining from food which she found necessary to relieve her pains. This probably accounts for her regaining weight to 89·1 kg (14 st) at 18 months; she is at present enjoying relief with cimetidine.

Patient 2

Mrs F., a 52-year old housewife, was encouraged by her general practitioner to join the group. She had a lean husband, no dog, and no children. She suffered from medical problems including hypothyroidism and hypertension and also from depression and anxiety. She had recently been made redundant from her job as a millworker. She formed no close link with any other group member and did not take much part in group deliberations, preferring to focus concretely on dietary aspects. The group showed kindly tolerance of her behaviour. Her husband, a joiner, was absent from home frequently during the six months of the weight control group and it seemed that she valued her membership of the group as a counter to her feelings of loneliness. She kept a detailed food diary for about half the duration of the group but had very little idea of food values or calories and required help with the calculations involved. Her starting weight was 76·6 kg (11 st 8 lbs), her goal 63·6 kg (10 st). At the six-month mark she had reduced her weight after fluctuations to 70·0 kg (11 st). At this point T.K. considered that she might be hypothyroid on her current dose of thyroxine; this was increased and she continued to attend him in the surgery at frequent regular intervals for measurement of blood pressure and weight. Her weight came down to a satisfactory 63·6 kg (10 st) and has remained there. She still, however, has her problems of hypertension and anxiety and depression.

Discussion

Assessment of our results

Craddock (1973) discussed the problems of comparisons between studies in which groups of differing origins and composition have been followed during and after weight-reduction régimes, for varying periods of time. We have not found any other report from general practice with which our group's experience can be compared. Though our follow-up is much shorter than Craddock's, like him we observed differing patterns of weight reduction. During 18 months of observation of this group we have seen also that important life events have effects on weight reduction which sometimes seem to outweigh the effects of the group: family illness and death of a relative were events often associated with otherwise unexplained increases in weight.

What is overweight?

Not surprisingly, life insurance company estimates are on the harsh side and in retrospect these were probably not greatly useful for our purpose. For the patient who declares that her weight is a problem—medically, socially, sexually, or functionally in any other way—it seems better to decide on a personal weight loss in relation to her own needs rather than try to conform to an arbitrary norm. Some people are overweight by table standards but content to be so with no apparent disadvantages. It may be useful to ask patients to remember a stable weight at which they used to feel comfortable and ask them to consider this as a target. Psychological treatments may not be an appropriate first approach for obesity resulting, for example, from certain medical conditions or low metabolic rate, or considered to be the consequences of an unusually sedentary way of life.

Drop-outs

One of the most important problems reported by other workers in the field is that of the non-attenders (Stunkard, 1959). Drop-out rates in weight control groups seem higher than in other therapeutic groups. Members who failed to attain target weight loss tended to drop out despite support from the group and offers of individual help from the therapists. It may well be that the drop-outs represent a particular group who merit particular study.

Adverse effects of weight loss

Opinion is divided on the possible adverse effects of weight loss. For example, Stunkard (1957) reported that 54 of 100 patients attending a nutrition clinic experienced weakness, nervousness, irritability, fatigue, or nausea. Bruch (1974) describes emotional disturbance during dieting in adolescents. On the other hand, Shipman and Plesset (1963) conclude that dieting bears no causal relationship to depression. Silverstone and Lascelles (1966) in a general practice study came to the same conclusion, providing there was no previous history of psychiatric illness. Space prevents further discussion of this issue but speculation on the problems described in the case histories may be of value. It should be emphasized that these were the only difficulties encountered in spite of careful post-group interviewing.

Did Mrs E. become overweight because she habitually ate to treat or prevent dyspeptic symptoms which would otherwise have been intolerable? Perhaps by doing so, she prevented the development of the ulcer which declared itself when she began long fasts between meals.

Looking back, we suspect that for Mrs F. the complication of weight control, added to her otherwise rather difficult life, was not a useful intervention at that time. Individual rather than group therapy would probably have been a better approach and her general practitioner (T.K.) continued to monitor her weight and give support after her disengagement from the group.

Group dependency

After the first four meetings it was agreed to space the meetings further to prevent over-dependence on the

group and to encourage self rather than group control. On the occasions when sessions were omitted it was consistently noted that a large proportion of the group either failed to lose or even gained weight. The leaders raised this question in group discussion in an attempt to identify the most important helpful aspects—was it the presence of the therapist, discussion of diets or environmental control, discussion of individual problems, or non-specific group support? It was not possible to be certain about the answer, but the two points most frequently mentioned were the presence of the leaders and the importance of the weigh-in at the beginning of each session. At the end of formal group meetings arrangements were made for weekly weigh-ins at the health centre without the leaders' presence. The weigh-in appeared to be a vital ritual and it has been suggested (Lord, 1966) that the chances of success are directly proportional to the number of times weighing occurs; it forms an important part of commercial weight control meetings. The next planned phase is to involve members of the present group as leaders or helpers in new groups with guidance and support from the authors. If this is successful new groups could grow exponentially, providing worthwhile reward for effort already invested.

Post-group interview

In order to obtain information from individual members of the group, the authors and a research worker devised a structured interview which was administered at the end of the six-month period by the research worker who, seen as a relatively independent enquirer, would be less likely than the authors to receive 'socially acceptable' responses about the effectiveness of the group.

This provided considerable information which is still being assimilated, but some of the more interesting responses are worth reporting here. A majority considered that a target weight was not a good idea but calorie counting was considered useful; most did not want a strict diet but preferred a fixed daily upper calorie limit; the five pence per pound fine for failing to lose the weekly target was felt to be helpful; most found the Schachter-type environmental control aspects to be impractical, usually for family reasons. Exercise was overwhelmingly considered to be one way in which the effectiveness of the group could be improved. As a result of losing weight the greater part of the group mentioned the positive benefits of feeling better, happier, and fitter. The isolated disadvantages quoted were dislike of her face being thinner, and clothes not fitting any more.

When less successful weight losers were compared with more successful, there was some suggestion that the latter were given more support from their families, were better attenders, and were slightly more willing to accept Schachter's approach. They may also have had a better understanding of group processes. Successful losers were slightly more inclined to admit to eating when worried and tended to discuss the difficulty of attending the group when not losing. These findings seem stimulating and important and at the time of writing are pointers to future research.

Conclusions

Clearly the proof of the effectiveness of our approach must lie in modified eating habits resulting in weight loss maintained in the long term, and this is essential for any definitive evaluation. This remains to be done.

Perhaps our approach differs from the traditional prescriptive medical model, but it is this type of alternative which general practitioners and other members of the primary care team may usefully learn from their psychologist colleagues. We do not suggest that only psychologists should be involved in this type of endeavour; however, they have for some time been energetically concerned with passing on their skills to others, the more so since numerically they are thin on the ground compared with other NHS staff. Nor do we propose the methods we describe as the best or only way to run a weight control group. In the light of our experience and thought a new group will be run on rather different lines, and include a research component.

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Addendum

Dr Coupar is now Principal Psychologist Darlington District, Darlington Memorial Hospital, Co. Durham.

Estimated effect of breast self examination and routine physician examinations on breast cancer mortality

We examined the effects of breast self-examination and breast examination by physicians on the stage of breast cancer at diagnosis. Clinical information and pathological staging were compared with interview data on method of initial detection for 293 women. Tumours were detected in clinical stage 1, 53·8 per cent of the time when the detection method was routine physician examination, 37·7 per cent when it was self-examination, and only 27·0 per cent when detection was accidental. Sixty-nine per cent of women practising self-examination at the time of diagnosis discovered their tumour by this method. Differences were less apparent when pathological stage was considered. Tumours found during routine examination of the breast averaged 6·1 mm smaller in diameter than those discovered accidentally. We estimate that breast cancer mortality might be reduced by 18·8 per cent to 24·4 per cent through self-examination or routine physician examination, respectively.

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Maternity grants

The maternity grant has been £25 since November 1969 when £25 was worth £78 at May 1979 prices.

About 59,500 mothers are currently excluded from receiving a maternity grant and the gross cost of making all mothers eligible would be £1½ million per annum.

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