

# Psychodynamic mechanism and weight reduction in obesity group therapy – first observations with different attachment styles in patients therapists

## Psychodynamische Mechanismen und Gewichtsreduktion in der Gruppentherapie Adipöser – erste Beobachtungen zu den Auswirkungen der verschiedenen Bindungsstile

### Abstract

**Objectives:** Successful long-term results are extremely rare in non-surgical obesity treatment. Interactional difficulties with the attending physicians and the limited compliance of obese patients are a frequently described dilemma in repeated psychotherapeutic group treatment attempts. The type of relationship initiation and the attachment behavior probably play a central role in this connection but have not yet been systematically investigated.

**Methods:** This paper focuses on the attachment styles of obese subjects and their effects on psychodynamic group therapy within the context of a weight-reduction program.

**Results:** The attachment styles are characterized in 107 pre-obese and obese patients, and their effects on patients and therapists in group therapy are described.

**Conclusion:** The paper surveys the motivational situation, clinical pictures, and repeated group topics.

**Keywords:** obesity, attachment styles, psychotherapy, group, therapist

### Zusammenfassung

**Ziele:** Langanhaltende Therapieerfolge in der nicht operativen Adipositasbehandlung sind äußerst gering. Interaktionelle Schwierigkeiten mit den behandelnden Ärzten und eine eingeschränkte Compliance von adipösen Patienten stellen das immer wieder beschriebene Dilemma bei sich wiederholenden Gruppenpsychotherapieversuchen von adipösen Patienten dar. Die Art der Beziehungsaufnahme und das Bindungsverhalten spielen hierbei vermutlich eine zentrale Rolle, wurden bisher jedoch noch nicht systematisch untersucht.

**Methoden:** Der Beitrag fokussiert daher als einen neuen Zugangsweg die Bindungsstile Adipöser und deren Auswirkungen auf die psychoanalytisch-interaktionelle Gruppentherapie bei TeilnehmerInnen eines einjährigen Gewichtsreduktionsprogramms.

**Ergebnisse:** Es werden die Charakteristika der Bindungsstile bei 107 untersuchten übergewichtigen und adipösen Patienten sowie deren Effekte auf die Gruppentherapie beschrieben.

**Konklusion:** Es wird ein Überblick über die Motivationslage, die Störungsbilder und die wiederkehrenden Gruppenthemen der TeilnehmerInnen gegeben.

### Introduction

In industrialized countries, obesity is becoming an increasingly pressing economical problem as well as a health hazard. Currently, around 13% of the adult population in

Germany [1] and almost one third (31%) of adults in the U.S. is considered obese with a body mass index BMI  $\geq 30$  kg/m<sup>2</sup> [2]. There seems to be an irreversible upward trend in these figures. Despite all efforts, therapeutic success in obese patients is very low [3], [4].

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Stroebe [3] references longitudinal studies, according to which only around 5% of the patients managed to maintain their reduced weight for five years.

A large influence on the course of obesity, the patient's will to recover, and the success of the treatment is usually attributed to a good relationship between physicians/therapists and patients. Without a positive relationship, therapeutic measures may fail because the patient does not comply, as he may not, for example, understand or follow therapeutic advice, or take the prescribed medication. Interactional difficulties with the attending physicians and the limited compliance of obese patients are a frequently described dilemma in the repeated attempts to treat obese subjects [5], [6]. These difficulties could be attributed to a subject's insecure attachment style, which usually has a strong impact on the relationship with the therapist. Yet, systematic research concerning attachment styles of obese subjects is missing. In order to investigate the relationship between the attachment styles of obese subjects and their effects on interactional group therapy, we have accompanied and unsystematically observed a group of obese patients who took part in a one-year weight reduction program. The aim of these observations and description is to build hypotheses for further clinical investigations. Clearly, the long-term goal will be to identify if the attachment style and the quality of the patient-therapist-relationship are prognostic factors for successful weight reduction and thus to create a basis for the modification of therapeutic measures. Successful weight reduction thereby is defined as a long lasting reduction of 5% [7], [8]. The studies that have thus far examined prognostic indicators of success in weight reduction failed to yield uniform results (for reviews on this topic, see [9], [10], [11]). Most studies on the predictive quality of attachment styles for the success of treatment show that the degree of attachment security is the best predictor of treatment success [12], [13]. Therefore we plan for the first time in the context of obesity treatment to examine if the attachment style and the patient-therapist-relationship have any influence on the treatment outcome of obese adults.

The attachment theory assumes that humans and most mammals have a biologically predisposed attachment system that provides protection from inner and outer dangers and anxieties. Different infant behavioral strategies motivate the caregivers to look after children in need of protection [14], [15]. Bowlby understands attachment to be the expression of an emotional nucleus of felt security and perceived protection from danger in the presence of an attachment figure [16]. The precipitate of these early relationships and attachment experiences thus characterizes the (inner) representance world of the mature individual (for an overview of attachment theory see [17], [18]). One important co-factor in the development of obesity seems to be an immature affective regulation, which has its roots in the interaction with the primary caregiver [19] and is related to the early attachment experiences. Hilde Bruch stresses on the motivational aspects of the development of obesity in early

childhood [20], [21]. Obese subjects have not learned to distinguish hunger from other bodily needs or emotional agitation. Sharpe and colleagues [22] demonstrated the association between insecure attachment styles and high scores of weight already in pre-adolescent and adolescent girls, which places them at risk for eating disorders. Also the influence of a disordered hunger and satiation regulation established during childhood is mentioned [23]. This disordered regulation is often caused by parents using food as reward or punishment. In such cases, offering food is often used as a replacement for affection and as a strategy to solve problems. Any form of frustration is thus regulated with eating. Additionally, such children have not learned to distinguish between different motivations (e.g. fear vs. hunger), or to react appropriately. Several studies (cf. [23]) have shown the strong influence of family structures on the development of obesity during childhood.

Applying these findings to elements of the attachment theory which also focuses on early-childhood experiences, suggest the following hypothesis: The same aspects of the parent-child-relationship leading to an insecure attachment style also form the basis for the development of obesity. We can assume that those children who have been offered food to compensate for all kinds of needs, have also experienced inadequate care in other aspects. This would typically lead to an insecure attachment style. In contrast, children who experienced adequate care and who have learned to distinguish between hunger and other emotions will develop a secure attachment style. For obese subjects with a secure attachment style, it can be assumed that the development of obesity is caused by one of the many other possible factors.

Research on the way in which different attachment styles can affect various psychotherapeutic interventions is increasing steadily [17], [24], [25], [26], [27], [28]. Strauss [29] suggests a sensibility in relating the findings of attachment theory to the observations made in a psychotherapeutic interaction, particularly the therapeutic relationship as it can resemble the relationship to an attachment figure.

In the following, we describe the link between the different attachment styles of obese subjects and their effects on interactional group therapy observed by the group therapist [30].

## Methods

### Subjects

The study was conducted on 118 pre-obese and obese (BMI  $\geq 25$ ; mean  $36.2 \pm 6.9$ ) patients who took part in a one-year weight-loss program (aim of therapy: 5% weight reduction). The group of patients comprises 13 men (11%) and 105 women (89%), aged 20 to 71 (mean =  $52.6 \pm 11.5$ ). Some patients showed psychological symptoms like binge eating (16%), depression (26%) and anxiety (18%) in self rating questionnaires. Before being

included, patients were adequately informed about the study and signed a statement of consent.

## Therapy

The department of endocrinology at Charité Berlin has been running this multi part weight loss program since several years. Participants were mostly alerted to the courses by posters in the hospital, television programs and the Internet. The costs amounted to 450 €, up to 50 percent of which was refunded by the health insurance in some cases. Alternative therapy options like bariatric surgery were not offered at this time.

Depression and anxiety were assessed using the Brief Symptom Inventory (BSI) [31]. The patient-therapist relationship was determined in all participants and the therapist after the 3<sup>rd</sup> group session using the German version of the Helping Alliance Questionnaire (HAQ) [32], [33]. The second author of this article works as the group psychotherapist in the program, which presented the opportunity for the psychosomatic department to accompany the obesity groups. Interactional group therapy is one of several modules in this program, and took place every 2 weeks. The psychotherapy was done in groups of ten to twelve patients. The patients participated on average in 12 60- to 90-minute sessions of psychoanalytical-interactional group therapy. Between 2 and 5 patients in each group had previously taken part in psychosomatic health resort treatments or had had individual psychotherapy. Most other patients, however, had not come into contact with psychotherapy.

Interactional group therapy calls for an active behavior from the therapist, who uses supportive interventions such as giving advice, and often mirrors the acting-out of group members. Transference onto the therapist in the sense of a transference neurosis is not an explicit goal. Giving answers is generally preferred over giving interpretations. Thus, it is easier for the therapist to offer the patient a form of reality check, and encourage social competence [34]. Consequently, interactional group therapy is more adequate for obese patients, who most often do not have a primarily psychotherapeutic objective. The effects of the attachment style in group therapy were described in retrospective by the group therapist as well as the motivational situation, clinical pictures, and repeated group topics. A working group of five experts meets regularly to discuss the treatment process and provide collegial supervision for the therapist and the interviewer.

## Adult Attachment Prototype Rating (AAPR)

In the initial phase of the program, attachment styles of the patients were identified using the German version of the Adult Attachment Prototype Rating (AAPR) [35], which includes an interview focusing on attachment behavior in childhood and adulthood. Both interviewers (first two authors) had previously undergone intensive rater train-

ing. The attachment style was then rated by two independent raters, in order to ensure high reliability. Subjects were assigned to an attachment style only if the two raters agreed in their overall assessment. The AAPR has demonstrated its reliability and validity in a variety of studies [27]. It shows satisfactory psychometric features with respect to inter-rater reliability, internal consistency of scales, and discriminatory power of the individual items [25].

The experimental protocol was approved by the Institutional Review Board, and all subjects gave written informed consent. We certify that all applicable institutional and governmental regulations concerning the ethical use of human volunteers were followed during this research.

## Results

According to the Brief Symptom Inventory (BSI) 31% of the patients were conspicuous concerning psychological distress in the global scale ( $T \geq 63$ ), 26% had a conspicuous depression score and 18% showed an increased anxiety score. Although we did not explore eating disordered behaviour systematically we can report that 16% of all participants reported 8 or more eating attacks without vomiting per month (mean =  $6.26 \pm 18.03$  with a great range between 0 and 120, median = 0).

Based on the results of the AAPR, we were able to identify the attachment styles in a group of 107 pre-obese and obese patients, whereas 11 (9.3%) of the 118 attending patients did not participate in the attachment interview because of scheduling difficulties, difficulties with the video recording or dropout.

### Securely attached patients

54% of 107 subjects had a secure attachment style. However, the AAPR allows a further distinction which can be categorized as "clearly" or "probably" securely attached. 30% of the subjects were rated as "clearly" securely attached, whereas 24% of the patients were "probably" securely attached. Patients with attachment security describe relationship experiences coherently and are normally able to integrate good and bad experiences during the interview. They give a complete picture with appropriate affect regulation; reflection and reappraisal of experiences become evident. The importance and appreciation of attachments and relationships are emphasized in their narratives (cf. [36], [37], [35]).

### Insecure-ambivalently attached patients

The descriptions by patients with insecure-ambivalent strategies are usually affect-laden. In the immediate conversational situation, they are often virtually flooded by earlier events, and the time levels start to blur. They actually shift back in time and it occurs as if the long-time-ago experience happens now. The patients appear to be extremely caught up in their story. The narrative style is

often unstructured, and there are extravagant descriptions from which the narrators are not yet able to inwardly dissociate themselves. Experiences of drastic separation are largely unprocessed. Strong efforts directed toward others become evident together with indications of excessive dependency needs. These patients mostly experienced unpredictable behavior in connection with their primary caregiver (cf. [36], [37], [35]). Out of the 107 subjects, 21% were assigned to the insecure-ambivalent attachment style.

## Insecure-avoidantly attached patients

The insecure-avoidantly attached patients often give listeners a fragmentary picture; there are few concrete memories. The patients apparently had rejecting, non-bonding mothers. They describe experiences characterized by a lack of intimacy and support. At the same time, the affective burden is denied, and the parents are partially idealized without any perceptible signs of an inner relation. These people usually strive for independence and rely on their own strength, while separation experiences are trivialized. Little empathetic capacity and compassion are noticeable (cf. [36], [37], [35]). Out of the 107 subjects, 25% were assigned to this attachment style.

## Motivational situation, clinical picture and group topics

It can be assumed that the specific attachment pattern of each patient has been activated in the group and in the interview [15], [38]. Furthermore, we expect that both the subjective and objective success of the therapy depend on the interplay of motivation, clinical picture and attachment style, which are elucidated in the following. Motivations for group therapy and previous psychotherapeutic experiences were as heterogeneous as the patients' initial weight or their social class status. Based on our observations the patients can be divided into four general categories according to their motivational situation:

1. Those who say "yes" to the group,
2. "fatalists", who initially tolerate the circumstances,
3. "rebels", who can be subdivided into open and subtle ones,
4. those who stay away or appear irregularly.

An exceptional situation for psychotherapy in general arises in these weight-loss groups, because motivation to undergo therapy is commonly regarded as an essential prerequisite for therapy. This hardly applies to these groups, since the focus here is on a physical level and the goal for the patients is the weight reduction of about 5% and not the participation in group psychotherapy as one of many treatment components.

Considering the dominant clinical picture of obesity, the lack of psychotherapy motivation was no surprise in itself, but still constituted a difficult hurdle: Even though there

are genetic fundamentals for the over-weight, obesity also testifies to a somatization, which can in turn be understood as a defense against a psychic form of expression. The subconscious fear of many patients regarding psychotherapy is probably directed towards a reversal of this somatic shift [39]. Nevertheless the patients started the program with the intention to reduce weight by developing a stable self-regulation. But how this stable self-regulation was to be achieved had not been defined at the beginning. In all of the groups the same problems arose concerning the inability to feel and verbalise emotions. At some point the groups realized that they react by eating instead of feeling. At this stage the patients planned to support one another to clarify and identify their emotions.

## Clinical picture

More than half of the patients in the weight reduction program describe themselves as being "addicted to food", and show related behavioral patterns. Their thoughts often center around eating: "When is the next time I will be able to eat, and how much? How much should I eat when I am in company? How much food do I have at home?" and so forth. Moreover, obese persons can possibly suffer from the social consequences of their addiction. As a result they can retreat due to possible discrimination at work or social settings.

Flores [18] has shed some light on the attachment styles of addicts and the implications for group therapy. However, there is a clear difference in the therapeutic approach for substance addicts and for persons with eating disorders. Abstinence is one of the requirements for the psychotherapeutic treatment of alcoholics and drug addicts, although relapses may occur repeatedly during the treatment. In the weight reduction program, the improper eating behavior still remains unchanged, especially during the initial phases of therapy, as abstinence of eating can obviously not be achieved. Thus, the affect regulation can still be achieved through disordered eating behavior, and the need for emotional regulation by others can be denied. As Flores [18] (p. 67) puts it, "The denial of the need for others is what leads individuals to seek gratification (e.g., drugs, alcohol, food, sex, work, and gambling) outside the realm of interpersonal relationships." Other studies similar to Flores' work on addicts have shown that for obese subjects, food is used as self-medication or self-regulation of mood, resulting in an "inability to control carbohydrate consumption results which has been suggested to be one factor hindering the weight loss of the obese" [40] (p. 175).

The biographic narratives, the interaction in the group and the reactions of transference and countertransference revealed the relatively homogeneous psychodynamic background of the clinical picture. Patients often described a long-lasting emotional deprivation experience in early childhood, which mostly results in undifferentiated orality. Hence, these patients have an increased need to re-experience the denied relationships but at the same

time are unable to shape them. Increased food intake can hence be understood as a substitute for such relationship experiences aimed at avoiding social dependence.

In coping with their increased emotional needs, the group members showed predominantly three different social strategies:

1. altruistic renunciation,
2. appellative passivity, and
3. open oral greed.

### **Altruistic renunciation**

If the unfulfilled need cannot be reconciled with their self-perception and their aspiration to independence and autarky, some of the subjects try to fulfill their own need in others by way of altruistic renunciation: Through this, the other person is excessively taken care of regardless of their actual needs. Only through identification with the other person does the subject feel cared for. In addition, the caregiver hopes to produce a similar behavior toward himself. While this strategy does not conflict with their self-image of modesty, it often overstrains relationships by the unwanted extensive care and by the increased disappointment of not having their actions reciprocated. In the group therapy, subjects with this pattern of behavior for example insist on giving others time to speak even if the others do not want to. These subjects would then support and coach others, up to the point where it appears as if they are acting on the other's behalf. All this would be clad in phrases such as "But I mean only well!" A phenomenon of the countertransference was observed such that the therapist first urged the patient to use the time for themselves but was then slowly taken by a subtle fury which was connected to the imposing and self-denying quality of altruistic renunciation.

### **Appellative passivity**

Subjects of appellative passivity try to cater to their needs by encouraging others to fulfill their needs for them. By remaining passive, the other person is thus forced to act for both themselves and the subject. Again, this allows the patient to maintain their self-perception of having no needs of their own and to deny them in a process of delegation, while getting others to attend to them. However, this strategy also usually leads to dysfunctional relationships: The other person feels increasingly angry as he has to solely contribute to the relationship and, as a result, seems to be the only one who actually has needs and requires attention. In the countertransference of the group therapist, this causes also a narcissistic offense and a pendulum motion between active commitment and sulky refusal.

### **Open oral greed**

A final strategy in group therapy with obese patients is open oral greed. The immense hunger for attention and

care is again not at odds with the patient's image of being self-sufficient, since the unconscious right to compensate on account of the early deprivations cancels out the shame of asking too much. In their mind the suggestion of being a victim grants them the right to make unlimited demands. The therapist is thus often put in the role of the denying and failing mother, and is considered the perpetrator when she, for instance, does not contribute to the therapeutic interview but also forbids self-supply, i.e. of food and drinks during the sessions. In the countertransference, impulses of distancing and justification are triggered, which bring about anger of being unjustly accused.

Patients often oscillate between these three strategies of dealing with their increased needs. For example, at the beginning of the session, patients asserted that they didn't need any of this (altruistic renunciation), but soon used the entire session exclusively for themselves irrespective of the needs of others (open oral greed).

In all three strategies, patients manage to fulfill their strong needs in a form that is consistent with their self-perception of having no needs at all. Yet, this also means that the behavior is not psychically corrected. On the other hand, the countertransference, which in all three strategies is characterized by anger, also shows the failure of this social behavior to compensate for the increased need for orality. All of them disrupt relationships and jeopardize a long-lasting, correcting, and emotionally satiating shaping of relationships. After these mostly fruitless attempts to build relationships, patients tend to switch to self-supply and eat generously.

In the therapeutic process, the patients are encouraged to consciously accept their increased needs for emotional attention. It facilitates the advancement of social competences in group therapy, which are to fulfill interpersonal needs more adequately, and to support each other with mutual feelings and actions. This cannot be achieved in every group.

### **Group topics with obese patients**

The patients in the therapy groups often lack consciousness of their problems, as the psychic aspects causing obesity or their effects are repressed. If they do realize a problem, it usually concerns the esthetic or health related effects of obesity but not the aspects of dysfunctional relationship and attachment behavior. Acknowledging that self-care in the form of food leaves them empty and unsatisfied requires a great and conscious effort on the part of the obese patients. They are generally not used to contemplating their swallowed feelings, expressing, differentiating, and finally assigning them to certain experiences and events. Patients with eating disorders typically rather act them out and somatize them. The experience of an entire group trying to clarify their own feelings, perhaps even if one of them empathizing and sharing experiences contradicts mostly all of their previous experiences. The excessive identification with the role of the care giving mother is also a frequent topic

resulting in a lesser pronunciation of other personality dimensions. The patients justly feel that they are neither considered nor accepted or appreciated with all the facets of their personality. But in the course of psychotherapy they have to be made aware of the connection to their one-sided role concept. The mirroring of role patterns occurring not only in everyday situations but also in group therapy, and especially of their effects on the group's interaction, oftentimes allows the patients to test other roles in small steps and to get unexpectedly great appreciation. Such exemplary relationship experiences make it easier for them to analyze their own deficits, which have previously been in the background.

Time and again, the want for the clarification of affects accompanied with aggression arises. Patients have diffused feelings of anger, offense, or general listlessness, but do not realize their actual feelings of aggression. Their rage and frustration toward themselves and their insufficient self-representation on the one hand, and toward the person who caused the frustration on the other hand are resolved by "chewing" and "swallowing" the corresponding events, using food as a substitute.

### Treatment problems with respect to the attachment styles

The influence of the group varies according to the patient's attachment style. As Mikulincer and Shaver [17] explain, securely attached adults project their positive representations onto the group. They feel good in the company of others, they trust in the support of the group, and when they engage in the group, they are emotionally free and feel open and secure. Likewise, group cohesion plays an important role for the insecure-ambivalent, as it gives them a sense of security [17].

It has also often been pointed out that insecure-avoidant individuals do not value subjective group-related therapy factors such as group cohesion, altruism, and intimacy in the groups [41], [42], [25]. The research of Mikulincer and Shaver [17] suggests that a cohesive group can even aggravate the poor functioning. It seems that attachment-related anxieties and discomforts are intensified, since the group threatens the subject's sense of complete self-reliance. As a result, the patients with avoiding strategies attribute their weight loss to rather sportive engagement during the program and to the change in their diet than to the evaluation of the causes of their dysfunctional eating habits. Such group members usually do not expect anything from the group therapy, do not open up as much and do not want to deal with the arduousness of self-reflection. Since they do not ascribe positive effects to the group, the latter is denied the harvest of their labors. On the other hand, a longer stagnation in weight reduction commonly leads to a relapse into the old eating behavior and into relationship patterns that have already been identified as harmful. The result is often resignation, shame and self-hatred, which then fosters an attitude of "now, it doesn't matter anyway."

### Effects of the attachment styles at group psychotherapy

As expected, the attachment prototypes of the patients cannot be exactly alike. The patients with a distinct attachment pattern polarize and thus also illustrate the descriptions presented here. In spite of this, we are not dealing here with an exclusively subjective experience report, since several observations were shared by the nutrition consultants not involved in the psychotherapy. Most of the patients repeatedly complained about being neglected and receiving inadequate support in the cooking course, as well as in medical attention and in sport activities, even though objectively, offers had been abundant. During case conferences, there was an intensive exchange about phenomena within the groups, in the course of which the preferred defense mechanisms crystallized. These are described in the following and rely on observations that were confirmed in the discourse, but not collected systematically.

Securely attached subjects have a well-balanced range of ways to behave and work things through. In countertransference they usually engendered in the therapist a greater willingness to establish an attachment regardless of sympathies and thus surely also increased their readiness to feel empathy. Securely attached obese patients display a whole range of defense mechanisms, especially denial, and repression.

Insecure-ambivalently attached people were found to be very concerned with keeping the group together by organizing telephone lists, for example, and suggesting meetings outside the group or a private continuation after the termination of group therapy. On the whole, insecure-ambivalently attached individuals find it more difficult to bear inner tensions without disburdening themselves by speaking or acting. Thus, for example, they are quick to surge forward with personal revelations. They mainly relate only to the therapist and virtually flood the group, often without perceiving their effect on others and remaining in touch. In countertransference gratitude is also occasionally felt for the ice-breaking pioneer work these patients often undertake in the group, while increased dosing, structuring and protecting functions are triggered in the therapist at the same time. The preferred defense mechanisms in the groups are: reaction formation, identification, idealization, and projection.

Insecure-avoidant individuals present themselves in a totally different way: they usually came to the interview with their questionnaires carefully filled out and filed. These patients almost always shook the framework of the group with discussion on the topic of "Why are we not allowed to eat, drink, and knit in the group?" They liked to lean back in their chair and say at the beginning of a group session: "You have probably prepared something." Strikingly, these patients frequently reported legal proceedings with neighbors, employers or others. Some of them appeared to smell "evil in the world" directed against them. They could be designated as conspiracy theorists, but it may also be said that they exhibit

anankastic and paranoid features. In countertransference they arouse feelings of anger at wasted attachment chances but also trigger impulses to win them over and get them interested in the group. The defense mechanisms of the insecure-avoidantly attached are intellectualization, rationalization, isolation of affect, devaluation, and a tendency to control others.

The way in which the attachment style presents itself, however, ultimately depends on the “power” of secure or insecure strategies. In the described sample only 30% of the patients following the AAPR were “clearly” securely attached. Furthermore a significant higher level of psychopathology in the “probably” securely attached and the insecure attached patients was found. This fact and the difficulties with the regulation of emotions as well as the activated insecure parts of the “probably” securely attached in the interactional group therapy led to a problem- and conflict-oriented focus in the description of the groups.

Nevertheless in terms of weight reduction, the patients have benefited significantly from the program ( $p < 0.001$ ), whereas surprisingly no difference in regard of a successful weight reduction could be found for securely and insecurely attached patients ( $p = 1.0$ ). No differences were also to be seen between the ambivalently and the avoidantly attached patients in our sample. On the other hand the improvement of the patient-therapist-relationship from the beginning to the end of the treatment seems to have an impact of a successful weight reduction of 5%.

## Discussion

We wanted to describe our observations of the effects of attachment styles of obese patients in psychoanalytical interactional group therapy, in order to contribute to a hypothesis on prognostic factors for obesity treatment. Our observations show that a relatively homogenous clinical picture of obesity, leads to recurring and hence classifiable coping strategies of the patients. Although these strategies produce an intrapsychic relief, the somatization of the problems causes obesity and on an interpersonal level dysfunctional relationships. Group therapists of obese patients therefore have to expect a rather bad prognosis as well as a relationship that is hard to handle. Studying the process also in relation to attachment styles broadens the perspective which facilitates and improves therapeutic work. A connection between the described psychodynamic of the clinical picture and the resulting group dynamic will surely be of advantage for future treatments. Despite the comparatively large portion of securely attached patients, obesity groups are difficult. This is due to the patients' general experience of deficiency – irrespective of their attachment style. Because of the behavior of the primary caregiver, the patients in our weight reduction program developed specific inner working model for relationships. At the same time, the process of individuation as well as the character

structuring and the establishment of later neurotic experience and behavioral patterns took place. In this way, a combining element was created, which marked the therapy of obese subjects: the recurring topic of being hungry and having increased needs. But as a consequence of their different biographical background, not all of the obese subjects have the same attachment style which leads to different strategies in dealing with the requirements of an interactional group therapy. According to different studies [43], [25], especially ambivalently attached subjects (in this case with Binge Eating Disorder and obesity) benefit from an interactional group therapy, which focuses on expressing affect, exploring relationship patterns, and encouraging self reflection in patients. In this regard they differ significantly from avoidantly attached patients. Rather for them, Horowitz, Rosenberg and Bartholomew [44] recommend a cognitive therapy. Strauss and colleagues [27] (p. 584) also assumed that avoidant patients would benefit less, “because a confronting and interpreting psychodynamic group treatment could prove too difficult for dismissing patients”. Tasca and colleagues [28] suggest that interpersonal or psychodynamic therapists have to identify avoidantly attached patients before treatment and actively prepare them for the interpersonal and emotional stressors of this sort of treatment. This kind of preparation and motivation of avoidant patients has in our situation so far not been possible but is hoped to be implemented in future treatments.

Why is the process more laborious in some groups than in others? These are mostly groups with extreme avoiders who show few secure strategies. In many cases, these persons cannot be reached by psychotherapy, at least not at the present time. Their often rigid defense formation comprised of rationalization, devaluation, affective isolation, and an enhanced level of aggression and hostility increase the overall resistance of the group, which means that anxious, distrustful components can also partially surface in other patients. On a structural level self-regulation was integrated only moderately as well as the capacity for attachment, self-perception and communication. Thus it is important to make sure that destructive influences, particularly in the decisive initial phase, do not set the norm for the group. For group psychodynamic interpersonal therapy with obese BED-patients, Tasca and colleagues [28], [43] reported relating to all attachment styles an overall higher level of conflict in the group climate and an activation of attachment-related schemas than in a group cognitive behavioral therapy.

It can be assumed that, because of the attachment style, there had been a preselection of the patients. We believe that an increased number of individuals with a secure attachment style could imagine benefiting from a one-year program. Subjects with an insecure attachment style, on the other hand, probably did not have the courage to register themselves. Goodwin and Fitzgibbon [45] showed in a study with anorectic and bulimic patients that the group of insecurely attached patients with an eating disorder often refused an offer of outpatient treatment which

would also explain the large percentage of securely attached patients in our sample. The insecurely attached are unwilling to commit to such a one-year group program. As stated before, generalization of these first results and observations is not possible due to the presupposed effects of selection. Yet they could be checked with a statistically improved, prospective design.

## Conclusions

In contrast to other long-term group therapy interventions, which also focused on the change from an insecure to a secure attachment style [18], [26], a change of a patient's attachment style is unlikely, as we considered only twelve sessions. Thus the patients will have considered the therapist only in part as a secure basis [15]. Our observations suggest an absolute need to help patients to develop better emotion regulation skills and the need for long-term therapy focussing on the implementation of a supportive patient-therapist relationship and its improvement during therapy. Therefore sufficient time is needed to establish a relationship with the group and an effective therapeutic alliance as well as to correct the self-structure in order to be then able to give up excessive eating permanently and succeed also on a physiological level concerning long-term weight reduction.

## Notes

## Conflicts of Interest

None declared.

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