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(Dis-)solving the Weight Problem in Binge-Eating Disorder: Systemic Insights From Three Treatment Contexts With Weight Stability, Weight Loss, and Weight Acceptance

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Abstract

Binge-eating disorder (BED) is a severe eating disorder strongly associated with obesity. Treatments struggle to provide safe and effective ways of addressing weight in a BED context. This study explored a two-phased treatment for BED developed at a major out-patient eating disorder service in Denmark. The study used interviews and participant observations to gain insight into experiences and processes related to weight and body issues in three treatment contexts that addressed weight stability, weight acceptance, and weight loss. Using systems theory, the study proposed *a relational weight problem* that embeds feelings of non-acceptance due to weight, a merge of weight and identity, and an internalized body- and weight-critical gaze of others. Contrary to critical claims that weight acceptance discourages people with obesity from engaging in weight loss efforts, this study suggests that acceptance and a disentanglement of weight and identity are prerequisites for weight loss for this group.

Keywords

binge-eating disorder; psychology; psychotherapy; body therapy; obesity; weight loss; systems theory; weight stigma; body image; overvaluation of weight and shape; interviews; participant observations; qualitative; Europe

Background

Eating disorders are serious psychiatric illnesses that affect broadly across race, gender, and socioeconomic status (Kessler et al., 2013). Age-of-onset typically occurs in childhood or adolescence with body dissatisfaction and unhealthy weight loss behaviors as shared risk factors (Hilbert et al., 2014). Binge Eating Disorder (BED) is the lesser-known but most prevalent of the eating disorders affecting 2 - 3 % of the population (Hudson, Hiripi, Pope, & Kessler, 2007; Kessler et al., 2013). BED is strongly associated with obesity, but long-term weight loss remains a challenge. The present article argues that we need to move beyond the individualized psychiatric or medical framework to fully understand the complex problems that arise at the intersection of BED and obesity. This involves attending to contextual and interactional influences.

Binge-eating disorder (BED) was acknowledged as an independent diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013) and is characterized by episodes of binge-eating in the absence of inappropriate compensatory behaviors. People affected by BED often alternate between periods of binge-eating and strict dieting leading to dramatic fluctuations in weight and an overall increase in weight over time (Dingemans & van Furth, 2012). The majority eventually develop obesity (Hudson, Hiripi, Pope, & Kessler, 2007). Psychotherapies effectively reduce BED psychopathology but rarely lead to weight loss (Vocks et al., 2010). In light of a steep weight trajectory pretreatment, weight stabilization is considered a good outcome (Barnes & Blomquist Grilo, 2011). However, the dominant conviction is that obesity severely affects physical health, and so, weight loss remains a separate treatment goal for BED (for critical

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reviews of weight loss interventions, see Clark, Fonarow, & Horwich, 2014; Mann et al., 2007). Currently, weight is addressed pharmacologically and behaviorally with poor to moderate short-term results (Grilo, Reas, & Mitchell, 2016; Wilson, Wilfley, Agras, & Bryson, 2010). There are continuous calls for more effective weight management strategies for BED.

Even though BED and obesity exhibit shared risk factors (Haines & Neumark-Sztainer, 2006), and crossover is common (Neumark-Sztainer, 2005), the eating disorder and obesity fields are fundamentally divided with limited exchange of knowledge (Neumark-Sztainer, 2009). This leaves the intersection of BED and obesity greatly underexplored and, as we shall argue, critically restricted in terms of how to understand and address weight. People with BED are caught in counteracting goals and health messages (Ferrari, 2011; Greenhalgh, 2016; Neumark-Sztainer, 2005). While public health interventions promote early detection of weight problems and initiation of behavioral weight loss efforts (Mann, Tomiyama, & Ward, 2015), eating disorder studies persistently warn of the adverse effects of focusing on weight. This is evident in increased unhealthy dieting behavior and weight and shape concerns, both of which are strongly and consistently predictive of both eating disorders and obesity (Bacon & Aphramor, 2011; Cena et al., 2017; Neumark-Sztainer, Wall, Larson, Eisenberg, & Loth, 2011).

Parental obesity and eating disordered behavior and parental perceptions (Allen, Byrne, Forbes, & Oddy, 2009; Allen, Byrne, Oddy, Schmidt, & Crosby, 2014) and comments about the child's weight, shape, and eating (Hilbert et al., 2014; Neumark-Sztainer et al., 2010; Wansink & Latimer Pope, 2017) have been associated with increased body dissatisfaction and body weight. Perceived weight stigma and weight-related bullying have equally been associated with later development of eating disorders, obesity, and poor body image (Aphramor, 2005; Friedman et al., 2005; Puhl & Brownell, 2012).

It is evident that existing approaches to weight do not effectively solve the weight problem facing people affected by BED; rather, it seems to seriously risk contributing to it. Eating disorders and obesity are complex problems that are strongly associated. However, the present article argues that much research informing BED treatment is constricted by a narrow focus on isolated factors (such as binge-eating, body dissatisfaction, and body mass index [BMI]) and on the individual person (Bracken et al., 2012).

Therefore, the present study used a systemic framework. We explored how BED and weight problems developed, were sustained, and changed in the contexts of three different treatment settings. The aim was to inspire relational and contextual understandings of BED and weight, which could point to alternative ways to increase the physical, mental, and social health of people affected by BED.

Theoretical Framework

The study used cybernetic systems theory (Bateson, 1972) to inquire into the multiple factors, relationships, and contexts that made up the problems identified as BED and obesity. Systems theory involves a shift in focus from individuals to contexts and from linear to circular reasoning. This moves the subject of inquiry from isolated factors and primary causes to structures, processes, and relations. According to Bateson, all that co-varies can be seen as systems. All systems comprise subsystems and are embedded in suprasystems.

Cybernetics is the theory of system regulation through feedback loops. Systems theory poses that phenomena are more than the sum of their parts, and interactions therefore give rise to new phenomena. The systemic notion of circular causality occasions a simultaneous inquiry into problems and solutions as any cause is always also the effect of what came before it. A derived attempt is therefore to "understand the problem by its solutions" (Nardone, 2004). Similarly, systems theory holds no assumptions about the beginning of a problem; instead focus is on the disturbances to which the problems are reactions. In second-order cybernetic systems thinking, long-lasting problems are understood as arising from continual maladaptive attempts to solve them:

> We assume that once a difficulty begins to be seen as a "problem," the continuation, and often the exacerbation, of this problem results from the creation of a positive feedback loop, most often centering around those very behaviors of the individuals in the system that are intended to resolve the difficulty: The original difficulty is met with an attempted "solution" that intensifies the original difficulty, and so on and on. (Watzlawick, Weakland, & Fisch, 1974, p. 4)

We also looked at *problem-defined systems* (Anderson & Goolishian, 1988). This concept considers the reality of a problem to be linguistically shaped by those interacting around it (relatives, society, and health care professionals). If there is no languaged concern or complaint, there is no problem.

Method

Design

The data for this article were taken from a multimethod study exploring a two-phased treatment for BED. The study comprised a quantitative single-group effectiveness study evaluating Phase 1 (systemic and narrative group psychotherapy). Pre–post measures of eating disorder pathology, functional level (Sheehan Disability Scale), general psychopathology (Symptom Checklist-90-Revised), and quality of life (World Health Organization

Well-Being Index) were elicited through electronic questionnaires and Eating Disorder Examination (EDE) interviews. We conducted a qualitative ethnographic study of Phase 1 and Phase 2 (Weight Loss and Wellbeing/Weight Acceptance) using in-depth interviews and participant observations. Qualitative data were analyzed before the completion of the quantitative data collection. Data were analyzed separately in accordance with the specific methods and converged to compliment results and explore contradictions (Creswell & Plano Clark, 2011). These insights are discussed elsewhere.

Setting and Treatments

The study was conducted at a major out-patient eating disorder unit in the capital region of Denmark. Complying with the European International Criteria for Diseases (ICD, World Health Organization, 1992), BED is yet to be recognized as an independent diagnosis in Denmark. The presented eating disorder unit is the only public treatment service in Denmark to offer BED treatment. From 2013 to 2016, the unit received funding from the Danish Health Authority to evaluate and expand their treatment program to include a weight management component. The present study formed part of the evaluation and was granted access to the treatment facility, patients, and data.

The BED treatment was multimodal and in accordance with official recommendations and guidelines for BED treatment (Danish Health Authority, 2005). A full treatment lasted 1 to 1½ years.

Phase 1. Phase 1 consisted of 20 weekly group sessions of systemic and narrative therapy and five group sessions of dietetic counseling. Groups had two trained psychotherapists and seven patients. New patients entered as others finished. Optional treatment elements included consultations for couples, dietetic and social counseling, multifamily meetings for family and support networks, mindfulness, and Basic Body Awareness Therapy (BBAT). Patients were to keep a food diary, work toward normalizing eating patterns to reduce binges, and stay at a stable weight within plus/minus 5 or 7 kg (11 or 15.5 lbs.) depending on BMI. Patients signed consent forms in agreement. Weight was monitored before each therapy session. Excessive weight changes elicited extra dietetic guidance and a reflection period of 3 weeks where no attention was given to weight. During this period, patients were to explore the causes of weight change and decide whether to continue or terminate treatment. Treatment was conducted as individual therapy in groups: One therapist interviewed a patient, and group members and the two therapists provided feedback according to Tom Andersen's (1987) principles for reflecting teams. Listeners shared what had resonated with them or inspired them on hearing the interview, and what had come across as important to the interviewed person. All clinical staff used externalizing (White, 2007), a narrative practice, which linguistically seeks to separate problems from the person. Externalizing questions include "What is the eating disorder's plan for you/your life?" and "Do you agree with it?" The aim is to minimize shame and blame and encourage a joint effort to explore and work against the identified problems. Two main problems were externalized in the treatment: *the eating disorder* and *the critical voice.* The eating disorder was used about thoughts, feelings, and behaviors ascribable to the eating disorder. The critical voice was presented as an "ally of the eating disorder" and represented feelings and expressions of self-criticism and hopelessness.

Phase 2. In collaboration with therapists, patients could choose to proceed in a Weight Loss group or a Wellbeing/Weight Acceptance group for 6 months. To aid patients in choosing groups, assemblies were arranged where therapists and former patients from the two groups shared information and experiences. Groups had eight to 10 patients and were open to new patients as others finished. Groups met weekly (Weight Loss group) or bi-weekly (Wellbeing/Weight Acceptance group) from 8:30 a.m. to 12:00 p.m. followed by a joint unsupervised lunch. *The Weight Loss group* was modeled on a national weight loss project "Small Steps to Weight Loss" (Danish Health Authority, 2015) and structured around a series of eclectic psychoeducation sessions supplemented with dietetic guidance and elements of meditation and body therapy. The expected weight loss was presented as a maximum of ½ kg (1.1 lbs.) a week or, as announced by the therapists, "getting experiences with doing weight loss in a safe environment by making small lifestyle changes in eating habits and physical movement." Attendance required abstinence of binge-eating to counter relapse. Care providers were a medical physician, a physiotherapist, and a dietician. *The Wellbeing/Weight Acceptance group* was inspired by Health at Every Size principles (HAES®, Bacon, 2008). The aim was presented by the therapists as "gaining greater acceptance of yourself and your body, and finding enjoyment in eating and bodily movements." The main component was BBAT supplemented with mindful eating exercises, meditations, and therapeutic counseling of BED symptoms. Patients were weighed, but there were no weight demands. Care providers were a psychotherapist, a physiotherapist, and a dietician.

Participants

The participants for this study were a subsample of participants included in a quantitative evaluation. A total of 111 participants entered Phase 1, 82 completed, and 35

continued in Phase 2 (Weight Loss 19, Wellbeing/Weight Acceptance 16) of which 27 completed (Weight Loss 14, Wellbeing/Weight Acceptance 13). Twenty-two patients who completed Phase 1 or 2 during a 6-month observation period were invited for in-depth interviews. Twenty accepted (Phase 1, 5; Weight Loss, 8 [of which one had dropped out]; Wellbeing/Weight Acceptance, 7). One participant (Wellbeing/Weight Acceptance) declined due to work load and one (Phase 1) did not respond. Participants were three men and 17 women aged 22 to 58 ($M = 34.8$), and BMI ranged from 28 to 55 ($M = 39$). Twelve were married or cohabiting, 20 were unmarried or divorced, 11 had dependent children. Eleven were actively employed and nine were on sick leave. A large majority (27) had previously received more than five psychotherapy sessions, and five had previously been admitted to inpatient care. All but two had been affected by BED for more than 5 years. The majority (25) had experienced trauma before their 11th year. All 33 consented to the observational study (11 in each group). The nine participants, cited in this article, were given the pseudonyms: Astrid, Sara, Liz, Ida, Signe, Tanja, Marius, Ingrid, and Eva.

Data Generation

The data for the present study were generated by Lene Meyer at an out-patient eating disorder Unit in Denmark from November 2015 to May 2016 using participant observations and in-depth interviews.

Participant Observations

The researcher simultaneously attended a Phase 1 group, a Weight Loss group, and a Wellbeing/Weight Acceptance group. She was present in all weighing sessions and group sessions and stayed with either patients or therapists for breaks. On request by the patients, she was not present for lunch as they wished to speak freely about issues outside of treatment. During Phase 2, the researcher occasionally took part in body therapy activities, mindful eating, and meditation. During Phase 1, she attended two multifamily meetings and no other activities outside the therapy room. The researcher engaged in conversations when invited by the participants. During observations, she took handwritten notes of conversations, activities, and reflections, which were later transcribed. The observations provided insights into processes and interactions underlying change during treatment, especially how patients and therapists worked with body and weight issues.

Interviews

Participants were invited to take part in interviews at their homes, the treatment facility, or over the phone. Interviews lasted between 30 minutes and 3 hours with interviews at the participants' homes taking longer than interviews over the phone. Interviews were flexibly structured (Burgess, 1984): The researcher invited the participants to engage in a conversation about how BED and weight problems developed, worsened, and eventually changed in treatment while remaining responsive to what participants found important. All participants were asked about their thoughts and experiences of the demand for weight stability during treatment, their choice of attending Phase 2, and possible bodily experiences. All were asked about treatment elements (food diary, the group, multifamily meetings, and the method of externalizing) and about sequences from the observational study that had stood out to the observer as difficult or decisive for the participants. The participants most often engaged with the interviewer as a messenger, who could convey knowledge about BED to the public.

The observations and interviews served to mutually contextualize and complement each other: Interviews provided contextual knowledge about the problems and solutions in the development and treatment of BED and unfolded the changes apparent in therapy in "real life." Observations allowed the researcher to trace the small steps, dilemmas, and negotiations that made up these changes.

Ethics

Referring to the committee law § 2, the National Committee on Health Research Ethics (DNVK) [40503] judged that the study could proceed without approval due to the nature of the methods. Participants received oral and written information about the study and gave separate, written consent to interviews and observations. Observations of group psychotherapy raise ethical concerns about respecting the needs and boundaries of individual participants. The observer was presented as "a fly on the wall" and sat at a table in a corner facing away from the group. Participants could ask the observer to not attend or leave at any moment. The observer contemplated eventually facing the group, but felt it was too invasive. During an interview, a participant shared an experience of feeling overwhelmed by having her difficult thoughts written down by the observer as she spoke them, but she had decided it was easier to let the observer stay. This served as a reminder to be vigilant and discrete throughout. During weighing sessions, the observer took care not to see the participants' weight as this was judged sensitive. An ethical commitment was to give voice to the participants and strive to present the inherent meaningfulness of their stories.

Data Analysis

All interviews and field notes (except notes on recurring routines and long passages of informal talk) were transcribed and entered into NVivo® 10. Audio recordings of

interviews were continually revisited to preserve meaning and contextualize codes and general findings. Data were coded for *Context, Actors, Interpretive Nodes*, and what was perceived as *Problem* or *Solution*. Coding, organization of data, and processes of analyses followed NVivo® guidelines (Bazeley & Jackson, 2013), as these appropriately operationalized the systemic analytical framework. Organizing the codes in *node trees* provided an overview of structures and relations between codes. Listening through the interviews, we found that participants talked from many perspectives and with many voices. This inspired us to subcode Actors as *Internal*—eating disorder, self, body, and weight—and *External*—relatives, strangers, group members, clinical staff, and external health care professionals—and *Context* as *Time*—childhood, problem development period, before, during, and after treatment Phases 1 and 2—and *Place*—treatment facility, home, public spaces, other health care settings. Exploring the *eating disorder, self, body*, and *weight* in *matrixes*, we found important differences across time, actors, and contexts in what were considered problems and solutions. These revealed relational and social processes underlying the development of eating and weight problems and changes in the participants' sense of self. We also became aware of circular mechanisms between the different internal and external actors that worsened the eating and weight problems over time. The analytical process was aided by journaling and node memos to keep track of emerging ideas.

Findings

The applied systemic perspective pointed to two central features that characterized changes in eating and weight problems over time and across contexts. First, the accounts outlined a *relational weight problem* that emerged in communicative interactions between people occupied with the participants' weight from an early age. Second, self-sustaining behavior patterns developed around a shared belief that weight loss was the solution and the person was the problem. We will demonstrate how demands for weight stability in treatment created an overall sense of calm as problems and solutions changed place: Weight loss was no longer considered a solution and the participants were no longer considered the problem. As participants and their close relatives began to act, think, and speak differently about weight, the relational weight problem was gradually dissolved. The outside world continued to pose demands for weight loss and pass weight-based judgments, but the participants found themselves relating differently. Overall, meeting themselves with acceptance and being met with acceptance by others emerged as a pathway for change.

On the Creation of a Weight Problem

> Astrid: I've been fat all my life . . . It's always been like, "Astrid, she's chubby or fat." It's kind of a family weakness. It's something in the genes. And at 7, I needed specially tailored clothes, and I was put on a diet at the doctors. So, I went there with my mum and was weighed, and I learnt that it had to be skimmed milk and half a piece of rye bread for breakfast and da da da.
>
> Interviewer: When you were 7 years old? That's a long career . . .
>
> Astrid: Yes. I think I've tried everything; cabbage diets, egg diets, da da da da, always at it. I've always considered myself to be way way too fat.
>
> Interviewer: Your weight was a problem that needed to be solved?
>
> Astrid: Yes.
>
> Interviewer: Or your body was something that needed to be solved?
>
> Astrid: Yes, well, it's always been like, when I couldn't keep a diet and put on weight, then it was like it was me, that I wasn't okay [starts to cry]. It's always been like, when I couldn't do the simplest thing in the world, eat food and keep a stable weight, then it had to be because I was stupid or something. So, it's always been about hiding it, you know, always thinking, "am I good enough?" depending on my weight. And when it's high, it's filled with self-hatred.

Astrid explained that the problem for her was not so much her body and weight, it was how unsuccessful weight loss attempts had made her feel about herself. *She* became the problem and weight loss the solution, presumably the solution to feeling wrong and unacceptable. She felt that her inability to lose weight had to be kept "hidden," which meant keeping her body hidden.

Like Astrid, most participants' stories began in childhood. For some, the weight problem was almost congenital as they were exposed to intergenerational bodily self-hatred and stories about how their genes predisposed them to weight gain. It is unclear if participants were objectively overweight as children as no one spoke of their weight, weight-related health problems, or their experiences of their own body or weight. Marius remembered how the heaviness of his body had limited him in sports and how this compromised his identity as competitive. Otherwise, the body and weight as problems were almost entirely understood and recounted from the perspectives of others. Health care professionals, parents, and others talked about or reacted to the participants' bodies and weight as wrong and in need of dietary restrictions and forced exercise.

The following is from an interview with Sara who had just completed the Weight Loss group. She remembered how her mother's face had functioned as her scale:

> My mother was my scale when I came home, even when I moved out, I always knew when she looked at me that she would think, "iiih, you've lost weight" or "uuh, you've gained weight." So, I didn't need to weigh myself.

This and similar accounts pointed to an outside gaze on the body and a weight-dependent acceptance, which were both internalized. Eva reflected on childhood memories of weight-related bullying where experiences of being fat merged with a deep-seated sense of being wrong.

> There's always been something completely wrong [with me], and I've never known what it was. So, the only thing that I could think of was that it was because I was overweight.

The accounts clearly depicted weight as an arena for interpersonal positioning. Stepping on a scale, looking at their bodies, imagining others looking at their bodies all became ways for the participants to know themselves and relate to other people. Within this context, binge-eating served multiple purposes: It comforted and protected against unpleasant feelings, comments, and self-critical thoughts, and it became acts of resistance to own or other's demands for weight loss and restrictive eating. This is evident in the following interview excerpts:

> It could be some stupid little thing, a comment, something, and then I could just feel how I would get hungry. You know, completely. (Astrid)

> Maybe it's like, when I've spoken badly to myself then maybe I'd comfort myself because I'd been so cruel to myself. Actually, that might be the reason: That it [the eating disorder] isn't as justified when I speak nicely to myself. (Liz)

> . . .(T)hen, the eating disorder is a good friend, one that accepts you when you're sad and, "I'll comfort you." Someone who accepts that, "that dietician she is such an asshole and well stupid," and then "just you go ahead and eat something because poor you that she talks to you that way." (Ida)

> Even now, at 42, if food is forbidden, I instantly feel an urge to eat it. (Sara)

For a subgroup, binge-eating began as a response to other life stressors (divorce, loss, attention deficit hyperactivity disorder [ADHD], asthma, arthritis, or accidents) which tended to reappear after treatment. Signe explains,

> But the further away the eating disorder gets, the less I can use it as a way of coping, and then these things slowly reappear, which might have been what I'd used the eating disorder for in the first place.

Others felt a complete loss of control and estrangement from their body because of rapid weight gains due to medication, injuries, or cessation of smoking. Irrespective of the "initial problem," a system of interrelated problems and solutions developed around the endless attempts to lose weight. For some, this lasted up to 50 years. Once the "weight problem" was talked, acted, and experienced into being, the problem moved beyond physicality and became relational and about identity, knowing you are fat and knowing that others know you as fat. This distinction between "a physical weight" and "a relational weight" was neatly summed up by Ida: "Well, I've always known I was fat, even before I was fat." An emergent conviction was that "I am the problem and weight loss is the solution," which was greatly reinforced by others (health care professionals and close relatives). We now look at how treatment initiated changes by claiming that neither weight nor the person was the problem.

Weight Stability—Chaos and Calm

The combined treatment demands for weight stability and eating regular meals, as well as weight monitoring, led to several interrelated changes that were consistent with the treatment rationale. Participants saw that their weight could be stable even when eating without restrictions, and that weight loss attempts sustained their eating problems. In recognizing their stories in other group members and consistently talking about the eating disorder as something separate to them, they also came to see that they were not the problem the BED was. Overall, participants tried on a set of *alternative behavior patterns* (Weakland, Fisch, Watzlawick, & Bodin, 1974) where previous problems became solutions.

The following field notes are from one of the weekly weighing sessions preceding therapy where participants were required to step on a scale and see their weight. The researcher started in the waiting area and walked in with the first participant who was called in by one of the therapists.

> In the waiting area, group members laugh and talk about life in general, body issues, what they consider the latest silly diets, society, health care politics, news on the BED diagnosis, and where to buy clothes. They leave for the adjacent weighing room one at a time, one therapist in the corner, the other noting down today's weight in a folder. Some participants leap in with a loud "good morning," others fall quiet. Based on the exchange of words, it is hard to guess the current weight status. Fluctuations of plus minus 100 g (3.5 oz.) to 2 kg (4.4 lbs.) are presented by the therapists as "this is what we call a stable weight," and participants are encouraged to "come and have a look. If we look at your chart over time you can see that your weight is stable." If weight continuously goes up or it changes dramatically, the therapists ask about episodes of

> binge-eating, birthdays, indulgence, or they suggest extra dietetic counseling. Mostly, there are logical explanations to weight changes. One participant reacts to her weight with an "ahgr" to which one of the therapists replies rather abruptly, "what was that?" Reactions to weight are met with "so, what are your thoughts? Does the eating disorder have an opinion about this?" Another participant steps on the scale and looks at the ceiling, steps down and rushes off. The therapist quietly calls her back, and the participant explains how the eating disorder had reacted with thoughts about restrictive eating after her last weighing. The participant is allowed not to see her weight this time as a way of experimenting with the eating disorder, to observe how it reacts. The overall aim, however, is for her to look at her weight.

The silence in the weighing sessions suggested that participants were to endure any distress related to weight change or being weighed, and eventually come to experience the intended effect. In an interview, Astrid recounted an episode where she had gained 1.4 kg (3.1 lbs.) in 1 week. She was very upset, but had felt it was impossible to bring it up in the group as she knew it was "foolish" to react so strongly. Like others, she explained that her fear was that her weight would sky-rocket.

> I was certain I could gain 10 kg [22 lbs.] in a week or two weeks . . . but I was also on it [the scale] eight times a day; before and after I went to the toilet, washed my hands, brushed my teeth, almost even after changing my clothes . . . And after having weighed far more than 100 kg [220 lbs.], then gaining 2 kg [4.4 lbs.] for example would make me panic completely. Two kilos meant that I now weigh 78 [172 lbs.] and tomorrow 80 [176.5 lbs.].

The following week, Astrid had lost 1.5 kg (3.3 lbs.) and concluded that having to be confronted with her weight was "both the worst and the best." Generally, weight emerged as a sensitive topic best hidden from one's own and other's gaze. Group members went to great lengths not to see each other's weight. If someone by accident entered the weighing room before the therapists were ready, they quickly covered their eyes in case the scale showed the last participant's weight.

Like many others, Astrid explained in the interview how she was initially surprised and frustrated at the prospect of weight stability, but ended up feeling calm.

> So, during the first 3 weeks, it turned out to be the most wonderful thing that I had to be weight stable. That's what's given me the whole calmness, I think. My husband even says that the whole family has felt it as a kind of calmness that I had to be weight stable because there had always been that quest for "next week, I'm being weighed."

Relatives' perceptions of what constituted the problem also shifted as they were involved in treatment. Gradually, they stopped pressing for weight loss which Ingrid experienced as a big relief.

> And after they've kind of understood what BED was about and what it had done to me and others, then there wasn't this expectation from them that now comes that weight loss that I've accomplished so many times in my life; big weight losses that eventually resulted in everything coming back on. So, that actually freed me of a burden that it wasn't about weight loss.

In treatment, the physical weight did not change, but the conversations about weight did, thus gradually dissolving the relational weight problem. At a multifamily meeting for BED patients and support network, however, a husband said that, while he had come to understand that weight loss was not the answer, he still struggled every time he had to explain it to others. The understanding of the problem as one of weight persisted in the outside world.

Weight Acceptance and Weight Loss —Two Choices, One Destination

On completing Phase 1, participants could choose to continue in a Weight Loss group or a Wellbeing/Weight Acceptance group. Despite the different goals and modules of change in the groups, the participants' reflections and transformations occurred around the same question: "Do I actually want to lose weight and why?" For some, for the first time in their lives, simply having a choice had a dramatic effect. The following will demonstrate that irrespective of the intervention that participants chose a paradoxical turn led them all in the direction of acceptance. Every single participant wanted to lose weight for health reasons, but they came to realize that weight was not their biggest problem and they would never be able to lose weight before they began to accept themselves.

Choosing weight acceptance. Like many others who chose the Weight Acceptance group, Astrid remembered initially wanting to choose the Weight Loss group. At an assembly arranged to help patients decide on which group to choose, she heard a former patient reflect on weight and self-acceptance, and she changed her mind.

> Listening to her made me think: "I've been on loads of diets, but did I ever feel happy when I was thin? No, I didn't. So, it must be something else." Then I thought, "yes, that's exactly it. It's something else." It's about thinking what other people think of me because I weigh 80 kg [176.4 lbs.] and worrying that they might like me more if I weighed 60 kg [132.3 lbs.]. That's the real problem. (Interview)

The problem was "something else" and the solution to that problem was not weight loss; it was greater self-acceptance and acceptance from others regardless of weight.

In this group, participants had goals of letting their lives be guided by enjoyment. This was in complete contrast to what they described as "the eating disorder's punishment and reward system." In a treatment session, Tanja said that she used to binge after exercising to reward and comfort herself for what had felt like a punishment. When enjoying exercise, it felt rewarding in itself. Astrid said she would exercise only to punish herself for binging. For everyone, moving their bodies for purposes other than weight loss was new and provoking. After many years of living "from the neck up," body therapy elements made the participants sense a need to reconcile and reconnect with their bodies. Acceptance entailed the courage to be gentle and caring toward the body rather than constantly working against it and trying to "get it into a certain size." Participants shared experiences of how self-hatred had manifested itself as lumps and tensions in the body. Many had viewed their body entirely from an outside gaze. Eva explained how this had shaped the way she would sit in a chair.

> . . . The whole thing about letting go and suddenly not having to think about how I stand and walk and lie and sit. It made me cry . . . I realized just how hard it is to sit and squeeze your legs together when they naturally want to fall to each side. It's extremely hard on your thighs and hips. I can't even do it anymore because I'm aware of just how hard it is . . . And I don't want to. It's not like, if my knees are 5 cm [2 in.] closer to each other that people will suddenly think I weigh 30 kg [66 lbs.] less.

The concept of a relational weight comprising a weight-critical gaze and a weight-defined identity seemed to have also been embodied. It had shaped the way Eva moved, sat, and held herself. Like many others, body therapy elements helped Eva to attend to her body through her senses and shift attention inward away from the critical gaze. Once she became aware of how constricted she had been, it became more important to her to feel comfortable than to meet outside expectations.

In mindful eating sessions, participants were encouraged to use their senses to experience food, but, mostly, participants ended up in their heads instead of their bodies. Many encountered "the voice of the eating disorder" in the form of an all-or-nothing attitude: having to eat every bite and every meal mindfully, or rules about not being permitted to enjoy food, doing it wrong, or food seeming dangerous and disgusting. Here, it helped to not think too much and shift attention outward. Sharing food experiences with others became a source of enjoyment, appreciation, and reconnection. Susan shared an episode with the group where she had eaten a roll with butter with her daughter. In so doing, she had felt connected with her daughter and the shame of eating an otherwise completely forbidden food had disappeared.

> You know, I enjoyed eating the exact same as my daughter . . . the comfort of it because it was something we were doing together. I haven't allowed myself to do it in many years. It wasn't shameful.

Others used the increased awareness of eating to reassure themselves that they had in fact eaten and they had met their needs. This came across as related to earlier experiences of food deprivation.

Choosing weight loss. On entering the Weight Loss group, participants reencountered weight loss as a solution. Ingrid was initially relieved, and she expected "a magic cure" that could finally save her:

> I think my expectations were that, "now, it'll save me" kind of thing. "Now, comes Phase 2 with the solution that I didn't get in Phase 1."

However, alongside the reintroduction of weight loss as a solution, participants were overwhelmed with feelings of self-blame and of being wrong. In a telephone interview, Sara reflected on why she had not managed to lose weight in her Weight Loss treatment.

> Sara: [T]hose self-blaming thoughts that I had had before they just came back. They hadn't gone.
>
> Researcher: And they came back once you began to think that, "now, I have to lose weight?"
>
> Sara: Yes. Because, then, when I didn't lose weight or did what I was supposed to then I began to blame myself quite a lot again. And then I realized that maybe that wasn't what I had to do right now, because it triggered the eating disorder so much.
>
> Researcher: . . . is self-blame something that you have known to be linked to the eating disorder?
>
> Sara: Yes, very much. Every time I opened the fridge, I've almost had a voice speaking to me very reproachfully, which to some extent has been my mother, because she was always on my back when I was younger, because I was a bit chubby. And every time I opened the fridge then [Sara makes a shaming sound with her tongue] then she would be there. Well, she's not alive anymore, so she was just there when I opened the fridge, and lately it's really only been my own voice, but it was somehow sparked by her years ago.

Throughout the Weight Loss treatment, participants and therapists struggled to understand why participants so clearly wanted to lose weight yet consistently failed to make the necessary changes. The primary therapist encouraged participants to "practice whatever could trigger the eating disorder in the safe environment of the

treatment." This suggested that strength and courage were the necessary driving forces, but like in the Wellbeing/Weight Acceptance group, it eventually became clear that change was only possible through enjoyment and self-compassion. Week after week, Liz worked with the therapists to strengthen her motivation to go on long bike rides. The driving argument was that, for change to happen, she had to do something differently. She had all the right bike gear and a nice bike, but she told the therapists that as soon as she went on her bike, critical thoughts would overwhelm her. In the interview, the researcher reminded her of the bike rides and her struggles to stay motivated. She laughed and said, "there was nothing good about those bike rides," and elaborated,

> I could sometimes feel that because I couldn't keep up the same pace then "I'm just in such poor shape" you know, compared to others or something, feel wrong, you know, too fat or, it would start off a negative spiral of thoughts about, like, everything.

The issue was never resolved in treatment, but at home, where no one could see her, Liz began to do small exercises. She gradually began to meet herself with "gentleness," and at the time of the interview, she biked to "enjoy the feeling of the wind" and to "just get out a bit and use my body." Despite not having lost weight during treatment, she found that she was in a "more valuable place." She related differently to herself and others, she compared herself less, and took it in when other people complimented her. Once, a bus stopped next to her and someone stared at her through the window, and she concluded it was because of her funny helmet:

> How liberating that it wasn't about me maybe being too fat; that there might be other reasons for people to look at me. (Interview)

Overall, self-compassion and acceptance stood out as solutions which implicitly pointed to non-acceptance as an important problem. When asked in the interview what the Weight Loss group had done for her, Ingrid replied that weight had become a purely physical thing.

> In Phase 1, I had to separate myself from the eating disorder . . . Now, I've separated my eating disorder from my weight. Now, weight is purely physical. Everything else was a mix of other people's expectations about weight loss and my own self-critical thoughts, and all those ups and downs that followed when the weight went up and down.

Ingrid was the only participant to lose weight during the time of the observations, but she had tried to ignore her weight loss in fear that "the eating disorder would like it too much." Reflecting the duality of the eating disorder, another participant Ida had realized that her eating disorder had prevented her from losing weight. She wanted to be accepted for who she was.

On returning to the outside world, participants were consistently confronted with weight loss demands. This threatened their progress, but they found themselves relating and reacting differently. They no longer agreed that weight loss was the solution and they were the problem.

Discussion

The present study used systems theory to explore BED and body and weight issues in three different treatment settings with weight stability, weight acceptance, and weight loss. The purpose was to inspire relational and contextual understandings of BED and to offer alternative ways of increasing physical and mental health in BED. Echoing established risk factors for obesity and eating disorders, the presented personal accounts revealed that participants' eating and weight problems did not develop in a social vacuum.

The analytical trails revealed two systemic problems centered on weight: (a) a life time of weight loss attempts created behavior patterns that sustained and exacerbated the participants' eating and weight problem. By installing weight stability, the continuous recreation of the emerging problems ended leaving participants and their relational network with a deep sense of calm. As suggested by Weakland et al. (1974), the solution to long-lasting problems is available at all times but difficult to implement because of strong cultural norms and beliefs. In this instance, the idea of weight loss as a solution to excess weight is so powerfully supported in all contexts that no one considered prescribing weight stability to people with obesity. (b) We proposed the concept of a relational weight problem, which emerged from the communicative interactions between those people who were concerned about the participants' weight. These included parents, peers, partners, health care professionals, and even strangers. The relational weight problem embedded feelings of non-acceptance due to weight, a merge of the individual's weight and identity, and an internalization of a body- and weight-critical gaze. In this context, binge-eating not only comforted and protected the participants but also caused more self-hatred, thus illustrating relational influences and circular processes underlying both the eating and weight problems.

We found that self-critical thoughts affected the participants' willingness to let their bodies be visible, to take up space, and be active in public. This is supported by established effects of weight stigma and internalized weight stigma on exercise habits (Vartanian & Novak, 2011), eating, and weight loss (Carels et al., 2009; Mensinger, Calogero, & Tylka, 2016).

When trying to lose weight, participants were confronted with self-hatred and feelings of being wrong, which made change impossible. Across the treatment contexts, change only occurred when the participants' weight ceased to be the main problem. This meant that the participants themselves were no longer the problem, thus allowing for self-acceptance and self-compassion. Consistent with prior research showing experiences of reconnection through yoga (McIver, McGartland, & O'Halloran, 2009), acceptance helped participants reconnect with their bodies and with other people, which again enabled them to eat and move more freely.

A misconception that drives much critique of size acceptance initiatives (Bombak, 2014) is that acceptance discourages people from losing weight (Mann et al., 2015). On the contrary, the present study adds to a growing body of literature that supports a weight neutral and body accepting approach to health (Bacon, 2008; Bacon & Aphramor, 2011; Dollar, Berman, & Adachi-Mejia, 2017; Mensinger, Calogero, Stranges, & Tylka, 2016) and extends it by pointing to possible underlying processes.

Strengths and Limitations

To our knowledge, this study is the first to take a systemic perspective on BED. Strengths include generating contextual and interactional understandings of BED and weight that involve other people and the surrounding society as active agents. Interactional understandings may help to lift shame and blame from the affected people and point to additional pathways for change. More generally, systems theory enables intersectional inquiries of what arises when two categories of problems coexist, for instance, psychiatric, medical, and social problems as is often the case in clinical reality. The study must be considered in light of limitations. Despite the study's emphasis on exploring contexts, the researcher only participated in treatment settings. Similarly, the study touches on issues of embodiment that could also have benefited from participation in lived life situations.

Implications

The study raises concerns about the consequences of weight focus as a way to prevent and solve weight problems. We argue that weight cannot be understood fully from a medical perspective but needs to be seen in relational and social terms and as a matter of identity. In the light of poor long-term weight loss outcomes, a contested link between BMI and health, and risks associated with food restriction for BED, alternatives to the current weight loss treatments must be explored. Addressing weight-related prejudice and feelings of being wrong encourage healthy eating and physical activity. It is imperative that health care providers who work with eating disorders and weight management are educated about the risks associated with individualizing weight.

Conclusion

The proposed concept of a relational weight problem offers a useful concept for approaching body and weight issues in BED beyond the individual's physical weight. The concept crosses borders between the individual and the outside world and between the eating disorder, body, and weight. Attention to social and relational aspects of weight could inspire to build practices that emphasize the involvement of close relatives and awareness of social underpinnings of eating and weight problems. Contrary to critical claims that weight acceptance discourages people with obesity from engaging in weight loss efforts, we suggest that acceptance and a disentanglement of weight and identity are prerequisites for increased health for this group.

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