Experiences from a 10-week weight-neutral treatment program for patients with clinical binge eating disorder and higher weight

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Research Article

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Abstract

Background

Weight based stigma might drive the development of both higher weight and binge eating disorder (BED). To improve treatment and outcomes, a deeper understanding of how stigma and shame are related in health-care practices is needed. The current study was designed to gain insight into how participating in a 10-week weight neutral treatment program for patients with binge eating disorder and higher weight was experienced.

Methods

Semi structured interviews were conducted with 10 patients who had completed the BED-treatment. The intervention was group based, emphasizing stigma and shame, using models of attachment and affect regulation in the presentation of BED. Interviews were analyzed guided by van Manen's hermeneut-phenomenological approach.

Results

A profound feeling of inferiority due to higher weight appeared to have kept the participants stuck in a behavioral cycle of dieting, weight loss, bingeing and weight regain. In addition, participants, and health care professional's mutual acknowledgement of driving elements of binge eating in treatment, and less focus on behavioral change related to weight and eating, appeared to stimulate a feeling of equality. Feeling equal was described by participants as facilitating increased awareness and tolerance of bodily sensations and emotions, and a deeper understanding and self-caring attitude towards themselves. Feeling less shame was described as important for self-disclosure in family relationships, leading to increased understanding and support from others. Simultaneously, our findings indicate that uncertainty related to coping with food, eating and weight in unchanged, stigmatizing surroundings was profound after end of treatment.

Conclusions

The results indicate that relational dynamics of inferiority and equality may maintain and reverse BED-symptoms respectively. Health-care professionals engaging in a more equal distribution of power trough recognition, compassionate acceptance, and mutual investigation of subjective experience might contribute to reducing stigma and shame and the burdensome notion of inferiority among people with higher weight suffering from binge eating disorder.

Trial registration
The study was approved and registered by the Data Access Committee at Nord-Trøndelag Hospital Trust August 8th, 2019, registration number 2019_2335.

**Plain English summary**

Ten patients were interviewed about their experiences with participation in a 10-week weight neutral treatment program for people with binge eating disorder (BED) and higher weight. The treatment given was group based, emphasizing stigma and shame, using models of attachment and affect regulation in the presentation of BED. Participants described a notion of inferiority towards other people due to their weight, maintaining their attempts of dieting and weight loss with subsequent bingeing and weight regain. Participants and health care professional's mutual acknowledgement of driving elements of binge eating in treatment, and less focus on behavioral change related to weight and eating, appeared to stimulate a feeling of equality. Feeling less shame was described as important for self-disclosure, leading to increased understanding and support in relationships. Simultaneously, our findings indicate that uncertainty related to coping with food, eating and weight in unchanged, stigmatizing surroundings was profound after end of treatment. Health-care professionals engaging in a more equal distribution of power trough recognition, compassionate acceptance, and investigation of subjective experience, might contribute to reducing stigma and shame and the burdensome notion of inferiority among people of higher weight suffering from binge eating disorder.

**Background[1]**

The burden of weight bias, and how it contributes to increased morbidity and mortality among people living with higher weight is well documented (1–3). Weight-based stigma grows from an assumption that causes of obesity[2] are under the individual's control, and that obesity is a result of personal failure (4). Based on this belief, people living with higher weight are often perceived as lazy, stupid and that they lack knowledge, self-discipline, motivation, and personal control (5). The medical approach to weight loss (eat less, exercise more) in healthcare has been questioned in the social sciences due to implications on stigma maintenance (6). In addition, long term effects of these weight-loss treatment have poor scientific support (7–9).

A subgroup of individuals living with higher weight suffer from binge eating disorder (BED). Among people seeking weight-loss treatment, rates of BED span between 2 and 49% (10, 11). BED-diagnoses were introduced in the 1950s, but have not until recently been recognized as an eating-disorder category of its own (12). Weight bias might have contributed to BED often being invisible and overlooked (13, 14). Considering the etiology, stigma is a possible contributor to the development of BED as stigmatized people tend to adopt or internalize weight-bias as a way of thinking about themselves, leading to low self-esteem, evoking negative feelings, trigging binge eating behavior (15, 16).

Knowledge regarding stigma and how it might drive the development of both higher weight and BED should be integrated into clinical contexts (4, 17). To improve treatment and outcomes, a deeper
understanding of how stigma and shame are related in health-care practices is needed (18). Because shame is a painful and threatening experience, a wanting to hide and to avoid shame-provoking situations, are common defensive reactions (19). As weight-stigma often appear in healthcare settings (20), shame is held to be a barrier to seeking treatment, to inhibit self-disclosure relevant for treatment and to heighten risk for drop-out (21, 22). Taken together, there is an overall need for a better understanding and care for people with eating disorders who also have higher weight (23).

The screening and treatment of BED in Norway is unsystematic and scarce, both in mental health care settings and specialized obesity-clinics. Therefore, a pilot study called People Need People (PNP) was designed (24). PNP is a weight-neutral, group based psychoeducational treatment program emphasizing stigma and shame, using models of attachment and affect regulation in the presentation of BED (ibid). The aim of the ten-week program is to expand the patients’ understanding of the driving elements of binge eating disorder, hence methods to reduce symptoms (such as weighing, exercise and diet recommendation, self-monitoring, and behavior reporting) is not included. Results regarding feasibility, symptom severity and change in binge-eating frequency and health related quality have earlier been reported (ibid). The current study was designed to gain insight into how participating was experienced by patients. The research question was: What are the experiences of participating in a weight-neutral eating disorder treatment that specifically addresses the underlying factors contributing to binge eating disorder?

Theoretical framework

The research was anchored in a phenomenological framework. In this perspective, individuals and their surroundings are intertwined, irreducible and dependent. Hence freedom is not regarded as absolute, but characterized by the specific situation or context the individual is in (25). This implies that changes to either the environment or the individual somehow will affect the other.

The feminist phenomenologists Käll and Zeiler characterize this as the Bodily, Relational Autonomy, and state that individual capability for freedom or choice, is deeply rooted in the connectedness to others (Kall & Zeiler, 2014). Freedom or choice is realized as part of an ongoing, existential process of maintaining a meaningful relationship to the surroundings. Situated autonomy is also embodied, which means that agency can be performed through habits that are non-verbal and pre-reflexive. Taken together, freedom can never be reduced to just a detached, cognitive capacity, and resistance to change can be tacit and found in the context as well as in the individual. For example, changing food habits or other behavioral aspects of an eating disorder is more likely to occur if the context captures, facilitates, or allows the change to unfold. Anchored in this perspective, experiences related to the interaction between the participants and their surroundings, both in their everyday life and in the treatment-setting, are given specific attention in the study.

[1] Weight neutral in this context implied excluding weighing patients, using weight as outcome or process measure, and not including weight-loss strategies as topic of focus in treatment.
We are aware that language is important when dealing with complexity and conditions that are stigmatized. We use the term *obesity* because the paper is written for a medical audience, and patients are admitted to treatment due to being diagnosed with severe obesity. Talking with and about patients with higher weight we avoid the term obesity as research report people finding the term stigmatizing.

**Methods**

**Study context, recruitment, and participants**

Patients were referred from a specialized obesity out-patient unit in a tertiary care hospital to a mental health out-patient clinic for eating disorder treatment using the PNP-model[3]. Patients underwent clinical assessments according to standard clinical psychiatric care, considering both eating disorder pathology and body image disorder. A detailed description of participants, screening, and treatment is earlier published (24). For the study presented in this paper, ten of 50 participants were recruited during a period from July to December 2020., in line with principals of purposive sampling in qualitative research (26). Besides having participated in and finished the PNP-intervention, the sample was recruited with variation of demographic characteristics such as age, level of education, marital- and employment status (Table 1). Inclusion proceeded until sufficient information power was obtained (27). Common characteristics were high eating disorder pathology, BED-diagnosis, previous psychiatric treatment in psychiatric care for other mental illnesses and higher weight bodies. Eight of the recruited participants had early onset experiences of preoccupation with body and food. All participants reported one or more adverse childhood experiences in line with the definition described by Felitti and co-workers (28). All ten had participated in and completed the treatment program at the time of the interviews. TTEN was responsible for conducting the treatment sessions the patients took part in, and KHB was a co-therapist in the first of the five treatment groups conducted.
Table 1
Demographic and characteristics of the participants.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Male</td>
<td>2</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>20–30</td>
<td>2</td>
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<tr>
<td>30–40</td>
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<tr>
<td>40–50</td>
<td>3</td>
</tr>
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<tr>
<td>Living with partner and/or children</td>
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<tr>
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<tr>
<td>High school</td>
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<tr>
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<tr>
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</tr>
<tr>
<td>Public welfare</td>
<td>3</td>
</tr>
<tr>
<td>Fulfilling DSM-V criteria for binge eating disorder</td>
<td>10</td>
</tr>
<tr>
<td>Earlier treatment for other diagnosis in specialized psychiatric outpatient care</td>
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<td>Self-reported onset of preoccupation with body and/or food</td>
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<td>Teens</td>
<td>2</td>
</tr>
<tr>
<td>Adulthood</td>
<td></td>
</tr>
<tr>
<td>Having experienced Adverse Childhood Experiences (28)</td>
<td>8</td>
</tr>
<tr>
<td><strong>Eating disorder pathology</strong></td>
<td>Mean (SD)</td>
</tr>
</tbody>
</table>
Data generating

The study has a qualitative design. To capture the participants’ lived experiences, first and second author conducted semi structured interviews. The interviews took place, face to face, at the mental health clinic, each interview was audio-recorded and lasted for 60–90 minutes. TTEN performed the interviews, KHB sat by, observing, taking notes and asked questions for clarification. An interview-guide consisting of three main topics was used as a rough thematic framing of the interviews. The participants were first asked to give descriptions of their everyday-life, function, eating-disorder symptoms and experiences from clinical settings prior to the intervention at hand (PNP). Secondly, participants were asked to share their experiences with the treatment’s content and form. Lastly, they were asked about their needs after finishing the treatment. Consistent with phenomenological informed interviewing, we encouraged the participants to elaborate on details regarding concrete experiences instead of sharing attitudes, opinions or interpretations related to situations (29). We also aimed at being flexible and open to the way each participant narrated their experiences and the evolving of each interview (Ibid).

Data analysis

The interviews were transcribed verbatim by the first author and analyzed guided by van Manen’s hermeneutic-phenomenological approach (29). All three authors performed a wholistic reading by reading all ten transcripts. Taken together, the impression was that having experienced something distinct from earlier treatment stood out as significant. The first author then went on with a reading guided by the lens of the five existentials (lived body, lived time, lived space, lived relation, lived objects). Organization of the material through the existentials was presented for the second and third author, and relevance towards the main theme “having experienced something distinct” was discussed. First author then wrote forth the analysis, now organized in three themes with the heading’s inferiority, equality, and time capsule, with the first theme overarching the two latter. In the final part of the analyses, first author integrated paragraphs from the interviews that exemplified and nuanced the three themes, re-wrote, and discussed with the co-authors.

The last readings were also partly driven by theory, or what van Manen describes as insight cultivators (29). Two analytical concepts: chronic shame (30) and intersubjective thirdness (31) was drawn upon when investigating the material. In contrast to the feeling shame, chronic shame denotes an attitude or way of being that can characterize persons having experienced oppression or social domination (30). The anticipation of shame can become a defining feature of the lived experience, causing a continuous sense of social anxiety, personal inadequacy, and relational disconnection (Ibid s 740). The concept guided the reading of experiences concerning self-perception and agency both within and outside clinical
encounters. The concept of *intersubjective thirdness* refers to patient-therapist relations characterized by mutual recognition of each other’s subjectivity, mutual contribution to the therapeutic relation, and the breaking up of a doer-done to distribution of power (31). The concept contrasts therapeutic relations where both therapist and patient might feel forced to either defend their own worldview or surrender to the other’s perspective (“eat or be eaten”). The concept of intersubjective thirdness was specifically fruitful when trying to grasp the participants’ relational experiences from the treatment.

**Researcher characteristics and reflexivity**

Both KHB and TTEN have lengthy clinical experience from specialized eating disorders treatment and psychiatric care in general. Staying open to the participant’s lived experiences without seeing through glasses of classifications such as diagnosis or symptoms, or in terms of change and recovery as symptom-reduction was central given the first and second authors’ clinical experience with eating disorders.

By involving an experienced, phenomenological oriented qualitative researcher (EN) in the analytic process, we sought to challenge and critically explore KHB and TTEN’s taken for granted knowledge. EN is an experienced researcher within the field of obesity and had no clinical or academic connection to the PNP-program prior to her contribution in the analytic work on the material.

**Findings**

The first theme, *Inferiority – under constant (de)valuation*, captured how experiences with their bodies, symptoms of eating disorder and treatment prior to attending the treatment intervention was described by the participants. This theme is recognized as vital for how the participants experienced the BED treatment that was given, and how they encountered life after end of treatment. In this sense, the first theme frames the two latter: *Equivalence – shared human ground* and *Time capsule – life on hold*.

**Inferiority – under constant (de)valuation**

The participants were unison in their description of the body being wrong in profound ways[4]. They experienced the body first and foremost as too large, having always felt that way, also in periods of slenderness. The body was perceived as an obstacle due to size, and the participants experienced pain, heaviness, exhaustion, and sleep-deprivation as hinders for activity and movement. The participants also described bodily awareness as an experience of chaos, where being large triggered feelings like destress, fear, anger, and despair. Taken together, the participants experienced the body’s shortcomings as existential, defining their very being, as described by Gail:

> It is a feeling of being a failure, that there is something wrong with me, that I am destroyed.

The complicated and negative relationship towards their own body was not merely described as a question of weight. The participants also stitched their early acknowledgement of their body’s betrayal to
traumatic experiences such as severe violence, sexual abuse, bullying, and fear of alcoholic parents or partners. Commonalities in these experiences were the notion of an imbalance of power maintained by violence, or the threat of violence, leaving the participants exposed and vigilant and with a feeling of defenselessness as described by Ruth:

I have been vigilant since I was a little girl, I remember a bed in the house I grew up in, you could pull it out to be longer, I get sick when I see beds like that .... It was a sexual assault.

Experiences with weight stigma in professional life, among friends and within the family, was common for all participants. A general experience was that mothers had induced diets for them from an early age, or that mothers through comments, gazes or tactile communication woke their awareness of body-shape and weight. Beth said:

I have listened a lot to my mother, she also has an eating-disorder. We grew up with comments like “Do you really need that extra potato?” or “Do you really need that extra portion? It was always in my thoughts when eating.

Participant's feeling of inadequacy compared to health-care professionals was described as a feeling of inferiority and vividly described by all participants. Clinical encounters were reduced to being screened and treated for different body parts not working because of their weight, according to the participants. The participants longed for health-care professionals to take interest in how living with a large body felt, and how the inability to lose weight or sustain weight loss affected their psychological wellbeing. They also described prior situations in health-care settings where they felt that their knowledge and experience was not considered, triggering a sense of humiliation and shame, a form of infantilization, as Eva formulated:

As a nurse in my late twenties, having three kids, I know some things about nutrition, I know what I should and should not eat, but there [in lifestyle-treatment] I found myself in a grocery store, with a group of obese people led by a skinny nutritionist, and we were told to look at the content declaration of different foods, a box of cottage cheese for example, it was so humiliating [...] I guess the intentions were good, but the method, it was so shameful, she was young, fit and skinny, it was so obvious that it was “her and us”.

Being preoccupied with the bodies of professionals they had met in medical contexts was furthermore verbalized. Slender bodies of the health care-workers made participants feel a marked distinction, placing themselves on the lowest shelves in the hierarchy of success and self-control. Social events with friends were also colored with the same self-consciousness and were often associated with extensive avoidance of social involvement. When socializing, the participants used rather ambivalent strategies to cope with the feeling of inferiority. On the one hand they described reluctancy to share their struggles around trauma, the body, and the eating-disorder, while on the other they described using humor, mocking their own body as a way of coping. Making fun of themselves created emotional distance, described by Beth:
I always made jokes about myself first, which may look like body-positivism to others, they don’t think that a fat person jokes about being fat, but in 99% of incidents you will, because it hurts less if you joke about it first, before they do, because you know they will.

The only situation where the participants described the body in a positive way was when talking about planning and practicing binge eating. Binge eating started early in life for many of the participants. Phrases like experiencing pleasure, being calm, reducing stress, my only joy, something to look forward to, and keeping all the pain on a distance, were described as effects of binge eating episodes. However, the effect and the positive feelings prior or following binge eating episodes lasted for a short period of time, soon followed by diametrical sensations like pain, nausea, sweating, heart-beating, along with feelings of anguish, disgust, shame, and being a failure. Binge eating was thus described as a deceitful way of relief. The painful aftermath often fueled the next binge eating episode, keeping the participants in a cycle of dieting, loss of control, bingeing, and a profound feeling of not coping with eating and weight loss.

Enhanced well-being and practical functioning in their everyday life was put forward as incentive for weight loss among the participants. However, diminishing extreme body-shame was described as the strongest motivation when entering therapy. A broad spectrum of diets and weight cycling over the years, both within and outside health-care settings, were described. The participants expressed regret for spending money on diets, and time lost dieting, but not achieving their weight-goal, however they kept on striving. Jane said:

I wanted to become thin, I just wanted to be thin, everyone that is thin are happy. I thought that if I became thin, everything would be just fine.

Feeling inferior to others due to the body being too large was central in the participants description of self-perception and everyday functioning throughout life. The body stood fourth as an object under constant surveillance and valuation, never found good enough, neither in the eye of the participant nor in the imagined eye of the other. Layer upon layer of embodied stigmatizing situations were unraveled, some colored with derogatory wording, others by violence. Words witnessing deep contempt for themselves were used by participants, and constant preoccupation with shame was expressed. Avoidance of, and in, social settings and binge eating behaviors were described as coping mechanisms for protection, stress reduction and to create positive emotions. The body was perceived as a constant reminder of inferiority among the participants, and dieting to become thin was expressed as a strategy to reduce feelings of relational asymmetry.

Equality – shared human ground

The participants revealed that they had low expectations prior to the BED treatment. Most described an initial skepticism towards group-therapy, which was rooted in fears of being inhibited by social anxiety. Uncertainty and fear related to sharing experiences in general, and that their experiences would not be
familiar or understandable by others were common among participants. The feeling of validation in therapy seemed somewhat like a surprise. Jane said:

Someone has understood what I say, it can’t be that wrong when numerus people are describing the same experiences, it can’t.

The underlying assumption of having false or wrong experiences (that trauma memory, shame and loss of control over eating was connected), was challenged when their experiences were mirrored by fellow participants. Shared experiences were most often ones they had never verbalized. Kai said:

I feel like, there was a room (the therapy room) where I could talk, just a little bit, about my stuff, I was allowed to open on a subject I don’t talk to many others about, we trusted each other in the group. What the others talked about made sense to me. It made me look forward to coming. I did not worry.

The feeling of being validated occurred both when interacting with fellow patients, and when listening to and discussing the content of the sessions with the group therapists. The participants expressed that the topics complemented rather than contrasted their own experiences. Instead of pointing on certain themes that were important in the intervention, participants emphasized the totality of the treatment program. Eva summed it up:

I feel like, if you take the ten group sessions, it’s like they are ten missing pieces in a puzzle.

The structural and pedagogical foundations of the PNP intervention were described as pleasing to the participants. The therapists’ usage of everyday language, power-points with little text, animated films to illustrate complex emotions, concrete examples to deepen theoretical points and the invitation to use the paper and crayons spread were all described as important and useful approaches. The participants connected the pedagogical methods to feelings of being focused, giving them the ability to grasp the content of the sessions. Beth phrased the experience like this:

I felt very comfortable, I had no problems following what was presented, my thoughts were not drifting at all, I felt very focused.

The relationship with the group therapists was described with nuances altering their self-perception. The overall experience was described as a feeling of being on the same level, Jane said:

There has been no top-down attitude, I haven’t felt like a patient.

The participants made a distinction between being a patient and feeling like a patient, emphasizing the group therapists’ self-disclosures and usage of own examples showing vulnerability, and own shame experiences. The participants described that the therapists use of self-disclosure offered a sense of being of the same kind, that there was no “us and them”. Ann expressed:

*They are not different, they are human beings, very human human beings.*
The feeling of being met with an open mind and having the treatment-focus adjusted in line with what patients shared, was also held as important to the participants. The group sessions were experienced as open conversations, opposed to a prefabricated lecture. Mutual turn-taking between health-care professionals and patients contributed to this experience. Gail said:

*She [the group therapist] is curious of how I feel and think instead of telling me what to do.*

Simultaneously, participants described therapists taking charge at crucial moments during sessions as essential for the therapists’ credibility, as a need of balance between being given the opportunity to think for themselves and being able to rest in the group-therapists responsibility of the therapeutic process was identified. For example, the participants liked that the therapists did not humor them and appreciated being challenged and asked to elaborate and clarify. They described consequently being stopped when talking themselves down, such as making jokes about themselves or expressing weight stigmatizing attitudes using words like lazy, stupid, or lacking discipline. Ruth stated:

She didn’t just echo me or the others, I can’t get away by saying that’s just the way it is, I can’t hide.

Perception of selfhood and agency was challenged and nuanced when interacting with fellow patients and health-care professionals in the treatment intervention. The experience of being equal stood forth as crucial to the participants. The importance of equality was especially valuable as it contrasted their past and repeated and profound feelings of inferiority. The participants described how structural and relational aspects of the treatment altered how they perceived distribution of power between themselves and others. Validation of the complexity of weight and life, and not being given a recipe to change, was central to their experiences.

**Time capsule – life on hold**

Participants loss of hope for a better life was strongly connected to the passing of time without experiencing a substantial or desired change in neither everyday functioning nor weight, even in the hands of specialized healthcare.

A common experience among the participants was difficulties gaining access to mental health treatment despite being referred by their general practitioner with substantial mental health distress. Their binge eating disorder went undetected even after earlier psychiatric assessments, despite their disclosures of long-standing patterns of using food to regulate their emotions. Instead, participants described being labeled with a broad spectrum of other mental health diagnosis; mood-disorders, different anxiety-diagnosis, and personality disorders. Some of the participants however expressed that receiving a psychiatric diagnosis other than BED validated the multifaceted nature of their challenges, acknowledging the complexity of their struggles with food and weight. Even so, most felt left with unease, as central aspects of their suffering were ignored when assessed. Several expressed a feeling of failure
when neither weight treatment in the obesity-clinic nor psychiatric health care helped them cope with their struggles with food, weight, nor body image. Ann described:

I was not examined [...] I don't know what they are doing, it seems like they just refer me away all the time [...] you lose hope, all hope, no one can help, they just send you in circles.

Taking part in a weight neutral treatment like PNP was described as entering a time capsule, yet a different one. Many described the treatment as validating and power-balancing. However, there also seemed to be a tension between the positive experiences with the treatment, and the limited endurance of the program as the participants experienced a strong need for continuation of the therapy, needing both psychotherapy and body oriented follow up treatment. The difficulty of being cut off from a therapeutic process they did not foresee the ending of was hard, and expressed like this by Sue:

I need help to put all the things I've learned into a system, learn how to continue to get out of it in the best possible way, I feel like everything is up in the air, but so far it just hangs there, I don't know how to take it down.

Nevertheless, the informants ascribed meaningful and positive changes, such as tolerating and containing feelings, being able to differentiate between hunger and craving for binge eating due to distress, and a deeper understanding of themselves which led to a kinder and more caring attitude after finishing the PNP intervention. More, feeling less ashamed was vital for participants, making openness and increased understanding and support in close relationships easier. However, worries of living in a society that stigmatizes larger-weight bodies and the equality felt in “PNP-time-capsule” was expressed as a discrepancy and Eva said:

We have used all our lives tearing ourselves down in a way, and ten therapy sessions is maybe not enough to repair that, now someone finally understood, and then we were let free again, it feels so short [crying] you want to stay longer. We go back to our lives where things are like they always were, people understand precisely as little as before, it is the same shame and stigma out there, it is not as protected and safe as in this [therapy] room.

The participants described gaining new experiences, not being judged, or stigmatized, while in therapy, however their surroundings remained the same. It appeared as if the participants felt the time stood still due to structural forces outside their control. The “time-capsule” described was maintained by stigma, dieting as attempts to lose weight, and the notion of inferiority on constant repeat.

[3] Patients that are admitted to the obesity-clinic have an BMI $\geq 40$, or $\geq 35$ with comorbid medical complications.

[4] The participants described a polarized perception of the body, either in negative terms as described here, or as silent or cut off from consciousness. This dual notion of the body can be interpreted as an expression of body-image distortions and will be investigated in depth in a separate paper.
Discussion

The discussion will elaborate on dynamics of inferiority and equality and investigate implications for future treatment of patients with binge eating disorder and higher weight. Experiences with treatment of binge eating disorder and how living with a higher weight body is depicted by our findings, indicating that relations to others are interwoven with participants eating disordered patterns. More specific, the profound feeling of inferiority due to higher weight appeared to have kept the participants stuck in a habitual carousel of dieting, weight loss, binging and weight regain. In addition, our findings show how participants and health care professionals mutual acknowledgement of driving elements of binge eating, and subsequent weight increase, seemed to stimulate a feeling of equality when participating in the program, facilitating valuable change in self-perception and agency. Simultaneously, our findings indicate that uncertainty related to coping with food, eating and weight in unchanged, stigmatizing surroundings was profound after end of treatment.

The notion of inferiority is a finding which connects eating behavior to perceived relational asymmetries and may give insights into how dieting and binge eating can be driven both by the striving to be good (thin) enough when compared to others, and by the need of coping with painful feelings of rejection and self-contempt from attempting to feel equal. Hence, consideration of context may be relevant in treatment settings. The cognitive capacity of making choices about physical activity and food, irrespective of contextual factors, is central in both standard psychological therapy for binge eating disorder (e.g. CBT) (32) and weight loss interventions (33, 34). Simultaneously, the influence of context dependent responses in weight-loss maintenance is stressed in previous research (35, 36). Thus, our findings call for alternative theories on autonomy and rationality in treatment of BED in patients with higher weight. The concept Bodily, relational autonomy, demonstrates how the meaningful coexistence between the individual, their surroundings, and other people, holds the capacity for both promoting and limiting choices through pre-reflexive, bodily interaction (37). For example, a constant notion of being wrong, maintained by extensive weight-stigmatizing experiences preceded dieting and binging according to the participants in this study. Hence, their attempts at eating healthy was difficult because so many relational situations, described as occurring both in everyday life and in health care settings, made them feel inferior. Their feelings of inferiority interacting with others drove binge eating behaviors which surpassed rationale choices assumed to enhance health and everyday function (e.g., exercising and eating healthy). To cope with expectations of feeling ashamed, participants described avoidance of social events, reluctance to self-disclose violability, and making fun of their own body's when socializing with friends and family, whereas binge eating episodes was described as a strategy to cope with concrete feelings of shame. Shame grown out of time-limited, discrete events can be labeled chronic, and concepts of chronic shame (30) can enlighten developmental aspects of inferiority found in our study. Thus, the depth and range of inferiority experienced by the participants, and how avoidance becomes a central attempt at coping can be better understood. Anticipations of shame were by the participants not described as an overwhelming feeling, but as an expectation often outside conscious awareness. In line with the terminology of Dolezal shame has become global and diffuse, causing a continuous sense of social anxiety, personal inadequacy and relational disconnection (30). Relational distress stemming from chronic shame, can
according to Dolezal be a symptom of systematic oppression and social dominance, and also caused by childhood maltreatment and various psychopathologies (30), as described by the participants in our study. Their description of weight bias experiences and various ACEs also corresponds with studies showing that people with higher weight and BED are prone to both systematic oppression trough stigma (38) and high incident of adverse childhood experiences (like abuse or neglect) (39, 40). Limited social functioning and challenges with eating patterns described by the participants may further be understood by their feelings of chronic shame as it holds the capacity of shaping everyday living, experience becomes structured around avoiding shameful exposure (30). Our findings may indicate that individuals with higher weight and BED practice extensive avoidance of social exposure and avoid self-disclosure when in social situations, to cope with profound and tacit anticipations of shame. Hence, medical advice given in therapy to increase healthy behaviors in patients with BED may be avoided due to chronic shame. The participants description of avoidance behaviors is also in line with empirical research on eating disorders (16, 41), in which diverse factors (e.g., avoidance of negative self-evaluations, triggers for eating, eating situations, size- and shape-related information, public bodily exposure, intimate relationships, therapeutic programs, friends or family who remind the individual of their difficulties) have been identified as coping strategies. More, notions of inferiority described by the participants in our study, making them ‘bypass’ or ‘compensate’ for shameful exposure, adds to earlier knowledge on avoidance in BED (Ibid). Feelings of inferiority driving avoidance, may offer nuanced insight into relational dynamics of weight-related stigma in treatment of patients with higher weight, and how BED-symptoms may be maintained through anticipations of shame.

Opportunity to tell their story, feeling understood and mirrored, both by the content of the PNP and the way therapists delivered the treatment was emphasized by the participants in this study. Participants described an increased awareness and tolerance of bodily sensations and emotions, and a deeper understanding and self-caring attitude towards themselves was expressed after finishing the treatment. Positive treatment outcomes also included feeling less shame in relations to others, important for their self-disclosure and increased understanding and support in relationships. That the treatment setting promoted feelings of equality, inducing valuable changes in participants, is a finding in line with earlier referred theories of Käll and Zeiler suggesting that altering the context can change how a person conceive herself and move about in life (37). Participants described their behavioral choices as relative to perceived degrees of relational balance to others (e.g., the therapist). Hence, situations dominated by feelings of inferiority seemed to stimulate avoidance behaviors, whilst feelings of equality in therapy seemed to reduce feelings of shame and facilitate better self-care and relational support in their everyday life.Attributing change to qualities of the therapeutic relationship corresponds with previous therapy-research (42), stressing the importance of alliance, collaboration, goal consensus, empathy, positive regard in addition to affirmation and collecting and delivering client feedback (Ibid p 309). A further elaboration on the importance of relational qualities found in our interviews, can be anchored in therapeutic theories of intersubjective thirdness implying that the therapeutic situation consists of two mutual subjects sharing a common project of investigation and understanding (31). The participants described experiencing reciprocity, both in relation to fellow patients with BED and with the group
therapists. Reciprocity was described as experiencing the therapists and other patient’s presence, interest, listening and willingness to learn, of sharing important moments and of being challenged. Thus, social interaction in terms of dialogue and validation of subjective experiences was deemed valuable by the participants. The therapeutic attitude of observation and interpretation, where the therapist becomes the doer and the patient the done to, contrasts with intersubjective thirdness:

One of the most common difficulties in all psychotherapeutic encounters is that the patient can feel “done to” by the therapist’s observation or interpretation; such interventions trigger self-blame and shame, which used to be called by the misnomer “resistance” (although they may indeed reflect intersubjective resistance to the analyst’s projection of her shame or guilt at hurting the patient). In other words, without compassionate acceptance, which the patient may have seldom experienced and never have internalized (as opposed to what ought to be), observation becomes judgement (31).

In our study, the participants experienced mutual investigation of meaningful aspects of their lives influential for managing their binge eating behavior while in therapy. The participants described group therapists as facilitating feelings of equality, consequently modifying their diet-binge cycle to cope with shame. Hence, preserving subjectivity instead of feeling like an object for health professionals observation and advice in therapeutic relations, as the participants in our study described, seemed to facilitate change as shame and self-blame was less likely to occur (31). This finding adds to the earlier suggestions on how to prevent reproduction of stigma in clinical settings for people with higher weight; educating health care professionals on the complexity of obesity and conducting weight inclusive approaches (4), or performing respectful treatment and secure access to quality health care (17). Therefore, awareness of the power distribution between patients and professionals should be introduced when planning and conducting treatment for people with higher weight and BED.

Fear of weight-stigma outside the treatment setting made the participants question whether feelings of equality experienced in the PNP-intervention, and their improved function, would sustain after treatment. A profound feeling of being stuck with both their high weight and BED-symptoms was illuminated by the theme Time capsule – life on hold. Maintenance of dieting, bingeing and subsequent weight gain in stigmatizing surroundings is understandable, as our findings indicate that attempts at weight-reduction often is induced to compensate for feelings of inferiority related to weight-stigma. Socio-political aspects of chronic shame and BED such as oppression, domination, exclusion, and marginalization, have earlier been addressed by (30) and (13) respectively, and may be of importance when evaluating treatment outcomes of patients with BED. In addition, our findings demonstrate the challenges of assessment and treatment of BED in patients with higher weight as this patient group is seen in both psychiatric and somatic hospital departments. The identification of eating disorders was according to our participants not coordinated, highlighting needs of a better organization of assessment and treatment of eating disorders among patients with higher weight. Multi-disciplinary teams including eating disorder clinicians may be beneficial, as discussed in the Australian guidelines for management of eating disorders for people with higher weight (23). Weight management in multi-disciplinary treatment is nevertheless challenging, as evidence based weight-loss recommendations for people with BED are lacking (43). More,
as restriction may trigger binge-eating behavior, and long-term weight loss is proved hard to obtain regardless of eating disorder pathology, Ralph and colleagues were not able to reach consensus on how to target weight in their guidelines (23). Questions related to the delivery and efficiency of non-surgical weight-loss treatment offered to patients with BED and higher weight may also be discussed in light of our findings on relational asymmetry. Practitioners may consider that giving medical advice on nutrition and exercise patterns in a doer-done to position (31) to patients with BED and higher weight, notions of inferiority might be amplified, maintaining restriction and bingeing.

To conclude, our findings show how relational dynamics of inferiority and equality may maintain and reverse BED-symptoms respectively. Health-care professionals treating BED in patients with higher weight should consider recognition, compassionate acceptance, and mutual investigation of subjective experience in treatment for a more equal distribution of power (31). Relational symmetry in treatment might contribute to reduction of weight stigma and shame, and the burdensome notion of inferiority among people of higher weight suffering from eating disorders.

**Strengths and limitations**

Considering the high prevalence of BED, especially among patients seeking medical weight management, and the lack of effective treatment alternatives, inclusion of patient experiences with BED in development and evaluation of treatments is needed. Hence, conducting in-depth interviews with participants to investigate subjective experiences from the PNP-intervention, can be regarded as a methodologic strength of this study. Further, participants in the study represented diversity in age, sex, ED-pathology, and status of employment, as well as having had their BED-diagnosis confirmed by validated diagnostic assessments. Furthermore, the participants included had a complex psychopathology reflecting “real-world data” outside the context of a controlled trial. Thus, the current sample can be considered a strength regarding transferability of the findings into clinical contexts of specialized BED-treatment. Moreover, two of the researcher’s familiarity with the patient population could be valued as a strength in this study as clinical experience generated a rich and nuanced material. Extensive clinical experiences with BED, including therapeutic focus on complex topics like stigma, shame, body image, childhood trauma, and self-contempt, enforced nuanced follow-up questioning of the participants’ description of their experiences, sharpening our sensitivity for when and how to ask for elaborations. However, the first and second author’s two-fold roles towards the participants might be considered a limitation, with a need for reflexivity (44, 45). Participants may have constrained their potential sharing of difficult or shame-evoking experiences from interactions with us in the treatment setting when being interviewed as participants in the study. First, because assertiveness is a core challenge for people suffering from eating disorders (46). Second, it might have been perceived crucial to the participants to maintain a good relationship with us as health-care professionals when treatment-alternatives for patients with BED are limited or non-existent in Norway. Fear of compromising their future treatment of eating disorders might have restricted the participants in sharing experiences that could be recognized as implicit critique by us, or the treatment given. In this respect, we might have missed nuances in the informants’ experiences that could have enriched our analysis, possibly verbalized with researchers they had had no prior relation to.
However, establishing a relationship with the participants during the PNP-intervention, identifying driving factors of their binge eating, might have lowered barriers that often inhibit people with higher weight to talk about shameful experiences, also reported by the participants. Finally, when analyzing the material, first and second authors familiarity with BED might have limited openness when interpreting the data. Letting theoretical insights partly guide the analysis, involving an external reader (third author), performing thick descriptions of methodological dispositions aiming to be transparent and reflexive, were efforts made to communicate validity in our study (47, 48).

**Abbreviations**

BED
binge eating disorder
PNP
people need people

**Declarations**

*Ethics approval and consent to participate*

The study was approved by the Regional Ethical Review Board of Mid-Norway and the Data Access Committee at Nord-Trøndelag Hospital Trust. The participants received oral and written information about the study, and all signed an informed consent form prior to their involvement. The participants were informed that they could withdraw their consent at any given moment without any consequences for their ongoing or future treatment. All names and other personal characteristics of the informants were changed to secure anonymity.

*Consent for publication*

Not applicable.

*Availability of data and materials*

To ensure full anonymity for the participants, the data generated and analyzed during the current study are not publicly available. Transcribed interviews are available from the corresponding author on reasonable request.

*Competing interests*

The PNP-treatment was conducted within the public health care system of Norway, KHB and TTEN therefore have no commercial interests in the treatment-model. The authors declare that they have no competing interests.

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Authors' contributions

KHB and TTEN conceived the study. KHB and TTEN conducted the interviews. KHB performed the transcriptions, led the analysis, and wrote manuscript drafts. TTEN and EN provided critical feedback and helped shape the analysis and manuscript to its final version. All authors read and approved the final manuscript.

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Trail registration

Not applicable.

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