Looking on the bright side in therapy

Clients' and therapist's understanding of the use of positive psychology principles to address emotional eating.

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This work is dedicated to John Wigham, an exceptional friend, who always looked on the bright side of life, come what may.

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Abstract

This study examined whether principles of positive psychology including strengths-based work might usefully be applied in counselling psychology practice and psychotherapy, and sought to understand the process of therapy incorporating such elements. Seligman and Csikszentmihalyi (2000) define positive psychology as 'the scientific study of positive human functioning and flourishing on multiple levels that include the biological, personal, relational, institutional, cultural, and global dimensions of life.' As the medical field begins to appreciate the value of positive psychosocial factors in the prevention and management of pathology, positive psychiatry and psychotherapy (Rashid, 2009; Jeste, 2012) are emerging, and this study aims to further understanding of this. Specifically, this study sought to ascertain whether, and how, such an approach might assist when applied to one area of psychological difficulty: emotional eating. Emotional eating is conceptualised as eating in response to negative affect or distress (Kubiak et al, 2008).

The research used a case study approach to track three individuals' experiences of applying positive psychology principles (called the 'Positive Slimming' programme) to their eating patterns over a period of 20 weeks. The therapy initially focused on strengths-based work, then evolved during the course of the 20 weeks to become a more holistic approach incorporating wider positive psychology principles as the clients responded well to this broader approach. Qualitative and quantitative data were collected and analysed. Clients reported that changes occurred during the course of therapy, including overcoming emotional eating and developing intuitive eating habits, and weight loss for all participants. Thematic analysis and principles of grounded theory were used to analyse the qualitative data on the clients' and the

therapist's understanding of how changes came about. These perspectives were compared, and differences and similarities were incorporated into one joint theoretical model supported by the findings. It is hoped that this model will offer counselling psychologists and psychotherapists a structure for incorporating positive psychology principles into their practice when working with clients who seek help to change their emotional eating patterns, and will also offer a basis for considering how positive psychology principles may be useful to help address other psychological difficulties.

Contents

Appendices

List of Figures

List of Tables

INTRODUCTION

Background

Over recent years positive psychology has developed into a flourishing area of psychological research and practice. Traditionally, the emphasis within psychology has been on studying and treating human deficits and limitations, and the focus has been on what is wrong with a person, on pathology and on repairing damage. In contrast to this, positive psychology investigates what is right with human nature, strengths, virtues, and other factors which allow people to flourish (Seligman and Csikszentmihalyi, 2000). Positive psychology does not deny the importance of understanding psychological limitations and psychopathology, but seeks to achieve a more balanced understanding of human psychological functioning by investigating factors associated with psychological well-being and optimal functioning, in order to integrate these aspects into a more holistic approach. It is not the intention within the positive psychology approach to encourage a dichotomy, as if psychology is split into 'positive' and 'negative' psychologies; it is not a divisive approach but instead seeks to be inclusive of positive as well as challenging psychological experiences.

Personal strengths are central to positive psychology, as focusing on strengths relates to achieving optimal functioning and encouraging psychological health, not merely striving for the absence of psychological illness. Founders of the strengths movement argue that the development of certain strengths, such as optimism, hope, perseverance and courage, helps build resilience and the ability to cope, buffering against dysfunction and psychological disorders (Boniwell, 2008).

In this study, when I refer to the strengths-based approach, I am locating it as an element within the broader positive psychology approach, which includes other areas such as understanding and developing positive emotions, well-being, flow, psychological health, and positive individual traits including personal virtues and strengths.

Personal interest of the researcher in the area of study

My own interest in exploring the application of the principles of positive psychology to psychological difficulties stems from attending the first European Positive Psychology conference in 2002, when I recognised that, unwittingly, I had been using a strengths-based approach and including principles of positive psychology within my own clinical work as a counselling psychologist. Perhaps this is not so surprising, having been brought up by my perpetually optimistic mother, a strong, determined, independent thinker and do-er, who made a point of never worrying about anything before it happened, encouraging me and my siblings to be self-reliant and take any challenges in our stride, believing – and telling us – that we would manage and cope with whatever we faced.

The conference triggered in me a curiosity about not only which elements of my (newly-defined in my own mind) positive psychology approach might be effective within therapy, but also an interest in examining the process of such therapy – what it is, how it might work, whether what I thought was helpful was also what patients thought was helpful and vice versa. Studying for the Practitioner Doctorate at Metanoia has provided the structure to pursue this interest in a rigorous and constructive way.

My therapy training includes psychoanalytic psychotherapy, Cognitive Behavioural Therapy (CBT) and systemic therapy, and numerous short courses on many practice-based subjects including trauma therapy, mindfulness and positive therapy. Currently I offer predominantly CBT in my practice as I am often asked by referring psychiatrists to assess patients for CBT and, if I consider that it is an appropriate approach, to provide the therapy. I enjoy working from a CBT approach and in my experience it can often help considerably to address the psychological difficulties experienced by my patients, who mainly present with depression, anxiety, panic, obsessive compulsive disorder and phobia. Given that I work in a private psychiatric hospital for inpatients and outpatients, much of the therapy is time-limited and funded by medical insurance companies. Some patients self-fund but they are in the minority. Medical insurance companies frequently specify that they will only fund evidence-based treatment and they follow the guidelines of the National Institute for Health and Clinical Excellence (NICE) to determine which treatment approaches they will fund for patients with psychological difficulties. As CBT is recommended by NICE for depression, anxiety and related disorders, patients at the clinic with these difficulties are often first assessed by a psychiatrist to ascertain whether they are likely to benefit from this approach. If so, they will be referred to a psychologist such as myself who offers CBT, and if not, other options are discussed. When relevant, it is usual when working within a CBT model to explore some elements of a patient's past and reflect on the impact of these. It is also the case that, far from being a predictable 'cook-book' approach, it varies widely in that CBT is tailored to each patient and each therapist will, over time, develop their own style of providing CBT, as I have. Although the main principles of CBT, namely that 'feelings follow thought' and 'thoughts determine how we feel and what we do' remain the core of my CBT

interventions, I have often experienced that helping a patient to identify their personal strengths and apply them to the challenges they face results in positive outcomes. Consequently, when it seems suitable I integrate a strengths-based approach as well as other aspects of positive psychology within the framework of the CBT I provide, while remaining loyal to the principles of CBT.

I have felt encouraged to pursue this way of working as I have experienced interesting, and at times, moving and therapeutically beneficial occasions when I have asked a patient about their personal strengths. Often, in therapy sessions, a patient explains the detail of the psychological difficulties they are experiencing, their symptoms and the adverse effects of these on their life. They typically focus on their negative current and past experiences and this perspective is generalised to a negativity which extends to the way they perceive themselves, resulting often in a low sense of self-esteem and reduced confidence. The focus of our sessions is, therefore, on what has gone wrong and how the patient has thus far felt helpless to initiate change. When I feel that we have established good rapport I sometimes make the following simple intervention, and the atmosphere of the session often changes significantly: 'What are your top three personal strengths?' I ask – a question which usually has a noticeable effect both on the tenor of our discussion and on the patient. Typically, the patient is rather taken aback and surprised by my question. There is an air of curiosity and sometimes a glimmer of positivity in what had, until then, been an overwhelmingly negative account of past, present and anticipated future events and feelings. In my experience this intervention intrigues the patient and offers an accompanied exploration into an area of their sense of self which has often been overlooked for some considerable time. Some patients become enthused about the

prospect of (re)discovering their strengths and reflecting on how they might apply them to their current and future challenges.

Having experienced this response in individual therapy sessions, my own intrigue into the potential value of this strengths-based intervention resulted in the development of a strengths-based therapy group which I led for clinic day patients. The group was an open, rolling group which took place for one hour each week for patients with a range of difficulties including anxiety, depression, and past addictions. The focus of each meeting was for group members to identify one or more personal strengths and discuss how they had applied them in the past, then consider how they could apply them to current and future challenges. The group was supportive to any member who found it difficult to identify their own strengths by offering feedback which usually enabled a person to at least begin to acknowledge some qualities. I received informal positive feedback from some group members stating that the strengths-based approach was helpful. This was confirmed by other psychologists in the clinic who mentioned to me that their patients had reported to them that they had been able to make good use of the approach of my group.

My clinical practice has included many patients who have presented with emotional eating issues, using eating as an unhealthy coping strategy to distract from negative emotions. They are dissatisfied with their eating habits and recognise the negative impact on their lives of their unhealthy relationship with food. However, they do not fulfil the diagnostic criteria for the eating disorders Anorexia Nervosa, Binge Eating Disorder or Bulimia Nervosa (American Psychiatric Association, 2013). These eating disorders involve serious disturbances in eating behaviour, such as extreme and unhealthy reduction of food intake or severe overeating, as well as intense feelings of

distress and/or extreme concern about body shape or weight. I have frequently found working with patients who seek to address their emotional eating to be engaging and rewarding, perhaps partly because when they develop a healthier relationship with food the results are so wide-reaching and have a positive impact on many areas of their lives. They often lose weight during the therapy, develop greater self-esteem, rediscover enjoyment of food and mealtimes, take greater pride in their appearance, receive positive feedback from others, become more confident and become more engaged with and enthused by life. Food has the potential to have an extremely positive, life-affirming role in a person's life, for nourishment of course, but also for the social, celebratory, familial and pleasurable roles food can have. However, when the relationship with food is an unhealthy one, for some people it becomes their unkind master, and they can feel like a 'slave to food'.

Given the positive feedback I have had relating to the strengths-based interventions I have provided for a variety of psychological difficulties, combined with my enthusiasm for working with people who have a difficult relationship with food, I am keen to investigate how deliberately focusing on strengths and other principles of positive psychology to address emotional eating might help, in the hope that the study will yield some useful and practical insight into successful therapeutic intervention for this very widespread problem.

Within the current context of weight management options, in my view, the NHS is providing somewhat piecemeal offerings to patients regarding nutritional and diet advice to help patients lose weight. There does not seem to be support for emotional eaters to address their psychological reasons for their weight problems. Even when obese patients undergo weight loss surgery, the emphasis is on what they eat and

will eat post-surgery with scant – if any – attention paid to the reasons why they became overweight, nor to their psychological triggers to their urge to overeat, which can remain as an ongoing, difficult challenge post-surgery.

There are various non-NHS options for weight management, such as slimming clubs, which typically involve one group meeting a week and a diet plan to follow, as well as encouragement to increase exercise. With increasingly widespread use of the internet, various online weight management programmes are available and these too usually offer a diet plan based on what a person is instructed to eat. A few programmes offer group sessions to discuss 'food addiction', however this type of intervention is unusual. In my view there is scope to incorporate some psychoeducation regarding emotional eating in such non-NHS weight management programmes as well as within the NHS. This seems an obvious intervention to offer within the NHS, when relevant, given that there is research evidence that suggests that regaining weight lost on a diet is less likely when emotional eating is addressed (Byrne et al, 2003). Given that GPs are in such a strong position to advise on interventions to benefit a person's health, they are in a good position to encourage changes in patients' eating habits, including raising their awareness of the central role of emotional eating in weight issues. Stubbs et al (2011) report on a commercial weight loss organisation, Slimming World, which offered a 'slimming on referral' partnership with the NHS for health practitioners to refer overweight patients for 12 weekly sessions in order to lose weight. The approach focuses mainly on food choices and not on addressing emotional eating. The course was free for patients to attend and resulted in an average of 4% initial body weight lost during the course. Follow up data on weight loss maintenance or weight regain is not given. The course

facilitators are not psychologists, they are self-employed franchisees who attend some training days offered by the organisation.

Within the self-help literature on weight loss, there are some books which include some information on emotional eating and offer aspects within their various programmes to address this aspect of an individual's unhealthy eating habits (Cohen & Verity, 2001; Tribole & Resch, 2003; Koenig, 2007). The authors have a variety of professional expertise to offer, including nutritional expertise, fitness training and psychotherapy.

The position of Positive Psychology

Some researchers, including Seligman (2003), who is considered to be the 'father' of positive psychology, believe that a strengths-based approach is a major effective ingredient in successful psychological therapy as it is currently provided. He suggests that good therapists, regardless of their theoretical orientation, help patients build 'buffering' strengths as well as deliver specific damage-healing techniques, and he proposes that the most effective interventions in successful psychotherapy may, indeed, be the strengths-based interventions. In contrast to talents, strengths are traits that can be developed and learned through effort, whereas talents are inherent and require pre-existing aptitude which can be cultivated, rather than developing through effort alone (Seligman, 2002). The intriguing question of which elements of therapy are particularly effective has been addressed by a number of scholars including Stern (2004), who suggests that 'vitality affects' in the shared present moment are experiences in therapy which can lead to change. He argues that such moments echo mother-infant interactions, and the shared moments which are the

core of human experience and which are central to therapy and change. Seligman's proposal that strengths-based interventions are the most effective aspects of therapy is controversial and has prompted some critique of positive psychology, including Miller (2008), who argues that the new science of positive psychology is founded on erroneous arguments, lacking in clear definition of terms, the identification of causal relations where none exist, and unwarranted generalisations. Miller claims that positive psychology does not show that positive attitudes explain achievement, success, well-being and happiness, but instead associates mental health with a particular personality type: a cheerful, outgoing, goal-driven, status-seeking extrovert. In contrast to Miller's view, positive psychologists believe that optimism, leading to well-being and the leading of a meaningful life, can be learned. Seligman claims that this is achieved by identifying and applying 'signature strengths' to work, social life and helping others. However, there are no shortcuts to happiness. While the pleasant life might bring more positive emotion to one's life, to foster a deeper more enduring happiness, we need to explore the realm of meaning:

> 'Positive emotion alienated from the exercise of character leads to emptiness, inauthenticity, to depression and, as we age, to the gnawing realization that we are fidgeting until we die' (Seligman, 2002).

One of the frequent criticisms of positive psychology is that it oversimplifies happiness (Norem, 2008). There is a need for increased nuance and complexity and an appropriate caution regarding 'positive education', which, according to Norem, is an example of policy recommendations getting ahead of the science, without enough evidence of the long-term effects and corollary effects to support large-scale programs. She has also been critical of the emphasis within positive psychology on

optimism. She says that for certain people, whom she calls ‘defensive pessimists,’ thinking about what could go wrong spurs them to take more effective actions. She reports that research has shown that defensive pessimists can be encouraged to be more cheerful, but their performance suffers. Seligman acknowledges that there is some psychological benefit from pessimism, but, comparing optimism to antibiotics, he claims that only a small minority are hurt by it and that it is necessary to recognise that the benefits far outweigh any potential minimal and rare negative effect. However, Norem claims that 25 to 30 percent of people are pessimists and therefore the potential adverse effect cannot readily be dismissed.

Wood and Lee (2009) make a similar critique citing new research that people with low self-esteem actually felt worse, rather than better, after repeating positive statements like ‘I'm a lovable person.’ Positive psychologists say that such research is entirely compatible with their findings that merely stating affirmations will not achieve an improved state of well-being, a view shared by Fredrickson (2009) who has repeatedly argued that trying to force oneself to feel positive is a recipe for ‘toxic insincerity.’ I would put forward the view that particular interventions, such as positive self-affirmations, which seem to concur with the approach of positive psychology need to be researched before any claim of effectiveness can be made. Simply including positive content within an intervention is not a guarantee of effectiveness.

Positive psychology has also been criticised for overlooking the very real problems experienced by depressed people which require addressing. My own view is that positive psychology is complementary to other types of therapy and is not intended to be a replacement for approaches which seek to focus more directly on psychological difficulties.

It is important to acknowledge that positive psychology appears to favour particular human experience by defining and emphasising character strengths and virtues, avoiding more difficult existential issues. This creates tensions between positive psychology and humanistic psychology (McDonald & O'Callaghan, 2008). Furthermore, some current sociopolitical projects such as the Increased Access to Psychological Therapies (IAPT) scheme, and the focus on promoting wellbeing as a goal of public policy, view well-being as resulting from self-reliance, including independence of social welfare. This stance therefore includes a strong argument for wellbeing *replacing* welfare as the central concern of social policy (Wood & Newman, 2005), raising the question of whose needs are primarily being addressed – those of individuals or politicians? Williams (1999), drawing on Winnicott, (1973) suggested that welfare provision should include opportunities for individuals to achieve a 'good-enough' sense of well-being, to include integrity, respect and recognition but not necessarily one in which individuals are expected to aim for complete self-efficacy.

This perspective of the emerging 'politics of happiness' includes implicit assumptions about the individual which overlook the complexity of human experience. It seeks to minimize or eradicate negative emotions through interventions which include a reductive analysis of emotions, seeking to promote individual well-being by encouraging an idealised set of behaviours evaluated by simple outcome measures including return-to-work figures. I would argue that the danger here is that complex and difficult emotions are seen to be a barrier to well-being and must therefore be eliminated, overlooking their potential as useful and valuable resources to be used within the therapeutic relationship to help clients, albeit often with less measurable results.

It is important, then, to be aware of the value of exploring limited self-reliance and the capacity for tolerating difficult emotions, uncertainties and doubts without seeking clear action-oriented outcomes, but instead, maintaining personal integrity and unity. A state of uncertainty, rather than relentless striving for facts, reasons or fulfilment, need not be seen as contrary to well-being (Taylor, 2011). However, in the current socio-political context, well-being is associated with acquiring measurable behaviours seen to promote independence. I suggest that we attempt to retain sight of the complexity of well-being, including recognising the value of experiencing difficult emotions as well as positive emotions.

Positive psychologists aim to use empirical research to describe, not prescribe, what contributes to human flourishing. I believe that positive psychology research can be invaluable when concerned with deepening understanding of how psychological well-being can be encouraged. However, positive psychologists have been criticised as research on positive psychology has not always been available to support claims within the field, although research on positive psychology interventions is gradually becoming more widespread and attracting considerable financial support in America. For example, the National Institute of Mental Health has given more than $226-million in grants to positive psychology researchers between 1999 and 2008, beginning with just under $4-million in 1999 and reaching more than nine times that amount in 2008.

With regard to the current socio-political context of positive psychology in the UK, there have been some interesting applications of positive psychology which have had some publicity and therefore the concepts of this approach are not completely unfamiliar in the public sphere, although they are as yet not very widely known. For

example, Wellington College, in Crowthorne, Berkshire, incorporates principles of positive psychology into the school's approach to education, aiming to very deliberately develop each pupil's strengths. In September 2006 the decision was made to launch a course in happiness and well-being within the school curriculum for 4th and 5th Form students. This decision sparked enormous interest nationally and internationally, and several years on, continues to evoke attention. The approach of the school is based on a growing body of scientific evidence on the causal factors around happiness and well-being, which can then be applied in work with individuals and institutions. Having a better understanding of how to increase the likelihood of happiness with life, and how to channel the emotional pains of set-backs en route, are skills that can substantially improve an individual's progress and underpins the rationale of including lessons in happiness and well-being in the school curriculum. In the article 'Demand a Better Education: Dr Seldon's Call to Parents' (Seldon, 2012), Dr Seldon, the Master of Wellington College, describes the outcome which the school is striving for: that pupils will emerge from the school familiar with their strengths and able to apply them appropriately and constructively. The well-being course in the curriculum draws heavily on positive psychology, incorporating concepts of character strengths and flow - citing that 'becoming involved in challenging and absorbing activities is important to people's ability to cope better with life.'

Positive psychology is also being increasingly incorporated within the workplace in developing individual, team and organisational resilience. Individual resilience is succinctly defined by Windle (1999) as 'the successful adaptation to life tasks in the face of social disadvantage or highly adverse conditions'. Resilience at the organisational level must consider not only individuals within it but also the processes

and culture those individuals work with on a daily basis. Burton and colleagues (2010) showed that a group training programme to enhance resilience was effective, and there is more awareness that resilience is important in retaining employees as well as facilitating both internal and external change faced by an organization.

After becoming Conservative leader in 2005, David Cameron said gauging people's feelings was one of the 'central political issues of our time'. More recently, the Coalition government has also drawn attention to well-being and positivity, exemplified in 2010 by David Cameron announcing that a 'happiness agenda' would see ministers using a number of methods to measure how happy Britain is, including a survey of 200,000 people. The results were to allow each local authority to compare and contrast the happiness of their residents, and Cameron wanted government policy to react to the results. However, Cameron was widely criticised for this initiative, as it was thought that the £2m cost of the project was excessive.

Lord Layard, a Labour peer and professor of economics at the London School of Economics, Geoff Mulgan, chief executive of The Young Foundation and Anthony Seldon, master of Wellington College set up the Action for Happiness movement in 2010 to promote well-being. It has no commercial, political or religious affiliations. The movement is based on positive psychology and the belief that our mood can be altered. Lord Layard argues that an important part of well-being involves the development of resilience, as well as redefining happiness so people do not associate it with material success. He is also involved in promoting the development of resilience and well-being among children, and emphasises the importance of highlighting the benefits of resilience and encouraging more overall positivity.

Positive psychologists as well as economists recognise the interplay between mental health and employment issues, acknowledging that when psychological problems which are preventing people from working are addressed more widely, then affected individuals would be able to return to work and off benefits. Indeed, Lord Layard has been criticised for his part in supporting the IAPT initiative, seen by some as being primarily an economic strategy, by the British Association for Counselling and Psychotherapy:

> 'Layard reasoned that funding by the Department of Health (DH) to improve provision of psychological therapies in the treatment of depression and anxiety, would positively impact on the number of people who are fit to work. This increase would consequently reduce the cost of Incapacity Benefit for this section of the population, leading to potential savings for the Department of Work and Pensions (DWP). In bringing together prevalence statistics for depression and anxiety, costs of training and employing therapists, potential cost savings in the DWP, and the benefits to individuals and society of improved mental health and wellbeing, Layard was able to make a strong case for investment by central government' (British Association for Counselling and Psychotherapy, 2010).

The focus of this study

As the awareness of positive psychology has been growing, my interest in its potential areas of application within counselling psychology and psychotherapy has also increased, providing the focus for this study. Over recent years I have been exploring ways in which principles of positive psychology can be incorporated into therapeutic interventions addressing psychological difficulties, and have received

good – albeit informal - feedback from many patients who said they have benefitted from specific elements based on positive psychology which I included in their therapy. They reported that they found the interventions based on positive psychology were refreshing, uplifting and energising, and that these aspects of therapy were welcome and beneficial features during challenging times when they were trying to address their psychological difficulties. They also commented that the positive approach helped them to make changes beneficial to overcoming their psychological difficulties. As their therapist, I also experienced and welcomed the refreshing, energising and uplifting nature of the interventions based on positive psychology, and was intrigued to evaluate whether they helped to facilitate change for patients. Patients reported that they appreciated turning their attention to their strengths and being reminded of how they could effect change by applying them to their challenges. They spoke of often feeling optimistic and empowered after sessions, and less overwhelmed by their problems. My intention within sessions was not only to validate and address their psychological difficulties but also, by deliberately including positive psychology principles into our work, to provide them with a 'breather' from the negativity which often overshadowed positive aspects of themselves and their potential resources. I was intrigued as to what was happening in the process of therapy which included positive psychology, and whether this approach was helpful. As I wondered more about this, the initial ideas for this research study evolved in my mind as an exploration of my evolving practice and the evaluation of therapy which included principles of positive psychology.

Responding to what the clients found most useful in the intervention central to this study, I provided a holistic positive psychology approach which included some CBT skills development. The therapy was based on a strong and positive therapeutic

dyad, and included developing and applying positivity in several areas of each client's life, as well as exploring identity issues, raising awareness of the client's presenting problem, some strengths-based work and developing CBT skills. This approach differed from the therapies outlined below within the Literature Review in a number of ways: it used the therapeutic dyad as a specific resource; the intervention had an overall homogeneity but was tailored specifically to each client, instead of being a manualised approach (such as Quality of Life Therapy - QOLT) or suggesting set exercises (as in Positive Psychotherapy - PPT); it acknowledged the impact of the past on identity issues and on the presenting problem, helping the client to understand the context of their challenges; it encouraged applying positivity holistically to the client's challenges as well as to areas of life which were less problematic but had scope for positive change; and recognised that all these areas were interrelated. Additionally, the intervention incorporated CBT skills development to help apply the client's increased understanding and positivity to their daily life and to their future plans in order to facilitate change.

Recognising that therapy based on positive psychology principles is still evolving, this study focuses on exploring what it is and how possibly it might work. Although several of my patients have reported informally to me that this approach is beneficial, at this stage of its development there is a need to examine the nature of it and the process of it, rather than focusing on the end point of measuring the results and effectiveness. Once it is clearer what constitutes therapy which incorporates positive psychology within counselling psychology and how it might work, then it will be timely and appropriate to carry out research focusing more specifically on its results, effectiveness and outcome.

My earlier experiences in offering therapy based on principles of positive psychology were with patients who often had complex and very long-standing problems, and who usually had various sources of psychological support including medication, psychiatric groups, and in-patient or day-patient care programmes. In order to focus more specifically on whether therapy based on positive psychology principles might be helpful, I decided to choose to work with patients for this study who were experiencing less severe psychological difficulties and who were not receiving any other form of psychiatric support. Such patients would be functioning well but with a psychological difficulty which was problematic enough for them, and having enough of a negative impact on their life, that they would be motivated to address the problem. I have had experience working with several clients who presented specifically to address problems they faced with an unhealthy relationship with food, but who did not fulfil the criteria for diagnosis with an eating disorder. They described their eating habits as 'comfort eating', 'stress eating', 'boredom eating' and explained that they felt shame and guilt following this behaviour. If the behaviour led to overweight, they felt a lack of confidence which affected their work and personal lives. After much consideration, I decided to work with this client population, emotional eaters, for this study. They did not receive medication nor psychological input for this problem, yet they were seeking to address their unhealthy relationship with food. I planned to develop and provide a strengths-based therapeutic approach including CBT and principles of positive psychology to address this one specific area of psychological difficulty - managing emotional eating and encouraging a more appropriate relationship with food.

Emotional eating (EE) occurs when emotional and situational cues trigger eating, regardless of whether hunger is experienced. Nguyen-Rodriguez et al (2008) define

emotional eating as 'eating in response to negative affect' and Chesler (2012) gives a more detailed definition, stating that 'EE is shown to be a conscious behavior to ease emotional distress, as well as an automatic reaction to unrecognized negative feelings'. It can lead to weight gain, as well as exacerbating psychological distress including depression and poor self-esteem. Emotional eating is not included as a psychiatric disorder in the DSM-V, which recognises three specific eating disorders, anorexia nervosa, bulimia nervosa and binge eating disorder. However, the diagnostic criteria for binge eating disorder include aspects of emotional eating – as defined above as eating in response to negative affect – such as eating large amounts when not hungry; eating alone out of embarrassment and eating when bored or depressed (American Psychiatric Association, 2013).

In contrast to such negative emotional eating, a more satisfactory relationship with food is characterised by eating based on physiological hunger and satiety cues and is associated with psychological well-being. This type of eating can be termed 'adaptive eating', 'positive eating' and 'intuitive eating'. In this study the term 'intuitive eating' will be used and will denote eating in response to internal cues of hunger, satiety, and appetite (Bacon et al, 2005), also recognising that there are external influences from the media and wide-spread and varied marketing strategies which encourage us to consume food, but which do not seem to trigger emotional eating.

Emotional eating, or 'maladaptive eating', is a commonly experienced behaviour and is recognised by some overweight individuals to be an unhelpful strategy which they use to attempt to relieve the distress experienced through unwelcome emotions such as boredom, low mood, loneliness, rejection, stress and low self-esteem. The maladaptive eating behaviour can become habitual for some individuals and can be

experienced over a number of years, often leading to weight gain. Koenden and van Strien (2011) examined the associations between several lifestyle factors (including sports, alcohol, nutrition, overweight, and smoking, as well as various eating styles such as dietary restraint and emotional eating) and changes in BMI. They found a consistent main effect that emotional eating was the factor which was most related to weight gain. They concluded that in order to overcome the problems of overweight and obesity, psychological treatment strategies have to be developed to address emotional eating.

I have frequently heard from patients who engage in emotional eating that they are aware that they eat for reasons other than to satisfy physical hunger, and they are also often aware that although they engage in emotional eating behaviour initially to alleviate or distract from difficult emotions, it often causes them further distress. It is common that fairly soon after maladaptive eating, unwelcome feelings are evoked such as guilt, regret, shame and helplessness as well as, for some individuals, the physical discomfort of feeling over-full or bloated. Therefore a vicious circle is established: the person begins to experience an unwelcome emotion and distracts from the feeling by seeking some food and eating. The distracting behaviour is initially effective – the person is occupied with the multi-sensory experience of eating and is no longer focused on the difficult emotion. The sight, texture, smell and taste of the food are effective in providing a (usually) pleasurable experience and offers immediate gratification. It is, therefore, perhaps understandable that emotional eating seems, for some, an appealing option at times when difficult emotions are felt. However, typically, the respite is brief, as the positive aspects of the maladaptive eating behaviour are short-lived, only to be replaced by a range of physical and psychological feelings which result in the person often feeling worse than before.

Such behaviour shows the short-term view being prioritised over the longer-term view, and, often disappointingly for the person concerned, this perspective is simply repeated the next time distressing emotions are experienced. Although emotional eaters may recognise such behaviour as being unhelpful and 'eating for the wrong reasons', frequently they are unaware of why they engage in it or what to do differently in order to address their maladaptive eating. In this study I am restricting my focus to emotional eating, which causes considerable distress to those who engage in it, but is not such intensely disturbed behaviour as to fulfil the criteria for an eating disorder. The therapy offered in this study has been developed with the aim of offering a psychological approach to address emotional eating which will enable psychological and behavioural change to take place in order to encourage intuitive eating and the development of a healthy relationship with food.

In my view, the nature of the relationship a person has with food is key to their eating habits and a healthy relationship with food, based on intuitive eating as a response to the physiological cues of hunger and satiety, helps a person to feel relaxed about food. Emotional eaters often report obsessive thinking about food and feeling like a 'slave to food'. Many traditional weight management programmes focus on what a person eats with scant attention to addressing why a person eats. I would argue that attending primarily to what a person eats is not helping the individual to recognise scope to change their emotional eating habits and encourage a healthier relationship with food. The responsibility for monitoring the relationship with food is often taken over by those who develop diet sheets. All the dieter has to do when following a diet is to be compliant for the duration of the diet and eat as instructed. In my clinical experience, clients report that once the required weight is lost by following a diet, the dieter almost always reverts to their pre-diet eating habits. I would argue that this is

unsurprising, given that the relationship with food has not been examined or changed. Sumithran et al (2011) found that although following a diet often results in initial weight loss, more than 80 per cent of obese dieters fail to maintain their reduced weight for at least one year. Byrne et al (2003) discovered in their study of dieters' psychological factors associated with maintaining weight loss or regaining the lost weight following diets, that successful weight-loss maintainers are less likely to be emotional eaters, using food to regulate their mood, and those participants who regained the weight lost displayed the tendency to use eating to regulate mood.

The chosen area of focus for the application of the positivity-based approach for this study is influenced by the current socio-political climate directing attention towards problems of overweight within the population. There are initiatives to attempt to change poor eating habits, and to raise awareness within the population of what constitutes a healthy diet and the benefits of exercise for achieving and maintaining a healthy body weight such as the 'Healthy Weight, Healthy Lives' strategy (Department of Health, 2008) but psychological factors underlying unhealthy eating and consequent overweight are not generally addressed. This study is concerned with emotional eating, often referred to as 'comfort eating', which is commonly experienced and which causes unhealthy eating patterns and overweight. Research (Priory Clinic, 2004) suggests that 43% of adults eat to try and change a negative mood such as stress, loneliness, rejection or boredom. It is not the intention of this study to investigate severe eating disorders such as anorexia nervosa or bulimia nervosa, estimated to affect approximately 4% of adolescents and adults.

Socio-political context of weight reduction

Both areas of focus in this study, weight management and positive psychology, are currently relevant to individual, social and governmental issues in the UK and each has had media attention over recent years. Weight management has relevance to health service provision and costs, government directives and emotional eating, the subject of this study, has an important – yet so far largely overlooked – influence on weight management for many people. Positive psychology has been highlighted by the government and others in positions of influence as a helpful approach to increase well-being in the population.

So far, weight issues and positive psychology have largely been addressed separately but in my research I am seeking to bring them together, investigating the process which occurs when positive psychology is applied to address one aspect of weight management, namely emotional eating. Below I will explore the socio-political context of weight management and positive psychology in turn.

The 2007 Foresight report, 'Tackling Obesities: Future Choices' (Butland et al., 2007), is a major UK government report analysing the country's obesity problem and which acknowledges the increasing social and economic costs of obesity to the UK. It warns that at current rates, 60 per cent of men, 50 per cent of women and 25 per cent of children will be obese by 2050, creating health problems such as diabetes, cardiovascular disease and blindness that will cost the National Health Service an additional £45.5 billion a year in treatment.

The report analyses the causes of obesity in the UK and investigates the reasons why this is a growing trend. It emphasises the need to address the problem with a

thorough and integrated approach and has implications as to how local government can implement change. Local councils can provide leadership in order to develop healthier environments and encourage community opinions and behaviour to make positive changes to address obesity.

The Foresight Report reiterates that addressing obesity and understanding the growing trend is complex, and although there is passing acknowledgement that one aspect of change requires helping individuals exercise more and eat more healthily, the main emphasis in the report is on changing environmental factors which seem to impact eating habits negatively. The report argues that the interaction between various lifestyle changes which have occurred over recent decades, such as eating out more, driving more, having larger portions including 'super-sized' meals and snacks presented to us as the norm, and 'buy one, get one free' offers on food at supermarkets, has resulted in an 'obesogenic environment'. This term is defined in the report as: 'the total sum of influences in the environment on promoting obesity in individuals and populations'.

My own position on this is that it is unrealistic to expect change in environmental factors to influence individual choices sufficiently when, as in the case of emotional eaters, eating habits are driven by psychological factors. To rely on change in environmental factors to drive change seems to me to be absolving the individual of taking responsibility for their own health, well-being and weight management. It is also clearly the case that while everyone is exposed to similar environmental factors and lifestyle changes, not everyone has become overweight or obese.

Studies indicate that level of education can influence food choice during adulthood (Kearney et al., 2000), although interestingly, nutrition knowledge and good dietary

habits are not strongly correlated, because knowledge about health does not lead to direct action when individuals are unsure how to apply their knowledge. Information on nutrition comes from a variety of sources and is viewed as conflicting or is mistrusted, which discourages motivation to change (De Almeida et al., 1997). Therefore, it is important to convey accurate and consistent messages about food choices through various media, on food packages and of course via health professionals in order for it to be readily applicable by individuals.

I see scope for raising the awareness of the importance of developing a healthy relationship with food, recognising the interplay between emotions and eating behaviour, and exploring how best to address it constructively. The Foresight report suggests increasing access to education regarding nutrition and eating behaviour. I would suggest a useful addition to this would be to include education on understanding and addressing emotional eating, keeping the results from the De Almeida (1997) study mentioned above in mind.

The investment in compiling the Foresight report confirms that tackling unhealthy eating habits to address the growing obesity problem is a priority for the government. The emphasis on changing environmental factors has its place but in my view it only goes part way to helping people deal with their overweight issues.

The UK government is taking steps to try and raise awareness of healthy eating and provides weight loss advice through the NHS Choices website (NHS, 2012). The focus is on healthy eating and the 'Eatwell Plate', to encourage a balanced intake of food groups, with advice to eat less saturated fat, less salt and less starchy foods. The website also offers advice about fad diets and articles to encourage people to get more active to increase their physical fitness. In my opinion enabling such sound

advice to be freely available to the public is helpful but as there is no mention of emotional eating on the website I believe this is an important omission which needs to be addressed.

Considerable effort has been expended in providing the public with information about what they eat. Raising awareness of the nutritional content of foods through detailed food labelling enables consumers to make more deliberate choices as to what they choose to buy and eat. There are often greater amounts of salt, sugar, and additives in prepared foods than consumers expect, so food labelling helps to inform consumers. Over recent years there has also been more information in the media regarding the effects on health of eating foods containing salt, sugar and fat, therefore it would seem that people are more informed about healthy and unhealthy eating habits than previously. However, the level of dietary knowledge and healthy eating habits, and the application of such knowledge, vary depending on some social factors. A survey carried out on behalf of the Food Standards Agency (Nelson et al, 2007) discovered that men and women with lower levels of educational achievement tended to have less nutritious diets, most often citing lack of money available for food as the main factor affecting their food choices. Parmenter et al (2000) found that depth of knowledge about current dietary recommendations, sources of nutrients, healthy food choices and diet–disease links varied considerably between socio-demographic groups. They discovered a significant lack of knowledge about even the basic recommendations, especially regarding the relationship between diet and disease. Men had poorer knowledge than women, and knowledge declined with lower educational level and socio-economic status. The question remains as to how to inform those sections of society who engage most in eating habits which are detrimental to their health.

The government and the media have made considerable efforts into informing many people about healthy food choices and eating habits. However, the - in my opinion - equally important question of why we eat has been overlooked. If my experience with patients can be generalized to a wider population, it appears that people seem to be no more aware now than they were some years ago as to why they eat when they are not hungry, often in secret, or why they continue to eat even when they are full. Indeed, some of my clients have explained to me that they seldom, if ever, experience the feeling of hunger, and the feeling of fullness is so rarely acknowledged that it does not form part of the cues they use to regulate their eating habits. In these cases the individual's emotional cues, rather than the physical cues of hunger or satiety, determine when and how much they eat. There is enormous scope for the government and the media to raise the awareness of emotional eating so that people who engage in such behaviour can understand why they do so. Some patients who have engaged in emotional eating have told me that they find it very difficult to follow a healthy eating plan or a diet, resulting in frustration, disillusion and, unsurprisingly, more emotional eating. Some emotional eaters do lose considerable amounts of weight by following diets or perhaps by using meal replacements which result in a very low daily calorie intake. Disappointingly, such dieters almost always put on the weight lost once their diet has ended (Byrne et al, 2003). Indeed, research shows that the majority of people who complete weight-loss programmes manage to lose approximately 10% of their body weight but regain two-thirds of the weight lost in one year, and almost all of it back within five years (Institute of Medicine, 1995).

When a person has an unhealthy relationship with food, such as using food as a comforter, a companion, an anti-depressant, an emotional anaesthetic, a stress-reliever or to alleviate boredom, then this does not change once the individual ends

an externally-imposed eating plan, unless deliberate attention is given to the psychological aspects of their eating habits (Byrne et al, 2003). The emotional triggers for their eating have to be addressed in order that a healthy relationship with food can be developed, in which the individual eats to alleviate physical hunger and stops eating when they feel satisfied. Of course, wise choices will also be incorporated into a healthy relationship with food, which includes using food to nourish the body well in addition to alleviating hunger.

There are at times articles in women's magazines about emotional eating (Psychologies Magazine, 2011), and some television programmes (*Slave to Food*, 2011) which offer insight on this subject as well as advice. However, more frequently, emotional eating is mentioned without explanation or recommendation as to whether or how it might be addressed. A series of programmes on weight-loss surgery (*Fat Surgeons*, 2012) followed the experiences of individuals before, during and after their weight-loss surgery. One patient was extremely pleased with the outcome of the surgery carried out by the NHS as he had lost considerable amounts of weight and had as a result become more confident and active. However, he stated that he thought the treatment for his obesity 'didn't go far enough' as he would have liked to have been able to address the reasons why he had become obese. He had always felt a very strong urge to overeat and believed that this stemmed from psychological factors. This urge to overeat remained post-surgery, and although he was then unable to act on this urge, he had an ongoing struggle to overcome his cravings and found this very difficult to live with. It appears that the NHS was not able to offer him help with the psychological aspect of his eating habits so that he could develop a healthier relationship with food. Chesler (2012) has reported that untreated emotional eating is a risk factor for poor postoperative weight loss for bariatric surgery patients.

In my view the NHS could take a significant role in helping overweight patients address their issues with emotional eating, on both individual and public levels.

The National Obesity Forum (NOF) is an organisation which exists to raise the awareness of the implications of the rise in obesity on individuals and on the NHS. The NOF was founded in 2000 by medical professionals who aimed to convey to the Government and to healthcare professionals the urgency needed to prioritise the way weight management is delivered. The members of the NOF are alarmed at the growing prevalence of obesity and the associated health risks including type II diabetes, heart disease and premature death. The NOF remains concerned at the lack of prevention or structure regarding addressing obesity as a socio-economic issue with its consequences on society, industry, the NHS and the government. Despite efforts by the NOF to urge the government to take clear and bold steps to address the problem, Labour (1997-2010) failed to develop an initiative with any real impact. From the first strategy document produced by the Coalition (Oct 13th 2011) it unfortunately seems that there is still no clear commitment actively to address the issue of effective prevention and management of overweight and obesity. Considering the substantial professional opinion within the NOF, as well as the dire warnings expressed in the Foresight Report, the lack of urgency shown by the government to prioritise the delivery in primary care of structured management of overweight and obese individuals is disappointing.

Within the current socio-political context, the subjects of positive psychology and emotional eating investigated in this study are topical. The application of positive psychology principles has so far largely been within the fields of education and social work, with some attention on incorporating positive psychology within coaching

(Biswas-Diener & Dean, 2007) and also to help build resilience (Aspinwall, 2001). There has been some work on applying a strengths-based model to psychiatric difficulties (Rapp and Goscha, 2006) and such work may become more widespread as awareness is raised of this approach if it is shown to be helpful. Through this study and further research I hope it will become clearer as to whether therapy based on positive psychology might be an alternative to the deficits model or, perhaps, complementary to other therapy approaches.

Research aims

The aims of the study are:

- To ascertain whether clients seeking to address 'emotional eating' report changes during the course of therapy which incorporates positive psychology principles and if so, whether they ascribe any changes to the positive psychology interventions or to other factors.
- To compare the clients' understanding of any change-enabling factors, and their experience of the therapy, to my understanding and experience of it.
- To develop my evolving practice in this area and offer a model for others to research and develop their practice.

Additionally, as a practitioner-researcher and a psychologist who has always been interested in putting theory into practice, I hope the study will help me to hone my therapeutic skills and awareness by increasing my own understanding of how best to support and help patients overcome their psychological difficulties. By carrying out this study I am keen to understand whether incorporating strengths-based work and

other interventions based on broader positive psychology principles could indeed be helpful within my therapeutic practice, and if so, how to include them in the most appropriate and effective manner. The results of exploring and evaluating such positive psychology interventions can be shared with other practitioners for their consideration, and offer them a model for researching and developing their own practice.

I am particularly drawn to investigate the experiences of emotional eating through case studies in order to gain a detailed insight into this very common difficulty which adversely affects the quality of so many areas of a person's life. If the Positive Slimming Programme (see Appendix 1) programme I have developed is shown to be helpful in addressing emotional eating and encouraging intuitive eating, then I hope the programme can be made use of by others.

The case study approach is particularly suitable for the purpose of this research, as it enables an in-depth, holistic study of individuals and the therapeutic process. In this study, it allows the researcher to explore meaningful characteristics of complex phenomena, the interrelatedness of various aspects of the clients' lives and their experience and understanding of the therapeutic process.

Contribution to the field

The study examines the therapeutic process when applying a positive psychology approach to the management of emotional eating, conceptualised as eating in response to negative affect or distress (Kubiak et al, 2008) to a problematic level for clients, but not severe enough to fulfil criteria for diagnosis with an eating disorder,

and to the development of intuitive eating. This is an application of positive psychology interventions, including a strengths-based approach, which has not been widely explored or evaluated.

My aim is that the research offers some useful information about how therapy based on positive psychology principles might work – in other words, is anything going on in the therapy which may help to facilitate changes to address psychological difficulties?

I hope that my research has made a theoretical contribution by developing an understanding and explanation of how therapy which incorporates principles of positive psychology actually works. I explored the differences between how I, as the therapist, think this model of therapy works in practice and how the clients think it works in practice, and I have reconciled the two by bringing them together in one theory.

My study also makes a methodological contribution in that it explores a way of researching and developing my own practice, which I hope will be of interest to other practitioners. I believe that we need to try and understand how the therapy we offer in the consulting room might enable change for our clients, so that we can work with awareness to be effective therapists.

Although this study focused primarily on the therapeutic process, changes which took place during the course of the therapy were measured during and at the end of the course of sessions. The study offers a platform for further outcome-focused research on Seligman's view that building strengths and learning to apply them usefully is the effective factor in psychological therapy, regardless of theoretical orientation. Within

the Positive Slimming Programme I also incorporated interventions based on broader positive psychology principles and explored the place of these within the therapeutic process. The results of this research study offers practitioners and clients new perspectives on whether a strengths-based approach, as well as other positive psychology interventions, may enable changes to be made which help address a common problem – maladaptive eating. As the development of this approach to address emotional eating is still in its infancy, future research could usefully focus on its effectiveness and results achieved.

One aim of each client in this study was to lose weight during the course of the therapy. Although there are already some psychological approaches to weight loss, as described below, in my view I am adding an approach which is experienced by clients to be encouraging and constructive, in contrast to some other weight loss approaches they felt were rather punishing and critical. Additionally, they reported that they found the positivity inherent to my approach was uplifting, and said that they benefitted from applying it in a holistic manner not only to their presenting problem (emotional eating) but also to wider areas of their lives.

I am not able to attribute changes reported by clients in this study directly to the therapy, as this research focuses primarily on process. However, as changes reported seem linked to focusing on principles of positive psychology within the Positive Slimming Programme, then future research on outcomes assess causality and could determine whether there is scope for this approach to be offered to provide an appropriate method of addressing unhealthy eating habits and overweight to those people in the general population for whom emotional eating is a problem. If so, then the approach developed in this study could be refined to produce a replicable

programme, which could be delivered cost-effectively to a wider population by suitably trained counsellors who would be supervised by a counselling psychologist.

I hope that this study helps to define how positive psychology interventions might enable individuals to make changes which may be applicable to other areas of psychological difficulty, thereby inviting therapists to incorporate positive psychology principles in their work with clients presenting with various psychological difficulties.

Literature Review

In this section I will begin by looking at the controversial view from positive psychology regarding strengths-based therapy, then I will turn to the applications of strengths-based approaches to various client groups. Next, I review a broader approach to incorporating positive psychology into therapy. I continue by identifying features of emotional eating before exploring various theories which seek to explain emotional eating. I then look at studies which emphasise the importance of trying to address emotional eating, especially when related to weight loss attempts. I review literature related to other weight loss methods including existing psychological approaches to weight loss. Following on, I introduce a sociological perspective on weight issues and gender issues regarding weight. Next I discuss bringing positive psychology and emotional eating together by addressing emotional eating using a strengths-based approach. Finally in this section, I look at ways others have evaluated their own practice to explore therapeutic process, in order to compare how I might explore the process of the therapy delivered in this study.

Controversial view from positive psychology

One of the founding fathers of positive psychology, Martin Seligman (2003), believes that helping a client to build personal strengths and make deliberate use of them is 'a major effective ingredient in psychotherapy as it is now done'. He acknowledges that therapists, regardless of their theoretical orientation, help build buffering strengths as well as deliver damage-healing techniques. He proposes that the strengths-based elements within therapy are common to successful therapeutic work, and are precisely those factors which are effective in enabling change to occur. His view is that this common feature explains the comparable success rate across the various theoretical approaches of psychological therapy. His reductionist view is controversial, as he is dismissing the contribution of many of the fundamental elements of therapy valued by very many theoreticians and practitioners.

This study seeks to explore Seligman's view, by investigating whether a therapeutic intervention which deliberately applies principles of positive psychology, including strengths based work, to the presenting problem might work.

Theoretical position

The theoretical position of the positive psychology approach incorporating strengths-based interventions provided in the Positive Slimming Programme resonates with resilience theory and attachment theory. The strengths-based approach is based on the belief that normal human development is towards fulfilment and healthy growth, and that each individual has strengths that help them realise this potential. This perspective aligns with resilience theory, which argues that most people will adapt positively despite exposure to significant adversity, helped by protective factors,

competencies and strengths (Masten, 2001; Ciccetti, 2010). The strength-based approach includes the practical application of resilience theory, and incorporates other theories and ideas such as attachment theory, empowerment and wellness. Attachment theory describes how human beings respond within relationships when hurt, separated from loved ones, or perceiving a threat (Waters et al, 2005). Bowlby defined attachment as a "lasting psychological connectedness between human beings" (1969, p.194) Central to attachment theory is the belief that an infant needs to develop a trusting relationship with at least one primary caregiver in order to develop well socially and emotionally, and in particular for learning how to regulate their feelings effectively. Attachment develops as a result of the person's ability to develop trust in their caregivers and self. In infants, attachment to a familiar caregiver means the child will seek proximity with this person when they are distressed and alarmed, with the expectation that they will receive protection and emotional support. Saleeby (1996) argues that a secure attachment developed in infancy and childhood is a major factor in developing psychological resources and strengths which can be applied usefully in a person's life.

However, attachments between infants and caregivers form even if the main caregiver is not sensitive and responsive (Umemura, T. et al, 2013). This has important implications as infants and children cannot escape from unpredictable or insensitive caregiving relationships. Instead they must manage themselves as best they can within such relationships and develop their own ways of responding to distress and regulating their emotions, in some cases discovering an alternative source of comfort such as food (Bost et al., 2014).

The relevance of attachment theory to this study is clear: the basic tenet of attachment theory is that we have fundamental needs to feel loved, safe and secure in order for healthy emotional and social development to occur. If these needs aren't met, difficult feelings from childhood are triggered – loneliness, rejection, abandonment, fear – and coping strategies develop which may include emotional eating. Some individuals cope by substituting the missing secure attachment to a caregiver with an attachment to food to provide a feeling of being nurtured, resulting in emotional eating (Wilkinson et al., 2010). However, if an individual uses food to feel safe, to feel loved and to soothe difficult emotions, then attempting to regulate their eating habits is likely to remove this strategy resulting in the difficult emotions being experienced as overwhelming. For many emotional eaters, food is like a 'mother' and they relate to food as one might relate to a mother – to meet needs for nurturing, comfort, compassion, connection and understanding.

Applications of strengths-based approaches

The main areas of application so far of the strengths-based approach based on positive psychology principles have been within child, adolescent and family counselling, educational settings, social work, and the fields of coaching and building resilience.

For example, within the field of social work, Dr. Charles Rapp, Dr. Dennis Saleebey and others at the University of Kansas School of Social Welfare provided early findings about the value of strengths-based case management. They reported that patients whose social workers offered them a strengths-based approach to their problems were able to accomplish many of the goals they had identified in treatment on leaving state psychiatric hospitals (Rapp and Chamberlain, 1985). Since that time

they have contributed to our understanding of the conceptual basis for strengths-based work (Saleebey, 2006; Rapp and Goscha, 2006).

The application of a strengths-based intervention within education was demonstrated in a study which was conducted with college students enrolled at a private American university (Williamson, 2002). The researcher set out to determine if there was a difference between the performance of a group of students introduced to strengths-based development and a control group who were not. It was found that the study group who were offered the strengths-based intervention performed better academically by the end of the first semester than the control group.

The effectiveness of a strengths-based intervention in the studies mentioned above suggests that further investigation into other applications of this approach is warranted. There is little empirical research regarding my particular interest - evaluating the therapeutic application, process and outcome of a strengths-based approach to psychological difficulties within counselling psychology. It appears that there is an absence of research studying the process and effects of applying such an approach to address emotional eating, the focus of this study.

Positive therapy perspectives and practice

Researchers have proposed that positive psychology can be incorporated into therapeutic encounters and is relevant to many approaches. In particular, Joseph and Linley (2006) suggest that client-centred therapy provides a suitable basis for 'positive therapy' to flourish. They argue that 'positive therapy' has two necessary components: 'the meta-theoretical person-centred assumption that the client is their own best expert, and the idea that within each person there is an intrinsic motivation towards growth and optimal functioning.' (p 100). This perspective is applied in their

own work on post-traumatic growth (2005). They emphasise that our fundamental theoretical assumptions about human nature determine how we practice as therapists, including our choice of approach (when we have a choice) and the manner in which we apply that approach. In their view, 'positive therapy' is ideally placed to complement Rogers' theory that individuals have a self-actualising tendency, and that the therapist's stance is to facilitate this in a non-directive way. In contrast, in my view there is a place in therapy for a therapist to take a more directive stance when he or she considers it to be helpful and, for example, offer skills development and psychoeducation, as well as to raise topics for exploration even though the client may not have expressly identified these as therapeutically important. This view is typical within CBT, an approach I often use within my practice, and is also reflected in the solution-focused approach, derived from the work of de Shazer (1988) on brief therapy, and which requires a degree of directivity from the therapist to help clients focus on their solutions rather than on their problems. This entails helping them to define, envisage and achieve solutions to their problems, drawing on extrinsic and intrinsic resources – including clients' own personal strengths – available to them.

The positive psychology based intervention I provided, which included some strengths-based work, offered a different emphasis from other therapy approaches which incorporate some positive psychology elements, such as solution focused brief therapy (SFBT), well-being therapy (WBT), Quality of Life therapy (QOL) and positive psychotherapy (PPT), although, as discussed below, there are some shared aspects.

SFBT includes strength-based work and also specifies a number of strategies to help the client, including questions aimed at defining the client's preferred future,

discussions about problem-free areas of life, questions about when the presenting problem is less severe or absent, as well as clarifying the wide range of resources – both internal and external – available to the client (Greenberg et al, 2001). Unlike the broader approach of SFBT, I intended that the central focus of my strengths-based elements would concentrate mainly on internal resources, specifically identifying and applying personal strengths. The strengths-based aspects of the Positive Slimming Programme provided within this study share some elements of the solution-focused therapy model developed by de Shazer and others in the 1980s and 1990s. Indeed, Sharry (2003) claims that the greatest contribution of the solution-based model is the strengths-based approach underpinning it, focusing on clients' resources, skills, preferred futures and collaboration within therapy. He comments that a shift in focus onto strengths and resources can offer much in making the nature of therapeutic conversations constructive and collaborative, whereas, in his view, a focus on pathology 'may be reinforcing the problem and increasing the sense of difficulty'.

WBT (Fava, 1999) is based on Ryff and Singer's multidimensional model of psychological well-being: autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance (Ryff, 1989; Ryff & Singer, 1998). It includes some CBT skills development to encourage the individual to recognise, then re-evaluate, negative thinking patterns which detract from positive events in their life. The aim is for positive events to have a greater impact on the individual's mood and life.

Frisch (2006) developed Quality of Life Therapy, a manualised treatment programme based on 16 areas of life he deemed were crucial for psychological health including relationships with others, self-esteem, health, circumstances and goals. Quality of

Life is not defined in terms of functional ability, medical or psychological symptoms, but instead by subjective well-being. This is enhanced in Quality of Life Therapy by addressing unhelpful cognitions and encouraging behavioural changes which are expected to increase the individual's quality of life.

Positive Psychotherapy (PPT) aims to provide an alternative treatment for depression by increasing positive emotion, engagement and meaning in life instead of targeting depressive symptoms directly. Seligman and his colleagues (2006) hypothesise that a lack of positive emotion, a lack of engagement and the lack of a sense of meaning in life may be the causes of depression, not merely consequences or correlates of depression. If so, then helping a depressed person increase these will ease depression. There are 12 exercises taught in group or individual PPT, designed to increase positive emotion, engagement and meaning. So far, PPT has been used primarily to help depressed patients, with promising results. However, it is hoped by Seligman and his colleagues that this therapy will also help other disorders.

Features of emotional eating

Emotional eating reflects an unhealthy relationship with food, is the practice of consuming food in response to emotional feelings, or, in other words, eating for the 'wrong' reasons. The term 'emotional eating' is frequently used to refer to maladaptive eating as a major source of comfort, as self-punishment, to distract from unwelcome emotions and to anaesthetise difficult feelings (Adriaanse et al., 2011; Koball et al., 2012). However, it can also include eating for positive reasons such as being in love, to provide treats and for celebration. Eating in response to both positive and negative emotions frequently involves a sharp increase in the intake of food and

can result in unwanted weight gain, although this is not always the case. Emotional eaters are often unaware of their overeating, and are unable to distinguish between hunger and emotional arousal.

Depression, anxiety, boredom, stress, and loneliness are often cited as triggers for emotional eating, as well as relationship problems and low self-esteem. It can also occur in social situations when a person feels under pressure to eat more than they need, perhaps responding to a need to appease others, to feel that they fit in or because they feel nervous and inadequate when with other people. Certain situations also trigger emotional eaters to eat even when not hungry, such as passing a bakery or being alone at home when they might overeat in secret. Negative thoughts, especially relating to oneself and poor self-worth, can also trigger emotional eating, which in turn results in further critical thoughts and so a vicious cycle becomes established. For emotional eaters, eating becomes a habit which prevents learning skills that can more appropriately resolve emotional distress.

In contrast, a healthy relationship with food exists when a person uses food for the 'right' reasons, to ease hunger, to nurture the body and at times as a vehicle for social and celebratory occasions. Such eating habits are referred to as 'intuitive' and 'adaptive' eating.

Several psychologists (e.g., Carper, Fisher, & Birch, 2000; Fedoroff, Polivy, & Herman, 1997; Polivy & Herman, 1987, 1992) and nutritionists (e.g., Tribole & Resch, 1995) have claimed that 'intuitive eating' is adaptive because it is associated with an awareness of and a response to internal physiological needs relating to hunger and satiety as well as low preoccupation with food. They have identified three central

features of adaptive eating: (a) unconditional permission to eat when hungry and what food is desired, (b) eating for physical rather than emotional reasons, and (c) reliance on internal hunger and satiety cues to determine when and how much to eat. These components are interrelated, and the presence of each is necessary to reflect intuitive eating (Tribole & Resch, 1995). However, I would argue that it is unrealistic to expect that the physical and emotional reasons for eating can be separated as rigidly and as clearly as suggested above. The media, marketing strategies and sociocultural aspects of food also influence eating habits on an emotional level – not necessarily leading to an unhealthy relationship with food, but such emotional factors are present nonetheless.

Theories of emotional eating

There are a number of theories regarding emotional eating, which, like the traditional treatment approaches, focus on deficiencies in attributes and functioning.

For example, according to psychodynamic theory, emotional eating is the use of food as an emotional defence, needed because of poor ego functioning and an inability to tolerate emotional discomfort (Slochowar, 1983). Early supporters of the model suggested that emotional eating represents a psychosexual fixation at the oral stage of development. Bychowski (1950) saw emotional eating in terms of weak ego strength: '…they (emotional eaters) behave like an addict deprived of his drug….Food means strength and serves to weaken the Ego.' In essence, psychodynamic theory focuses on emotional eating as the result of confusion and apprehension in recognizing and accurately responding to emotional and visceral states related to hunger and satiety. I would argue that this perspective overlooks the influences of external factors which are experienced by the individual, such as

past and current family attitudes and behaviours, and sociocultural aspects relating to the role of food, eating habits and appearance.

Cognitive behavioural theorists argue that emotional eating results from cognitive distortions which are associated with emotional distress (Fairburn & Cooper, 1989). Central to cognitive behavioural theories of eating disorders is the hypothesis that beliefs and expectancies regarding body size and to eating are biased in favour of selectively processing information related to fatness/thinness, dieting, and control of food intake or body weight. In my view this stance acknowledges the individual's here-and-now experiences and perspectives but overlooks the impact of the past in influencing the person's relationship with food, with their appearance and with their sense of identity.

The importance of addressing emotional eating

The value of seeking to address emotional eating is made clear by research which shows that emotional eating is 'positively correlated with Body Mass Index' (BMI) (van Strien, Frijter, Roosen, Knuiman-Hijl & Defares, 1985; Wardle, 1987) and that it interferes with attempts to lose weight (Leon & Chamberlain,1973; Blair, Lewis & Booth 1990).

In 2011 The British Psychological Society published a report on psychological perspectives on obesity, in order to redress the balance of information in the literature on obesity which to date emphasises food choices, eating less and exercising more (BPS, 2011). The report argues that psychological factors have largely been overlooked in the treatment of obesity. Psychological issues including poor motivation to exercise, low self-esteem, using obesity as a buffer to protect

against intimacy, and using food for emotional management are highlighted. Newson and Flint, in their paper within the report entitled 'Applied Psychology and Obesity Management' argue that

> 'obesity is as much a psychological issue as a physical condition. Psychological issues can be linked to the cause or consequence of obesity. Whichever, the former or latter, psychological difficulties can affect the ability to manage weight. It is therefore paramount that psychological techniques and therapies are integrated in to weight management pathways and are utilised to support individuals and populations to maintain a healthy weight.'
>
> (Newson & Flint, 2011, page 27)

In the same report, Julia Buckroyd, in her paper 'Emotional Eating as a Factor in the Obesity of Those with a BMI≥ 35', emphasises that for obese people who have been using food as a way of regulating their feelings over considerable time, emotional eating has become part of their 'survival strategy', and they will not give up this coping mechanism (albeit an unhealthy one) unless they discover an alternative, effective way of managing their emotions (Buckroyd, 2011).

Furthermore, it has been identified that weight loss surgery patients do not always achieve as much post-surgery weight loss as expected, nor is the weight loss achieved always maintained over time. Walfish (2004) found that 40 per cent of a sample of bariatric surgery patients could be identified as 'emotional eaters' and recommended psychological treatment to address this problem in order to increase the likelihood of long-term maintenance of post-surgery weight loss.

It has been shown that addressing emotional eating is clinically useful in helping achieve weight loss targets. For example, a follow-up study of 187 participants involved in a weight-loss project organised by the British Heart Foundation showed that one year later, changes in emotional eating tendencies predicted weight loss and success in achieving target weight over the previous year. Those who decreased emotional eating lost more weight and made more progress towards target weights than those who did not decrease emotional eating (Blair et al., 1990). Teixeira et al. (2010) showed that becoming aware of emotional eating and developing strategies to manage it helps to achieve sustained weight loss. In their study of 225 overweight and obese women, they concluded that minimising emotional eating and adopting a flexible dietary restraint pattern are critical for sustained, long-term weight loss for a period of two years.

Approaches to weight loss

Many approaches to weight loss have been developed and offered to overweight individuals to help them lose weight, including restrictive dieting (Shai et al., 2008; Sacks et al., 2009), increased exercise (Pronk & Wing, 1994; Jeffery et al., 2003), financial incentives (Finkelstein et al., 2007; Volpp et al., 2008), medication (Ravussin et al., 2009), psychological treatment (Rapoport et al., 2000; Tapper et al., 2009; Forman et al., 2009) and hypnosis (Cochrane & Friesen, 1986). There are commercial group weight loss programmes such as WeightWatchers, which generally include a food plan, an activity plan, behaviour modification through cognitive restructuring, social support and a weekly weigh-in, all delivered at a weekly group meeting lasting approximately one hour (Heshka et al., 2003). Most approaches to weight loss help some individuals lose weight, but almost always the weight lost is regained.

Some features of various approaches have been evaluated by Foreyt and Goodrick (1994) to ascertain the correlation between certain factors and weight loss, maintenance of weight loss, and weight regain. They conclude that weight loss is positively related to self-monitoring, goal setting, social support, and length of treatment; maintaining weight lost is helped by regular exercise, self-monitoring, and continued contact with therapists; whereas weight regain is associated with inconsistent and restrictive dieting, life stress, negative coping style, and emotional or binge eating patterns. They argue that the factors which help successful and sustained weight loss are normalising eating patterns, regular exercise, social support, realistic goal weights, focus on health rather than appearance, self-esteem, and addressing emotional and binge eating. It is interesting to note that the holistic approach of the Positive Slimming Programme offered to clients in this study includes the factors identified by Foreyt and Goodrick which help achieve and maintain weight loss.

Some severely obese patients are treated by surgical procedures, such as inserting an adjustable gastric band, with varying long-term results, as over a number of years the procedure is progressively less effective for some patients (Doherty et al., 2002).

Psychological approaches to weight loss

There are a number of psychological treatment approaches which have been used to address obesity and help individuals lose weight. Behaviour therapy has been used since the 1960s and has been shown to help weight loss (Wilson, 1980; Wing, 2002), but almost invariably patients regain the weight lost within three years or sooner (Cooper & Fairburn, 2001). It is remarkably difficult to maintain weight lost after the

duration of weight loss interventions (Perri & Corsica, 2002). Klem and colleagues (1997) examined the successful maintenance of weight loss and discovered that increased social, emotional, or health reasons (or a combination of these) for losing weight were important factors for almost all their research participants in triggering and maintaining weight loss. They reported that the successful weight loss and maintenance attempt differed from previous unsuccessful attempts by individuals, as the social and health triggers for losing weight were followed by more intense exercise and dietary regimes which were incorporated into the individuals' lifestyles after their weight loss.

Cognitive Behavioural Therapy (CBT) treatments have been shown to be effective for problems associated with overweight and obesity such as binge eating (Fairburn et al., 1993; Wilson, 1994) and distorted body image (Rosen, 1997). Cooper and Fairburn (2001) developed a new form of CBT specifically designed to address those psychological processes hypothesised to hinder successful maintenance of weight lost beyond the duration of the intervention. However, when evaluated, although this new CBT treatment helped to achieve weight loss, it was not effective in maintaining the new lower weight at three year follow up (Cooper et al., 2010).

Some CBT treatments have been developed with the expectation that weight loss is likely to occur, but without focusing on restrictive dieting – instead they aim primarily to achieve a lifestyle change by enhancing well-being, increasing exercise and encouraging healthy eating in order to result in clients losing weight (Rapoport et al., 2000; Sbrocco et al., 1999; Tanco et al., 1998). Rapoport and colleagues achieved encouraging results with this approach, which was provided to overweight women who achieved weight loss, improved emotional well-being, reduced distress,

increased activity and fitness, improved quality of diet, and increased cardio-vascular health. Their improvements were maintained at follow up after one year. These results are particularly intriguing and relevant for this study, which offers a holistic intervention including CBT and a positive psychology approach, aiming for change in several areas of the clients' lives – not only those related to their emotional eating and overweight.

Other innovative approaches to weight loss include adapting behavioural therapy to incorporate acceptance-based therapy components, such as aiming to strengthen participants' commitment to behaviour change, build skills to tolerate distress, and promote mindful awareness of eating habits. An exploratory study of this approach has shown encouraging and thought provoking results (Forman et al., 2009). On average participants lost weight during the 12-week intervention and had lost more weight by 6-month follow up. Psychological changes related to eating habits, including emotional eating, as well as cognitive shifts, mindfulness and motivation were reported.

Other studies have explored the impact of including the development of mindfulness skills in weight loss interventions and report encouraging initial results, inducing changes in psychological well-being, eating habits and weight loss (Tapper et al., 2009; Dalen et al., 2010).

Some of the psychological approaches already developed have some shared elements of the Positive Slimming Programme intervention in this study, namely incorporating CBT skills, enhancing psychological well-being, encouraging increased exercise, and encouraging mindful awareness of eating. However, none specifically

targets emotional eating, or draws deliberately on applying positive psychology principles to help achieve weight loss, both of which are central to this study.

Sociological perspective on the issue of overweight

A sociological approach to the issue of overweight allows for an examination of some of the external influences that help to explain the variation in overweight within a population. Often obesity and weight control are considered as individual problems, but there have also been many studies examining influences outside of the individual such as social class, race, or neighbourhood (Ross & Mirowsky, 1983, 2001; Olvera-Ezzell, 1994). Sociological research suggests social factors which may influence obesity include social class, demonstrating that lower social class position is associated with higher calorie intake and a higher weight (Gerald et al., 1994). Furthermore, media influences have been shown to influence weight, for example, time spent watching television has been associated with overweight, not only because television is a sedentary behaviour but also because television advertising influences consumption practices (Dietz & Gortmaker, 2001).

There has been much research in recent years on gender differences relating to eating habits, weight issues, dieting and body image. Males and females differ considerably in the frequency and nature of problems with weight and body image, and also in the relationship of these to self-esteem and psychological difficulties such as depression (Cohn & Adler, 1992; Betz et al., 1994). Research has shown gender differences relating to eating disorders and body image. Normal-weight females tend to perceive themselves as overweight, whereas normal-weight males perceive themselves as underweight (Connor-Greene, 1988). Such research studies on

gender differences and eating, weight and body image issues help to increase understanding of causes, correlates and consequences of problems with weight.

Bringing positive psychology and the problem of emotional eating together

Emotional eating has been shown to be a common factor that hinders attempts to lose weight. Given that emotional eating contributes to maintaining overweight, as well as being a factor which causes weight lost to be regained after a diet ends (Byrne et al., 2003), there is a clear need to investigate how it can be addressed.

Traditionally, the identification of, and treatment for, eating disorders focuses on risk factors and overcoming maladaptive behaviours. Tylka (2006) points out that 'the study of eating behaviors largely has been a pathology-based endeavor because it has explored and identified correlates and predictors of disordered rather than adaptive eating' (Tylka, 2006, page 226).

The area of this study, exploring the process of applying positive psychology and strengths-based interventions to managing emotional eating and encouraging adaptive eating, as far as I can ascertain, has not yet been thoroughly researched.

There seems to be an absence of published research on applying principles of positive psychology to addressing emotional eating. However, there is an online weight loss programme which has been developed in Australia by Professor Tim Sharp, called 'The Happiness Diet'. It is based on principles of positive psychology, in particular, Professor Sharp's theory of the primacy of positivity (2011) which emphasises the unhelpful consequences of waiting for events, results or circumstances to improve before a person feels happiness. Professor Sharp terms

this unhelpful pattern 'the tyranny of when'. He suggests that it is typified by thoughts such as 'I'll be happy when….I've lost weight/I've got more money/I've met the love of my life' …and so on. Although he acknowledges that it can be constructive to aspire to a healthy weight, a better financial situation, a compatible partner etc., Professor Sharp argues that for many people, even if they achieve these aims, they continue to identify other aspirations which they need to achieve before they can feel happy. Happiness remains elusive, just out of reach. The Happiness Diet teaches participants how to feel happy first and then, with the resulting increase in positive energy, motivation and inspiration, he claims that it is significantly more likely that goals will be achieved - including, obviously, losing weight but also living a great life and also achieving more in other areas. The results of the Happiness Diet, which is delivered as a six-month, online interactive programme with online coaching support, seem to be encouraging but have not yet been evaluated and published (Sharp, 2012, personal communication).

There are certain parallels between the Positive Slimming Programme provided in this study and the Happiness Diet developed by Professor Sharp, in that they both emphasise the psychological aspects of weight loss, they both encourage a focus on strengths, goal-setting and behavioural change applied to eating habits. Both programmes assume the dieters are already aware of what to eat and what not to eat to lose weight, therefore this aspect of weight management is not the focus of the work – unlike many approaches to weight loss. It seems that the Positive Slimming Programme includes more content on how to identify and regulate difficult emotions which trigger maladaptive eating, as well as addressing the shift in self-identity, which in my view needs to occur for long-lasting change in weight to result. However, as the Happiness Diet also includes online coaching support, it is not clear whether

these aspects are included. Any future publication of the results of the Happiness Diet will be helpful in being able to more clearly identify differences and similarities between it and the Positive Slimming Programme.

Examining practice

As therapists, what is it that we think we are doing in the therapy room that is helpful to patients? I remember a supervisor of mine saying, years ago, 'Therapy is all about change. Patients come to us because they are seeking change.' In order to facilitate change, we choose to engage in various interventions depending on our theoretical orientation, perhaps offering insight, empathy, unconditional positive regard, a clear focus on the therapeutic relationship, skills development – guided by our theoretical framework and set within a particular context. There is much research on factors which influence treatment effectiveness, and studies that show that about 75–80% of patients who enter psychotherapy show benefit (Lambert & Ogles, 2004; Wampold, 2001). Norcross (2011) concludes that the therapeutic relationship accounts as much for why patients improve as the treatment approach. Seligman (2003) has stated that in his view, identifying, building and applying personal strengths is the most effective element of therapy, regardless of approach.

In this study I did not focus primarily on the outcomes of the therapy delivered but, as the approach is still in its infancy with scope to evolve, I explored the process of therapy in order to find out whether my understanding of what was helpful reflected the patient's understanding of what helped.

I sought to get a sense of the patient's voice, expressing their own understanding of how the therapy was helpful, what they thought worked, and how, and – equally

importantly – what didn't work for them, thereby providing a richness of data only possible through qualitative research.

By examining the process of therapy from the clients' view and from my own, I have been able to refine my evolving practice of including positive psychology principles when working with clients, to increase the likelihood of it being helpful.

Research questions

In order to further our awareness of the potential applications of positive psychology, the research questions to be investigated in this study are:

1. What was the process of the therapy for the client? What changes did clients report and what is the clients' understanding of how the therapy might have helped them develop a healthier relationship with food and develop 'intuitive eating'?
2. What was the process of the therapy for me as therapist? What is my understanding of how the therapy may have helped clients develop a healthier relationship with food and develop 'intuitive eating'?

RESEARCH APPROACH AND METHODOLOGY

In this section I describe how decisions were reached regarding the research approach and methodology. This study, in which I take the dual role as therapist-researcher, is a mixed methods design, including both qualitative and quantitative data collection. In this section the rationale for these choices will be given, as well as explaining why principles of Grounded Theory and thematic analysis are used to analyse the qualitative data. I continue this section by detailing the process of setting up the Positive Slimming Programme, including decisions regarding the recruitment of participants. I then provide an introduction to each of the three participants whose experiences form the case studies and continue by detailing the delivery of the intervention, data collection and analysis. Finally, issues of validity and ethics are discussed.

Case Study Research

The approach used in this study is case study research, to explore the process of including positive psychology and a strengths-based approach to address emotional eating and encourage intuitive eating. I have used a mixed methods approach, drawing on both qualitative and quantitative approaches in order to generate multiple sources of data.

When deciding on case study research as the most appropriate method for this study, I took into account the strengths and limitations of the approach (Searle, 1999; Hayes, 2000; McLeod, 2008; Hanley, 2012). For my purposes the advantages seemed particularly relevant, particularly that the approach offers rich, detailed information which is especially valuable in exploratory research such as this study.

Case studies can help show how different aspects of a person's life are interrelated, therefore providing insights which encourage a holistic view of the client. Case studies can sometimes highlight aspects of a phenomenon which stimulate new research. They can also contradict established theory, by exploring the fine level of detail of cases which would not have been examined within other research approaches.

McLeod (2010) argues that case study research is particularly useful when trying to understand and explain how a new approach is evolving. He states, 'when an innovative therapy approach is first developed, it is necessary to be able to provide evidence of how it operates, and how effective it is, in order to persuade colleagues of its potential.' (page 2). Given that it is likely there will be very few, if any, practitioners aware of and offering a new approach, 'the only way to generate convincing evidence of the possible value of a new approach is to publish case study reports.' (page 2). Indeed, the case study has a long and established place in introducing new approaches to the field of therapy. Psychoanalysis (Freud, 1901), behaviour therapy (Wolpe, 1958), and eye movement desensitisation and reprocessing (EMDR) (Shapiro, 1989) all depended on case studies to develop, draw attention to then build up credibility in their innovative methods. For the development of theory, case studies allow detailed observation of how different factors operate, and at this level of detail, it is possible to analyse factors such as context, the interaction of elements of the therapy as well as how therapy and any changes unfold over time.

The criticisms of the case study approach include the lack of generalisability of results from the individual cases to the wider population. However, Flyvbjerg (2006) argues against this, claiming that

> 'One can often generalize on the basis of a single case, and the case study may be central to scientific development via generalization as supplement or alternative to other methods. But formal generalization is overvalued as a source of scientific development, whereas 'the force of example' is underestimated."

Interestingly, Eysenck (1976), who originally considered that the case study was no more than a method for producing anecdotes, later realised that 'sometimes we simply have to keep our eyes open and look carefully at individual cases - not in the hope of proving anything, but rather in the hope of learning something!' - acknowledging that in-depth study might bring out more universal aspects of experience.

Some researchers have argued that there is scope for researcher subjectivity in the analysis of qualitative data, which could result in preconceptions intruding on the results and conclusions (Diamond & Sigmundson, 1997). However, this claim has been challenged by researchers who have conducted intensive, in-depth case studies and report that their preconceived views, assumptions, concepts, and hypotheses were wrong and that the case material has compelled them to revise their hypotheses on essential points (Geertz, 1995; Wieviorka, 1992). My own position reflects this view, as in this study the original emphasis on a strengths-based approach shifted in the light of feedback from clients during the research.

It is, however, generally agreed that because they involve such detailed data collection and analysis, case studies are very time consuming to carry out, and there is scope for increased credibility in the data analysis and findings.

After much consideration I decided to take on the dual role of therapist–researcher. Initially I thought of collecting and analysing data from therapy based on the Positive Slimming Programme provided by a different therapist. However, I concluded that I would miss much of the detail of the process of therapy unless I was directly involved in the sessions. The position of therapist-researcher is complex and demanding, involving identifying and managing the tension between the roles of therapist and researcher, as well as managing the boundary between closeness and distance in terms of these roles (Arber, 2006).

Furthermore, it is impossible even to attempt to enter the research process with a neutral and open mind when involved as both therapist and researcher. Therapeutic training, skills and experience mean there is a degree of awareness by the researcher of the topic under study when examining the therapeutic process. As Rose (1985) argued, "There is no neutrality. There is only greater or less awareness of one's biases." (p. 77). Reflexivity is therefore central in attempting to address this, and keeping a personal reflexive journal is one way in which to increase awareness of 'what belongs where' in the research process.

In case study research it is a particular challenge to hold the tension between including methodological rigour, and remaining loyal to the therapist-researcher's interpretation and analysis of data, which contains depth and richness of detail. Criticisms of the case study approach include describing perceived potential

problems such as ‘narrative smoothing’, the process by which the therapist selectively recalls elements of therapy which confirm his or her interests and theoretical framework, while overlooking contradictory aspects (Spence, 1989, 2001). Lack of credibility in the data analysis of case studies led to highlighting the importance of greater rigour in case study research (Dukes, 1965; Shapiro, 1961). Consequently, more systematic methods of case study research have been developed, resulting in the following five forms: single subject designs, theory-building case studies, pragmatic case studies, hermeneutic single case efficacy studies, and narrative case studies (McLeod, 2010).

Each genre of case study design is suited to address different types of research questions. Early behaviour therapists used single subject (N = 1) designs as a method to monitor behavioural changes by observing the behaviour before, during and after therapy (Wolpe, 1958). This remains valuable as an approach which can help answer questions on the effectiveness of therapy and whether changes can be attributed to the therapy (Barlow & Hersen, 1984). Theory-building case studies have evolved to use more rigorous methodology than the early psychoanalytic case studies and are useful to understand, in theoretical terms, the process of therapy and to test and refine an existing theoretical model (Stiles, 2007). Pragmatic case study design attempts to address the concerns relating to bias and selective reporting in case studies (Fishman, 1999). This form involves case reports written by the therapist, along with much detailed information including therapy protocols, test scores, and therapy transcripts, to be rigorously peer reviewed in print and online. The long-term aim is for a comprehensive, accessible resource to be built up to help answer pragmatic questions about the practice of therapy, which methods work for different types of client, and how strategies can be adapted and tailored for clients. A

different emphasis is included in hermeneutic single case efficacy design (HSCED) developed by Robert Elliott (2001, 2002), which seeks to answer questions about therapy effectiveness. Unlike other single case studies, HSCED includes both qualitative and quantitative process and outcome data, investigating whether changes in the client are attributed to the therapy or other factors. It also offers researchers a clear protocol and guidelines for data analysis. Finally, narrative case studies aim to answer questions relating to the experience of therapy from the stance of the client or therapist - or both. They involve, for example, collecting and analysing diary notes written by the client and/or therapist to record their experiences within therapy (Yalom & Elkin, 1974) in order to compile an account of what happened in therapy from either point of view. As in the current study, there is scope to combine elements from the different forms of case study in order to fulfil the purposes of the research to be carried out.

I will discuss below some of the considerations which led to the case study approach being the approach of choice for this research, in particular, the thought processes which took into account the following three concerns: the aims of the study, the impact of the study on the participants, as well as the sense of fit between me as practitioner-researcher and the case study approach.

I considered that a case study approach was the approach of choice for the study as the aims of the research, as well as the specific research questions, focused on the process of applying a strengths-based and positive psychology intervention to address emotional eating. In my view I would gather a richer source of data from attending to a few individuals' accounts in depth, rather than collecting a broader but less detailed spectrum of accounts from a larger number of participants. As my

research aims included theory-building, I decided to undertake in-depth case studies on three clients, in order for the analysis from each case to build up to more substantial findings. Three in-depth case studies felt manageable within the time and resource constraints of this study, providing sufficient variety and data to be useful. In order to allow for the potential for clients to withdraw from therapy, I planned to recruit six clients and hoped that I would be able to write up three case studies.

As the case study approach allows the depth of personal experience to be explored, it provides a richness of information which can offer insight into the process of change experienced by a person. I therefore decided that it was the most suitable way to gain some understanding of the process of going through the Positive Slimming Programme. What were the challenges, the rewards, the obstacles and the easier elements of the journey? How might a person negotiate these? What helped, what hindered? What changes might occur for a person during the course of the programme, and what was each client's understanding of how these changes happened? Did they consider the positive psychology approach and strengths-based aspects of the programme had any part to play in this? Was their understanding of how the programme may have helped be similar or different to my understanding of how it may have worked? As I was seeking to understand the process of therapy, the 'inch wide, mile deep' approach of case study research seemed particularly suitable for this. I was keen that the clients could voice their experiences of the therapy, and am intrigued by Yalom's approach to this. Yalom (1974) examined his therapeutic practice by devising a way of hearing his patient's voice by – literally – comparing notes, as described in his account of working with Ginny, a patient he saw individually, having previously worked with her when she was part of a therapeutic group which he ran. Both therapist and patient wrote their own accounts of each

individual therapy session, and exchanged written accounts every 6 months. This revealed that there was often much left unsaid in therapy sessions, and that both therapist and patient had what seemed like a parallel process of therapy going on which was unspoken, yet considerably influenced each of them as individuals, as well as their joint venture of the therapy. Reading the account of their work together is powerful and thought-provoking, challenging some assumptions expressed by both therapist and patient.

Yalom's interesting approach to examining his practice has some aspects which I felt are relevant to this study. Encouraging his patient to express her own voice privately and out of earshot – initially – of the therapist seemed to enable her to say what was otherwise unspoken. The detail she included was revealing and exposing, and this was mirrored by Yalom's own very open accounts. In my view this way of reflecting on therapy could be adapted within my study to enable me to examine my practice and to see whether the understanding of the therapy process was mirrored between myself and each patient. Each client was encouraged to write their own progress journal, and I arranged for post-intervention interviews with each client to be carried out by a third party to provide the 'out of the therapist's earshot' aspect of the feedback, and to be interviewed myself on how I thought the therapy may have helped.

The Positive Slimming Programme provides the participants with an opportunity to experience and develop a positive psychology approach to addressing their maladaptive eating habits. An early element of the programme entails the identification and application of personal strengths, a process which – when unfamiliar to a person – can pose considerable challenges. In my previous work

leading a positive psychology group for psychiatric day patients, I had seen that the notion of having any personal strengths, let alone identifying and applying them, was a very unfamiliar concept for some people. The time, encouragement, patience and respect inherent in feedback offered by other group members was necessary for some people to feel even a little comfortable with the – to them – new idea that they have personal strengths and that these can be made use of as a valuable resource to effect change.

I recognised that by offering participants in the Positive Slimming Programme individual sessions, I may need to express a similarly encouraging, patient, respectful voice to the participant when helping them identify strengths and recognise them as a potentially powerful resource. In an individual session, in contrast to the group session, I would not have the added weight of several people's perspectives. However, as the participants in the Positive Slimming Programme were not inpatients, I expected they would be less fragile and, therefore, hoped that one voice – mine – would be heard.

Another consideration when deciding on which research approach would be most suitable for this investigation, was that I wanted to be mindful of how the people who joined the Positive Slimming Programme would experience being part of a research study. I anticipated that putting oneself forward to take part in a slimming programme, which was specifically described as a programme which examines the 'why' of emotional eating, could seem daunting and potentially personally exposing for some people. In contrast, joining a more familiar slimming programme which focuses on a diet sheet, telling a person 'what' to eat and what not to eat, without looking at longstanding emotional issues may seem less challenging, more anonymous,

psychologically 'safer' and more predictable. All the people who came forward to take part in the Positive Slimming Programme were aware that the programme was being offered as the focus of a research project, and it was likely that, if they fulfilled certain criteria, they would be asked to be part of the research. They knew at the outset that there would be psychological questionnaires to complete pre- and post-programme, that they would be asked to complete a personal progress journal, and that there would be a recorded, post-programme interview conducted by a research assistant on their views of the programme. Given the participants' investment in time and effort, and given that it seemed likely that they would be sharing some very personal observations during their journey, a case study approach seemed to me to offer the attention to detail which was both justified and respectful. I hoped that, by knowing that their experiences were being given considerable attention, and that they were each one of just a few participants, they would feel that the more personally revealing elements of their involvement in the programme and in the research would be suitably contained and valued.

The very personal, in-depth nature of case studies offers a wealth of opportunity for researchers to investigate phenomena in great detail, but this close-up view of individuals comes with responsibilities on the part of the researcher to consider ethical issues and the impact of such scrutiny on the participants. Anonymity is a particular issue which needs careful management. It is also crucial to provide the opportunity for participants to access support in case they experience difficult feelings, memories or reactions during the research. Ethical issues are discussed in more detail below.

As a practitioner-researcher, reflecting on my experiences of carrying out case-study research has helped to clarify my own identity as a practitioner. The 'inch-wide, mile-deep' nature of case-study research is also the approach I endeavour to apply to my psychology practice in the consulting room. Many of the patients referred to me are either inpatients or outpatients seen within a private psychiatric hospital, and who have seen a psychiatrist for either an assessment only or for ongoing psychiatric attention. Many patients seen in that setting have their psychological therapy sessions funded by medical insurance companies, which vary greatly in the amount of therapy they will pay for. Typically they fund between 5 and 20 or so sessions, with the average being 15 to 18 sessions. With that in mind, as a practitioner I discuss with the patient realistic aims from therapy. In my experience, it is helpful to focus on one area of psychological difficulty and develop insight and skills to effect change. Typically, patients say that improvement they make in one area of their life 'spills over' into other challenging areas. I draw primarily on a cognitive behavioural approach and use this to encourage patients to develop a collaborative working relationship with me and to develop skills to apply to previously difficult situations. However, we do not overlook the value of understanding the significance of background, past experiences and what would be termed 'the subconscious' or 'the unconscious' in other approaches. Having undergone a four-year psychoanalytic psychotherapy training several years ago, I appreciate the complexity of each patient. However, within my psychology practice I rarely have the opportunity to work long term with a patient, and so use the time we have, usually over some weeks or months, to try and help him or her make a positive difference to their experience of themselves, others and their world. Working within such fairly brief therapy interventions I find the 'inch-wide, mile deep' image helpful, rather like a rock core sample taken from a many-layered expanse of rock. Geologists drill down into the

ground for information with hollow tubes to provide the information they need to put the story together, reading the core samples obtained in order to understand what has occurred in the past to create the layers seen. As a therapist I try to understand with a patient how past events have created the layers seen in the depth of their story in order to enable change in the present to occur.

Using a case study approach for this project meant that I could incorporate my preferred working style into my research, a stance which offers me both congruence and a sense of authenticity as a practitioner-researcher.

A mixed methods research design

A mixed methods design for research has become more popular in the social sciences in general over the last three decades and is now seen as a legitimate and stand-alone research design. It allows qualitative and quantitative methods to be combined in one study and enables researchers to enrich their results in ways not possible with one form of data (Hanson et al, 2005).

However, there has been considerable debate regarding the philosophical basis of mixed methods research. In the 1960s and 70s, when qualitative research was becoming increasingly popular, and it was becoming clear that there were philosophical distinctions between traditional postpositivist and naturalistic research. Guba and Lincoln (1988) identified differences in the paradigms of these worldviews which led to a dichotomy between traditional inquiry paradigms and naturalistic paradigms. The issue referred to as the 'paradigm debate' (Reichardt and Rallis, 1994) argues that a traditional postpositivist philosophical paradigm can only be combined with quantitative methods and that a naturalistic paradigm can only be

combined with qualitative methods. This view held that if certain paradigms and methods could not 'fit' together then a mixed methods research design was untenable (Smith 1983). However, Reichardt and Cook (1979) argued against this, stating that philosophical paradigms and methods are not inherently linked, for example, just as quantitative procedures are not always objective, nor are qualitative procedures always subjective. My own position on this is to agree with the more recently expressed view that mixed methods within a single research design can complement each other and benefit from the generalisability of quantitative data and the detailed, in-depth nature of qualitative data (Greene and Caracelli, 2003).

I incorporated some psychological questionnaires in the introductory information session I conducted with each potential participant, in order to measure each client's pre-therapy level of self-esteem, the extent of their emotional eating, and whether they were depressed (see Appendix 2). The Intuitive Eating Scale was part of the screening procedure and was included to confirm that the participants did indeed engage in emotional eating behaviour prior to the study, and to provide pre- and post-intervention scores for this behaviour. Measuring any change in weight seemed a simple and obvious quantitative measure, even though maladaptive eating habits do not always result in overweight. Through my clinical experience I have become aware that some emotional eaters are obsessed with food and engage in eating in response to emotional cues without becoming overweight, but very frequently emotional eaters struggle with an unhealthy relationship with food which results in them being overweight – often for years. In order to be able to include this simple, objective measure, I made the decision to select as participants only emotional eaters who were seeking not only to address their emotional eating but also to lose

some weight. I monitored each participant's weight by weighing them on a weekly basis to produce a very straightforward record of weight gain, maintenance or loss.

Based on my previous experience of working therapeutically with emotional eaters, I anticipated that the participants' self-esteem might improve during the course of the therapy and this could easily be measured pre- and post-programme to see whether any change did indeed occur.

Qualitative data on the process experienced during the intervention was collected through participants' personal journals, their Mood and Food diaries, my session notes, my supervision notes, my own reflective journal during the period of the study and post-intervention interviews of the clients and of myself as therapist-researcher. The semi-structured interview schedule is shown in Appendix 3 and the transcript of one of the post-intervention interviews is shown in Appendix 4.

Research design issues

Initially, my intention in this study was to examine the process of a positive psychology intervention which had a predominantly strengths-based focus, and evaluate whether this approach might help clients make changes. My experience of providing a strengths-based focus for individual patients and therapy groups has been encouraging, as clients have often given positive feedback regarding this aspect of our work together. For this research, I envisaged providing an intervention to address emotional eating (the 'Positive Slimming Programme') which would include as its primary focus a strong emphasis on identifying and applying the client's personal strengths to develop a healthier relationship with food. Clients would be

encouraged to identify their relevant personal strengths, and to apply these strengths in situations when they would typically respond by emotional eating in order to change their eating habits. Additional therapeutic input if appropriate would include CBT skills development to manage unhelpful thinking patterns, to ease unwelcome emotions, and to develop skills for self-soothing, and I expected to introduce some broader positive psychology principles within the therapy if and when they seemed appropriate.

However, fairly soon in the course of therapy it became clear that the clients were responding well to a broader approach based on wider positive psychology principles and strategies, developing and applying positivity beyond the initial focus on strengths. The intervention therefore evolved to provide a more holistic approach, incorporating a wider range of positive psychology elements than I initially expected. The evolving nature of the focus of this study reflected the flexibility which can exist in individual therapy, when the therapist is sensitive to the clients' experience of and responses to the therapy and tailors the interventions accordingly, while remaining loyal to the theoretical framework of the therapeutic approach used. Although the emphasis of the intervention shifted over the course of the therapy, the purpose of this study remained loyal to my initial intention.

Outline of the Positive Slimming Programme

I designed the Positive Slimming Programme specifically for this research study, drawing on my clinical experience of a strengths-based group I previously developed and delivered to psychiatric clinic day patients to address a wide range of psychological difficulties. I also drew on my knowledge of other psychological

approaches to weight loss and of positive psychology. The intervention evolved during the course of therapy in this study as I took into account the clients' responses to their individual therapy sessions and adapted the content accordingly. It focuses predominantly on why we eat, rather than on what we eat, and thereby differs from many 'slimming groups' and programmes which focus on diet plans to regulate the type of food eaten and result in weight loss without addressing the slimmer's relationship with food. The participants were all recognised to be emotional eaters through the IES questionnaire and all wanted to lose weight during the programme. The aim of the Positive Slimming Programme was to enable participants to identify their unhealthy relationship with food which underpins emotional eating, and to revise their relationship to food by applying their strengths and using other positive psychology interventions to see if changes occur that lead to intuitive eating and weight loss.

Participants were required, as far as possible, to attend weekly individual sessions, each lasting 45 minutes, over the 20 weeks of the Positive Slimming Programme. There was a review of progress with each client after 12 sessions. The 20-session course was referred to as the 'Positive Slimming Programme'. I took on the dual roles of therapist and researcher, so all sessions were conducted by me as therapist in the interests of consistency of delivery and to minimise therapist effect. As researcher, I made notes following each session based on the content, any changes reported, aspects of the therapeutic process and my own reflections on the session, for later analysis.

The sessions included three broad areas of content:

1. A broad positive psychology approach, including strengths-based interventions, to address emotional eating as well as applying positivity to wider areas of the clients' lives
2. Skills for developing a healthy relationship with food and intuitive eating, and broader applications of these skills
3. Raising awareness of the psychology of emotional eating, including identifying and appropriately regulating difficult emotions, understanding the impact of the past, addressing issues of self-regard and recognising that shifts in a sense of self are essential for long lasting change to occur.

These three areas are described in more detail below:

1) Sessions included identifying personal strengths and recognising when they could be applied effectively, in particular, discussing how these strengths can be applied to challenges regarding emotional eating in each week ahead. Participants were asked to complete progress journals during each week to record how they apply their strengths to attempt to deal with any situations which would usually have triggered emotional eating. From session 2 onwards the past week's experiences of this were reviewed when relevant to the client. The sessions also included psychoeducational content on the differences between emotional eating and intuitive eating. A Positive Psychology stance was also taken in order to help with the wider context of a person's life, enabling priorities to be recognised. I was intrigued by the view of Sharp (2011), who has suggested that emotional eaters should focus on overturning the frequently held belief that happiness will follow once a person

has lost weight, and instead recognise – and act on – the view that if a person works on what makes them happy first, then the focus on food will dissipate. This view was incorporated into Positive Slimming sessions and goal setting in non-food areas of each participant's life was included.

2) Cognitive and practical behavioural changes in emotional eating behaviour were encouraged through relevant skills development, mainly CBT-based, to encourage intuitive eating habits and a healthier relationship with food. This included strategies such as cognitive restructuring, and also using 'The Hunger Scale'. The Hunger Scale is used by using a mental scale from 0 to 10 to rate the intensity of hunger, when 0 represents not feeling hungry at all, and 10 represents feeling ravenously hungry. If the client rates their hunger at 6 or above, she will eat, but if it is at 5 or below, she will not eat but will deliberately try to address the trigger to the urge to eat instead.

   Within this behavioural element of the programme, some attention was also given to the role of exercise, especially within a sedentary lifestyle. Most people are very well aware that exercise is healthy, and this aspect of the programme was not aimed to alert the participants to this, but when relevant, the focus was on what had held the participants back from engaging in a more active day-to-day lifestyle and to try and use a strengths-based approach to manage any such obstacles.

3) Given that the maladaptive eating occurs as a result of emotional cues rather than physiological hunger, when developing the therapy I expected that clients would need to address the way they dealt with difficult emotions if they were to overcome emotional eating. I therefore included some content based on cognitive behavioural therapy so that participants could discover that they could regulate the intensity of difficult emotions and 'self-soothe' by

recognising unhelpful thinking patterns and re-evaluating core beliefs. I was keen for them to recognise that it is helpful to experience a wide range of feelings, even difficult ones, in order to feel balanced as a person. Difficult feelings do not need to be avoided or supressed, nor is distraction always needed – they can be regulated then tolerated. Feelings can give us valuable information about what in life needs to be addressed. I also believed it would be helpful to consider with each participant the impact of their past and their sense of self-identity, as from my previous experience of working with emotional eaters I am aware that frequently they have carried with them a longstanding view that they are, for example, 'the large one' in a social group or family, and that for many, such a role includes more self-critical elements. Some emotional eaters I have worked with in the past have described how they see themselves as 'the frumpy one', 'the unattractive one', 'the worthless one' and/or 'the invisible one'. The experiences of feeling like 'the invisible one' vary. One client described how she felt that people saw her as 'a large person first, an individual second – if at all'. She felt that her individuality was completely overlooked by others. In other instances clients described how they felt 'invisible' as they believed that, being overweight, they were 'not taken seriously' by other people and their views and needs were dismissed as unimportant. My prior awareness of this type of experience from previous clients who were emotional eaters led to my decision to include work on self-identity in the Positive Slimming Programme. I considered it could be important for a participant to address how changes in the way they present to the world would affect them emotionally. How would they feel if they no longer felt 'invisible' to others? If their views were sought, heard and valued? If their looks were noticed and appreciated? If others saw them as attractive

and paid them compliments? I believed that any achievements in overcoming emotional eating that resulted in weight loss could be sabotaged unless the client were prepared to explore whether their self-regard also required re-evaluating, and if so, to address this positively.

Each participant's weight was monitored at each weekly session. An aim of all clients was to lose some weight, so weighing regularly provided a quantifiable measure of one aspect of change.

For each client the final weekly individual session included discussion of relapse prevention. Together we reviewed progress made in various areas of the client's life and what might have helped this progress occur. I asked the client how she would be aware of any slip in her progress, which might manifest in potential unwelcome changes in her feelings or behaviour. I emphasised that her rate of progress was likely to vary, and that just because we were discussing a potential slip in her progress this did not mean it would necessarily happen. The discussion was aimed to set her expectations realistically, so that if the client experienced some difficult days or stages she would be aware that this was normal and not to be disheartened by such variation. I explained that there are three 'at risk' situations which might explain a return of some old eating habits and accompanying feelings: if the client were overtired, under extra pressure and/or physically unwell. I suggested a stepped approach to any slip in progress. Firstly, to see whether any of the three 'at risk' situations were present, and if so, to address the challenges if possible and expect that her progress would be back on track in a day or two. However, if this approach did not help, I suggested the client 'go back to basics' and revise her awareness of how to manage emotions by reviewing the CBT materials received during the course

of therapy – and to apply any strategies she thought could help, including resuming completing the Food and Mood diary sheets, noting down and challenging unhelpful thinking patterns which led to distress, and drawing on positive resources available to her.

Further details of the Positive Slimming Programme are documented in Appendix 1.

The Research Process

Participants and sampling

As the focus of this study was to examine whether a positive psychology approach may help address emotional eating, and also to compare how clients and I experienced and understood the process of this intervention, participants were selected as cases for instrumental case study research, constituting exemplars of the phenomenon of interest, i.e. emotional eating. The recruitment process reflected this requirement, firstly by publicising the study in a targeted manner and secondly by confirming that potential participants were indeed 'emotional eaters' by checking that they scored within the relevant range for such a definition on the Intuitive Eating Scale (Tylka, 2006).

The sampling plan was mixed purposeful sampling, selecting information-rich cases for in-depth study. One type of purposeful sampling used was snowball - or chain - sampling, making use of my contacts who might have known of suitable participants for the study, who may in turn have known of others. I discussed the study with colleagues at one of my places of work, a multidisciplinary health clinic. Some practitioners at the clinic work as weight loss coaches focusing on nutrition awareness and I hoped they would know of individuals who were seeking to address

emotional eating. I hoped such individuals would in turn contact other potential participants with information about the research, and so on. Another type of purposeful sampling used was opportunistic sampling, making use of new leads generated from publicising the study through notices in local gyms and an advertisement in the local press.

I undertook case studies on 3 participants who completed the 20-session programme. To allow for potential dropouts from the study, I initially recruited 7 participants. Once 7 people who fulfilled the inclusion criteria had put themselves forward to join the programme, I ceased actively recruiting. However, one recruit did not return after the initial introductory session, and two others attended one further session then contacted me to say they would not be proceeding. One of these explained that she was studying and did not feel able to commit to attending regular weekly sessions after all because of time constraints, the other said she had changed her mind about joining the programme. Of the remaining four, one left the programme following the review session at week 12. She had been experiencing health problems which required imminent hospital investigations and she felt unable to commit to our regular weekly sessions from then on. She said she had benefitted from the programme, and her weight had reduced steadily over the course of therapy. At our final session I explained to her that I would be happy to work further with her should she wish to return to the Positive Slimming Programme at some point in the future. She did not get in touch, but I felt that it was important for her to know that further sessions were available to her regardless of the timing of her health problems. The other three participants all completed the 20 session programme and each also attended an individual follow up session approximately three months after

session 20. I analysed the data collected on these three participants, whose experiences I explored as case studies and have written up in detail for this study.

Participant selection criteria were as follows:

- Adults over 18 years old
- Participants' acknowledgement that they engage in emotional eating which prevents them from maintaining a healthy body weight. Confirmation of this by scoring within the relevant range for emotional eating on the Intuitive Eating Scale which was completed as part of the pre-programme recruiting stage.
- Individuals would be excluded from participating if they suffered from a severe eating disorder such as anorexia nervosa or bulimia nervosa. This restriction is in place as the focus of the study is on addressing emotional eating which is widespread in the general population; it was not the aim of the study to investigate anorexia nervosa or bulimia nervosa.
- Motivated to address their emotional eating and develop intuitive eating.
- Overweight, and motivated to lose weight during the 'Positive Slimming' programme.
- Intention and availability to attend and undertake the 'Positive Slimming Programme', consisting of 20 weekly individual sessions. Potential participants were informed that they could withdraw from the research but remain in the Positive Slimming Programme.
- Participants to be willing to monitor and record their weight during the programme.

- Initial intention to provide the data required for the study from questionnaires, a progress journal and a post-programme interview.
- Participants with a BMI score of over 40, indicating morbid obesity, would be excluded from the study.
- All participants required medical clearance from their GP (see Appendix 5) before starting the therapy programme to address emotional eating.

A questionnaire, based on the above criteria, was given to individuals interested in taking part in the study in order to ascertain eligibility to participate. The initial contact from each potential participant was telephoning me, therefore I was able to inform them verbally of the selection criteria during the telephone call, then confirm these points at the introductory session.

I have taken seriously the very personal nature of the detail within a case study, and have tried to respect each client's privacy by disguising some of their details, while keeping the sense of their individuality and presence intact. When describing each client below, I have made some changes to their identities in a number of ways including changing their names and other personal details, and substituting their own job title for a role requiring similar levels of education and training. I have done the same regarding the personal details of their family members.

Ethical considerations

During this study I adhered to the British Psychological Society research ethics guidelines (British Psychological Society, 2010).

The very personal nature of case study research, looking in depth at participants' experiences, means that it has to be particularly sensitive regarding issues of anonymity and confidentiality.

Participants in the proposed study were given an information sheet about the study and a form of informed consent (see Appendix 6) to sign prior to the programme. The aim of these documents was to ensure that the participants engaged voluntarily with the programme, without coercion and in the knowledge they could withdraw at any time. It was made clear to the participants that, if they chose to withdraw from the research, they could remain in the Positive Slimming Programme and their involvement would not be affected by their withdrawal from the research. Furthermore, the participants were assured that they would remain anonymous in records of the research, the written thesis, any future publications and presentations of the research. They were also assured that the information they provided would be securely stored and used responsibly. Information pertaining to the study, including participants' personal data, completed questionnaires, notes and audio recordings of interviews, were stored securely in a locked filing cabinet within the researcher's home office. There should be no adverse consequences of their involvement in the research, but participants were aware that they would be given details of contacts regarding therapists and relevant organisations for possible referrals or information in case of complaint or need for support, should personal or difficult issues arise that were not satisfactorily addressed within the programme.

The project was approved by the Metanoia Research Ethics Committee (see Appendix 7) prior to beginning the research. However, as the recruitment phase proceeded, there were two ethical challenges which I faced.

Firstly, as the recruitment process was through snowball sampling and by displaying notices in the public domain, it was thought unlikely that any participants would be previously known to the researcher. However, one person, whom I have called Jane when writing up the research, who did come forward was previously known to me. The ethics of offering a – hopefully beneficial – intervention to individuals, then choosing not to make it available to a person who seemed likely to fit the inclusion criteria, posed a concern which required careful thought. Jane was aware of our connection before she contacted me about participating in the project, as she recognised my name which was included on the publicity material for recruiting participants. During her initial enquiry about the project she and I discussed whether our previous contact would hamper working together on addressing her emotional eating through the Positive Slimming Programme. In essence, it was a boundary issue regarding the appropriateness of accepting a patient for therapy, and as such, not unfamiliar. The level of knowing each other was minimal – for reasons of confidentiality I do not wish to detail the context of our contact, but it can be summed up by saying that 'our paths had crossed' intermittently, perhaps four or five times, over two or so years. At each occasion we had either simply acknowledged each other in an amiable manner or chatted for a few minutes. It was not expected that the level of frequency or the nature of our contact would change – other than contact related to this research. After discussing whether our prior awareness of each other would hinder therapy, we both agreed that, as our previous contact was minimal and had felt relaxed, we felt comfortable for her to proceed with taking part in the Positive Slimming Programme.

Secondly, offering a service in the public domain and inviting participants to come forward to receive the service, and hopefully benefit from it, posed an ethical concern for me as I wondered how I should respond when it seemed that more participants had come forward than I needed for the project. I planned to write up three participants' experiences, and was hoping to recruit six in case some dropped out of the programme. At one point there were enquiries from eight potential participants. This raised questions regarding whose needs I was primarily addressing – mine or theirs – and whether it would be ethical to turn participants away who fulfilled the inclusion criteria. I only really had time in my working week to offer a maximum of six individual sessions relating to the Positive Psychology programme. As a psychologist, with the well-being of others as a central concern, would it be ethical to raise hopes of help then not fulfil expectations that the help would be forthcoming? After discussion with my supervisor I decided that I would offer the programme to anyone who responded to the recruitment publicity and who fulfilled the inclusion criteria, and, if necessary, would have to rearrange other working commitments to accommodate this decision. I tried to minimise the likelihood of too many respondents by pacing the recruitment publicity, so that I could monitor the numbers of potential participants as they made contact. I did not publicise the programme any further after the time when there were seven respondents who had made contact and wished to meet for an initial introductory session. I met all seven and they all expressed interest in taking part in the Positive Psychology programme and in the research. However, two did not return to begin the programme, and one dropped out after the first session, leaving four participants who attended regular sessions - one for 12 sessions and three for 20 sessions. I had hoped to write up case studies on three clients, and fortunately three clients completed the 20 sessions so I was able to write up these cases.

It is realistic to expect that taking part in case study research may have some effects on the participant, not all of which may be positive or welcome. In order to address this constructively, participants were asked routinely during sessions whether they had any issues they wished to discuss. Clients had all completed a consent form prior to beginning therapy, and they were made aware that they could choose to withdraw from the research study at any time without ending therapy if that were their choice. In view of this, I treated their consent as an ongoing process for the duration of the study.

In a similar vein, it is realistic to expect the involvement in such in-depth research to have an impact on me, as practitioner-researcher, and I wrote a personal research journal to reflect on thoughts, feelings and memories evoked by the research involvement and in this way monitored my own process during the project, consulting with my supervisor if I required one-to-one support. A more formal account of the impact of the research on me and my evolving understanding of how positive psychology and the strengths-based approach may work in therapy was captured in the post-therapy interview of me by a colleague, and the data analysed.

Participants

Introducing Jane:

As discussed above, Jane and I had met very briefly on a few occasions prior to the research.

Jane was a quietly-spoken woman in her mid-fifties, who initially seemed to find it hard to have much eye contact during our sessions, typically looking down or away when we spoke. She dressed in loose clothes and, whenever I saw her, wore the same pieces of pretty, understated jewellery which, I later discovered, have

sentimental significance as they were gifts from her family. She expressed her individuality through her choice of accessories – at each session she had a noticeably eye-catching handbag or pair of shoes which were colourful and unusual. This was rather intriguing – she was clearly not averse to being noticed, but she chose to catch the attention of others through her choice of colourful and unusual accessories, rather than any other, more personal, aspect of her appearance. During our sessions she often chose to be separate from these colourful and individual pieces, setting her bright handbag on a separate chair, and kicking off her shoes which were often left, askew and almost out of sight, under her seat as she tucked her feet under her legs to curl up comfortably in the armchair.

Jane had worked as a social worker for many years, and as part of her working role drew on her knowledge of counselling skills. She enjoyed her work helping others and had good working relationships with her colleagues, although she told me that she often took on more responsibility than appropriate for her job role as she found it hard to be assertive at work.

Jane is happily married and she and her husband have three grown-up sons, all in their twenties. Two sons lived at home, and one lived locally.

She had grown up in a family in which hard work was admired; her parents were down-to-earth and rather critical of frivolity or spending money on oneself. Jane's teenage interest in fashion and makeup was dismissed as 'vanity', 'putting on airs and graces' and 'thinking she's better than the rest of us'. Jane has an emotionally rather needy, unmarried sister with whom she is fairly close, and, although they have very different priorities and lifestyles, Jane has always been supportive to her.

When I asked Jane why she had come, she explained that she had engaged in emotional eating for all her adult life, and she had a history of losing weight then putting it on again, then felt demoralised, guilty and a failure. She had focused on 'what' she was eating and had joined various diet groups to support her efforts to lose weight. She said that, in her view, addressing her eating habits from a psychological approach through the Positive Slimming Programme was her 'last chance' to finally lose weight for good and to feel proud of herself for doing so. She wanted to lose at least three stones in weight 'eventually' but during the 20-session Positive Slimming Programme she hoped she would lose one stone.

Introducing Isabel:

Isabel was in her late thirties, with an outgoing, friendly manner and a ready smile. She had a steady gaze and engaged interestedly and receptively in conversation. She was quietly confident and assertive, comfortable in stating her own view when it differed from another's opinion, and open to considering new ideas. Her relaxed sense of humour emerged from time to time, and at these times her otherwise pensive expression lit up and allowed a glimpse into her more playful side.

Isabel was a full-time mother looking after two primary school age children. Before she had her children she worked as a marketing manager. She admitted that, although she enjoyed her work and received positive feedback from her employers, she was pleased to have had the opportunity to spend time on other areas of her life when she became a full-time mother. Over the past few years she had been involved with a number of committees related to her local parish council, and had taken up a voluntary role in a charity.

Isabel was happily married and described her husband as very supportive. They married 10 years previously and had a close, relaxed and trusting relationship. Since Isabel gave up work, she and her husband took on a rather traditional division of labour at home, he as the competent provider, and she as the home-maker who made the decisions relating to the children, family and home.

Isabel's father was successful in business and worked away regularly. She remembered him putting much emphasis on her school achievements but he was otherwise somewhat absent and busy with work-related activities. Her mother did not work after she had a family. Isabel has a younger brother, but they were never particularly close. During her teenage years and early adulthood Isabel was often required to look after her rather frail father who had intermittent health problems. Her parents lived locally to Isabel's home and she had frequent contact with them.

She explained that her reasons for enquiring about joining the Positive Slimming Programme included a desire to lose some weight, as she was considerably heavier after having had her children than she had been previously and she 'didn't feel herself' at her current weight and size. She had tried diets and exercise intermittently over the last several years but without long-lasting success, recognising that she was eating 'for the wrong reasons'. She had a long-standing interest in psychology and was keen to find out how a psychological approach could perhaps help her develop a healthier relationship with food.

Introducing Caroline:

Caroline was in her early forties, and had a lively and enthusiastic manner. She was initially slightly guarded in our sessions but quickly relaxed and spoke openly about

herself and her emotions. It became clear that her background and lifestyle were somewhat unconventional and her appearance reflected this in that she chose to wear unusual clothes incorporating interesting fabrics and textures. She engaged readily in our discussions and had an animated and expressive face, sometimes smiling and laughing, and at other times carefully considering ideas in a thoughtful manner, and occasionally tearful.

Caroline has always worked during her adult life, and was keen to point out that even when there were no immediate opportunities of work suited to her training as a lab technician she would turn her hand to anything to make a living, including being a children's nanny, renovating and selling furniture and teaching English conversation to foreign students. Caroline was clearly resourceful, independent and imaginative. She was happily married for the past 8 years and had a young daughter aged 6. Caroline took her parenting responsibilities very seriously and read widely on the subjects of parenting and child psychology.

Her family background was characterised by conflict and she described it as dysfunctional. Her parents were cautious people, keeping themselves to themselves and rather insular from neighbours and the wider community. Caroline described growing up within a 'them-and-us' atmosphere, because it seemed that outsiders were perceived with suspicion. Caroline was the second oldest of five children and remembered frequent arguments between her parents and also between the siblings. Caroline 'escaped' into studying and achieved well at school, although this was of little interest to her parents. She spoke about her siblings as being on the edge of society, involved in heavy drinking sessions and living on benefits. Her father worked hard and was a good provider, but Caroline remembered her mother being unhappy

and angry much of the time. It was not a happy childhood, and Caroline felt strongly as she was growing up that she didn't belong, as she had very different interests, priorities and values to the rest of her family. She felt closest to her father, who died several years ago. Caroline attended occasional family events but said they were always stressful, characterised by negativity.

She explained that she was aware that food was used for 'the wrong reasons' in her family of origin, as mealtimes were often fraught, but they were the only times that most of the family came together. Caroline had a difficult relationship with food – she could not remember ever feeling hungry, and realised that she ate to distract from difficult feelings. She said that she felt ashamed of being overweight, and recognised that she was often overly apologetic in an attempt to please others. She often felt excluded when with others, and as a result felt lonely. She was interested to see if a psychological approach to changing her relationship with food could help not only her eating habits and help her to reduce her weight but hoped that the Positive Slimming Programme would improve her self-esteem and overall sense of well-being.

Data collection and analysis

As this study incorporates a mixed-methods research design, a variety of data collection methods have been used, including quantitative and qualitative methods.

The collected quantitative and qualitative data were analysed with the aim of ascertaining whether clients had experienced changes during the therapy, and if so, to understand the process of how the therapy may have helped to enable change.

A multiple case study design was utilised, in which analysis of the first case led to tentative hypotheses, explored and modified in the light of the subsequent two cases, in order to develop a conceptual framework that accounts for them all.

Quantitative Data Collection

The sources of quantitative data are as follows:

Intuitive Eating Scale (IES)

Rosenberg Self-esteem Scale (RSES)

Beck's Depression Inventory (BDI)

Participant's weight records

Positive Slimming Programme review forms

I describe each one in some detail below.

Intuitive Eating Scale

The questionnaire used to assess any change in each participant from emotional eating to engaging in intuitive eating was the Intuitive Eating Scale (IES) (Tylka, 2006), and was completed by each participant twice. Firstly, during the pre-screening recruitment stage to establish eligibility for the study and again at session 20, the final session of the Positive Slimming Programme.

Rosenberg Self-Esteem Scale

The Rosenberg Self-Esteem Scale (Rosenberg, 1965) was completed by all participants pre- and post-intervention to monitor any change in their level of self-esteem which may have occurred during the course of the programme.

Beck Depression Inventory

The Beck Depression Inventory was also completed by the participants before and after the programme. Like the EIS and the Rosenberg Self-esteem Scale, it is a self-report questionnaire. It was used in this study to measure whether the clients reported any symptoms of depression at the start of the programme, and whether there were any changes in their reporting of such symptoms after the course of therapy.

Participants' weight records

In order to assess whether any weight loss occurred during the course of therapy, participants' weight was monitored and recorded by me as the researcher at each session of the 20-week intervention and at the follow-up session. One set of scales was used throughout the study for all participants and for every session, for consistency.

Positive Slimming Programme review forms

At session 12 of the programme I reviewed with each client how they felt the therapy was helping them, and gave them a simple questionnaire devised by me to complete so that they could rate how helpful, or not, each structured intervention had been thus far, using a Likert scale.

Quantitative data analysis

The Intuitive Eating Scale questionnaires were scored according to the IES scoring procedure (Tylka, 2006). Pre- and post-programme scores were compared to ascertain whether clients engaged more in intuitive eating during the course of the Positive Slimming Programme.

For both the Rosenberg Self-Esteem Scale and the Beck Depression Inventory, pre- and post-intervention scores were compared for each participant.

Participants' weight at the beginning of the programme was compared with their weight at the end of the programme. The participants' weight was monitored and recorded weekly at the programme sessions by me, thereby producing a clear record of whether weight changed during the study period.

The Positive Slimming Programme review forms completed at week 12 provided a one-off rating by clients recording their perceived level of helpfulness of each structured intervention of the programme thus far.

Qualitative data collection

The sources of qualitative data are as follows:

- Clients' personal progress journals
- Clients' 'Mood and Food' diaries
- Semi-structured post-programme interviews of clients
- Semi- structured post-programme interview of me as therapist-researcher
- My own reflective journal
- Session notes
- Supervision notes

I will describe each data source in some detail below.

Clients' personal progress journals

In order to explore the process of how a strengths-based approach and positive psychology might help individuals to manage emotional eating and engage in intuitive eating, participants completed a personal progress journal – a diary to record regularly, at least weekly, their experiences of identifying, developing and applying their personal strengths to manage their emotional eating and encourage intuitive eating. This journal was also used to record challenges the clients experienced in applying the principles of the Positive Slimming Programme, as well as observing which aspects of the programme seemed to work well for them.

Clients' 'Food and Mood' diaries

Each client was encouraged to complete a 'Food and Mood' diary for at least the first two weeks of the programme. This was aimed to gather information regarding their triggers for emotional eating.

Semi-structured post-programme interviews of clients

A semi-structured interview, loosely based on the Change Interview (Elliott et al, 2001) was conducted post-programme with each participant to explore the process of therapy for them, their understanding of any changes during the course of therapy, and – if relevant - how they thought the positive psychology approach and strength-based strategies may have helped them develop a healthier relationship with food and develop 'intuitive eating'.

This interview was carried out immediately following session 20 by a psychology graduate who was not involved in delivering the programme sessions. I thought carefully about whether I would be the most suitable person to carry out these interviews, but concluded that if I were to be the interviewer it may hinder clients in

delivering any negative feedback. I will discuss this decision in more detail in the section on validity below.

Interviews were audio-recorded and then transcribed verbatim.

Semi- structured post-programme interview of me as therapist-researcher

As my research seeks to compare my own understanding of the process of therapy and how a positive psychology approach may help develop a healthier relationship with food with that of clients, an interview of myself carried out by a psychologist colleague seemed a suitable way of collecting relevant input on this from my perspective. The interview was carried out after the therapy was completed, audio-recorded and transcribed verbatim.

My own reflective journal

I completed my own reflective journal during the course of the programme to record my experiences of the study, including the impact on me of being both practitioner and researcher, as keeping the journal enabled me to document my feelings and emotions during the research. This reflexive stance also helped me to consider how, in my role as researcher/therapist, I thought that the therapy had an impact on the clients. As well as keeping track of my emotional reactions, keeping a journal also enabled me to monitor my assumptions and challenge these. It provided me with the opportunity to examine the tension between my role of therapist and that of researcher, and the challenges of this dual relationship.

The content remained personal to me and was not shared with the participants.

Session notes

Session notes compiled by me as the therapist at each session provided an additional source of data for comparison purposes regarding process as well as any progress perceived by me compared with any progress reported by the participants. Approximately three months after session 20, an individual follow-up session took place with each participant. Each was weighed to monitor whether their weight had increased, decreased or remained stable. I took session notes which provided data on whether any positive changes which occurred during the programme were maintained by clients, and also on whether they reported any challenges to doing so.

Supervision notes

I used my supervision notes as a source of data drawing on discussions in supervision regarding, for example, relevant themes which seemed relevant and which aspects of the Positive Slimming Programme to focus on and include more than others as the therapy proceeded. Supervision also provided a helpful opportunity to reflect on the impact of my therapist-researcher role on me.

Qualitative data analysis

Unusually, I have used both thematic analysis and grounded theory to analyse the qualitative data in this study. Each analytic approach has a different task. Thematic analysis is used to provide a description of the clients' experience of the therapy, whereas in contrast, grounded theory goes beyond description and is used to build an explanation or theory – in this study, an explanation of the clients' theory of change, and my own, from my position as therapist-researcher. I considered that using both analytic methods would address the tension in the study between on one hand capturing a description of the experience of therapy, and on the other hand also

getting an explanation from clients of their ideas about how they came to make changes.

Thematic Analysis

Given the research questions of this study, I considered that thematic analysis would be a suitable approach to identify relevant themes in the data from the clients' journals, their Mood and Food diaries, and my own session notes. The purpose of this approach in this study is to provide a description of the clients', and my own, experience of therapy. Thematic analysis offers a method for organising rich and complex data and capturing the intricacies of meaning within data (Guest, 2012). In this study these data are analysed inductively, themes being strongly linked to the data without trying to fit them into a pre-existing model or theory, as is the case with deductive approaches. However, it is realistic to recognise that even an inductive approach is coloured by my own – as the researcher – set of values, experiences and cultural influences. Thematic analysis is suitable for this study as it offers a flexible approach for analysis of a large quantity of rich data. Further advantages are that it offers a method of studying phenomena beyond the researcher's experiences, and the data initiates the researcher's interpretation of themes. However, reliability is a concern as the themes could evoke a variety of interpretations by different researchers, and the flexibility of thematic analysis can cause confusion as to which aspect of the data to focus on (Braun & Clarke, 2006).

Data collected from participants' journals, their Mood and Food diaries and from my session notes were analysed using thematic analysis. Thematic analysis is a method for identifying, analysing and reporting themes within qualitative data. Boyatzis (1998) suggests it is a tool to be used across different qualitative methods of

analysis, and Ryan and Bernard (2000) view thematic coding as a process carried out within 'major' analytic traditions, including grounded theory as in this study.

In order to avoid the frequent criticisms that thematic analysis is poorly defined as a method of qualitative analysis, I will describe in some detail the process involved in using it within this study. My aim was to provide a rich thematic description of the entire data set, in order to get a sense of the predominant or important themes. Themes within the data were identified using an inductive approach, which is a process of analysing the data without any preconceived coding frame, so that the themes which are identified are strongly linked to the data (Patton, 1990). This form of data-driven thematic analysis is similar to the analytic process within grounded theory. It helps to locate the thematic analysis within the paradigm of the study - in this study the qualitative analysis reflects the research epistemology which is an critical realist approach, assuming a largely unidirectional relationship between language enabling the articulation of meaning and experience (Potter and Wetherell, 1987; Widdicombe and Wooffitt, 1995).

The phases of thematic analysis are similar to stages of other forms of qualitative analysis – becoming immersed in the data, identifying initial codes, sorting and combining codes into overarching themes (and subthemes), reviewing and refining themes to check that they reflect meanings in the data, then identifying the 'essence' of each theme, interpreting their implications for understanding the data and in answering the research questions. In this study, thematic analysis of the clients' journals, Food and Mood diaries, as well as my session notes, will help to interpret the data in relation to the research questions.

Grounded Theory

The research method utilised to analyse the qualitative data from the post-intervention interviews in this study is informed by grounded theory, originally developed by sociologists Glaser and Strauss in the 1960s (Glaser and Strauss, 1967). In contrast to thematic analysis, grounded theory goes beyond description as it is about building an explanation or theory, in this case, an explanation of each client's theory of change as well as my own. Grounded theory incorporates guidelines which are both systematic and flexible to investigate qualitative data in order to generate theory 'grounded' in the data. It contrasts with much other research as it is explicitly emergent. It does not test a hypothesis; instead it sets out to generate theory to account for the phenomenon which is the focus of the research. In 1967, Glaser and Strauss described grounded theory as involving 'the discovery of theory from data' (p. 1). The use of the term 'discovery' suggests that the researcher uncovers something that is already there. Similarly, the concept of 'emergence' (of categories and of theory) also plays down the creative role of the researcher in the research process. The purpose of the grounded theory approach is to 'get though and beyond conjecture and preconception to exactly the underlying processes of what is going on, so that professionals can intervene with confidence to help resolve the participant's main concerns' (Glaser 1978). Grounded theory is included in this study as it helps to move from a description of what is happening to an understanding of the process by which it is happening (Corbin and Strauss, 2008).

The grounded theory approach has evolved since Glaser and Strauss' initial version, resulting in three main types of grounded theory design: emerging design (Glaser, 1992), systematic design (Strauss & Corbin, 1990), and the constructivist approach (Charmaz, 2003, 2006). Glaser's emergent design approach emphasises the importance of letting the theory emerge from the data rather than using specific,

preset categories. It has been argued that such a view of the research process in grounded theory is heavily influenced by a positivist epistemology, which assumes the researcher is separate from and not affecting the research outcomes. The suggestion that categories and theories can 'emerge' from data, and that it is possible for a researcher to avoid the imposition of categories of meaning onto the data, reflects the view that phenomena create their own representations that are directly perceived by observers. The systematic design described by Strauss and Corbin emphasises specific steps used in data analysis - open, axial and selective coding – and the development of a logic paradigm or visual representation of the theory generated. The focus is on validation criteria and a systematic approach, offering the researcher guidelines on how to structure data. Charmaz (1990, 2000, 2002, 2006) introduced a social constructivist version of grounded theory that argues that categories and theories do not emerge from the data, but are constructed by the researcher through an interaction with the data. According to this version, 'The researcher creates an explication, organisation and presentation of the data rather than discovering order within the data. The discovery process consists of discovering the ideas the researcher has about the data after interacting with it' (Charmaz 1990, p. 1169, original emphasis). Charmaz' constructivist approach aims to offer a voice to research participants, by focusing on the meanings which individuals attribute to the subject under investigation in the study. The participants' thoughts, feelings, values and viewpoints are explored rather than collecting facts and describing behaviour.

Charmaz' constructivist approach resonates with my own views that data and theories are not already present, available to be discovered, but are constructed by the researcher as a result of interacting with the phenomenon of interest and the research participants. Data are thus co-constructed by researcher and participants, and are shaped by aspects of the researcher including his or her perspectives,

values and cultural influences. This position takes a middle ground between the realist and postmodernist positions by assuming an "obdurate reality" as well as assuming multiple realities and multiple perspectives on these realities. In this study I have used specific types of coding underpinned by this constructivist approach. The analysis of qualitative data in this study is informed by grounded theory, but does not follow the methodology fully. For example, it was not possible to continue collecting data from new participants until saturation was reached as is typical in grounded theory research, because of the study design – providing therapeutic intervention over 20 weeks then analysing the data. I believe that analysing the data in this way is useful within this study, and as Mason (2010) argues, the point of saturation is a rather difficult point to identify and a rather elastic notion. He points out that as new data will always add something new, but with diminishing returns, the cut off between adding to emerging findings and not adding, might be considered inevitably arbitrary.

Data from the post-programme semi-structured interviews has been analysed using principles from a grounded theory approach, through coding, identifying categories and core categories which emerge from the material in order to generate theory. Grounded theory is a systematic theory, using theoretical sampling, coding, constant comparison, the identification of a core variable, and saturation. In line with the principles of grounded theory, the early questions within the post-programme interviews are designed to be very open, thereby encouraging participants to express those elements of their experiences of the strengths-based programme which are the most relevant to them. As critical issues emerge across interviews, the interview questions become more focused and draw on constant comparison and memoing in order to identify the potential emerging theory (Glaser & Strauss, 1967). The constant comparison method inherent in the grounded theory approach involves

initially comparing data set to data set and later comparing data set to theory. Memoing entails noting hypotheses regarding categories and relationships between categories.

The initial stage in the data analysis of the interview transcripts was open coding, the process of selecting and naming categories from the data. The next stage after open coding was axial coding, achieved by utilising a 'coding paradigm', a system of coding that seeks to identify causal relationships between categories in order to understand the phenomenon to which they relate. Next, the selective coding stage involved the process of selecting and identifying the core categories and systematically relating it to other categories. Categories are integrated together and a Grounded Theory is developed.

Data from the semi-structured post-programme interview of me as therapist-researcher was also analysed according to grounded theory principles and used for comparison purposes to compare my experience of the therapy process with that reported by participants, and to compare my understanding of how the strengths-based approach may have helped with that of the clients.

The content of my reflective journal was not formally analysed, however rereading it during the course of the data analysis provided a personal and private reminder to me of my thoughts during the course of the research. Similarly, my supervision notes were not formally analysed, however, they informed decisions I made during the analysis of the other data sources.

Validity/trustworthiness

As I have taken on the roles of both practitioner and researcher in this study, I have reflected on the impact of my dual-role position on the validity of my observations. They are to some extent subjective, and I have tried to be aware that I could be more readily noticing what I hope is the case for participants, that is, a positive outcome. It is my hope and expectation that my awareness of this has helped to address this. In an attempt to redress this, I have included some quantitative measures, the results of which are independent of my interpretation, as well as other methods of triangulation.

In this section I continue by specifying the psychometric properties, reliability and validity of each of the quantitative questionnaires completed by clients pre- and post-therapy, then continue by discussing triangulation and how it has been included in this research.

Intuitive Eating Scale (IES)

Intuitive eating has been proposed to be fairly consistent over time (Tribole & Resch, 1995). The test-retest reliability of the IES is demonstrated (Tylka, 2006) to be 0.90 over a three-week period (ps < 0.001). By carrying out a number of studies to assess the psychometric properties of the EIS, Tylka (2006) obtained evidence for the construct validity of the total IES and its subscales.

Rosenberg's Self-Esteem Scale (RSES)

Rosenberg (1965) reported internal consistency reliability for the RSES ranging from 0.85 to 0.88 for college samples. Internal consistency estimates for the scale for other populations typically fall within the range from 0.77 to 0.88, indicating acceptable internal reliability. Additionally, test-retest estimates for the RSES range

from 0.82 to 0.85, demonstrating very good test-retest reliability. The RSES is considered to show not only reliability but also construct validity as a test to measure self-esteem (Blascovich & Tomaka, 1993; Robins et al., 2001).

Beck's Depression Inventory

The reliability and validity of the BDI have been well researched. The test-retest reliability reported by Beck et al (1996) was a very high 0.93, and the test also has a high internal consistency of 0.91. At least 35 studies have shown concurrent validity between the BDI and such measures of depression including the Hamilton Depression Scale and the Minnesota Multiphasic Personality Inventory-D, and tests for construct validity have shown the BDI to be related to a range of biological factors, attitudes, and behaviour related to depression, anxiety, stress , loneliness, disrupted sleep patterns, alcoholism, and suicidal behaviour (Beck et al., 1988).

Clients' weight

Each client's weight was monitored at every weekly session by me using the same set of scales every time. This overcame the problem that some weighing scales can vary in their accuracy. By recording the clients' weight at every regular session, which took place at the same time each week for each participant, the potential variation in weight, which many people experience at different times of day, was managed.

Triangulation

In order to increase the credibility and validity of the results in this study, I have incorporated triangulation, the application and combination of several data collection methods in the study of the same phenomenon.

Research triangulation is based on acknowledging that a concept may well be better understood and enhance confidence in the findings if it can be seen and measured from two (or more) different perspectives. If essentially the same conclusion is reached from a second perspective as from the first perspective, it is likely that I will feel more comfortable with my conclusion, as I have validated the first conclusion by checking from a different angle and seeing the same thing again. However, even though triangulation may produce similar findings, we should be wary of concluding that this means that the findings are unquestionable. It may be that both sets of data are flawed. Nevertheless, if more than one method of triangulation is employed (Denzin, 1970), it seems likely that the validity of findings is enhanced.

Denzin (1970) distinguished four types of triangulation: methodological triangulation, which entails more than one data collection method such as combining the use of quantitative as well as qualitative methods; investigator triangulation, when more than one researcher collects and interprets data; data triangulation, entailing gathering data at different times and on different people; and theoretical triangulation, referring to using more than one theoretical position to interpret data; and. As I will describe below, this study has included three of Denzin's triangulation types: methodological, investigator and data triangulation.

I incorporated methodological triangulation into the study by using several different methods of data collection, such as pre- and post-intervention quantitative measures including the Intuitive Eating Scale, weight records, and the Rosenberg Self-Esteem Scale, as well as qualitative data from participants' journals, the researcher's session notes and post-intervention semi-structured interviews.

Investigator triangulation was used through the post-intervention semi-structured interviews of the participants being carried out by a person not involved in the delivery of the programme. I made this decision in order to try and avoid bias which might have occurred if the interviews had been carried out by me, as the practitioner-researcher. I considered that I had developed a good rapport and therapeutic relationship with each client, and hoped they could be frank with any views of the programme, both positive or negative, but I kept in mind the possibility that there may have been a wish to 'please the therapist'. It would have been difficult to ascertain whether this would have been a factor or not, therefore, I decided to eliminate this potential complication and arrange for the interviews to be carried out by a person previously unknown to the clients. The female psychology graduate who conducted the interviews was familiar with interviewing from her own degree research projects. She had previously done some administrative work for me related to medico-legal psychology reports, and I knew her to be intelligent and thorough, aware of issues of confidentiality, and with a respectful interpersonal manner. We met to discuss the research study and the Positive Slimming Programme in detail, prior to the interviews so that she was familiar with the approach and the content of the therapy. I can only speculate as to how the post-therapy interviews might have been different had I conducted them myself. Furthermore, the clients were all aware that I would be analysing the content of the interviews, and it is difficult to know the impact of this on their responses during the interviews. I decided to involve a third party to be the interviewer to avoid potential bias, but perhaps the clients would have been more direct with me, not less as I supposed, if I had been the interviewer as they already knew me and we had a good working relationship. Overall, with investigator triangulation in mind as well as potential bias, the use of an independent interviewer seemed the more suitable option.

Investigator triangulation was also included by having a psychologist colleague of mine interview me after the therapy. She was in a position to pose questions to me about aspects of my understanding of the therapy process which I may not have thought about myself, thereby teasing out information and views which enriched the data.

Furthermore, in the interests of increasing validity through investigator triangulation regarding the analysis of qualitative data, a peer colleague has been involved in checking codings during the data analysis stage of the project.

I considered carefully the possibility of including participant checking, or respondent validation of my interpretation of the journals and semi-structured interviews, in the interests of potentially increasing validity of the results. This option is not without its own complications, as participants might disagree with an interpretation not because it is wrong, but because it places them in a difficult position, or it may not coincide with their own views. Alternatively, they may agree with the researcher's interpretations because they accept them as information rather than suggestions for comment. In view of these potential drawbacks, I concluded that I would not include participant checking. This decision was only reached after much consideration, taking into account the ethical issue that in case study work, participants may be potentially identifiable and participant checking can also serve to confirm that the clients accept the way they are portrayed in the study. I believe that I have disguised personal details sufficiently to mean that the clients are not identifiable by others, whilst keeping the pertinent details in each description as well as a sense of their individuality and presence intact.

With data triangulation in mind, permission was sought from participants for follow-up contact after the 20 session programme. This was granted by all participants and was scheduled to take place approximately three months following their last session of the programme. Follow up contact entailed a face to face individual session lasting 45 minutes with me to see whether changes during the therapy reported by clients were maintained, as well as for clients to comment on their understanding of how these changes had been maintained. Session notes were taken by me.

However, it is worth noting that, although there seems to be an assumption that when triangulation is used, the results will provide a clear perspective of the phenomenon being studied, Mathison (1988) challenges the purpose of triangulation. She proposes that to expect triangulation to provide converging results is somewhat unrealistic, and suggests that *'triangulation as a strategy provides evidence for the researcher to make sense of some social phenomenon, but that the triangulation strategy does not, in and of itself, do this.'* (Mathison, 1988).

FINDINGS

In this section I present the findings from the data in four parts, each part addressing one aspect of my research questions (page 61) in turn as follows:

Findings Part I:

> What were the quantitative outcomes for clients at the end of this therapy and at follow up?

Findings Part II:

> What was the clients' experience of the therapy?

Findings Part III:

> What was the clients' understanding of how the therapy may have helped them?

Findings Part IV:

> What was my experience of the therapy and my understanding of how the therapy may have helped clients?

Findings Part 1

What were the quantitative outcomes for clients at the end of this therapy and at follow up?

I begin Part 1 with a table of results summarising all the clients' pre- and post-therapy questionnaire scores and their weights. This is followed by collective results graphs for each measure and finally a brief summary of these results.

	Jane		Isabel		Caroline	
	Pre-therapy	**Post-therapy**	**Pre-therapy**	**Post-therapy**	**Pre-therapy**	**Post-therapy**
Becks Depression Inventory	9	8	20	5	37	4
Rosenberg Self-Esteem Scale	23	23	17	20	11	18
Intuitive Eating Scale (IES) Overall Score	3.14	3.33	2.14	3.28	2.57	3.57
IES Subscale: Unconditional Permission to Eat	3.66	3.66	2.22	3.33	3.77	3.33
IES Subscale: Eating for Physical Rather Than Emotional Reasons	2.5	2.5	1.17	2.83	1.5	3.66
IES Subscale: Reliance on Internal Hunger/ Satiety Cues	3	3.66	3	3.66	1.83	3.83
Weight (kgs) (Weight loss) BMI	92.2 34.7	86.5 (-5.7) 32.5	67.4 25.0	63.6 (-3.8) 23.6	90.7 34.0	78.5 (-12.2) 29.7

Key
BDI: Lower score indicates less depressive symptoms
RSES: Higher score indicates higher level of self-esteem
IES: Higher score indicates higher incidence of intuitive eating
All IES subscales: Higher score indicates higher incidence of intuitive eating

Table 1 - Clients' pre- and post-therapy questionnaire scores and weights

Depression

The post-intervention scores from the Becks Depression Inventory (BDI) showed improvement in mood for all three participants compared with the pre-intervention scores, as shown in Figure 1 and Table 2 below. When the BDI is scored, the total score shows the severity of the symptoms of depression - the higher the score, the more severe the depressive symptoms. The standard cut-off scores are:

0 - 9	Normal mood
10 - 18	Mild depression
19 - 29	Moderate depression
30 - 63	Severe depression

Table 2 - Standard cut-off for Beck's Depression Inventory

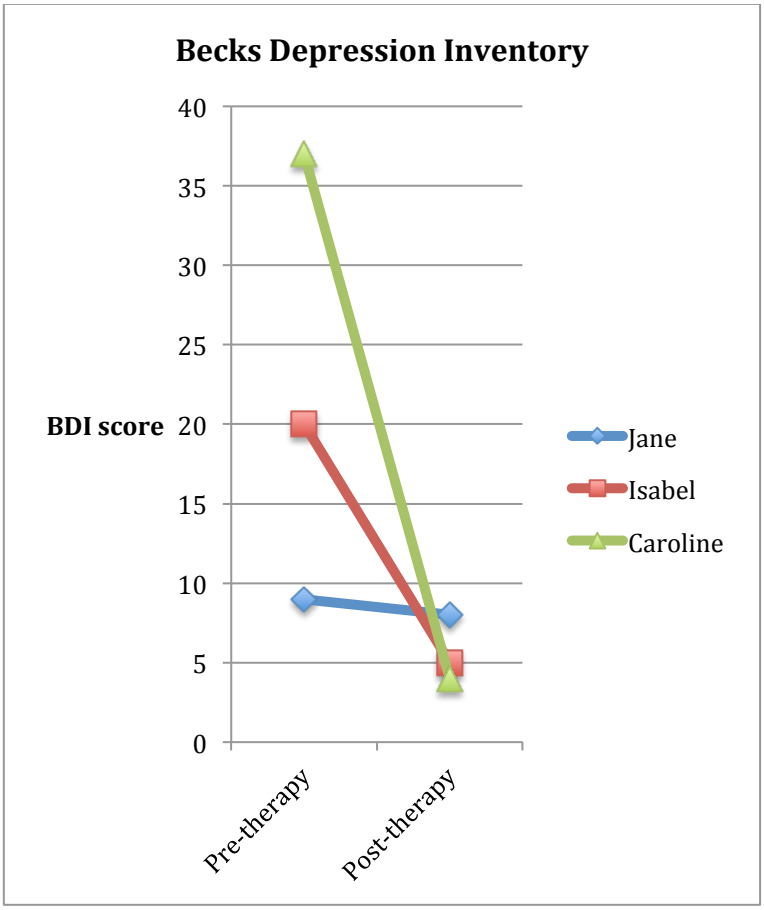

Figure 1 - Graph of clients' pre- and post-therapy BDI scores

	BDI score	
	Pre-therapy	Post-therapy
Jane	9	8
Isabel	20	5
Caroline	37	4

Table 3 - Table of clients' pre- and post-therapy BDI scores

Two participants' scores on the BDI moved from indicating some degree of depression into the normal mood range, and one remained within the normal mood range from pre- to post-therapy.

Self-esteem

The post-therapy scores from the Rosenberg Self-Esteem Scale (RSES) showed increased levels of self-esteem for two participants compared with their pre-therapy scores, and no change in the already fairly high pre-therapy score for the third participant, as shown in Figure 2 and Table 4 below.

The Rosenberg Self-Esteem Scale ranges from 0-30. Higher scores indicate greater levels of self-esteem. Total scores between 15 and 25 are within normal range; scores below 15 suggest low self-esteem.

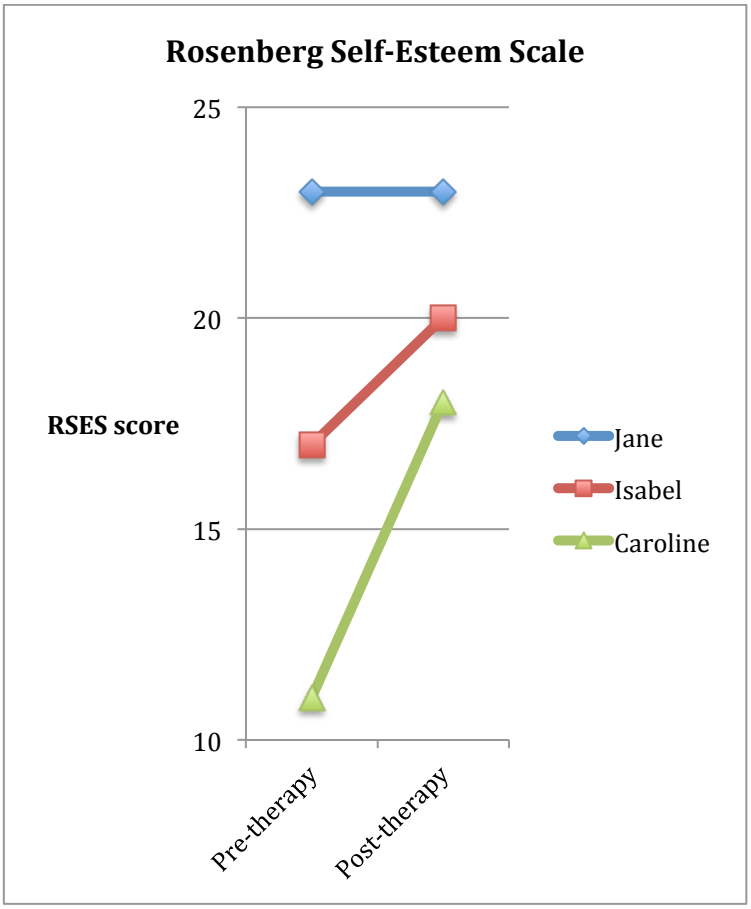

Figure 2 - Graph of clients' pre- and post-therapy RSES scores

	RSES score	
	Pre-therapy	Post-therapy
Jane	23	23
Isabel	17	20
Caroline	11	18

Table 4 - Table of clients' pre- and post-therapy RSES scores

In this study the post-intervention scores for the Rosenberg Self-Esteem scale showed a noticeable increase in self-esteem for Caroline and Isabel, compared to their pre-intervention scores. Jane's pre-therapy self-esteem score indicated a fairly high level of self-esteem and remained unchanged post-intervention.

Intuitive Eating

The Intuitive Eating Scale (IES) produces an overall score for intuitive eating as well as three further scores measuring separate elements of intuitive eating. Higher scores indicate greater intuitive eating. The participants' results for the overall IES scale are reported in Figure 3 and Table 5 below. Their results for the subscales are included within the results summary table above (Table 1) - the Unconditional Permission to Eat subscale, the Eating for Physical Rather Than Emotional Reasons subscale and the Reliance on Internal Hunger/Satiety Cues subscale.

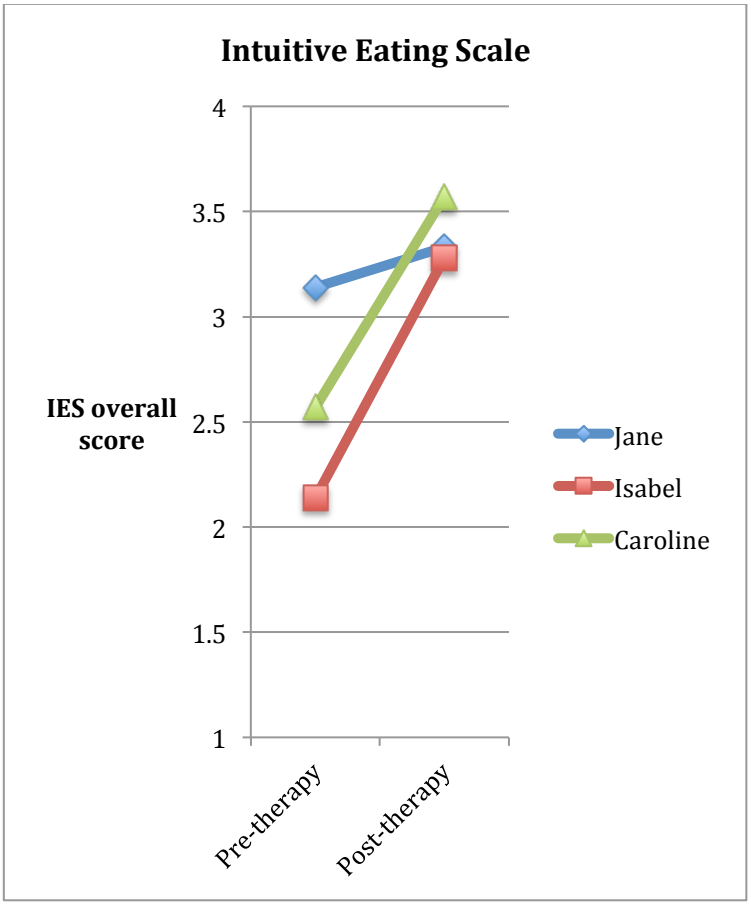

Figure 3 - Graph of clients' pre- and post-therapy overall IES scores

	IES overall score	
	Pre-therapy	Post-therapy
Jane	3.14	3.33
Isabel	2.14	3.28
Caroline	2.57	3.57

Table 5 - Table of clients' pre- and post-therapy overall IES scores

The results show that the post-intervention overall IES scores for all participants were higher than their pre-intervention scores, indicating that intuitive eating had developed during the Positive Slimming Programme. The IES subscale scores for two participants – Isabel and Caroline – were mostly higher than their pre-intervention IES subscale scores The post-intervention IES subscale scores for the

third participant, Jane, either remained the same as her pre-intervention scores or went up slightly.

Change in Weight

Each participant was weighed at the beginning of each individual session during the 20-week programme and at follow-up three months later. As shown in Figure 4 and Table 6 below, all three participants lost weight during the programme. The amount of weight lost varied from 3.8 kgs to 11.9 kgs.

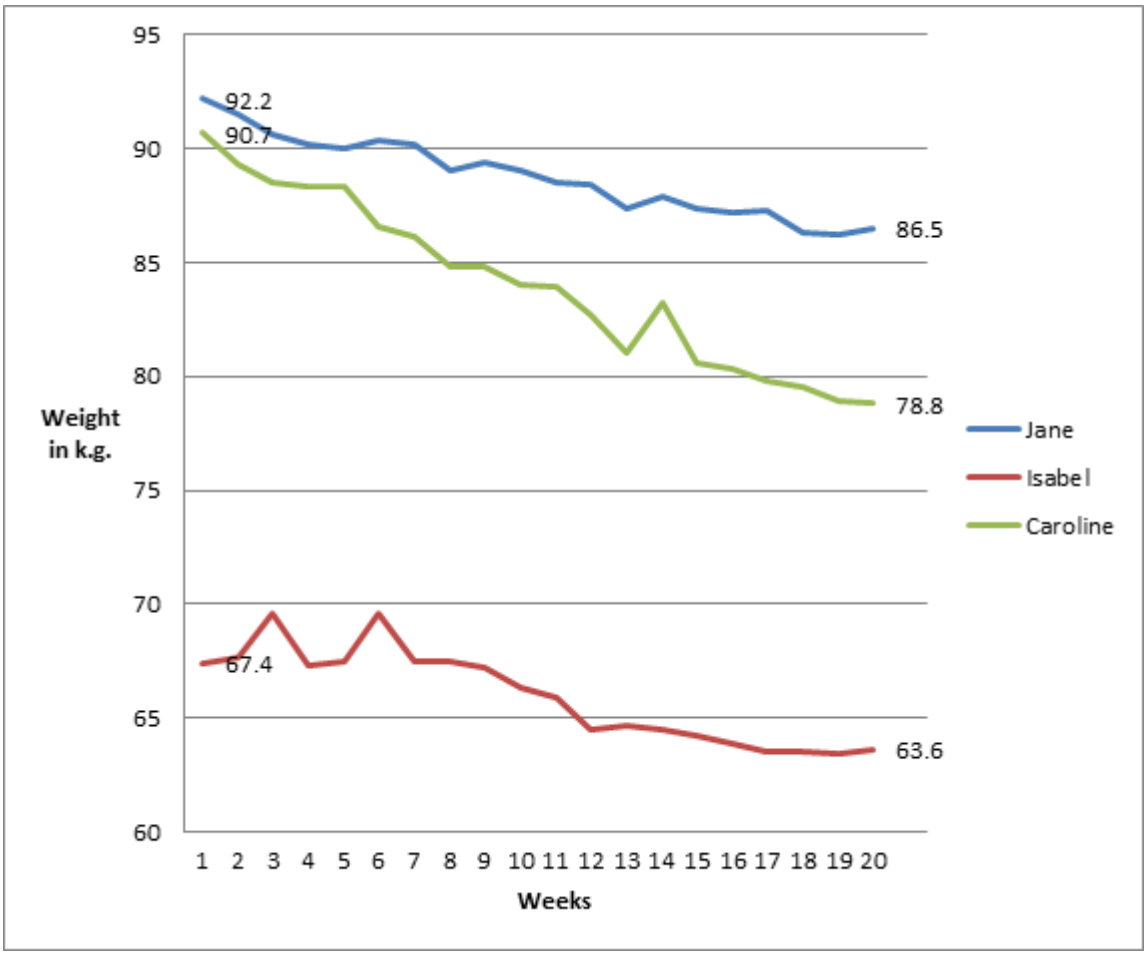

Figure 4 - Graph of clients' weight changes during the 20-week programme

The exact weights during the 20-week programme and at follow-up are detailed below.

Week	Jane	Isabel	Caroline
1	92.2	67.4	90.7
2	91.5	67.7	89.3
3	90.6	69.6	88.5
4	90.2	67.3	88.3
5	90.0	67.5	away
6	90.4	69.6	86.6
7	90.2	67.5	86.1
8	89.0	67.5	84.8
9	89.4	67.2	away
10	89.0	66.3	84.0
11	88.5	65.9	83.9
12	88.4	64.5	82.7
13	87.4	64.7	81.0
14	87.9	64.5	83.2
15	87.4	64.2	80.6
16	87.2	63.9	80.3
17	87.3	63.5	79.8
18	86.3	63.5	79.5
19	86.2	63.4	78.9
20	86.5	63.6	78.8
Follow up			
after			
3 months	84.6	64.0	79.7

Table 6 - Table of clients' weight changes during the 20-week programme and at follow-up

At the follow-up session, three months after the programme ended, each participant was weighed again. The results varied – Jane had lost almost 2kgs, Isabel had put on 0.4kg and Caroline had put on 0.9kg.

Summary

According to the quantitative assessments, all three clients improved in mood over the 20 weeks of therapy. Two clients raised their levels of self-esteem and the third client's already high level of self-esteem remained unchanged. They all increased their scores for intuitive eating and lost weight over the course of the intervention.

Findings Part II

What was the clients' experience of the therapy?

Part II begins with Table 7 below, which gives an overview of the themes which convey the clients' understanding of the therapy process, drawn from the thematic analysis of the qualitative data from the clients' journals and Food and Mood diaries. The main themes which were identified were shared by clients although this was not the case with all the subthemes.

This thematic overview is followed by individual accounts of each client's understanding of the therapy process, by presenting in detail the thematic analysis of the qualitative data from her personal progress journal and Food and Mood diaries. The final part of each individual account presents the challenges experienced by each client during the therapy process which were documented in their journals and Food and Mood diaries.

Qualitative data results

The main themes and subthemes identified through thematic analysis of participants' progress journals and Mood and Food diaries are summarised in Table 11 below.

Main theme	Sub themes	Jane	Isabel	Caroline
Approach to weight loss	Psychological approach	√	√	√
	Individual focus	√		
	Writing journal		√	

Relationship with food	Raising awareness	√	√	√
	New eating habits		√	
	Awareness of satiety cues			√
	Understanding impact of past/identity issues			√
Addressing cognitions related to food, moods and self	Cognitive change	√	√	√
	Assertiveness		√	
Positive behaviour	Behaviour change	√	√	√
	Increased exercise	√	√	
	Goal setting	√	√	√
	Relaxation		√	
Therapeutic dyad	Accountability	√		√
	Validation	√	√	
Positivity	Positive focus	√		√
	Positive shift in self-regard	√	√	√
	Personal strengths	√	√	√
Challenges	Daily weighing	√	√	
	Completing Food and Mood diaries	√	√	√
	Content-based challenges		√	
	Varied rate of weight loss		√	√

Table 7 - Main themes and sub-themes identified in clients' qualitative data

Jane

Themes identified through thematic analysis of Jane's progress journal entries and her Food and Mood diaries

Jane embarked on the Positive Slimming Programme in a determined but anxious frame of mind. She was clear that she wanted to make changes and wrote in her journal:

'I know that I cannot continue putting on weight.'

Approach to weight loss

Psychological Approach

In Jane's view a new approach to losing weight was likely to help her. She believed that the Positive Slimming Programme would help her by looking at the psychological aspects of her eating habits, which she had not focused on before, but the prospect was also daunting:

> 'I know emphatically that a weight loss diet will not work – I feel quite scared that this is my last hope.'

Jane had a history of many attempts to lose weight and, although she had lost some weight in the past, she had always regained the lost weight. She recognised that her overweight was having a negative effect on her. It was affecting her physical health, causing her pain in her legs and back, and it was a significant reason for her general lack of confidence, especially relating to her appearance. She had not felt comfortable with her body shape for over twenty years.

Jane was already aware that she engaged in emotional eating, and that her previous weight loss attempts had not taken this into account. In her view, gaining insights into

the reasons why she was eating and her relationship with food would help her to change her eating habits and lose weight, as she wrote in her journal:

> '[I need to] consider what the food I'm eating is providing for me.'

Individual focus

She identified that during therapy the focus on her as an individual helped her:

> 'It helps that this is an individual approach – not one-size-fits-all.'

Some of her previous dieting attempts were in group settings, when she had felt that much of the content was irrelevant to her, therefore she valued the focus on her individual issues which the Positive Slimming Programme offered.

Relationship with food

Raising awareness

Jane expressed in her entries in her journal and Mood and Food diaries that she found it helpful to raise her awareness of how she related to food. Through her Mood and Food diaries it became clear to her that she frequently used food as a reward on a daily basis. For example, she had developed a longstanding habit of rewarding herself with sweet treats on her way home from work, as well as once she got home from work, and during and after household chores. She found that by raising her awareness of how she used food in this way, she could make a more deliberate choice as to whether she ate at such times or not:

> 'Tempted to 'reward' myself when ironing, for example with a biscuit (but didn't).'

Once Jane became more aware of the way she related to food, and used food for reasons other than for enjoyment and nourishment, she acknowledged that, at times,

she ate when she was 'hungry' for recognition, admiration, comfort, satisfaction and attention. Raising her awareness of this helped her to be more honest to herself about her needs, and to be more open to addressing these needs more directly. When on a work-related course she wrote in her journal:

> 'I'm less inclined to 'think' about food these last two days because on the training course I'm valued, fulfilled and in my comfort zone re knowledge, and challenged and stimulated.'

Given that triangulation is a feature of this case study research, it is of note that Jane's quantitative data do not consistently reflect the changes which might be expected given her journal and diary entries relating to her raised awareness of her relationship with food and changes in her eating habits. For example, the only one of her IES subscales scores which changed over the therapy was her increased 'Reliance on Internal Hunger/Satiety Cues' subscale score, her other two IES subscale scores remained unchanged.

Triangulation offers additional perspectives on the phenomenon which is being studied, giving a rich, complex picture. However, the researcher has to attempt to make sense of the data from the various sources, which may be contradictory or convergent. In this section the differences between the outcomes of some qualitative and quantitative data in this study are noted, and will be explored in more detail later in this section and in the Discussion.

Addressing cognitions related to food, moods and self

Cognitive changes

Jane found it helped her to make changes by thinking more about why she was eating, and about what she was eating. Consequently, she made more considered choices.

> 'Consider what the food I'm eating is providing me – forgo empty calories, they are not nurturing my body.'

Jane often shifted responsibility away from herself for choosing to eat when she was not hungry, or for eating sweet snacks. For example, she would claim that 'I was tempted by the pudding', or 'Everyone else was eating biscuits, so I joined in', or 'It was time to have tea and cake'. Jane found our discussions on taking responsibility for choices helpful, and started to take a much less passive stance, no longer blaming the food, other people, or the time, for eating pudding, biscuits and cake. As she wrote in her journal:

> 'No-one tempts me but me - I'm my own devil on my shoulder.'

We discussed identifying unhelpful thoughts about food and reviewing them in order to 'stay on track' with her aims for changing her eating habits. Jane found this helpful and wrote in her journal:

> 'I need to up the ante and think! Think! Before I put something in my mouth.'

In one session I described to Jane the skill of 'self-soothing' - easing the intensity of difficult emotions by choosing to focus on, then challenge, certain thoughts. She found that this was an effective way of feeling more in control of how she felt and

acknowledged in her journal that she could use this skill instead of turning to food to suppress difficult emotions:

> 'I can practise self-soothing, instead of soothing by comfort eating.'

Positive behaviour

Behaviour change

A significant part of the Positive Slimming Programme included discussing the options available for clients to do things differently in order to gain a different outcome. This active approach was relevant to their eating habits as well as to other areas of their lives, and Jane found our discussions on behaviour change particularly helpful. For example, we discussed how she would prefer to behave around food when she was not hungry, and she acknowledged that she would rather make a deliberate choice herself as to whether she ate or not, and not eat mindlessly simply because other people were eating, or because there was food available, or because it was a time of day when she would typically eat. We discussed a strategy we called 'The Hunger Scale' to monitor her level of hunger. She kept in mind a scale of 0 to 10, when 0 represented 'not at all hungry' and 10 represented 'very hungry indeed' and she asked herself how hungry she was on this scale when considering snacks, meals, second helpings and puddings. If she felt she was at 6 or above on the scale, she decided she would eat, but if she was at 5 or below on the scale she decided she would choose not to eat and to do something else instead. She wrote in her journal:

> 'I was tempted to have a biscuit when everyone else was having one but I'm not hungry – so decided to write this instead.'

There were entries in Jane's journal illustrating new behaviour which stemmed from her new perspective on her eating habits. She began making more deliberate choices:

'…was tempted by chips – resisted – as I knew I'd planned oven chips for tea.'

She often wrote about her focus on not simply thinking about things differently but also doing things differently. Jane found that making some simple changes to her behaviour helped to change her eating habits and help her weight loss. For example, she always used to eat as she was preparing food. Instead, she tried making herself a cup of tea when she was about to prepare meals and snacks, and she found that sipping it from time to time during the food preparation was a perfectly pleasant and acceptable alternative to snacking. Also, as she wrote in her journal:

'Picking - when dishing up – how to overcome this – have a glass of water to sip when tempted!'

Another small behavioural change was to plan ahead to do something she enjoyed when she arrived home from work, instead of eating the usual sweet treats. She discovered that making phone calls to friends, or listening to some music, or reading a book or magazine for half an hour felt good, and she used these as non-food treats instead.

At times, Jane's **cognitive changes,** such as using positive self-talk, triggered **behaviour changes**. Jane found that phrases like 'If you don't love it, leave it' and 'You are not a rubbish bin' were useful to keep in mind and helped her to eat more intuitively, monitoring her satiety and only eating what she enjoyed and only until she felt comfortably full. There were further cognitive changes which resulted in behaviour changes including asking herself 'How will I feel afterwards?' when considering whether or not to eat a particular food, or have a second helping, or give in to the option to stay at home instead of exercising, for example.

Increased exercise was significant and helpful behaviour for Jane and was identified as a subtheme to the theme of **Positive behaviour**.

Jane found that increasing her exercise helped her to maintain her focus on becoming lighter and healthier, and her journal entries show that it had a positive effect on her:

> 'Felt really good to get 2 swims in this week.'

She made deliberate changes in order to increase her level of exercise:

> 'I went to the gym and swam as well. Usually it would be gym or swim.'

Her increased exercise was mentioned frequently in her journal, suggesting that increasing her exercise and including it daily helped Jane feel more positive and achieve her goals to lose weight.

Another subtheme to the theme of **Positive behaviour** which I identified in Jane's data was ***Goal-setting.***

In her journal, Jane wrote about the importance of both identifying and acting on her goals, as in the past her tendency was to let situations evolve without such planning:

> 'I need to get back on track and think to the future – spring/summer – I want to feel good then.'

This acknowledgement by Jane that goal-setting was helpful followed discussing her future plans in sessions and deciding on steps for change. We considered how future changes would affect Jane, her family, friends and colleagues, and she sometimes revised goals in the light of such discussions.

Positivity was identified as a main theme and this as well as the subthemes – ***Positive focus, Positive shift in self-regard*** and ***Personal strengths*** were shared by all three participants.

Positive focus

An emphasis on positivity underpinned the therapy, although not at the expense of acknowledging and addressing difficulties and challenges. However, keeping a positive focus in mind and applying a positive mindset to make changes was encouraged – not only to help make changes to eating habits but also to wider areas of life. Jane acknowledged in some journal entries that this aspect of the therapy helped her to make some changes. She began to use more positive self-talk, reminding herself to focus on what was already working well for her, as well as initiating changes to prompt more positive outcomes:

> 'Do what energises me and evokes more positive emotions.'
>
> 'I need to remind myself of the positive aspects of weight loss.'

Jane also began to focus on appreciating what was going well for her, rather than mainly noticing what was at fault or yet to be done:

> 'This has been the most positive experience of trying/succeeding to lose weight.'

Positive shift in self-regard

A key element of the Positive Slimming Programme was to raise awareness of how clients can increase self-respect and confidence. Jane acted on this to develop a more positive self-regard of herself, as the following quotes from her journal illustrate:

> 'I've been kind to myself this week by spending an afternoon at the spa.'

'I can praise myself for leaving some food on my plate and for exercising more.'

'A change today – I wore a top I'd not worn for a long time and felt more confident wearing it.'

'Trying to practice 'self-kindness' – sometimes manage this, sometimes it is hard.'

'More self-respect - respecting me and my body.'

'When I get compliments – take them.'

Interestingly, Jane's quantitative data measuring her pre- and post-therapy levels of self-esteem and depression do not reflect her increased positive self-regard as reflected in her qualitative data. Her pre-therapy score on the Rosenberg Self-esteem Scale was unchanged after the intervention, and her Becks Depression Inventory score went down by one point only. Results obtained through triangulation may vary as perhaps different methods of data collection tap into different areas of the client's experience. In this study the quantitative data from the questionnaires provided a snapshot of specific aspects of the clients before and after the intervention. In contrast, the qualitative data drawn from the journals and Mood and Food diaries was an expression of the clients' ongoing experience during the 20 weeks of the intervention. This will be explored in more detail in the Discussion section.

Personal strengths

Identifying and applying personal strengths seemed to resonate somewhat with Jane as a helpful strategy in making changes, although focusing on personal strengths is

mentioned only infrequently in her journal and diaries. For example, she noted in her journal:

> 'Determination, self-respect and self-love need to be my key.'

Therapeutic dyad

The therapeutic dyad was identified as a main theme which was common to all three clients, yet the clients focused on different aspects of the therapeutic dyad in their journals. I identified two subthemes to this theme within Jane's data: ***Accountability*** and ***Validation.***

Accountability

Jane acknowledged that some accountability for, and monitoring of her progress was a positive aspect of the therapy:

> 'Checking in each week is helpful.'

She mentioned that she often felt nervous about being weighed at each session, as if she feared 'being told off' if she hadn't lost weight. Being aware that I would be asking how she'd managed to deal with situations we discussed helped her to keep in mind our sessions and the specific topics we considered. At times she asked herself 'What would Rose say to this?' and 'What did I say I'd do?' when faced with a decision relevant to our sessions, whether food-related or not.

Validation

Early on in the therapy Jane expressed that she appreciated that I was taking seriously her decision and efforts to change. As the course of therapy proceeded she frequently said that she valued my attention and my efforts to help her, and that

she felt respected. In particular, she acknowledged that it felt positive to be able to be very honest about her relationship with food, which previously had evoked feelings of shame, without the expectation of being negatively judged. In contrast, she was being encouraged by me to recognise that there was scope for positive change and that if that is what she wanted, then that was what mattered. She noted in her journal:

> 'Sessions are helpful to reinforce and confirm that I've been heard.'

Challenges reported by Jane

Daily weighing

I had suggested to the clients that they weigh themselves each day to monitor how their weight might fluctuate, using the information to make decisions regarding their eating habits. If they gained a little weight or had not lost what they'd hoped, they could compensate during the following days by adjusting their portion size or choice of foods appropriately. Jane found that her daily weighing affected not only her eating habits, as expected, but her moods varied considerably depending on her weight. If she gained weight or lost less than she hoped, then she felt low and this at times became another trigger for her emotional eating, which was – understandably – difficult for her, as she wrote in her journal:

> 'A little bit perturbed by the weighing every day + how my mood can change with the slightest fluctuation – either up – or down.'

Social pressure

Jane found it was very challenging to leave any food offered to her in social situations. She discussed in therapy sessions that this was a challenge she

frequently faced when eating in company, unless it was her immediate family, especially when the food was already served to her on her plate, and confirms this in her journal:

> 'first 'supper date' since this programme began – v. difficult not to eat what's offered when someone has prepared and plated up food.'

She wrote about another form of social pressure when people commented that they had noticed she had lost weight. She felt pleased that her weight loss was noticed, but assumed that people then expected her to lose more weight and would think badly of her if she did not achieve this:

> '3 people…asked if I'd lost weight – that was good – it feels a little like 'the pressure to succeed' is on.'

Completing Food and Mood diaries

During the initial weeks of the programme, Jane found the Food and Mood diaries useful in identifying patterns and triggers for her emotional eating. However, she found it became tedious after a few weeks, and she was reluctant to continue completing them. Of her own accord, she started using the sheets for planning ahead to the following day's food intake and noted down whether she had stuck to her plan. This worked well for her and she continued with her own way of using the Food and Mood diary sheets.

Isabel

Themes from Isabel's progress journal entries and from her Food and Mood diaries

Isabel was keen to change her eating habits as she had not lost the weight she had put on since having her two children and felt uncomfortable carrying some extra weight. She said that she didn't really feel true to herself being heavier and larger than before, as she thought of herself as a petite, feminine person and was keen that her appearance would reflect this again. She was aware that she ate in response to difficult emotions, and was interested in how a psychological approach to weight loss might help her.

Approach to weight loss

Psychological approach

Isabel engaged readily with the therapy and was open to carefully considering the different elements of the programme. She had tried various diets in the past, but as she was very interested in psychology, the Positive Slimming Programme's psychological approach to weight loss appealed to her. She valued the varied nature of this approach:

> 'It's a different approach, a multi-pronged approach, and this has developed my motivation.'

Writing her journal

Isabel emphasised that a particular aspect of the Positive Slimming Programme which helped her was reflecting on her experiences in therapy and expressing this in her journal. I identified this as a subtheme in Isabel's data.

Isabel was enthused by writing her journal, and wrote in it regularly between sessions, embracing the opportunity the writing offered her to reflect on our sessions and on the therapy. She expressed that it felt beneficial to her to write about her feelings, her past, her goals and her day-to-day life:

> 'Good for me – rewarding and therapeutic and revealing – to write things down.'

Relationship with food

Raised awareness

By completing the Mood and Food diaries, Isabel became aware fairly quickly of the way she was using food for emotional reasons. She began to recognise that she often ate when she felt in a rush, in order to provide her with a pause in her hectic day. She also increased her awareness of her feelings and of how she used food as a distraction from unwelcome feelings. Furthermore, she noticed that she was using food frequently as a reward. Over time, Isabel became clearer about what she was really 'hungry' for and this helped her to change her behaviour, reflecting her raised awareness of how she used food:

> 'Feeling full with other things – (family life, using more support where possible) rather than reaching to fill empty feeling (not stomach!).'

Becoming more aware of her relationship with food helped Isabel make changes to her eating habits. This was frequently noted in her journal and was identified as a subtheme.

New eating habits

Isabel wrote in her journal about the changes she made to her eating habits:

‘Reduced portion size, eating healthier foods – less sweet foods, more fruit, drinking more water.’

‘Choosing healthier alternatives which are ‘treats’.’

As she began to take regular time to relax, she noticed that she was using food as a reward less than she used to, although she still enjoyed sweet foods as occasional ‘treats’:

‘Seem to be conquering the ‘grazing’/’binging’. I manage to stop at only 1 sweet thing.’

Addressing cognitions related to food, moods and self

Cognitive change

During therapy sessions we discussed how identifying unhelpful thinking patterns and changing them could be useful to change feelings and behaviour. In her journal, Isabel reminded herself to make cognitive changes as her negative, judgmental thinking had become habitual:

‘Raise awareness. Check back to thought that precedes ‘inner critic’ and change.’

She also recognised that she often thought in all-or-nothing terms, and began to realise that viewing herself, others and events in this way was not helpful to her. By addressing this, she began to pace herself more appropriately and set realistic goals, as well as view herself and others less judgmentally.

Assertiveness

Isabel recognised through therapy that she had been a ‘people-pleaser’ for many years. She enjoyed being well-liked by others and being caring and helpful. However, she began to acknowledge that this led to overcommitting herself to others

and left her little time or energy for herself, resulting in some resentment and emotional eating. We discussed assertiveness as an option which could address this, and Isabel found that by developing and using assertiveness skills she felt more self-respectful and this in turn affected choices she made. She wrote in her journal:

> 'Being discerning about all the people who want my time. Appointments with self.'

Consequently, she decided to step down from a committee, on which she had served for some years, but which lately had left her feeling drained and exploited. She also discussed her support arrangements with her mother, who had begun to expect Isabel to be very available to her at very short notice, which was not always practical for Isabel given her own home and family life. Isabel suggested that dedicating certain times during the week for her visits to her mother could be a more satisfactory arrangement for both of them. She wrote in her journal:

> 'Need to make time, make time for me and commit to it.'

But she discovered that it was initially difficult to change old habits and wrote:

> '…starting to compromise what I want (making calls to Mum when could have 10 mins for me.)'

Prior to learning her assertiveness skills, Isabel had believed that it would be uncaring and upsetting to her mother if she were to stop being constantly available to her mother, but recognised through re-evaluating this belief that she was paying a high personal and psychological price by being so available and decided that she wanted to introduce a more balanced approach to addressing her own and her mother's needs. By making this change and addressing her own need for a little more time for herself, her underlying resentment towards her mother disappeared, and Isabel's anger towards herself for colluding in her mother's previous expectation

that she should be constantly available to help also eased. She freed up time and energy, and felt proud of having taken positive steps to improve her situation. As a consequence of being more assertive, she experienced less negative emotions and engaged in less emotional eating. A few days later she wrote in her journal:

> 'Review week so far
>
> Haven't binge eaten
>
> Not eaten in evenings
>
> …remember how good it felt to 'create' space for me to breathe/think/be…felt need for a bit more freedom so took opportunity and carved an extra hour and half. Felt good. Need it more. Need to feel ok with it; not fret about consequences or feel anxious/guilty – this is just who I am. Need quiet time regularly.'

Positive behaviour

Behaviour change

A central message underlying the Positive Slimming Programme was that in order to make progress in losing weight, some behaviour must change. There were several areas for potential change which were encouraged in the programme. For Isabel, the focus on behavioural change was helpful and she noted a number of such changes in her journal.

One simple but effective behavioural change which Isabel made was to buy and use a pedometer. There were several entries in her journal relating to using her pedometer as a simple way to monitor the amount of day-to-day walking she completed.

Increased exercise

Isabel was particularly keen to get back to her exercise routine as one of the behavioural changes she made during the therapy. She had enjoyed exercise before she put on weight, and especially liked the post-exercise feelings of well-being:

> 'Doing well for being more active, 2+ vigorous exercise sessions this week. Great thing: - suddenly finally can feel bodily that I am starting to get fitter and stronger. Fab feeling.'

Goal setting

Isabel was enthusiastic about the goal-setting exercises and told me that she often discussed them with her husband. She initially joined the Positive Slimming Programme as she wanted to have a healthier relationship with food and lose some weight. During some sessions we focused on identifying her wider goals unrelated to weight loss, and she recognised that there were several areas of her life where there was scope for change, which would help her to live more congruently with her values and act on what was important to her. Once her goals were clearer, she began to take steps to realise them, and wrote in her journal:

> 'Defining what is important to self and taking action to include them.'

More relaxation time for self

Once Isabel recognised that at times her emotional eating was triggered by feeling rushed and out of control because of a hectic schedule and busy family life, she deliberately took some time for herself on a regular basis. She discovered that she was able to prioritise relaxation time if she scheduled it into her diary. Otherwise, good intentions for taking some time to relax were frequently side-tracked by

household tasks or other people asking for her help or attention. She noticed that she felt calmer, as well as enjoying more self-respect, by taking more time to relax.

Therapeutic dyad

Validation

Initially, Isabel found it was difficult to acknowledge that her own needs were equally important as those of other people, especially her family and friends. Since becoming a mother several years previously, her time, efforts and attention were primarily taken up by the demands of her busy family life, as well as her mother who was unwell. She made use of my input and encouragement to include herself within the group of people she cared for, with positive results, and noted this in her journal:

> 'I need someone to give me permission to focus on myself.'

Positivity

Positive shift in self-regard

As therapy progressed, Isabel recognised more readily that she was able to give herself permission to identify, focus on and attend to her own needs.

She developed a more accepting, self-respectful and positive view of herself, gradually acknowledging her personal strengths and achievements. This seemed to help her to value herself more, which in turn influenced choices she made for herself regarding her eating habits and appearance. Having lost some weight, she wrote in her journal:

> 'I feel more like me when I'm a petite person, wear different things, more worthy/appealing to others, am congruent within my own life.'

Personal strengths

In an early therapy session we focused on identifying personal strengths by using a list of strengths (with brief definitions of each) for reference. Isabel was interested in this exercise and was open to applying the personal strengths she identified. She reminded herself in her journal:

> 'Determination = another of my key strengths – use it!'

Over time, 'self-kindness' seemed relevant and useful for her to keep in mind, and she applied it to address negative self-talk as well as using it to help her make decisions as to which actions to take:

> 'Tricky family/friend overlap Wed – used self-kindness to overcome self-criticism.'

Challenges reported by Isabel

Daily weighing

Isabel was uncomfortable with weighing herself daily, although I had explained the reason for my suggestion to do so, which was that I believed that if there was any weight gain or displeasing results, daily adjustments would be easier to assimilate and act on than any weight gain noticed at our weekly sessions. However, she was uneasy with this and wrote in her journal:

> 'Challenge Daily weighing. Feels wrong and uncomfortable to me – obsessive and doesn't please me results wise, get demoralised when I've been 'good' + it hasn't worked.'

Mixed experiences of applying strengths

As Isabel began to identify and apply her strengths, she noted that some were helpful in some situations, but they were unhelpful in others. She found this challenging, and at times it was confusing for her, as noted in the following journal entry:

> 'Self kindness has been counterproductive – I allow myself to give in to temptation as I deserve/reward not being hard on myself. Self kindness not helping with diet.
>
> Self kindness has been a timely help in a difficult personal situation which was uncomfortable + made me realise I had made (to me) a grave error of judgement in a principle important to me. Managed this discomfort with actively talking to myself with self kindness.'

Completing Food and Mood diaries

Isabel noted in her journal that after some weeks she found it too demanding to keep up the daily recording of what she ate and her moods:

> 'Still weighing daily but have found it too difficult very late at night to complete Food/Mood diaries.'

Content-based challenges

There were times when we had discussed during a therapy session some changes which Isabel was keen to make, but she noted in her journal that it was not always straightforward to make the changes:

> 'I feel massively guilty at not [still] being constantly at children's disposal'

Another challenge Isabel faced, was that she seemed to be more comfortable in sessions when engaging in less personal discussions related to behavioural changes

and eating habits, whereas she found it more difficult at times when we discussed more personal psychological issues:

> 'Felt low after session. Am unfamiliar + uncomfortable with failure and this time I'm being observed failing myself repeatedly.'

Varied rate of weight loss

In Isabel's case, it took her a few weeks of participating in the programme before she lost any weight. Motivation to make certain changes seemed to vary during the early weeks, perhaps particularly because she was equating results purely with weight loss:

> 'Why motivation low? Not seeing instant results. Not important enough to me to be thin, over enjoying myself, being included and loving food. Always tips the balance the wrong way!'

Furthermore, she acknowledged that positive changes were occurring but it was difficult for her to see that her weight remained unchanged:

> 'Feel bit self indulgent giving myself so much navel-gazing. Feel am 'getting better' as well as stronger/fitter/more together (more whole….?) but weight loss not happening….Hmmm.'

Caroline

Themes from Caroline's progress journal entries and from her Food and Mood diaries

When Caroline embarked on the Positive Slimming Programme she began to recognise that she had been eating mindlessly. She was very unaware of satiety cues, and acknowledged that she could not recall feeling hungry. However, very

soon she gained insight regarding her relationship with food and was intrigued by how she had unwittingly been using food for 'the wrong reasons', frequently engaging in emotional eating.

Approach to weight loss

Psychological Approach

In her journal. Caroline acknowledged that she valued the psychological approach to weight loss when she reviewed the therapy she thought and wrote about which of the psychological elements of the programme she found most helpful:

> 'I think identity. Taking myself seriously. Acknowledging my strengths and using them to my advantage.'

Relationship with food

Raising awareness

Caroline discovered patterns in her eating habits through completing her 'Food and Mood' diary, seeing clear links between her eating habits and her emotional needs and writing about this in her journal:

> **'**I think it's true that food is used in loads and loads and loads of ways.'

Caroline became more aware of the function of food for her as the therapy proceeded. At times she linked the past to her current eating habits:

> 'I was feeling down and lost – had something to eat and felt more present – like 'if I eat I am here' and also as I was so lost and non-existent and couldn't do what I wanted – eating was something I could do. Reminded me of growing up with Mum and step-dad, when we weren't allowed to exist.'

She became enthused by understanding her relationship with food:

> 'It is like a revelation. I know 'motherhood' often ends in women losing themselves, which I'm sure I have, but also I no longer live any part of my old life as not a mother – no work, nor friends. All of this I've known all along really but I never thought of 'eating to exist' or eating to be present' before. And I think it's clear that I also eat 'as something for me' – to give me something.'

The more aware she became about how she was using food, the clearer she was about how to address her needs more appropriately, without using food to do so:

> 'It's like I've realized that food/eating does not really give me what I want.'

She became more aware of how her mood affected her eating:

> 'Really noticed on Sunday I really wanted to 'cram' food in my mouth – feeling down, powerless, inadequate, hurt, rejected etc etc!'

Awareness of satiety cues

At our initial meeting, Caroline explained that she never felt hungry, as she ate before she ever felt any feelings of hunger. Indeed, she said that she couldn't remember the last time she felt even slightly hungry. She became curious about rediscovering the feelings of hunger and fullness and using them as cues to eat or to stop eating, instead of emotional cues, in order to develop a healthier relationship with food. She became aware of her own satiety cues as therapy progressed:

> 'Have noticed that carbohydrate such as pasta really does not keep me full for long.'

Understanding impact of past/identity issues

Caroline wrote frequently in her journal that our discussions about her past and her sense of identity were helpful to her:

> 'Talked about identity in session today – finding this very useful.'

She became really interested in trying to understand how her negative self-regard, self-sabotage and compensatory emotional eating had developed:

> 'Realised today that my family have an unspoken 'pact' around self-abuse/destruction – and we all go along with it to a certain extent and when you don't, you're attacked, ridiculed or put down.'

Furthermore, exploring the impact of the past was helpful to Caroline in understanding her reluctance to draw attention to herself:

> 'Been thinking about identity. Very strong in family (of origin) not to exist. Realised they want me around to attend to them and slap me down if I come out of my box and immediately try and put me down – don't want me to go, want me there but not existing. I am very scared of existing, being noticed, having the spotlight on me.'

Our discussions encouraged Caroline to consider how she could feel most authentic and true to herself:

> 'Thinking about identity again – what is my real identity and what is my 'given' one.'

During the later weeks of the programme, Caroline considered which aspects of the therapy had helped her to make positive changes to her relationship with food. She concluded that exploring identity issues had been the most significant element:

> 'Need to think about what has been most helpful, useful to me out of the different approaches – skills/tools, emotional management, identity. I think identity. Taking myself seriously. Acknowledging my strengths and using them to my advantage.'

Addressing cognitions related to food, moods and self

Cognitive change

Caroline noted that new ways of thinking about food and her eating habits were helpful to her:

> 'Every day I am mentally planning what I'm going to eat in the day and I find this useful.'

In some of the therapy sessions we had focused on developing cognitive strategies based on cognitive behavioural therapy techniques, such as cognitive restructuring and reality testing, as well as developing skills to identify and challenge unhelpful thinking patterns. An exercise which Caroline refers to as 'the circle thing' involved the client learning how to regulate the intensity of their feelings through cognitive change (see Appendix 1).

> 'A good day today – generally felt good – used circle thing [cognitive strategy to manage difficult feelings] with step-dad – for me worked well.'
>
> 'Using circle thing all the time. It's great!'

'Managed difficult feelings – controlling them using techniques talked about and circle one, and seeing what I was personalising and what I wasn't. Now sorted so feel good.'

Being more cognisant of whether she was eating through preference or hunger, rather than eating because food was simply there, and might otherwise go to waste, was also helpful for Caroline.

'Eat what I want not what needs to be eaten.'

Positive behaviour

Behaviour change

As the therapy went on, Caroline made more and more changes to her behaviour and found this central to feeling more positive and developing a healthier relationship with food, which in turn led to weight loss. In her journal she noted how behavioural changes also had a positive impact on her mood:

'Today didn't buy anything to eat whilst out – which I was pleased about.'

Caroline made several journal entries about the changes she was making to her behaviour, which, over time, became her new habits:

'Husband working late tonight – would usually be eating now but managing to stay focused and not considering it as an option.'

Some of her new behaviour was surprising to her:

'Leaving food on a regular basis. This is a real revelation.'

'Am surprised at how I am quite happily preparing food and not eating it at the same time. I've never done this. I always had to have something if it was

around. Now I am very easily leaving it without a struggle. Very pleased with this.'

Over time during the course of therapy she continued eating less and her weight continued to go down:

'I am eating so much less on a daily/regular basis.'

Caroline discovered that even when she felt low, this did not mean she had to eat to suppress the feeling:

'Feeling down today but not eating too much.'

Over time, Caroline recognised that the behavioural changes which we had discussed in therapy were helpful to her and they became established as new habits:

'My 'habit' now is just simply to eat less – which feels very good.'

Goal-setting

Caroline recognised that at times during her adult life she had worked towards clearly-defined goals, such as moving abroad, buying a house, and finding work. Prior to joining the Positive Slimming Programme, her focus had been primarily on her mothering, and she put considerable effort into ensuring, as far as possible, that her child did well socially and at pre-school. She had not focused on goals relating directly to herself for some considerable time. During the therapy we spent some time on goal-setting which she found helpful in defining a sense of direction for herself:

'I think having a goal in mind for a certain time is useful to do – keeps me focused short term.'

As she proceeded in therapy and achieved some of her aims, she recognised that identifying and working on goals with realistic timings suited her:

> 'Definitely think I need definite goals to keep me on track.'

Therapeutic dyad

Accountability

Caroline acknowledged that knowing that I was interested in her progress helped her to stay focused on changes she was making during therapy, and realized too that she would need to feel accountable to herself for progress once therapy sessions came to an end:

> 'I need someone on my back to keep me on track – I will have to learn to do this myself.'

Positivity

Positive focus

Caroline had begun the course of therapy feeling very negative. Her Becks Depression Inventory score was very low. She rarely felt enthused and believed that it was mainly circumstances which affected those areas of her life which felt unsatisfactory. She noted in her journal that the therapy was helping her to address her external locus of control and enable her to gain a sense of taking charge of her own situation:

> 'Really beginning to enjoy this…and I'm finding it empowering.'

She welcomed experiencing more positive emotions:

'Feeling on top of the world today, really nice to feel like this. Feel very positive and feel that things are on the up. Great to feel like this.'

'Feeling strong and mature at the moment.'

'Been feeling very positive about things generally and the future.'

Caroline took readily to applying positivity to her thinking and to other areas of her life. She worked hard to develop, protect and maintain positivity:

'Will focus less on possible negatives and give more time to more productive thinking. Will not let other people sabotage my positivity with their issues.'

She noted how her more positive emotions affected her eating habits:

'The better I feel, the less I eat.'

Positive shift in self-regard

We spent a considerable amount of time in sessions discussing Caroline's self-image, which was quite negative at the beginning of therapy. She was very focused on being a good mother and put much effort into her parenting. She and her husband shared priorities regarding raising their child and this area of her life was going well. She also recognised that she had been courageous at times in her life in taking the initiative to make positive changes. However, she found it hard to recognise her many qualities as an individual which could mean that she was attractive to others personally and professionally. Over time in therapy she considered her positive traits and began to recognise their value.

She believed that her overweight meant that others did not take her seriously, and she believed other people saw her first as an overweight person, and only later – if at all – as an individual. We discussed how this perspective might include her own

dismissive attitude to herself. As she became more able to see herself more positively, her behaviour changed to reflect this and she applied for – and was offered – a good, well-paid job which was more demanding, prestigious and responsible than her previous work role. She recognised her own potential and acted on this new-found self-respect:

> 'To me it's about taking myself seriously not only in terms of look but generally in life.'

Caroline acknowledged that taking herself seriously was one of the most helpful elements of the therapy (as well as identity issues, as discussed in the earlier section on identity):

> 'Need to think about what has been most helpful, useful to me out of the different approaches – skills/tools, emotional management, identity. I think identity. Taking myself seriously. Acknowledging my strengths and using them to my advantage.'

Personal strengths

There were few journal entries relating directly to personal strengths, but as in the quote above, Caroline acknowledged in her journal that identifying and applying her strengths was one of the most useful aspects of the programme.

Challenges reported by Caroline

Completing Food and Mood diaries

Although Caroline completed the Food and Mood diary sheets thoroughly for the first few weeks, she noted in her journal that the ongoing task of completing the sheets daily was difficult to maintain:

‘Am getting less diligent in filling out these forms but am sticking to not eating as much…’

‘Feeling the focus wearing off – taken up thinking of other things – not filling these forms at time + not really wanting to.’ *(However, Caroline did continue to complete Food and Mood diary sheets daily for another month.)*

Varied rate of weight loss

Caroline was noticeably overweight and was keen to lose weight. During the programme she thought she was changing her eating habits and addressing her emotional eating sufficiently effectively to achieve sustained weight loss, but she noted in her journal that it takes time to discover what works best:

‘Have stuck to my plan, only really eating fruit and salad in day this week + meal in evening but it’s not really made much difference – lost a little but not that much. Meals in evening have been a bit heavy. However – think I’m better with breakfast lunch and light tea. Going back to that.’

Caroline lost weight fairly quickly, but there were stages when her weight stabilised and she found it challenging when she reached a weight loss plateau:

‘Looking back I have been hovering here [at a particular weight] for a month. Need to get back onto proper regime and stick to it. Need to get back to writing down food every day – keeping focused with weekly food plan too. Plus exercise.’

Findings Part III

What was the clients' understanding of how the therapy may have helped them?

In Part III, I present a collective analysis of all three clients' post-therapy interviews using principles of Grounded Theory.

In section i) I begin by presenting the findings which elucidate the clients' understanding of how the therapy may have helped to develop a healthier relationship with food and encourage intuitive eating. In section ii) I include findings which relate to challenges the clients faced during the course of therapy which they discussed retrospectively in their post-therapy interviews.

i) Findings from the post-therapy interviews relating to the clients' understanding of how the therapy may have helped to develop a healthier relationship with food and encourage intuitive eating

Concepts which I identified as core concepts were based in the participants' own language, and elucidate many aspects of their understanding of how their reported changes came about:

a) Addressing self-identity issues
b) Raising awareness of/understanding the relationship with food
c) Positivity
d) Behavioural and cognitive change

The data from the clients' post-therapy interviews suggests that the clients' understanding is that there are interrelated aspects to those elements of the therapy which they consider may have helped to enable the changes which occurred.

I have developed a coding paradigm which illustrates the early stages of this developing theoretical model showing the categories and their relationships to each other (Figure 5 below).

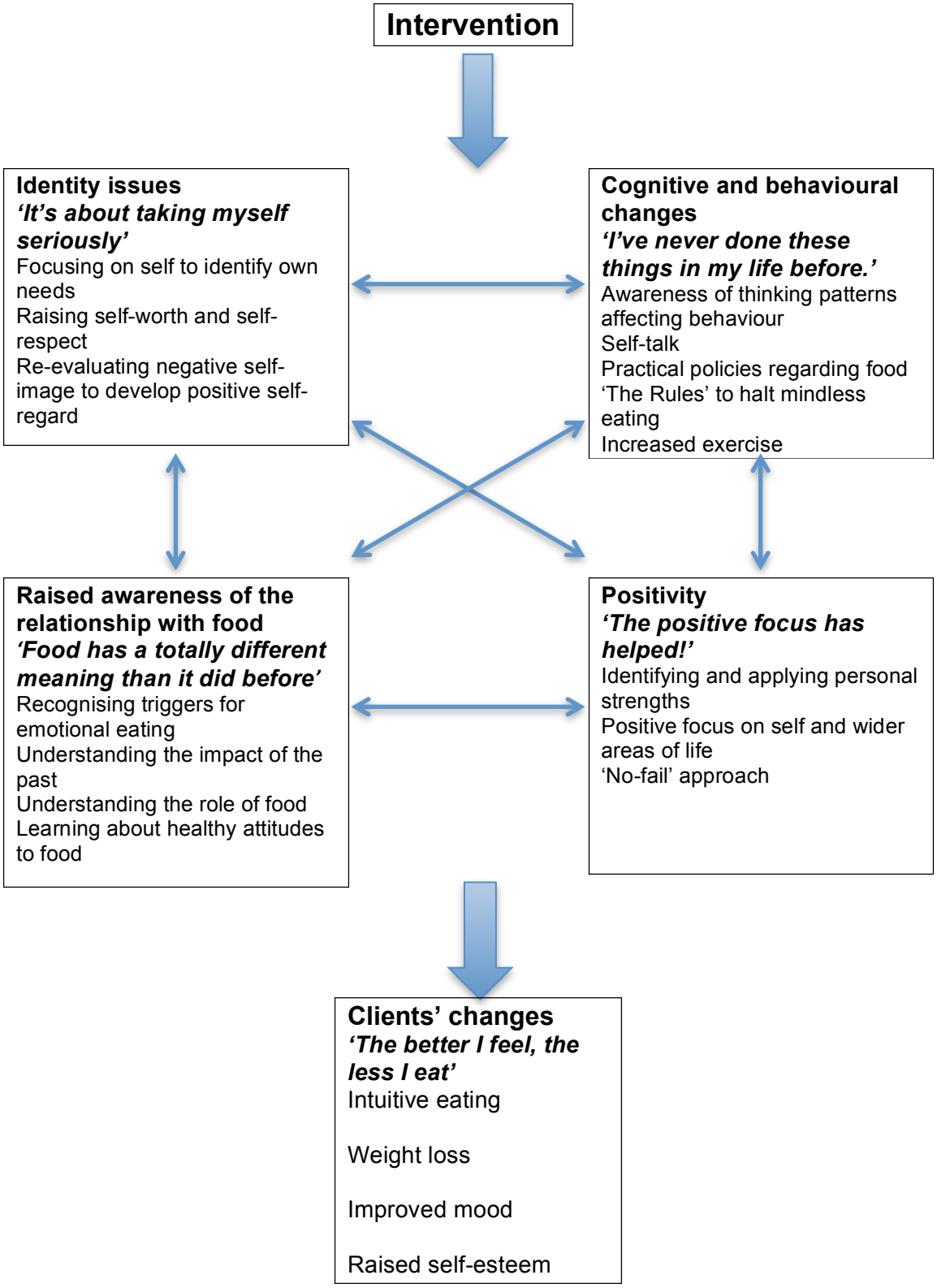

Figure 5 – Clients' post-therapy understanding of how the therapy may have helped to develop a healthier relationship with food and enable other changes to occur

Overview of model

When describing their understanding of how our work together might have helped changes to occur, the clients primarily attributed change to elements of the therapy content rather than process. They spoke about the interrelated categories of a) addressing self-identity issues, b) raising awareness of and understanding the relationship with food, c) positivity, and d) cognitive and behavioural changes, as being 'exceptionally helpful', 'most powerful', 'really useful', and 'empowering' in encouraging a healthier relationship with food. In the clients' view each category influenced the others, and the separate categories as well as their interrelatedness may have helped change to occur.

Exploring issues of identity together in sessions helped each client to identify what she actually wanted and needed, to acknowledge that she matters and to recognise her self-worth. Understanding these identity-related issues helped to prompt our discussions and inform the clients about their relationship with food. We became more aware of what triggered their emotional eating, how their background influenced this and the reasons they were using food. Clients reported that during the course of therapy they developed healthier attitudes towards food, less influenced by psychological and background issues. They developed cognitive skills to change their feelings and their behaviour, including changing their eating habits. The clients said that they thought that positivity they developed during therapy with me helped them make changes. In particular, our work on identifying their strengths and ways in which to apply them usefully, recognising what is right about themselves, their life and their future, and working with the 'no-fail' approach of the therapy. This increased positivity, echoed by me, helped the clients to consolidate and confirm their therapeutic work done on identity issues, as well as on developing a healthier

relationship with food by, for example, applying their personal strengths to making changes. As positive changes took place, the clients' positivity increased, illustrating the interrelatedness of the categories.

I will continue by describing in detail each of the core categories and their components.

a) Addressing self-identity issues

'It's about taking myself seriously'

All three clients made comments in their post-therapy interviews that reflected that they had begun to think differently about themselves, and they considered that focusing in therapy together on their self-identity had helped enable change.

Focusing on self to identify own needs

Jane was very clear that our work which encouraged her to focus on herself had helped her to make changes:

> 'The changes have come about because over the last weeks of doing this it has been about me and how **I** am personally with food, as opposed to being with a whole group of people whose needs are different. So it's because it's based entirely on **my** experiences and changing **my** attitude to **my** experiences of food.' (Jane's emphasis)

She also acknowledged that she found that the relational space within the therapy sessions was important in addressing what was important to her personally and enabling change:

> 'I think the one-to-one has been exceptionally helpful.'

Isabel expressed the view that focusing on herself within our sessions and in wider areas of life had been central in helping her make changes:

> 'I think they have come about out of spending a bit more time on myself, focusing on what I need and where I want to be in the future. And that's motivated me to change things back to a healthy balance really.'

She acknowledged that she had lost her sense of direction over recent years because of prioritising the demands of her family, and that our work together offered her an opportunity to take time to think about herself in order to identify more clearly what was important for her as an individual:

> 'It's really good for me to have time for me and to set goals of where I want to be in the future…..I've really valued having time to consider the things that I want again. I've had children in the last five years and the focus has been on them. I feel that I am coming back to **me**, this process has been really well-timed for that.' (Isabel's emphasis)

She went on to explain that she appreciated that our sessions gave her 'a kind of permission to have time to think about things or write in my journal during the week'.

Raising levels of self-worth and self-respect

Clients talked about times during our work together which helped them build up their sense of self-worth and reconsider self-respect.

Jane acknowledged that she felt that the respect shown to her within our therapy sessions – especially 'being able to be very honest with somebody and having that

honesty respected' - helped her to respect and value herself and this in turn helped her to make changes.

She also commented that at a time when she noticed that she was eating mindlessly, engaging in her old eating habit of finishing up other people's leftovers, she stopped and said to herself: 'You're worth more than that!' and this helped her to make more deliberate choices about her eating habits.

Isabel explained that she appreciated that our sessions enabled her to prioritise her own needs, and she reflected on changes she had made which had helped her to increase her sense of self-worth and also self-respect:

> 'The most valuable is combating the tendency to be critical of myself.'

Caroline commented that she became aware, through our discussions during the course of therapy, that in the past she had not taken herself seriously, and that this insight was useful in making changes:

> 'Well I think it's something I've not done in lots of ways in my life. And in a way, being overweight makes it (*ie not taking herself seriously)* easier to do as well, not only for myself but for other people. So being able to really look at this idea of identity and what being overweight meant to me – it allowed me to focus on other areas that weren't just about my weight, but were also to do with my work and also my relationships with others. And generally how I go about life. I needed to take things I'd done in my life more seriously and the hard work I'd put in more seriously. It started there and went [further], so that was my most useful, that's what I found most useful.'

Re-evaluating negative self-image to develop positive self-regard

The data suggested that by re-evaluating the negative image they held of themselves, the clients were able to recognise and acknowledge positive aspects of their looks and personal qualities which they had previously overlooked.

From my therapy sessions with Jane, I knew that she had been overweight for most of her adult life, and we had discussed how, as she lost weight, she might change the way she thought about herself. She used to think about herself primarily as a large person, and this seemed in some ways a comfortable, 'safe' option, as, in her view, she did not have to manage others' views of her as attractive, desirable and perhaps enviable. As she lost weight and others commented on her slimmer figure, we discussed how she might feel if she believed she was being were noticed more for her appearance. Initially she found it hard to imagine that others could see her as attractive and desirable, and, because of some long-standing sibling rivalry, assumed that others would criticise her for paying attention to her appearance. However, as she became more appreciative of herself, these concerns diminished and she felt more comfortable with the prospect of perhaps being seen more positively by others. When asked at interview about changing her sense of identity and self-image from being a larger person to a slimmer person, she responded that:

> 'It has been very helpful, although of course if someone saw me in the street they would still see me as a large person. But for me it has been quite noticeable that I am (slimmer) and I am aware I have lost a stone and for me that is fantastic.'

Re-evaluating her previously held, longstanding, negative view of her appearance and recognising that she could justifiably feel proud of her efforts to lose weight

enabled Jane to develop a more positive view of herself, acknowledge that others' compliments are justified and respond to them differently:

> 'So when people started to notice at work for example, I am now more able to accept what they are saying as a compliment as opposed to, you know, justifying it. So [before] somebody may say 'Oh have you lost weight?' and I would probably say 'I think I have' or 'Yes I have lost a little bit'. Whereas now I am more likely to say 'Yeah, I have and I'm really pleased.' So there is a change in the way I accept compliments.'

By changing her familiar, negative view of herself by realistically re-appraising (initially with me) her personal qualities, her achievements and her appearance, Caroline began to develop a more positive self-regard. Part of this shift included changing her sense of identity from being a larger person to being a slimmer person.

> 'I think that was really, really, really useful and I think for me it was the most useful, it was the most powerful. To me it's about taking myself seriously not only in terms of look but generally in life. So that I found really, really useful, really useful.'

b) Raising awareness of the relationship with food

'Food has a totally different meaning than it did before'

All three clients discussed in their post-therapy interviews ways in which their awareness of their relationship with food became heightened during the course of our work together. This suggests that they were potentially being impacted by

components of the programme which included completing Mood and Food Diaries, exploring the impact of the past on their eating habits, and identifying satiety cues.

Recognising triggers for emotional eating

Clients talked about making links between 'external triggers' as well as 'internal triggers' and their eating habits. 'External triggers' included surroundings, time of day, food being immediately visible and available, and other people eating, whereas 'internal triggers' referred to thoughts, 'self-talk' and emotions.

Jane found that she became aware of her triggers for emotional eating, so that if she'd had a 'bad week' she could evaluate her emotional eating by asking herself 'I wonder what's happened to you during the week that's made you do this.'

Isabel explained to me that over the course of the programme, she had become aware that at times she ate when she was not hungry. She noticed that she ate mindlessly at certain times and in certain situations.

> 'Generally, there seem to be two times of day, one is when I am preparing food for my children and I graze or was grazing, I don't do it anymore. And the other times are if I feel alone in the evening and it's sort of a boredom, alone thing. Entertainment, I suppose – isn't it?'

As we increased our understanding of her reasons for eating when she wasn't physically hungry, Isabel was able to make more aware choices as to how to respond to these 'high risk times'.

Caroline discussed that during the course of our therapy sessions she recognised that before the programme she used to eat regardless of time, place or satiety. Her

eating habits were not previously based on deliberate decisions to eat but she used to eat mindlessly:

> 'I mean before, I just used to eat! You know, if I was out shopping I'd buy something to eat, at home in the evening I'd just sit there and eat in the evening.'

Understanding the impact of the past

Caroline summed up one of the changes she made over the course of therapy by saying simply: 'I eat less now'. She said that this change had come about in part by our raised awareness of her relationship with food, especially the impact of the past on how she used food, and re-evaluating how she used food. She used to eat more than she needed, because she used to fear not having enough food. Previously, she ate when she could, in case later she didn't have the opportunity to eat enough. Having become aware of this, she was able to make more deliberate decisions regarding her eating habits.

> 'I would always panic about not having food. So if I was going to someone's house for tea I might eat beforehand, because they might not give me enough food when I'm there. Or if I'm staying for a few days I would like to have some little supplies because they may not feed me enough, which is never the case because people always do feed you really. But it's the idea of not having enough food.'

Understanding the role of food

It became apparent in her post-therapy interview that during our therapy together Caroline increased her understanding of the role which food used to play for her, and that in the light of this new understanding, she was able to re-evaluate how she

viewed and used food. She had previously directed her more general anxiety onto fear of a potential lack of food, and eating seemed to ease her anxiety. Furthermore, she used to consider that food was a sort of emotional crutch, providing constant support and consistency.

> 'You don't need food, to that degree. You know that food is not providing what you think it's providing, so it's panic about other things, not really about getting enough food. It actually is really ok to go without food, it doesn't really matter as much as I thought it did, I don't need it in the way I thought I needed it. I thought it sort of sustained me, not just by eating but sustained me as a person. I used it to get through each day and everything was rewarded by food. It was just what I did. Eating was just what I did. When in doubt, eat, so – boredom, feeling low, not even either of those, just eat. You're at home, just eat. You're out, just eat.'

Caroline described that during the period of our work together she re-evaluated her long-standing view of the role of food and began to acknowledge some aspects of intuitive eating – including recognising that food is fuel and nutrition, to be eaten as a response to hunger cues. She began to understand that food could be used in maladaptive ways as a response to emotional triggers.

> '(The programme) put food in its category, so food is for sustaining your body and to stave off hunger. … I am now aware of not only what I am eating but how it is affecting me. … and I'm considering all the other reasons why you eat that aren't to do with being full or what your body needs.'

She also discussed that the opportunity to explore and understand together with me the role food played in her life, helped her to clarify the vague notion she already had

that her family culture of eating included some maladaptive eating habits. Having gained some clarity on this, she was able to define for herself how she chose to use food.

> 'You see how you develop a certain culture of eating, and how food is used in various ways which I have then applied throughout my life and it is useful as it puts food in its place, you know, it doesn't mean this, it only means that. Without the ability to explore that it's not clear, so this has clarified these things by allowing space. I think it's true that food is used in loads and loads and loads of ways and I think I sort of knew that it was used in my family in lots of ways, but this clarifies it, allows you to form your own eating patterns.'

Caroline emphasised that through our joint discussions she had gained some understanding of the role that food used to play for her.

> 'Food has a totally different meaning than it did before, so it's really directed in my mind the purpose of food whereas before it was lost in a blur, where it could be a multiple of things.'

Learning about healthy attitudes to food

All three clients spoke about learning about healthier attitudes to food during the course of the programme. These 'healthy attitudes' reflected aspects of intuitive eating, such as identifying and responding to satiety cues, not categorising foods as 'good' or 'bad', enjoying food, and feeling relaxed about leaving food if it was either unappealing or more than they required to feel comfortably full.

The clients discussed that identifying and responding appropriately to satiety cues was helpful in developing a healthier attitude to food. Their raised awareness, developed in our sessions, of these cues helped enable change.

> 'I used to eat all the time when I wasn't hungry, now I'll save eating until I am hungry.' (Caroline)

Jane said that 'recognising that you…are full' was a useful signal which she began using in order to change her eating habits.

Developing - or rediscovering - the enjoyment of food was a further aspect of the clients' relationship with food which emerged in their interviews as significant in prompting change. It appeared that their enjoyment of food had been restricted by categorising food as 'good' or 'bad', 'allowed' or 'disallowed', always acceptable or never acceptable. For example, Isabel expressed that she was developing 'a more healthy enjoyment of food' by 'trying to monitor foods that I eat without being overly punitive…just not losing the enjoyment of it, not excluding foods by being too extreme with all or nothingness.'

All the clients expressed that the leaving food, instead of eating everything on their plate, or finishing others' leftovers, was a new behaviour for them which they engaged in and found was helpful in changing their attitude to food. This could have related to our discussions about this in therapy sessions.

> 'I remember the idea that I could leave food was a revelation. It was like if I don't want anything I don't actually have to eat it or if I'm full I don't have to finish what's on my plate. That, I remember, being a sort of revelation.' (Caroline)

c) Positivity

'The positive focus has helped!'

In their post-therapy interviews, positivity was a core category which each client deemed important in helping them make changes to their relationship with food. They included references to the attention placed on personal strengths as well as mentioning other applications of positivity which they found helpful.

Identifying and applying personal strengths

It emerged from the clients' post-therapy interviews that there were three aspects of the theme of personal strengths which we had discussed together which they found helpful. Firstly, identifying their personal strengths, secondly, applying them generally, and thirdly, deliberately applying them to their own challenges and personal situations.

> 'It was really useful, really useful…I am very good at using my skills for other people and this process has helped throw them back at me and focus on helping me use them to focus on me. That's been great.' (Isabel)

Isabel explained that she learned to applied her strengths to help herself:

> 'I am very determined albeit stubborn at times. This has been a really useful skill to direct in this way. I am very caring and good with other people. So, using that, we ended up terming it as 'self-kindness' to turn it back onto me and not be so harsh when I am not succeeding or to really feel proud when I am achieving something really good.'

Our work together on dentifying personal strengths and deliberately applying them was discussed by the clients as a process which they thought helped them to make changes.

> 'I remember one [strength] – that I am good at trying out new experiences, that was one of my things, and that was one that Rose said to use, like practise being hungry, see it as a new experience and I did. And actually, now I've said that, I now often go hungry so I don't know whether I've used them [personal strengths] more than I thought, maybe I have more than I thought…' (Caroline)

Positive focus on self and wider areas of life

Some of the clients' comments in their post-therapy interviews suggested that the positive focus of our work together helped them in a general way to re-evaluate their choices:

> 'I'm just going to say it [the positive focus] has helped! (laughs)' (Jane)

> 'I think it is going to be long term in a way that other approaches might not be, and it has been really – for want of a better word – positive. I have really appreciated it.' (Isabel)

One aspect of the positive focus of our sessions which was discussed in the post-therapy interviews was that it helped the client to be independent and self-directed regarding any changes they might choose to make:

> '…it feels like I am finding my own path. I think the positive approach allows you to do that – or it has allowed me to. And I feel that is actually quite

empowering as you make the decisions rather than being told by someone else what to do.' (Caroline)

'No-fail' approach

Clients talked about valuing the non-judgemental approach of our work together. They appreciated the accepting and inclusive nature of the approach, where foods, behaviours and choices were not seen in terms of negativity or failure.

'There isn't anything negative placed on food – there's no bad food or good food, it's all food and it all has a place. But just to be mindful of it, that's the positive bit.' (Jane)

Clients valued this 'no-fail' approach of our therapy sessions, which encouraged seeking alternatives and seeing them as simply 'different', instead of in terms of 'better/worse', 'winning/losing' or success/failure':

'Rather than thinking I won't have any of that food or I'll have masses of that food I am a bit better at smaller portions of it within reason…and that sort of knocks onto social life and things. So rather than thinking I can't go out for a meal I might just do things differently – I might socialise with a friend doing exercise or something like that, so just making it not feel punitive.' (Isabel)

Caroline talked about the 'no-fail' approach of our sessions offering her a sense of purpose and empowerment:

'Because you're making the decision and you're not following a set thing you don't fail either and that for me gives it it's point and purpose.'

'…quite empowering, that's how I found it – it's empowering, so you're not wrong, you haven't failed and I think that is what worked for me.'

d) Cognitive and behavioural change

'I've never done these things in my life before'

Data analysis of the clients' post-therapy interviews suggests that all clients valued the cognitive and behavioural changes which took place during the period of therapy. During our therapy sessions, there was considerable emphasis placed on making changes to thinking patterns and to behaviour, in order for each client to achieve a different relationship with food. I helped clients to develop skills based on cognitive behavioural therapy to identify and challenge unhelpful thinking patterns and to manage their emotions.

Practical policies regarding food

Early in the programme I suggested some practical suggestions for clients in order to encourage cognitive and behavioural changes related to their eating habits. All clients talked about some of these practical 'tips' being useful in making changes to their eating habits as well as to other aspects of their behaviour.

> 'Practical things…that I will continue for myself like trying to make time for myself on a weekly at the very least basis. And practical things like the rules that stick with you and help day to day with not overeating or eating the wrong things.' (Isabel)

Caroline also described how she thought that the practical policies such as regularly completing the Mood and Food diaries, and weighing herself daily, helped her to enable changes to occur:

> ‘The writing down of everything you eat, that makes you aware. I don’t do that any more, but I do weigh myself every day, then I can see that if I eat more I put on weight. I’ve never really weighed myself before, so by noting what I eat and by weighing myself I become aware of not only what I am eating but how it is affecting me. So I think those practical things have made me aware.’

‘The Rules’ to halt mindless eating

All the clients talked in detail in their post-therapy interviews about using quick, simple mental reminders to make changes to their eating habits. ‘The Rules’ – to use Isabel’s term – refer to the CBT-based perspectives I had suggested and which we discussed in therapy sessions for clients to keep in mind when they might otherwise have engaged in mindless, emotional eating. They include phrases such as:

- ‘You’re not a rubbish bin’ - which reflected new thinking about not finishing up leftovers.
- ‘Always leave something on your plate’ – emphasising that the client should decide how much to eat, instead of the portion being decided by the plate size or the server.
- ‘If you don’t love it, leave it’ – a reminder that eating a food is a deliberate choice, therefore if the taste, texture or amount of the food being eaten isn’t really enjoyable then a decision to leave it is appropriate.
- ‘Use the Hunger Scale’ – clients are encouraged to keep in mind that intuitive eating includes being aware of hunger and satiety cues.

It appeared that having clear ‘rules’ to guide choices was a strategy which was welcomed by clients:

> ‘Leaving something on my plate has been helpful…and not thinking that I am a dustbin has been very helpful.’ (Jane)

> ‘I actually found a lot of the eating habits things - like leaving food on the plate, gauging your hunger – I found them useful.’ (Caroline)

Isabel described that she extended the concept to develop her own rules to suit her situation:

> ‘The rules are the practical rules like ‘If you don’t love it, leave it’ or if your hunger scale is under 6 then I won’t eat. But I give myself extra ones like I try and have a treat just at the weekend. A high fat, high sugar treat. Rather than when I started this process I was having them 6 to 7 times a day.’

Self-talk

Self-talk refers to clients deliberately engaging in constructive and reflective internal communication based on re-evaluating their negative thinking patterns. The data within the clients’ post-therapy interviews suggest that they all frequently drew on self-talk as a strategy we had discussed together to make changes to their eating habits.

> ‘ I guess it’s like a little voice in my head when I am about to put something in my mouth. I slow down and almost have a conversation with myself. It happened yesterday at home – as an example – I’d be saying (to myself) What are you doing? Why are you doing that? Well, because it’s there. But if you **want** a sandwich **make** yourself a sandwich, **don’t** eat the crusts off other peoples’ food. Then the bit about ‘You’re not a dustbin!’ ‘ (Jane)

> ‘I think, I think – You don’t have to eat all of what is given to you, if you’re given food you can eat what you want and you can leave it. If you don’t like something you don’t actually have to eat it.’ (Caroline)

Awareness of thinking patterns affecting behaviour

All the clients mentioned that becoming more aware of their thinking patterns helped them to make more deliberate choices and saw this as a factor in enabling changes to be made. This awareness enabled the clients to re-evaluate unhelpful thinking patterns and develop new perspectives which led to changed behaviour.

> ‘Learning about the all or nothing thinking is going to pervade all sorts of areas in my life but it has been one of the most useful things to realise how much I do it and how much it affects my behaviour. So that has been really useful.’ (Isabel)

> ‘I have learnt that I can have a little of something and not go crazy with it so keeping the balance. The awareness of the all or nothing thinking has been really helpful.’ (Isabel)

Jane developed a new thinking process related to eating at her workplace, having discussed together with me in therapy how she might behave differently at a monthly buffet served at work:

> ‘Rose called it a brown buffet which is really helpful as I’ve never thought about that before. Everything is brown because it’s pastry or it’s deep fried or it’s chicken in breadcrumbs. Everything is brown. I would normally have just got a plate and thought that looks nice I’ll have that, I’ll have that. Now I’m

looking at it and thinking is there anything there that you would really want, would you have cooked that yourself and eaten it, if you had gone to a restaurant and that was on a plate would you actually want it. So it's about having a thought process before I actually eat.'

Clients talked about becoming more aware that thinking differently about the future, as well as about the present, enabled changes in their behaviour:

'I sort of plan what I'm going to eat now and even though I may not stick to it I generally stick to it, so I have an idea of what I'm going to eat during the day. Whereas before I would just eat, get up, see what's there, oh I'll have that, oh I'm out I'll have that… There was no idea even that you have a certain amount of food in the day, you just ate what came to hand really.' (Caroline)

'I'll say no to food. I've never done that, never done that. I'll say no thank you, or I don't want anything, or I'll leave food. I've never done those things in my life before.' (Caroline)

Increased exercise

In her post-therapy interview Isabel emphasised that a key behavioural change she made over the course of the programme which may have affected her eating habits, weight and mood was to increase the amount of exercise she was doing:

'A big change has been getting my exercise routine back into what I consider is normal for me and is healthier for me. I'm really happy that has changed.'

ii) Findings from the clients' post-therapy interviews relating to challenges they faced during the therapy

Difficulty changing established habits

Two clients discussed in their post-therapy interviews that the programme had presented them with the challenge of changing habits which they found difficult.

> 'It's been a bit of a challenge' (Jane)
>
> 'In the last year or so I've got into real emotional eating habits prior to starting this and breaking them has been difficult.' (Isabel)

Varied rate of weight loss

All the clients lost weight during the therapy programme. Their rate of weight loss varied over time and at times was accelerated or stabilised. This uneven, and to some extent unpredictable, nature of their rate of weight loss was discussed by two clients retrospectively in their post-therapy interviews as causing them difficulty for their own reasons:

> 'It's been a bit up and down. I've been fearful when I know I haven't had a good week and I'm going to have to get on the scales here and know what the results are…[as if] I was going to be told off…because that's my [previous] experience of being in a slimming group…' (Jane)

The inconsistent rate of weight loss reduced motivation for the programme and resulted in challenges which the client tried to overcome:

> 'There have been weeks when I have felt I was pretty good both with food and exercise [but no weight loss] and the way to handle that is to realise that this is a plateau and to maybe introduce something that will kick start the following week.' (Isabel)

Focus on the strengths-based approach

The Positive Slimming Programme was introduced to the clients as an intervention which included a strengths-based approach as part of a wider positive psychology therapy. Interestingly, the strengths-based element of the therapy was seen retrospectively by one client as part of what might have helped her make changes, but not particularly central to the therapy. Nevertheless, during the therapy, the client had acknowledged that identifying and applying strengths was helpful.

> 'I don't know, I don't know really, I don't know whether it [applying strengths] has or not [been helpful for weight loss] to be honest…I don't know whether I've used them more than I have thought, maybe I have more than I have thought, but in my conscious mind there are other things consciously that I feel have been more helpful.' (Caroline)

Findings Part IV

What was my experience of the therapy and my understanding of how the therapy helped clients?

In Part IV, I draw on data from both my process notes made during the course of therapy and my post-therapy interview transcript to focus on my experience and understanding of the therapy process. In order to include triangulation, multiple sources of data are analysed relating to my own understanding of the process of the therapy and how the process may impact the clients and their relationship with food. I have analysed the data using principles of Grounded Theory. My account below includes excerpts from my therapy session notes and from the transcript of my post-therapy interview by a psychologist colleague, thereby incorporating my understanding of what was happening during the period of therapy as well as my retrospective reflections on how the therapy may have helped clients' changes to occur.

I begin by presenting the findings relating to aspects of the therapy which seem, in my view, to have enabled change, thus reflecting both the focus of the research question and a positive psychology stance. Following this, I proceed by presenting data which illustrate challenges encountered during the therapy.

Analysis using principles of Grounded Theory of the data from my session notes and post-therapy interview transcript of me as therapist

Concepts which I have identified as core categories are:

a) The therapeutic dyad

Hope

Validation

Encouragement

Accountability

b) Developing and applying positivity

Positive focus

Personal strengths

Positive resources

Positive eating

Positive self-image

c) Raising awareness of and understanding the relationship with food

Triggers for emotional eating

Impact of the past – family culture of food

Developing a healthy attitude to food

Satiety cues

d) Addressing self-identity issues

Addressing past negative roles

Avoiding sabotage to progress

Increase positive self-regard

Dealing with unfamiliar responses from others

e) Developing skills to change cognitions and behaviour

CBT-based skills

'Micro-skills'

The categories b). c), d) and e) resonate closely with the themes and core concepts identified in the data from the clients' journals, Mood and Food diaries and post-therapy interviews. However, in contrast to the clients, who attributed change primarily to the content of the intervention, my understanding as therapist-researcher emphasises the therapeutic dyad as the primary, most likely element of the therapy to have an impact on clients and enabling change. Below is a coding paradigm which illustrates my understanding of the way in which the categories relate to each other:

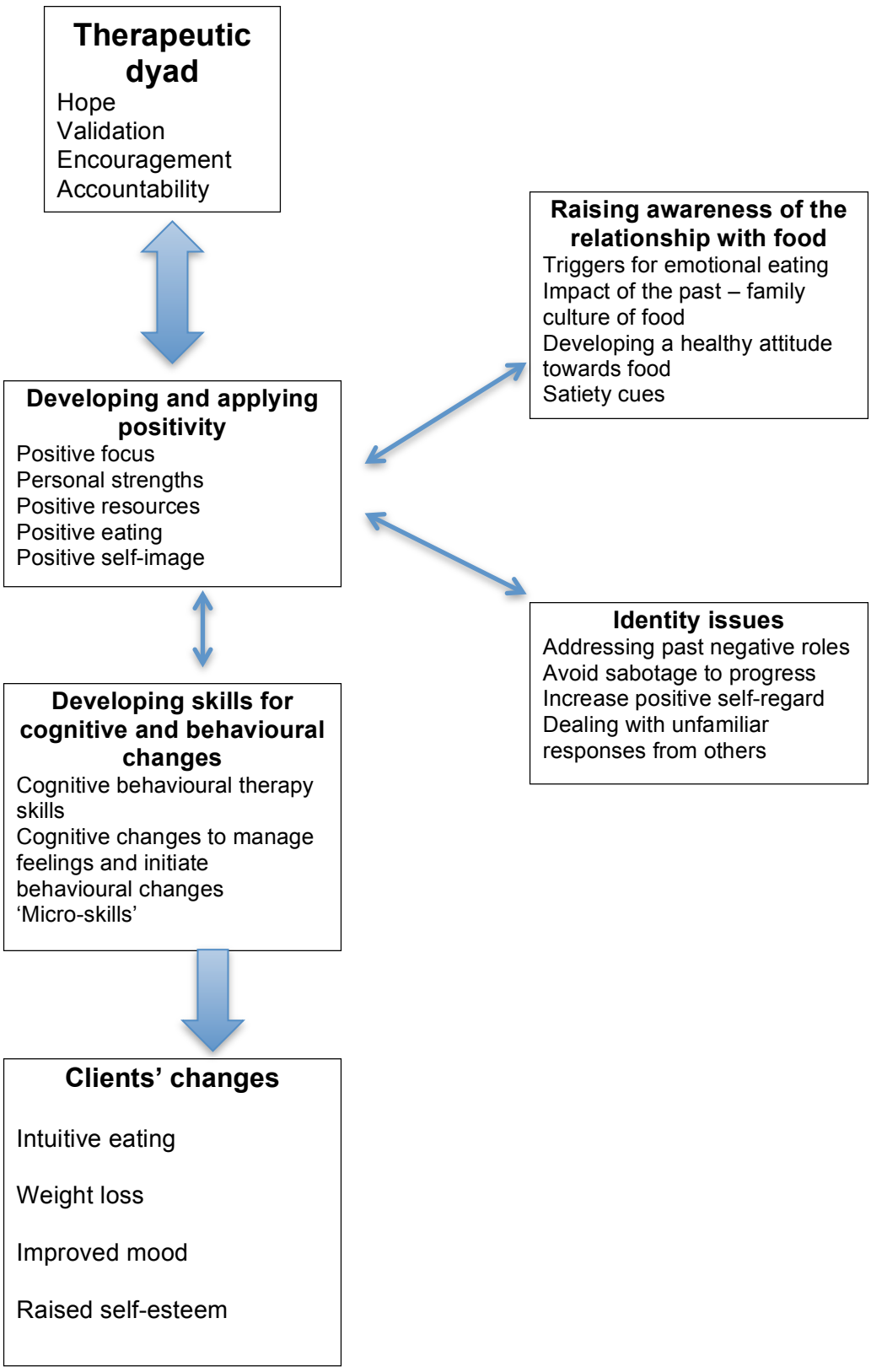

Figure 6 - Therapist-researcher's understanding of how the therapy might have helped to develop a healthier relationship with food

In my view, as illustrated above in Figure 6, it was primarily the therapeutic dyad which was the catalyst and the key to enabling change. As this was a positive psychology approach including strengths-based therapy, I ensured that my stance as therapist was one which provided a foundation of positivity within the therapeutic relationship. With hindsight, it may have been useful to have included a quantitative tool such as the WAI to measure the impact of the therapeutic relationship, but at the time of planning the research details my focus was on other aspects of potential change and the measurement tools I included reflect this.

Unlike the clients' accounts of how change may have occurred, my understanding is that there was a sequential aspect to the therapeutic input and that this was a key element in enabling change. I believe that clients had the opportunity to draw positivity from the therapeutic relationship and then apply it to their relationship with food as well to their relationship with themselves. This in turn enabled further positivity to develop. Specific skills development was included in the therapy to encourage cognitive and behavioural changes. My understanding is that the initial positive input provided by the therapeutic relationship continued to be influential throughout the therapy, and that the other elements of the therapy had ongoing influence on the therapeutic dyad. I think it likely that together, the interrelated categories helped to enable changes to occur; however, I believe that the therapeutic dyad was key to the impact of other aspects of the therapy.

There is convergence in the clients' accounts and my own in that we agree that working with positivity, raising the awareness of the relationship with food, addressing identity issues and relevant skills development all seem to have contributed to the changes which occurred. However, there is divergence in our

views as the clients did not articulate any hierarchical or sequential structures within their accounts of how the therapy may have helped change – to the contrary, their understanding was that the elements of therapy worked in a parallel, interrelated manner.

In the Discussion section I will explore in more detail the different perspectives the clients and I had regarding the therapeutic encounter – the similarities and differences between what I as the therapist thought I was doing in the therapy compared to what the clients thought I was doing in the therapy.

Core categories

I will explore each core category from my perspective as therapist in the programme in terms of how I consider each may have helped the clients to make changes to their relationship with food.

a) The therapeutic dyad

Given my choice to offer therapy from a positive psychology approach I tried to ensure that I expressed positivity to the clients when appropriate, although not, I hope, to the detriment of acknowledging and addressing challenges and distress experienced by the clients. I tried to provide a therapeutic relationship underpinned by a positive approach. In my post-therapy interview I reflected that:

> 'the therapeutic relationship was also part of what I was providing, and within that, what I think I was doing was providing encouragement, accountability, and giving each person the message that they matter'.

Hope – change is possible

The clients' first contact with the therapy was through a written publicity notice about the Positive Slimming Programme. The programme was described as a psychological approach to address emotional eating. All clients had tried other ways of trying to lose weight before they began this therapy and were already hopeful that a positive psychological approach would help them.

Each client contacted me by telephone, and although I was careful to say to them that there can be no guarantees in therapy, my enthusiasm for positive psychology and its applications will have been clear. My own hope that the therapy would help the clients to make changes to their relationship with food and lose weight was clear in my own mind, albeit unspoken. It seems likely then, that our very first contact was a contact between two hopeful people.

As the therapy progressed, hope remained central to our work. At times, clients expressed the fluctuations in their hope for change through the therapy, but I felt that it was important that I carried hope on their behalf, when it seemed justified, particularly if clients found it hard at times to do so for themselves. As I am of a slim build, perhaps hope was also present in that the clients told me that they saw me as having managed to do what they were trying to achieve, namely develop a way of enjoying food without overeating and becoming overweight.

Within the therapeutic dyad I think my positive stance on hope for change may have been helpful to clients.

Encouragement – 'You can do it!'

Working individually with each participant over 20 weekly sessions, then meeting again for a follow-up session three months later, led to the development of strong therapeutic relationships between myself and each of the participants. In my view I became an encouraging voice for the clients and this may have helped them to apply various aspects of the therapy in order to prompt changes. This included encouraging a positive perspective on the client herself, on her life and her future, thereby encouraging a sense of pride and acting on increasing self-respect. Additionally, encouraging the client to focus less on food, and instead to focus more on other valued aspects of life seemed to be helpful. I also encouraged specific behaviour changes and choices which were likely to foster positive emotions. For example, Isabel spoke about how exercise evoked positive feelings of satisfaction, being energised and proud of herself, so we discussed steps she could take to include exercise regularly in her lifestyle again, and I encouraged her to act on our discussion.

A regular opportunity for me to express my encouragement was at the beginning of each session. I was aware that the 'weigh-in' at the start of each session was very important for the clients. Understandably a participant would be pleased, proud and optimistic if the scales showed weight loss, and, in contrast, if the scales showed no change since the previous week or some weight gain, she may express a variety of emotions such as disappointment, resignation, anger at herself, shame, envy of others without a weight problem, or acceptance. I felt that my role was to express encouragement whatever the scales showed.

A further area where I believe my encouragement was helpful in perhaps helping change to occur was in fostering enjoyment of food. To varying degrees, the clients had negative associations to food and eating, and Jane and Caroline, in particular, felt that they had become 'slaves to food' and therefore it was difficult for them to relax and enjoy food.

Overall, in my role as therapist, I encouraged the clients throughout the therapy to keep motivated and focused on whichever stage and aspect of the therapy seemed most relevant. With the positive psychology approach in mind, I also encouraged them to identify what was still working for them as well as resources available to them to help change occur. An excerpt from my interview transcript illustrates this:

> 'With a positive slant on things, I was trying to encourage people to look at what was there that still worked for them and was available to them rather than get caught up with the tendency to focus on what wasn't working – which I think quite often happens in therapy'.

Validation – the client matters

In my view, offering validation to the clients in my role as therapist may have been a helpful aspect of the therapeutic dyad.

As therapy sessions proceeded, I believed that my ongoing attention to the clients validated their efforts to change their relationship with food and lose weight. I felt that I was giving the clients the message that they matter, that their efforts to change matter, that their current and future quality of life matter, and that their emotional life and well-being matter. In my post-therapy interview I reflected that:

'…it seemed to be important to acknowledge that their efforts to essentially improve their own quality of life mattered'.

By validating the clients and their efforts to achieve positive change, I believe I was helping them to prioritise changes and in my view this was likely to help them overcome any resistance to change and maintain progress. Resistance to change included both intrinsic and extrinsic resistance, such as variation in the clients' motivation, and sabotage from others to the clients' change and progress.

All three participants, at some point in the programme, expressed that it felt important to them that their progress mattered to someone – me, in their case. In my notes on session 6 with Caroline I wrote:

'Finding it easy not to eat. How done it? [She says] it matters. Some-one (Rose) cares.'

The clients said they felt validated by my attention, support and interest. Through such validation, I believe I was indicating to the clients that it was important to focus on themselves – not instead of, but as well as, focusing on others. In my view it required a foundation of feeling more positively about themselves, perhaps prompted by the positivity I offered regarding themselves, to enable the clients to prioritise themselves and their own needs sufficiently to warrant their focus. This was a theme which was raised in Isabel's follow-up session. We discussed what she believed was her greatest problem in managing her emotional eating prior to our therapy, and I noted:

'[Previously] needed support. Needed someone to give permission to focus on self.'

Accountability

Having agreed together in sessions with clients that they would try out new ways of doing things, whether to do with eating habits or wider aspects of their life, a sense of accountability developed which all the clients acknowledged, and they all said it helped to keep them focused on making changes. We started each session with an update, not only of their weight but also related to any changes they had agreed to consider, research or carry out. The clients were aware that the update was part of the regular structure of the sessions so they knew to expect it, and I frequently confirmed this by saying, when we had discussed changes that the client would follow up on in the week before the next session: ''I'll ask you about how you got on with this next time'. I believe that the sense of accountability the clients felt was a helpful aspect of the therapeutic dyad in enabling change. However, although this seemed to be helpful during the course of therapy, once the clients had finished the programme, some of the accountability they had felt within the therapeutic relationship also came to an end. This was confirmed during the follow-up session with Caroline. I wrote in my session notes:

> 'It was easier with someone [for Caroline] to keep focused.'

b) Developing and applying positivity

From the first contact with clients I believed that it was important to be open about the positive aspects of our work – especially as the therapy was called the 'Positive Slimming Programme'. All clients were aware from the beginning that the overall approach was based on positive psychology, however, none of them had any prior knowledge or experience of positive psychology. I described it briefly to them at the first point of contact as an approach which aims to identify what is working well for a person, including their personal qualities and strengths, and then encourages the

individual to apply those strengths to psychological challenges they face. In contrast to a more traditional approach when therapy tends to focus more on areas which are not functioning well and therefore require repair, positive psychology acknowledges difficulties but additionally – and deliberately - focuses on positive aspects of a person, their present circumstances and their future. Developing and applying positivity was a core element of our discussions in therapy sessions as well as becoming increasingly included in the clients' lives. I tried to encourage the clients to focus on what was working well for them in their lives, rather than concentrate on and feel overwhelmed by what was going wrong for them.

Positive focus

During the therapy my impression was that the generally positive focus of sessions enabled clients to achieve a realistic and balanced perspective of their difficulties. We acknowledged and explored clients' past experiences which they perceived to have had a negative impact on them, and undoubtedly, some of these had evoked much pain and distress for them. It is central to the positive psychology therapy approach that acknowledging, understanding and addressing psychological distress is important – as well as emphasising and promoting the positive aspects of human experience. In my post-therapy interview I reflected that:

> 'I was trying to keep the focus as far as possible…on what **is** working, what **is** possible. That was an important part of what I was doing.'

During the course of the therapy and the varied subjects we covered, both positive and negative, my impression was that the overall positive focus helped to maintain motivation and foster realistic optimism regarding change, it encouraged an

appreciation of the positive resources and opportunities available to the client, as well as promoting a sense of well-being, better mood and enthusiasm.

In my view the positive focus which I encouraged during therapy may have helped the clients make changes, as by applying positivity they discovered that this enhanced their views of themselves, food, and their present and future life, which in turn led to different choices and new behaviour. Clients discovered new perspectives, new experiences and new outcomes – or, more specifically, they discovered positive perspectives, positive experiences and positive outcomes.

Personal strengths

During the early sessions of the therapy I believed that focusing on the clients' personal strengths was likely to be a helpful aspect of the programme. Identifying and applying their personal strengths was a new experience for the clients. I gave each client a questionnaire to complete which helped to identify their personal strengths. We discussed when their top strengths had been useful to them in the past and together talked about how they might be usefully applied to challenges in the week ahead, especially related to their eating habits. As my research interest included how a strengths-based approach as part of a positive psychology intervention might help address an unhealthy relationship with food, I was intrigued to discover whether the clients engaged with this element of the therapy.

As the sessions continued, my impression was that identifying and applying personal strengths to address emotional eating was of some help to two clients, but somewhat less so for the other client. For example, Isabel seemed to engage well with working with her strengths, as I wrote in my session notes:

'Strengths – applied 'self-kindness' when thought had made mistake. Felt low, then actively kind to self'. (week 5)

'Challenging family and friends mix – difficult – used self-kindness'. (week 11)

In my notes following Caroline's session (week 20) I wrote:

'Strength – sees positives in others. Beginning to see more positives in self.'

It seemed to me as the therapy progressed that there were other aspects of the principles of positive psychology included in the programme which were perhaps equally helpful, or more helpful, than focusing on personal strengths to encourage intuitive eating and prompt changes. In my post-therapy interview I expressed that during the intervention I was trying to:

'help the person to identify their personal strengths and apply them to challenges. I thought that was going to be quite central to the whole process, but I'm not so sure.'

Positive resources

In therapy sessions we discussed positive resources, both internal resources such as personal strengths and external resources including supportive relationships. In my notes on Jane's session 12 I wrote:

'Discussed relationships – how could she ask others to support her'.

Jane seemed to expect to deal with challenges on her own, perhaps overlooking resources available to her which she would find supportive and helpful.

Positive eating

Clients told me that, at times, eating had negative connotations, including feeling like 'a slave to food'. I was keen for the clients to associate eating with a more positive

experience through developing a healthier relationship with food. We discussed how food can be enjoyed and used for the 'right reasons', including satisfying hunger and feeling comfortably full, and for celebrations, for shared social times, as well as for the enjoyment of taste, smell and texture. In my interview I spoke about encouraging clients:

> 'to enjoy food, enjoy eating, enjoy the positive sides of it without the overeating side.'

This was very different to the clients' use of food – at times - for the 'wrong reasons', using food as an emotional anesthetic, or punishment, and in my view I encouraged the clients to have a new perspective and new, enjoyable, experiences, which they sought to repeat through making changes.

Positive self-image

In our sessions we also discussed how each client might envisage a positive version of themselves, and their current and future life. Typically they would express how the way they dressed, their hobbies, their social life and their work aspirations would be different and more satisfying to them once they had lost weight. I encouraged them to, as far as possible, incorporate these desired changes as soon as they could, without waiting for weight loss, and we explored any resistance to this. I acknowledged this in my post-therapy interview, reflecting on how I tried to prompt the clients to develop a more positive self-image – incorporating a more holistic view of the individual rather than remaining focused on their weight issues:

> 'It was very much 'Let's see what you would be doing if this [emotional eating and overweight] wasn't such a problem for you, if you were already slim, what would life be like, and let's get that in place now anyway, rather than wait and then get it in place – let 's get it in place anyway.' I think that overall

perspective was helpful…..Developing a positive mindset about themselves as well as about the opportunity to change'.

All three clients acted on these suggestions. For example, Jane started wearing more colourful, more feminine and better quality clothes, Isabel arranged to go jogging regularly with a 'running buddy' and Caroline took the initiative to ask a neighbour to go for coffee together, researched new work options more appropriate to her high level skills and got a very good, well-paid position. I believe this aspect of the therapy helped to enable such changes by developing enthusiasm for making positive changes, gaining a clearer, positive, sense of direction for the client and a clearer sense of self-definition.

c) Raising awareness of and understanding the relationship with food

By putting themselves forward to take part in the Positive Slimming Programme, the clients had already expressed an awareness that they engaged in emotional eating. We spent considerable time in the early therapy sessions identifying the role played by food for each client.

Triggers for emotional eating

Clients were initially mostly unaware of the internal and external triggers for their emotional eating, but gained some clarity on this relatively quickly in the first few sessions of the programme. By completing their 'Food and Mood' diaries, they all recognised patterns which helped to identify why they turned to food even when they were not physically hungry. The 'Food and Mood' diaries were completed by the clients on a daily basis for the first few weeks at least, the aim of these being to identify which moods triggered emotional eating, and the circumstances within which emotional eating took place. I believed that this was a helpful and necessary step for

clients to take, in order for them to begin to become familiar with how they were perhaps using food 'for the wrong reasons'. I reflected in my post-therapy interview that during therapy:

> 'we looked at triggers they had for their emotional eating, both internal – their own psychological – triggers, and also external triggers like social situations, peer pressure and family pressure'.

In my session notes for Caroline in week 8, I wrote:

> 'At weekend wanted to cram in food:- powerlessness/despair
>
> 'Hungry' for company/friendship – discussed options
>
> Also sometimes eats by the clock, not hunger'.

My impression was that once the clients raised their awareness of how circumstances could affect their eating, as well as becoming clearer regarding how they used food to distract, anaesthetise, punish, and/or comfort themselves, they were in a position to make more deliberate choices regarding how they used food by addressing more directly the moods which triggered emotional eating, and this may have helped change to occur. Over time Isabel became aware that one of her triggers for emotional eating was feeling stressed and rushed. She recognised that eating at such times represented both a reward and an opportunity to take a pause at frantic times. She considered alternative options to food to address her triggers and implemented them. In my notes from her 16th session, I wrote:

> 'Stressful week, rushed but didn't result in bad eating habits'.

In my view Isabel's raised awareness of her triggers to emotional eating and addressing them may have helped her to change her eating habits.

Impact of the past – family culture of food

During some of the therapy sessions I explored the clients' past experiences of their family of origin including the culture of food and eating within their family. This exploration, in my view, helped to increase understanding as to why the client had developed an unhealthy relationship with food and why it persisted into adult life and the clients became more aware of the ways in which they had unwittingly also relied on eating 'for the wrong reasons'. It became clear that food was at times used in the client's childhood as a manipulative tool, as emotional blackmail, as an expression of and hope for love and affection, as an ill-fitting but available source of security and comfort. An excerpt from my interview transcript illustrates this:

> '…family culture can influence how a person uses food, or gets panicky about food, or the pressure that is put upon a person to eat when they are not hungry – a person may feel pressure because food is being used to indicate that the person is loved or vice versa, so food is used to appreciate the person'.

Additionally, some exploration of the clients' past experiences enabled roles to be identified which they had taken up, or been allocated, during childhood and which were still a powerful influence on their sense of self-identity and relationship with food.

I believe that the clients' raised awareness of the impact of the past on their relationship with food may have helped them to re-evaluate how they use food, then identify steps to take in order to develop a more positive relationship with food.

Developing a healthy attitude to food

Having identified the reasons why the clients had developed an unhealthy relationship with food, we went on to discuss and define what a healthy relationship with food entails. I discussed in my post-therapy interview that part of the therapy entailed exploring with clients:

> 'how to develop healthy eating habits – eating when they were hungry, stopping when they were full'.

In my view, this may have been an element of the therapy which helped change, as the clients began – for the first time – to re-evaluate the role of food and eating in their lives. I was interested to hear from clients that new perspectives related to their eating habits were particularly useful. For example, learning to say 'no' to food was new for all three clients, and all did well in implementing new behaviours, helped by phrases such as 'If you don't love it, leave it' and 'I am not a rubbish bin', as well as using The Hunger Scale, which may have helped clients to develop a healthier attitude to food by eating for the 'right reasons'.

Satiety cues

We also discussed satiety cues and feelings of physical hunger. I encouraged the clients to begin to notice them and use them as sources of helpful information. During therapy sessions clients reported that they also began to raise their awareness of how food affected their body, becoming more familiar with feelings of hunger, satiety, nausea and energy. They became more fluent with the physical effects on their body of certain foods and amounts of foods, recognising how differently they felt after eating, for example, fatty foods compared with fruit. For example, in my session notes for Caroline in week 8, I wrote:

> 'Notices how food leaves her feeling eg high fat → queasy'.

All the clients reported that they preferred feeling lighter and more energised when they ate healthier foods, and less volume, and I believed that this raised awareness may have helped to encourage a healthier relationship with food and corresponding behaviour change.

One client, Caroline, said at the outset of the therapy that she could not remember feeling hungry. Her childhood family's culture of food was complex, and she had developed eating habits motivated by a need to feel safe and validated through food. Consequently, for years she ensured that she ate whenever she had the opportunity, which meant she never felt hungry. Once we had explored the impact of the past, she was able to experience physical hunger and satiety cues appropriately, in order to help develop intuitive eating habits.

All clients said that The Hunger Scale which I described to them was helpful. This scale encourages the individual to rate how hungry they are on a scale of 0 to 10, when 0 represents not at all hungry, and 10 represents very hungry indeed. It is suggested that if the individual rates their level of hunger at 6 or above on the scale, and they wish to eat some food then they do so, but they should resist if they rate their level of hunger at 5 or below on the scale. This simple intervention encouraged the clients to develop a more positive relationship with food by eating for the 'right' reasons, by using physical hunger cues – instead of emotional cues - to determine whether or not they eat, thereby developing eating habits characteristic of intuitive eating.

d) Addressing self-identity issues

In my view exploring the clients' sense of self may have been an important factor in enabling change to occur.

Addressing past negative roles

Some discussions in therapy sessions related to negative roles described by clients which they had experienced within their families of origin, and which had remained influential in their adult lives, negatively affecting their self-esteem. All three clients had negative ways of seeing themselves, for example, as the one in the family who would polish off all the left-overs, or the one in the group of friends who didn't bother about her appearance, or the one in the family who wasn't allowed to be interested in her appearance, or the largest one in the group of friends.

I believed that reviewing the current relevance of such roles may help clients to make some changes. For example, Caroline told me about her family who were, as she described them, 'on the edge of society' with dysfunctional lifestyle choices, and with whom she felt she had little in common. She was motivated to pursue traditional opportunities which were available to her to ensure she could be independent of them as soon as possible. Consequently, Caroline studied and worked hard, becoming the first member of her family to go to university. She owned her first property at a young age and travelled widely, which she loved. However, her family ridiculed her efforts, dismissing them as unimportant and undeserving of interest or praise. She perpetuated the role of being a hard worker who put a lot of effort into apparently unworthy pursuits, and she – like her family – did not take herself seriously. Furthermore, she did not expect to be taken seriously by others, and consequently put herself forward for poorly paid work for which she was

overqualified, and did not seek much social contact with like-minded people. Her critical view of herself was exacerbated because she expected that other people would also judge her negatively for being overweight. We worked together in therapy on re-evaluating whether her long-standing role remained relevant to her, and worked on raising her self-respect. Once Caroline recognised that this role, which had been part of her experience and perception for four decades, was not helping her to feel at ease with herself or to realise her potential, she was able to acknowledge that she was worthy of being taken seriously by herself as well as others. She raised her expectations of herself, her work roles and deserved pay, and within weeks she had accepted and started a new, well-paid job which drew on her considerable skills. She believed that her colleagues respected her, and, importantly in my view, she reported an increased sense of self-respect which I believe helped her to make further, deliberate, positive changes.

In my post-therapy interview I reflected on this process:

> 'Hearing [clients'] accounts has been useful to broaden my awareness of how their backgrounds have influenced their use of food for various reasons, and how the situation perpetuates itself: how a person who is perhaps large, larger than their friends as a child or teenager, stays with that role of being the larger one in a group; how it needs a deliberate shift in identity to prevent being drawn back to that familiar role, even when a person has lost weight, otherwise they can get drawn back to feeling that they have lost something, lost the familiarity of that role'.

Avoiding sabotage to progress

All three clients had tried various ways of losing weight before they made contact with me, but any previous weight loss had not been maintained. During sessions we discussed possible reasons for this, including self-sabotage and sabotage from other people. For example, when I discussed self-sabotage with Jane, it seemed that an obstacle to maintaining progress had been her long-standing view of herself as someone who should not be interested in her own appearance. This reflected a role she had in her family of origin, who disapproved of her interest in fashion during her early adult life, and who held the clearly expressed view that people who paid attention to their appearance were vain and self-absorbed. The general view held within the family of people who drew attention to their appearance and attractiveness was: 'Who do they think they are?'. Jane had, unwittingly, sabotaged her previous attempts to lose weight by remaining within the 'approved' limits set by her family and internalised by Jane herself.

Some people in Isabel's current life also presented her with potential sabotage. In my notes from her session 12, having discussed who might offer her support in furthering her progress, I wrote:

'Support? Not friends or family – a bit sabotaging!'

This was reflected in situations such as eating out, which was particularly challenging for Isabel, when close friends commented on her weight loss, expressing envy and encouraging her to eat more than she had chosen, potentially sabotaging her efforts to eat more intuitively.

In Caroline's case, she recognised that in her family of origin food was used by her mother as a test of affection. Her mother's unspoken message seemed to be 'If you

eat food I've prepared for you it means you love me'. We discussed how Caroline might deal with this in a new way, rather than feel pressurised into eating more food than she wanted to eat when visiting her mother. I believe that by exploring past, current and potential sabotage to progress in changing eating habits, I helped my clients to raise their awareness of this, thereby enabling them to deliberately consider how important their efforts to address their emotional eating were to them. By reconfirming that such change was important to them, they were, I believe, able to apply renewed motivation and respect to their goals and increase their level of self-worth. In my view this may have helped changes to occur.

Increase positive self-regard

I believe that by addressing clients' negative self-regard by building confidence and raising self-esteem, they were able to make changes to the way they viewed themselves. They began to take themselves more seriously, and see themselves as women who are worthy of respect, kindness, pride and positive attention. Working in this way on a deliberate shift to their sense of self-identity, in my view, may have helped to prevent being drawn back to their old, familiar, negative self-regard. In my post-therapy interview I reflected that:

> '…the self-identity side of things, I think that was quite a core element of what I thought I was doing – helping them to raise their sense of self-respect, so they could respect what they needed, their own sense of self'.

If this identity shift does not occur, I believe that once the client has lost weight she could feel that she has lost the valued familiarity of her previous self-image, albeit a negative, uncomfortable self-image, and unwittingly be drawn back to it and perpetuate it through allowing old cognitive and behaviour patterns to return. In my

view this is a significant factor in 'yo-yo dieting', when people put on weight they have lost, and a repeated cycle of losing and gaining weight occurs.

Dealing with unfamiliar responses from others

All three clients were unhappy with being larger than they felt comfortable with, and all expressed concern at how other people viewed them. They were aware that their emotional eating was a symptom of underlying problems and believed other people would see them as visibly carrying their problems by being overweight. One client described this as 'visual evidence' of having problems, which she carried with her into every area of life. Another client, rather movingly, termed being overweight as having a 'badge of dysfunction', constantly visible to all, as well as to herself. Although this aspect of their self-regard was difficult to live with, it was nevertheless familiar and other people's responses to them, while they remained overweight, were predictable. The clients all expressed concern regarding how they would respond to other people interacting with them differently – it seemed daunting to two clients that they could be considered attractive, desirable, enviable and noticed for positive reasons. They recognised that, in part, their overweight was a safe option, reducing others' and their own expectations regarding work achievement and social integration. I noted after session 14 with Caroline that in her experience:

'Identity – overweight = hiding behind
= not taken seriously by others
= another reason for 'not belonging' '.

In my view, exploring these issues of identity may have helped the clients to become more comfortable with taking steps towards new experiences as they lost weight, and I hoped that the work on self-identity would help to maintain their progress.

e) Developing skills to change cognitions and behaviour

At the beginning of the therapy I explained to the clients that, in my view – reflecting the cognitive behavioural therapy approach – in order to have a different outcome, in their case to change their relationship with food and lose weight, it is essential to take action and do things differently. Understanding reasons for their emotional eating is important and helpful, but not enough to achieve a different outcome – in my view they would get different results only if they translated insights into changed behaviour and introduced new habits.

My impression from all three clients was that they were pleased when they changed their behaviour and achieved positive results, both when these changes were related to eating habits and also on a wider scale including other areas of their lives such as social contact, work-related issues, family relationships and pursuing new interests. My understanding is that by developing skills to deal differently with familiar but unsatisfactory aspects of their lives – including eating habits - and applying them, clients discovered that change was possible in situations which had previously seemed stuck, and this may have encouraged clients to make further behavioural changes. In my post-therapy interview I reflected that:

> 'As it turned out, it turned out to be quite skills-focused in terms of skills relating to how to manage the triggers for emotional eating, and how to manage the **feelings** they identified as triggering their emotional eating – how to develop healthy eating habits, really'.

CBT-based skills

During the therapy I drew on my experience of providing Cognitive Behavioural Therapy with the aim of helping the clients in this study to develop skills to have a

healthy relationship with food. One element of the Positive Slimming therapy programme included skills development for addressing unhelpful thinking patterns and for behavioural change and I hoped this aspect of the programme would help clients to manage the feelings which triggered their emotional eating, and to develop healthy eating habits. We discussed in sessions how to identify and re-evaluate their unhelpful thoughts so that they could make different decisions regarding how they used food. I noted in Jane's follow-up session that she had changed her cognitions regarding whether she could tolerate feeling hunger:

'Can 'hold on' longer. Ok to feel hungry for a bit of time'.

I believe that such CBT-based skills provided the clients with clear alternatives to their old ways of thinking and behaving around food which may have helped to change their relationship with food. For example, when we discussed in Isabel's follow-up session how she accounted for changes she'd made, I noted:

'Talking and writing → decisions → change'.

During the course of therapy my impression was that for two clients the skills development for addressing negative thinking patterns were somewhat useful, but that for all three clients the wider skills I introduced them to in order to initiate changed behaviour were very useful. The wider skills included self-soothing when experiencing difficult emotions, healthy eating habits, positive self-talk, managing food cravings, and goal setting.

Cognitive changes to manage feelings and initiate behavioural changes

When developing the therapy programme, I believed that as emotional eating is frequently an unhelpful strategy to avoid or suppress difficult emotions, it could help

clients to understand that feelings, even unwelcome ones, can be tolerated and seen as helpful sources of information. I regarded my role as therapist in the programme in part to be an educative one, and believed it appropriate to include new perspectives on how feelings can be perceived and experienced helpfully rather than feared and avoided. Having identified which feelings triggered emotional eating through the clients' 'Mood and Food' diaries, we discussed how, instead of perceiving the feelings as intolerable, they could be acknowledged, experienced and acted upon. For example, one client, Caroline, who frequently ate for short-term relief when she felt lonely, began to recognise that a more satisfactory outcome was to acknowledge her loneliness, recognise that at such times she was not really hungry for food, but 'hungry' for friendship and company, and needed to address this by taking steps to widen her social network with like-minded people. I wrote in my session notes:

> 'Update: Self-soothing? Useful.
>
> Opportunities to address 'hunger' for friendship? Potential friend at child's school'. (week 10)
>
> 'Friends – new contacts at school + mumsnet, old colleague – in contact'
>
> (week 18)
>
> 'Internet mum contact – ok, may meet again. Two school friends this eve – dinner'. (week 19)

Another client, Isabel, used to eat when she felt overwhelmed, rushed and stressed by demands from others and her very busy schedule. By recognising what she was really 'hungry' for, ie some time to feel at ease, to savour experiences and be fully emotionally available to others, she was able to make some practical changes in

order to pace events more realistically as well as to prioritise some time for herself to relax, plan and recharge. In my session notes for Isabel I wrote:

> 'Needs to be mindful of attending to own progress – new – is used to being the helper. Made time for self – felt good'. (week 6)
>
> 'Re time and being discerning. Remembered not to let others decide for her how to spend her own time'. (week 16)

I believe that the CBT-based skills we discussed in sessions may have helped to enable change more widely, for example, Caroline drew on these skills to identify more clearly the impact of family pressures on her to eat larger quantities of food than she wanted. I wrote in my session notes:

> 'Now - more able to let comments from her family 'go over her head' '.
>
> (week 17)

She used her new CBT-based skills to make her own decisions more independently, to express herself more assertively, and to behave differently. When she was with her family of origin, she began to change her cognitions and her behaviour – including her eating habits.

'Micro-skills'

In sessions we discussed new responses to triggers to emotional eating which I thought of as 'micro-skills' and which one client, Isabel, termed 'The Rules'. I believe the key here is the simplicity of the interventions – In my view this aspect of the therapy may have helped change to occur, as when faced with familiar triggers to emotional eating the clients could – quickly, simply and effectively – draw on a different perspective which prompted a different response. For example, the clients frequently told me that phrases like 'If you don't love it, leave it' and 'I'm not a rubbish

bin', as well as using the 'hunger scale' (ie if they rated their hunger at 6 or higher on a scale of 0 to 10 would they eat, otherwise they would do something else) provided them with a new and immediate way of responding to situations in which they had previously used food for the wrong reasons. I wrote in my session notes for Jane:

'Update: Hunger scale – (using it) at times, eg didn't have puddings'. (week 7)

In sessions we also discussed simple changes that clients could make such as using a smaller plate for their meals, reducing their portion size, changing their shopping habits and taking charge of what they eat by some planning ahead of food-related occasions. These may have been helpful in encouraging more intuitive eating. When we discussed in Jane's follow-up session what had helped her to maintain the changes she had made, I noted:

'More aware of 'if you don't love it, leave it', using smaller plate, more prepared eg brown buffet at work – takes fruit, not bought puddings for family'.

I wrote in my session notes for Isabel:

'Out of the various areas of the therapy – skills helped most' (week 20)

' 'Nitty-gritty' new habits most helpful' (follow-up session)

In my post-therapy interview I acknowledged that:

'…on a sort of micro-level, I think it was very straightforward, unsophisticated, but seemingly effective tools like phrases like 'if you don't love it, leave it', giving a person permission so that they could leave food, then in turn they gave themselves permission…reminding people they are not a rubbish bin, they don't have to finish up what's on the plate if it's surplus to their requirements or their appetite…unsophisticated but it did seem to go a long way'.

Challenges I encountered during the therapy

Unspoken issues

At times in therapy sessions issues cropped up which were left unexplored. Given that there were certain elements based on positive psychology and the strengths-based approach which I planned to include in the programme, I needed to be selective in how we spent time in sessions. Therefore, in my role as therapist I pursued certain issues raised by each client but left others unexplored. I reflected on this in my post-therapy interview:

> 'What we didn't discuss, really, was that they have weight issues and I have a slim build. We didn't discuss that, although it cropped up occasionally from the client's side, when they would say 'It would be nice to be slim like you…' or something like that – but we didn't explore the dynamics of that, or what was around for them being seen by somebody who is of a slim build'.

It was often challenging to decide whether or not to pursue issues that emerged in therapy sessions, but I tried to focus on providing an intervention based on positive psychology and a strengths-based approach, as this is the approach the clients had opted for and we had a limited number of sessions. This challenge was not specific to this therapy – whenever I work within a time-limited framework, decisions have to be made as to which issues are taken up and which are left unexamined. This requires, I find, tolerating the inevitable uncertainties and frustrations inherent in being selective in this way, accepting that we cannot explore everything and at times, perhaps, important issues may be missed.

Pressure to succeed

I was aware that all three clients had had previous attempts to change their eating habits and lose weight, but none had addressed their psychological aspects of weight loss before, although they all recognised that they engaged in emotional eating. They all expressed their interest in understanding reasons why they overate, and in applying this understanding to change their eating habits. I found it was a challenge for me to hold the balance between sharing hope for change, without feeling too much pressure to deliver and take responsibility for any change, which in my role as therapist I could not of course guarantee. In my post-therapy interview I discussed an example of this:

> 'One lady did say to me that she believed it was the last chance for her, and so we did joke a bit about that in terms of the pressure that put on me and on the programme – and on her – to get results. She said she'd tried everything else, nothing had suited her, and we discussed whether or not anything could suit her or whether she was resistant to any attempt to change'

Tailoring the programme to the individual client

A particular challenge for me in my role as therapist was to hold the tension of trying to keep each individual's needs clear as well as keeping the framework of the therapy programme in mind. In the study I was trying to evaluate how a strengths-based approach might be helpful in encouraging 'intuitive eating' and it was therefore important to offer consistency in the therapeutic approach for each client. The differences in how each client responded to the therapy meant that I adapted the programme to a certain extent to each person. There had to be sufficient flexibility in the programme, without compromising the integrity of the therapeutic approach I was claiming to be offering, but at times this was challenging. At times, unexpected

individual issues arose, which in my view warranted attention, and I therefore tailored the therapy to incorporate those issues, as I discussed in my post-therapy interview:

> 'One person was quite resistant to any suggestions, so we explored that. Another lady saw change…as being told what to do and she didn't really like that, we picked up on that and explored it. And another lady was quite a people pleaser and we picked up on that…So each individual did respond differently to the programme'.

Unexpected focus for the therapy

I had decided on the research topic for this study after much careful consideration, and was eager to explore how aspects of positive psychology, in particular, a strengths-based approach, might enable changes and encourage intuitive eating. I was prepared for much of the therapy to be focusing on identifying clients' personal strengths, then discussing how these strengths might be applied to their challenges which had led to emotional eating. However, it seemed that clients were less intrigued and inspired by identifying and applying their personal strengths than I thought would be the case, instead they seemed to find wider aspects of the positive psychology approach more relevant, as I expressed in my post-therapy interview:

> 'I had thought [that clients would think] 'It will be really good to identify my strengths and apply them' but it didn't really seem to resonate that much'.

The following excerpt from my interview transcript illustrates the challenge I felt in trying to stay focused on including a strengths-based approach:

> 'The original purpose of the study was to see how a strengths-based approach might have an impact on emotional eating, and it was quite a

challenge to keep the strength-based approach central to the intervention, because it didn't seem to strike a chord with people as much as I thought it might. The broader positive psychology approach did - I see the strengths-based approach as a sort of subset of the positive psychology approach, and I think there are other sides of the positive psychology approach which were easier to keep in focus and seemed more effective and more welcomed by the participants. So that was quite a challenge, to keep the strengths side central'.

DISCUSSION

In this section I begin by describing the shift in the focus of the intervention I provided over the course of therapy. I go on to summarise the findings for each of the four areas of inquiry. I then discuss how my findings compare to existing research and practice and how they contribute towards developing an understanding of how a positive psychology approach can be effective. I explore the similarities and differences between what I as the therapist thought I was doing in the therapy compared to what the clients thought I was doing in the therapy. I continue by proposing a theory which explains how an intervention based on principles of positive psychology works to address emotional eating, reconciling the different perspectives the clients and I had regarding the therapeutic encounter by bringing them together in one model.

Following the discussion on the theoretical contribution of this study, I go on to examine methodological aspects of the research, including strengths and limitations of the study, before continuing to discuss the implications of this study for future research. Finally I include a reflexive piece on how my part in the process may have impacted on the participants and on the study.

Shift of focus in the therapy

I originally aimed to investigate and provide an intervention based on positive psychology with strengths-based therapy as a focus, and including some CBT. However, as the therapy proceeded, it became clear that the clients were intrigued and enthused by the broader positive psychology approach which underpinned the

therapy, including developing more positivity regarding identity issues and their relationship with food - but the element of the therapy which focused specifically on personal strengths resonated less with the clients than I had thought might be the case.

The clients reacted with less interest in the strengths-based elements of the therapy than I anticipated. One reason for this may be that their levels of self-esteem were already reasonably high – or for one client, very high – at the beginning of the course of therapy. It is reasonable to expect that working from a strengths-based approach, which includes identifying and applying personal strengths, would be more interesting and useful to clients if they are unclear about their qualities. A person who has a good level of self-esteem already has confidence in their own worth and abilities, so there is less potential for the strengths-based approach to have a strong therapeutic impact.

Recognising this, it felt rather contrived to keep the central focus of the intervention on identifying, developing and applying strengths, as I had originally intended to do. Therefore, in keeping with my approach to therapy, together we worked on those aspects which the clients were most interested in pursuing and also found most helpful. This led to a more holistic approach than I had envisaged, keeping the strengths-based work included as one element of the therapy within a broader positive psychology based approach which included:

- developing positivity – including strengths-based work as part of this
- addressing identity issues – including the more positive focus on identifying the clients' needs and raising self-worth, rather than focusing on 'damage'
- raising awareness of their presenting problem, their unhealthy relationship

with food, and developing a more positive relationship with food instead

as well as:

- developing CBT skills to encourage changes in thinking and behaviour

and all of the above underpinned by the positive therapeutic dyad.

Summary of findings

Findings Part I:

What were the quantitative outcomes for clients at the end of this therapy and at follow up?

Quantitative measures were used to ascertain any changes in depression, self-esteem, intuitive eating and weight.

All three participants' mood improved over the course of therapy. Two of the participants, Caroline and Isabel, showed significant improvement in their mood as measured by the Beck Depression Inventory. Caroline's pre-intervention score showed severe depression, and her post-intervention score indicated non-depressed, normal mood. Isabel went from moderate depression to normal mood, and the third participant, Jane, who already had a low pre-therapy BDI score indicating normal mood, also showed post-intervention some slight improvement in her mood.

Two of the participants' self-esteem scores on the Rosenberg Self-Esteem scale increased over the course of the intervention, and the third participant's score remained unchanged. Caroline went from a pre-therapy score which was below the normal range to a post-therapy score which had increased to fall within the normal

range. Isabel's post-therapy self-esteem score was higher than her pre-therapy score - both of her scores were within the normal range. Jane's already high pre-therapy self-esteem score remained unchanged.

All three participants showed an increase in their overall scores on the Intuitive Eating Scale after the intervention, which is of particular interest as this questionnaire measured any changes in the phenomenon which was the central focus of this study, namely the clients' relationship with food and their eating habits.

The clients all lost weight over the course of therapy. Jane lost 5.7 kgs, Isabel lost 3.8 kgs and Caroline lost 11.9 kgs. At the follow-up session three months after the end of the course of therapy the clients were weighed again. Jane had lost more weight and was almost 2kgs lighter, Isabel had put on 0.4kg and Caroline had put on 0.9kg.

Findings Part II:

What was the clients' experience of the therapy?

Thematic analysis of the clients' journals and Food and Mood diaries identified a number of main themes which all clients described as forming part of their experience of the therapy, as well as subthemes, some of which were shared by all clients and others were relevant to only some clients.

The main themes and subthemes described by all clients were:

- The programme's psychological approach to weight loss was new, interesting, 'multi-pronged', and helpful to the clients
- The focus on the relationship with food – especially, raising awareness of the client's own relationship with food – provided useful insights

- Addressing cognitions related to mood, food and self – in particular, making changes to such cognitions – felt constructive
- The focus on 'positive behaviour' – especially changing behaviour, and also goal setting – felt empowering
- The therapeutic dyad consisting of the client and myself as therapist felt supportive
- Positivity - particularly making a positive shift in self-regard and the focus on personal strengths – was welcomed, as a contrast to other approaches to weight loss the clients had tried which felt punitive, depriving and humiliating

All three clients reported finding various aspects of the therapy challenging, but they all shared the experience of finding it difficult to continue to complete the Food and Mood diaries regularly after the first weeks of doing so.

Findings Part III:

What was the clients' understanding of how the therapy may have helped them?

By analysing the data from the clients' post-therapy interviews, I identified four core concepts which elucidate many aspects of the clients' understanding of how their reported changes came about. The concepts are:

a) Addressing self-identity issues
b) Raising awareness of/understanding the relationship with food
c) Positivity
d) Behavioural and cognitive change

The clients' emphasis was on aspects of the therapy content rather than the therapy process. They discussed the categories above as interrelated elements of the therapy which they thought helped to enable change.

Findings Part IV:

What was my experience of the therapy and my understanding of how the therapy helped clients?

Concepts which I have identified as core categories are:

a) The therapeutic dyad

b) Developing and applying positivity

c) Raising awareness of and understanding the relationship with food

d) Addressing self-identity issues

e} Developing skills to change cognitions and behaviour

Concepts b), c), d) and e) resonate with those I identified in the clients' qualitative data. However, in my view a primary element of the therapy which may have helped clients to make changes was concept a) above: the therapeutic dyad. I believe there was a sequential aspect to the influence of the concepts listed above for which the therapeutic dyad was the catalyst.

Comparing my findings to existing research

I continue by discussing how my four areas of findings compare to existing research and how they contribute towards developing an understanding of how therapy based on principles of positive psychology and a strengths-based approach can be effective.

1. The impact of positive psychology on mood, self-esteem, intuitive eating, weight loss (Findings Part I)

The main focus of this study was to explore how principles of positive psychology including a strengths-based approach might help develop a healthier relationship with food. However, as the therapy offered a holistic approach addressing several areas of the clients' lives, I was also interested to monitor whether certain other changes occurred. I measured the clients' mood and self-esteem before and after the intervention, and discovered that all three clients reported improved mood after the course of therapy. These findings reflect results of Positive Psychotherapy (Rashid, 2008), which specifically includes building client strengths to alleviate psychopathology. Seligman et al (2006) found that individual Positive Psychotherapy for depressed clients resulted in a reduction of their depressive symptoms. Within the Positive Slimming intervention in this study, identifying, developing and applying personal strengths was included as part of the therapy, so, although the aim of this study was not to measure the effectiveness of the various elements of the therapy, I speculate that perhaps this element of the therapy helped improve the clients' mood. Interestingly, Seligman and colleagues (2005) found that the manner in which strengths were used made a difference. They discovered that using strengths more regularly helped lift depressed mood in the short-term, but that the positive effects of this were not long lasting. However, when strengths were deliberately used in a new way, this led to depressive symptoms being eased for at least six months post-intervention. A link between weight loss and improved mood has been suggested by some researchers (Wing et al.,1984). Significant positive mood change was reported in 6 out of 10 studies of weight loss programmes investigated by Wing and colleagues (1984). The improved mood was related to active participation in a

programme, whether behavioural or non-behavioural. This suggests that improved mood does not occur predictably simply as a result of weight loss, and therefore the considerable improvement in mood of the clients in this study is interesting. Perhaps their weight loss was only one of a number of factors which led to the positive changes in their mood.

In this study, two clients developed improved level of self-esteem over the course of therapy. The third client already had a high self-esteem score at the start of the intervention. Although it was the main aim of this study to explore how changes might occur through applying a positive psychology approach, I did not set out to measure the effectiveness of the individual elements of the intervention, so cannot claim that specific results were due to the therapy. Nevertheless, self-esteem was measurably raised for two clients during the course of therapy and this is of interest. Nir and Neumann (1995) found that following a 10-week weight loss programme, weight regain over 47 months was linked to self-esteem. The higher the self-esteem score, the lower the average weight regain during follow-up, which suggests that working on improving clients' self-esteem during weight loss programmes is helpful. This is confirmed by Cochrane (2008) who argues that weight loss approaches are needed which enhance clients' sense of self-worth in order that they develop sufficient belief in themselves to make healthier decisions about their weight and well-being. He points out that frequently clients are offered CBT to address the psychological aspects of weight loss, but that self-worth cannot be altered with CBT alone, a view echoed by Wilson (1994). Negative self-perception is a powerful obstacle and prevents overweight individuals from developing attitudes and commitment which could help them pursue healthier choices relating to their weight (Cochrane, 2006; Swann et al., 2007; Salovey et al., 2000).

One aspect of the therapy we discussed in sessions was to increase 'positive behaviour', to include a range of behaviours which may potentially result in raised levels of physical and psychological well-being. One suggestion was to engage in more frequent physical exercise as part of the aim to increase 'positive behaviour'. Based on the findings of Argyle (2001), who studied the effects of increasing regular exercise and found that it resulted in several benefits including less depression and higher self-esteem, I propose that the increased exercise undertaken by clients in this study may have contributed to the positive effects on their mood and self-esteem, as well as to their weight loss. The link between increased regular exercise and weight loss has been reported (Gallagher et al., 2006; Jakicic et al., 2001). In an 18-month long behavioural weight loss programme, Jakicic and colleagues (2002) observed that the combination of changes in eating habits and increased regular physical activity improved long-term weight loss compared with either behaviour alone.

All clients engaged more in intuitive eating during the course of the study, scoring higher on the IES post-intervention, and they all lost weight. In sessions we discussed features of intuitive eating, including eating in response to hunger and satiety cues, coping with feelings without food and unconditional permission to eat, and I encouraged the clients to incorporate these into new eating habits, which they did. Recent studies (Madden et al., 2012; Heileson & Cole, 2011) have found that these features of intuitive eating are strongly associated with significantly lower body mass index than individuals who did not have these behaviours, and have demonstrated the effectiveness of intuitive eating interventions designed to increase adaptive eating (Young, 2011; Cole & Horacek, 2010). Their results support my view that encouraging 'positive behaviours' related to intuitive eating may have helped the

clients in this study develop a healthier relationship with food, resulting in weight loss.

The holistic approach of the Positive Slimming Programme, which included applying principles of positive psychology to various areas of the clients' lives, not only those directly related to eating habits, offered a 'multi-pronged' approach. McBride (1988) recognised the need for a holistic approach to weight loss, to take into account the complexity of influences on behaviour, including eating habits and weight-related choices. During the course of the Positive Slimming Programme in this study, clients' mood lifted, their self-esteem improved or remained at a high level, they developed intuitive eating habits and lost weight. This study is an exploration of the therapeutic process, examining how this approach might facilitate changes to occur. The focus of the study is not on the effectiveness of the intervention, so although it is notable that changes in these areas did occur, my aim was not to collect evidence to support a claim that the changes are primarily due to the intervention. There may have been external factors, independent of the therapy, which helped change to occur. However, all the clients expressed that there were factors within the therapy which they thought did indeed facilitate changes, as discussed below. As far as I have ascertained, there are few comparable interventions, especially attempting to address unhealthy relationships with food. One programme which does apply principles of positive psychology to address emotional eating is 'The Happiness Diet' developed and led by Professor Tim Sharp, who says of his findings:

> 'I can confidently say, that based on the feedback from many of those who've completed the program, that they have lost weight and just as importantly, they've gained happiness, confidence and a greater sense that they can now exert more control over their lives and achieve important, meaningful goals.' (Personal communication, 2013).

It is encouraging to hear that Sharp's holistic intervention based on principles of positive psychology, aimed at addressing emotional eating, is helping clients achieve not only weight loss but also wider positive changes in their lives. His results are similar to those which the Positive Slimming Programme of this study seems to have enabled for clients, and supports my view that a holistic intervention based on positive psychology is helpful in promoting change.

2. The clients' experience of a positive psychology intervention (Findings Part II)

Hearing the voice of each client expressing her experience of the therapy process is an important part of this study. It is an attempt to get closer to the clients' experience of the therapy in practice, and an acknowledgement that the therapy is not merely a function of the therapist, but that the client also plays a central role in the process of therapy (Rodgers, 2002).

Exploring the clients' experience of therapy is an opportunity which is often overlooked, one which can provide knowledge about otherwise covert processes such as unexpressed dissatisfaction or conscious resistance, and which can give useful information which can help therapists work more effectively with their clients (Elliott, 2008; Yalom & Elkin, 1974).

The clients in this study discussed a range of themes to describe their experience of the therapy. Most of the themes were related to the therapy approach, content and techniques. The therapeutic relationship was acknowledged by clients to be a valuable aspect of the therapy, although not emphasised in their accounts as being particularly central to their experience. This is somewhat at odds with other

researchers' findings, who have reported that clients expressed that the therapeutic tools were important, but only when embedded in a trusting and collaborative therapeutic relationship (Rayner et al., 2011). Yalom and Elkin (1974) wrote their account of therapy from the perspectives of both therapist and patient, giving a fascinating insight into how they each experienced the therapy. It is very clear from Elkin's writing that, as the patient, she considered that the therapeutic relationship was pivotal for her, summing up her experience as:

> 'I think I achieved something personal with you, Dr Yalom…..I used them [simile and metaphor] as a veil, until I could talk directly to you.'

It is disappointing that clients' accounts of their experience in therapy are few and far between, and those of which I am aware do not relate to a strengths-based therapy interventions, nor to a positive psychology approach, so it is difficult to compare like with like. In some therapeutic approaches the relationship is central to the therapy and acknowledged as an important – or, indeed, the main – therapeutic tool, so clients, in their accounts of their experiences of such therapies are, perhaps, particularly likely to mention the relationship as an important factor. The therapies described by Rayner and by Yalom and Elkin, mentioned above, included relational work. In contrast, in this study, the therapeutic relationship was not emphasised overtly in the therapy sessions as either a therapeutic tool or as central to the process. Despite this, the clients in this study did comment on relational issues being an important part of their experience during the therapy, particularly valuing the validation and accountability they felt was present within our therapeutic dyad.

Although in this study there were some aspects of the clients' experiences of the therapy which were common to all, each individual client emphasised a different

element of the programme which resonated more strongly for her. Jane found our discussions on behaviour change particularly significant for her, and she readily applied the behavioural changes we discussed. For example, following discussions in our sessions, she was able to engage in alternative, non-food related behaviours to replace emotional eating at times when she felt she needed a reward or a distraction. She also made cognitive changes to prompt behavioural changes to her eating habits, such as using the 'Hunger Scale'. Furthermore, she increased her regular exercise during the course of the intervention.

Isabel was enthusiastic about, and responded particularly well to, the positive approach of the intervention, relating strongly to both main themes of Positive Behaviour and Positivity. She took seriously her decision to develop more positive behaviour in her life and as she increased her levels of exercise, she enjoyed feeling her body becoming fitter over time. She also particularly valued the goal-setting exercises, defining and acting on short- and medium-term goals during the course of therapy. A major positive behavioural change she made was to prioritise some relaxation time for herself, thereby addressing her need to pause from time to time from her hectic lifestyle but without continuing to use food to create the opportunity to pause and rest. The strengths-based work resonated well with Isabel and she readily defined and applied personal strengths to her own challenges with good effect.

When describing her experience of the therapy, Caroline emphasised that raising her awareness of her relationship with food was both interesting and helpful in initiating change, describing her understanding of this as 'a revelation'. In particular, she valued exploring identity issues and the impact of the past on the ways she used

food. She began to recognise that, partly because of her overweight, she expected others not to take her seriously, reflecting her own dismissive view of herself - with negative consequences for her career and personal life. Caroline responded readily to the positivity within the approach and began to acknowledge her personal qualities and achievements. She began to take herself more seriously and applied for – and was offered – good, well-paid work roles appropriate to her high educational achievements. She was both surprised and pleased with this, as well as with some of the behavioural changes she made around food, especially leaving food and consequently eating less and losing weight.

The clients all commented that they experienced the Positive Slimming Programme as having an impact on various areas of their lives, not only on their eating habits, and they welcomed this. Their experiences of wide-reaching changes to their self-esteem, work, leisure and family lives echo the results of Sharp's 'Happiness Diet' mentioned above. In my view this may reflect the wide relevance of the subjects we discussed in therapy, including the impact of the past, identity issues, strategies based on positive psychology as well as some elements of CBT.

There were challenges within the therapy which the clients reported. One challenge, which was experienced by all three clients, was continuing to complete the 'Food and Mood' diaries which I had suggested they fill in daily. All clients filled the forms in daily for the first few weeks of the programme, during which time certain patterns regarding their triggers for emotional eating were noticeable. In my view the forms had by then served their initial purpose of identifying triggers for emotional eating, but as each client fed back to me independently that they felt a sense of accountability through monitoring and writing down what they ate each day, I suggested they

continue doing so. One client stopped completing the forms then went back to doing so, deciding that it was a useful exercise. After a few weeks, another client changed the exercise to suit her needs better, using the forms to plan ahead by deciding what she would eat and when the following day, and writing this down. With hindsight, I could have adapted the exercise by suggesting the clients use the diary sheets as intended for the first four weeks, then decide for themselves whether to continue using them or not and if so, to use them in whichever manner they found most useful. I think this would have given the clients more autonomy and a greater sense of taking charge of their experience. It would have fostered a collaborative approach and may have addressed the clients feeling that they were disappointing me by not persisting with filling in the diary sheets, a concern which they expressed during some sessions. Studies have shown that self-monitoring food intake by completing written food diaries correlates positively with weight loss and successful weight management (Burke et al., 2011; Foster et al., 2005; Sperduto et al., 1986), so encouraging the clients to persist with their food diaries was appropriate and was meant to be helpful.

I suggested to all the clients that they weigh themselves daily, in order to monitor frequently and regularly whether their weight is going up, down or remaining stable. Two clients expressed that they did not like to weigh themselves daily. I explained the rationale behind the suggestion to do so, which was so that they could compensate for any weight gain by exercising more or eating lighter meals that day. Furthermore, researchers have found that frequent self-weighing daily to weekly is associated with weight loss (Linde et al., 2005; van Wormer et al., 2009; O'Neil, 2005). However, the clients who did not feel comfortable with daily weighing reported that, if they had gained even a small amount, they experienced the weight result that morning negatively affected their mood to a disproportionate degree. Given that

weight fluctuates slightly from day to day for most people, it was very likely that on certain days the clients would indeed notice an increase in their weight, but for two clients this – albeit expected and normal experience – was difficult to tolerate. This reflects the findings of Dionne (2005), that daily weighing can be motivating for some individuals who want to change behaviour to lose weight, but for others it can be counterproductive to weight loss behaviour, resulting in giving up on attempts to lose weight, psychological distress and emotional eating. Considering retrospectively my recommendation to clients that they weigh themselves daily, based on research which concludes that this helps weight loss, perhaps it would have been more satisfactory for the clients had I suggested that they decide for themselves on the frequency of weighing at home.

Two clients found their varying rate of weight loss was difficult to tolerate. They felt frustrated that their weight loss was not consistent and predictable, and felt some disappointment during times when their weight was stable or increased. Perhaps emphasising at the start of the programme that any weight loss was likely to be at a varied rate would have helped these clients with this particular challenge.

3. The clients' understanding of how a positive psychology intervention may have helped changes to occur (Findings Part III)

The question of how the clients thought that the positive psychology based intervention may have helped them to make changes is a fascinating and important one, in the interests of hearing the clients' – often unexpressed and unheard – voices as well as being an attempt to define helpful aspects of the intervention.

According to the clients in this study, four interrelated aspects of the therapy helped

them to address their emotional eating and develop a healthy relationship with food: addressing self-identity issues, understanding their relationship with food, positivity – including identifying and applying personal strengths, and behavioural and cognitive change.

They explained that exploring identity issues helped to understand their relationship with food, and enabled them to make more deliberate choices regarding their eating habits. Feeling more aware of their emotional eating and making changes resulted in positive emotions which improved self-regard; feeling more positive and confident reduced the urge to comfort eat and prompted cognitive and behavioural changes – hence the interrelatedness described by the clients. From their comments, it seemed that they experienced the exploratory work on identity and their relationship with food as helpful in fostering their own understanding and patience with themselves, instead of berating themselves for 'eating for the wrong reasons'. These results reflect the findings of Cochrane (2008), who argues that an essential component of successful weight loss is to address the negative self-perception and poor sense of self-worth, which frequently originated in the past. Some individuals perpetuate this by interpreting their overweight as confirmation of their inadequacy (Cochrane & Friesen, 1986). Cochrane insists that cognitive tools and raised awareness of triggers for emotional eating are not sufficient for change to occur, but that it is crucial to address poor self-worth by encouraging the client to understand the negative impact of some past events and relationships which may have occurred at an early, formative age, then to develop strategies to enhance self-worth to enable the client to have faith in themselves to make positive changes required for weight loss. Cochrane (2008) suggests that by doing so the client develops an internal locus of control instead of seeking an external solution to their overweight.

Interestingly, the clients in this study put considerable emphasis on the behavioural changes they had made. They all said they found it helpful to have 'The Rules' – simple reminders of intuitive eating – to draw on, as well as the accountability and other aspects within the therapeutic dyad, in order to develop and maintain their new eating habits. Studies on behavioural aspects of weight loss have observed that although individuals trying to lose weight are clear about their weight loss strategies, most do not carry these out in practice (Weiss et al., 2006; Kruger et al., 2004; Greaney et al., 2009). This suggests that there is scope to investigate whether simple tools such as 'The Rules', and regular support, help individuals maintain new behaviours conducive to losing weight. All the clients included the therapeutic relationship as one of several positive elements of their experience of the therapy.

Given that this intervention included some strengths-based work it is interesting to discover that the clients did indeed think that identifying and applying strengths helped them to make changes, but they considered it was only one of several other aspects of the intervention which helped them. This meant it was identified as a sub-theme of the main theme of Positivity, and is incorporated into my theoretical model as such. Working from a strengths-based approach to address overweight does not seem to feature in research literature, as far as I can ascertain, so it is difficult to compare the experiences of the clients in this study with existing, relevant research findings. A strengths-based approach has been incorporated and documented in some social work, family and youth settings. For example, Clark (1997) worked from a strengths-based approach with young offenders, and observed that they showed more engagement, co-operation and motivation to make changes, by a 'consistent emphasis on strengths' within therapy sessions. It is not clear, however, whether his clients identified this aspect of their work as helpful or not. Brun and Rapp (2001)

have explored clients' perceptions of working from a strengths-based approach within social work. They reported that clients focus on acknowledging their strengths and short-comings simultaneously, and on their relationship with their case manager. Their clients also described feeling guilt when success was not achieved, which resonates with some feedback from the clients in this study relating to their feeling of having disappointed me, as their therapist, if their weight loss was inconsistent.

4. My understanding as therapist-researcher of how a positive psychology intervention may have helped changes to occur (Findings Part IV)

My experience of the therapy in my role as therapist-researcher added to my understanding of how the therapy may have helped the clients' changes come about. In my view there were both sequential and interrelated aspects of the various elements of the therapy which helped to enable change. Firstly, I believe that the therapeutic dyad between each client and myself as therapist was key to the therapeutic process for each client. The clients focused more on results than process, but using my 'helicopter view' from my position as their therapist, my view echoes that of Rogers (1959), who considered that the relationship was the crucial ingredient for therapy, and also reflects the stance of Fischer (1978) who sees it as the context for the therapy, improving the effectiveness of interventions. Many human problems may be shared, yet the way each person experiences the problems is highly personal and unique. In my view, this is acknowledged in therapy through the vehicle of the therapeutic relationship.

In this study, I believe that the therapeutic relationship was the cornerstone for the therapy, holding the tension between offering the clients a particular programme of

help for a defined problem (emotional eating) and recognising, respecting and addressing their individuality, including the differences in their backgrounds, personalities, hopes, the meaning they each made of their emotional eating, as well as their varied experiences of the therapy. I agree with Rapp and Goscha (2006), who suggest that our uniqueness as individuals is founded on our idiosyncratic configuration of strengths and, therefore, in order to help clients as individuals, psychological assessment and treatment must take this into consideration and include a strengths-based approach. Commenting on their observation of the professional practice of mental health professionals, they observed that the treatment plans they saw often seemed generic, promoting the homogenisation of people and diminishing individualisation. My own understanding that the therapeutic relationship in this therapy underpinned and facilitated change for the clients by focusing on their individuality reflects this stance, hence the prime position given to the therapeutic dyad in my theoretical model (Figure 7 below).

My experience and intention within each therapeutic dyad was that the relationship offered the clients positivity. As therapist, I promoted this by sharing the clients' hopes for change, by giving the clients validation for their individuality and for their efforts, by offering encouragement, and by providing a sense of accountability for the clients. I believed that the clients could draw from the positivity within the therapeutic dyad and apply it to other areas in their lives, including the therapy. We fuelled the positivity jointly – partly from my own energy, positive mindset and resources, and partly from assessing together the strengths and resources each client brought to the therapeutic endeavour. I encouraged a holistic and inclusive perspective on strengths and resources, including the clients' personal qualities, external resources including supportive relationships, and their aspirations (not only weight- and food-

related). This inclusive approach, and the elements of positivity within it, are shared by Rapp and Goscha, (2006) in their Strengths Model for helping people with psychiatric problems. They define four interrelated types of strengths which can be explored and used therapeutically: personal attributes, talents and skills, environmental resources, interests and aspirations.

All the clients had clear goals at the outset of therapy, including developing a healthier relationship with food, and weight loss. During the course of the therapy, goal setting was broadened to include goals defined by clients in several areas of their lives - not only relevant to eating habits and weight. In my role as therapist it seemed to me that my encouragement, giving feedback based on their efforts rather than results, was helpful to the clients in making progress towards their goals. My view that achieving goals is affected by feedback is confirmed by Locke et al (1981), who state that encouragement, positive feedback for effort and attainment, and information showing progress, all enhance the achievement of goals. Smith (2006) suggests that 'encouragement is a key form of positive regard that the therapist (in the strengths-based counseling model) intentionally provides to effect behavioural change in the client'.

The strengths- and positivity-based foundation to the therapeutic dyad in this therapy felt uplifting and energising for me as therapist. In contrast, working within a more problem-focused therapy approach, offering clients hope, encouragement, validation and accountability without the exploration of their strengths and resources can, in my experience, at times feel draining and tiring for me in my role as therapist. I have sometimes felt that the emotional demands of working as a therapist could lead to burnout, as acknowledged by Schaufeli and Maslach (1993). However, in my

therapeutic role in this study, I experienced a sense of absorption, characterised by being fully concentrated and happily engrossed in the work (Schaufeli et al., 2002). At times this felt close to what has been called 'flow,' a state which includes focused attention, a clear mind and effortless concentration (Csikszentmihalyi, 1990). I include mention of this here as an interesting and potentially useful experience, highlighting that a possible way of avoiding therapists' exhaustion and burnout could be by deliberately including more positivity in the therapeutic relationship and approach.

Given that my model emphasises that the therapeutic dyad, including shared hope, and the strengths- and positivity-based aspects of the therapy are central to encouraging change, it is interesting to note the findings of Lambert (1992), who reviewed 40 years of psychotherapy outcome research in an attempt to discover which elements of outpatient therapy enabled positive change for clients. He identified that client attributes, including personal strengths and resources, accounted for 40% of positive change, the therapeutic relationship accounted for 30%, hope and expectancy that change was possible contributed 15% and the therapeutic model was responsible for 15% of change. Although I have not attempted to quantify the proportions which each element contributes to clients' outcomes, my model suggests that the therapeutic relationship is the primary factor to enable change. Unlike the study by Lambert, my model includes a sequential aspect to the impact of elements of therapy.

Similarities and differences between the clients' and my own understanding of the therapy process

There were areas of convergence as well as areas of divergence in the clients' and my own views on what we were doing in the therapy and how the intervention was helpful. I identified four core concepts which the clients included in their discussions of how they thought their changes came about: addressing identity issues, raising awareness of and understanding their relationship with food, positivity, and cognitive and behavioural changes. These concepts resonated closely with four out of five concepts which reflect my own thoughts on how the therapy was helping, and in these four areas the clients and I shared broadly similar views albeit with different emphases on aspects of each core concept.

Regarding the concept of addressing identity issues, the clients included the following three elements: re-evaluating their negative self-image to develop positive self-regard, identifying their own needs, and raising their levels of self-worth and self-respect. The elements I included within the concept of addressing identity issues with the clients were increasing positive self-regard, addressing past negative roles, avoiding sabotage to the clients' progress, and dealing with unfamiliar responses from other people. It is of note that the clients emphasised developing internal resources, whereas although I also included developing positive self-regard as important, I otherwise focused on related areas which addressed the impact on the clients stemming from external factors – their past imposed roles, potential sabotage and unfamiliar responses from other people.

The clients' views and my own view were very similar regarding what we were trying to do regarding raising their awareness of, and understanding, their relationship with food. Within this core concept we all acknowledged the importance of those aspects of the therapy which helped the clients to recognise triggers for emotional eating, understand the impact of the past, and learn about healthy attitudes to food. We differed in one area of emphasis each – the clients emphasised that understanding the role of food was important, whereas I thought that noticing satiety cues was also a notable and key factor in enabling changes.

Positivity was a further core concept which was deemed important by the clients as well as myself in helping changes occur. We agreed that Identifying and applying personal strengths, and keeping a positive focus were valuable elements of the therapy. The clients also described the therapy as having a 'no-fail approach' which they thought was helpful. In sessions they discussed that they appreciated the non-judgemental and respectful approach of the programme, unlike their experiences with previous weight-loss attempts, when, for example, they had felt humiliated and judged by being weighed in front of a group. My emphasis within the core concept of Positivity was somewhat different, focusing instead on becoming more aware of the potential for positivity and developing it in various areas of the clients' lives. I thought this took place by identifying and developing positive resources, both internal and external; learning about 'positive eating' – savouring and enjoying food and eating mindfully; and also by creating a positive self-image and realising the potential to achieve it.

The fourth core concept shared by the clients and myself related to the importance of cognitive and behavioural changes. There was clear convergence in our views on

how these helped change to occur. Clients highlighted that it was helpful to them to become aware of how thinking patterns affect behaviour, learn to use 'self-talk', and develop practical policies regarding food. Their views reflected mine, and I summed up these elements as 'CBT skills'. The clients and I also agreed that it was useful to have simple reminders to change eating habits. The clients referred to these as 'The Rules' to halt mindless eating, and I referred to them as 'Micro-skills'. One difference in our emphases was that the clients included increased exercise as a specific element within this core category.

However, there are two more significant aspects to my own understanding of how the therapy was helping changes to occur which diverged from the clients' views. Firstly, I believe that there was a fifth core concept – the therapeutic dyad – which was key in enabling change to occur. The clients, however, did not specify this as such. Secondly, I suggest that there is a sequential aspect to the process of therapy – unlike the clients' view, which was that the effective elements of the therapy were strongly interrelated, each having an impact on the others concurrently rather than sequentially.

I will continue by discussing these two areas of divergence in turn. From my position as therapist-researcher, my understanding is that the therapeutic dyad offered the clients a reliable, safe and positive context within which change could occur. Given the chosen therapeutic approach of this therapy, my aim was to ensure that the therapeutic relationship offered the clients a foundation for positivity to develop which they then applied to help to raise their awareness of their relationship with food as well as to address issues of self-identity. Within the therapeutic dyad, I offered hope, validation, encouragement and accountability, which I believe served to help us then

focus on developing aspects of positivity which would be of value to the clients. These included identifying and applying personal strengths, specifying and using internal and external resources, discussing 'positive eating' – learning about intuitive eating habits as well as savouring the enjoyment of food, and also developing a positive self-image. Interestingly, the clients had all described the therapeutic relationship as being an important part of their experience of therapy, but did not include it as a relevant factor when considering how they thought change had come about.

In my view, the sequential aspect of my model is inherent in the process of the therapy. I believe that, having established a solid therapeutic dyad which included aspects of positivity as described above, the clients were then able to apply their personal strengths, resources, positive eating knowledge and positive self-image to raising their awareness of their relationship with food and to helping them address identity issues. Exploring each of these areas was beneficial for the clients and consequently positivity was enhanced. Once this was established, the clients were then more fully prepared not simply to develop skills for cognitive and behavioural change but also to apply them to their own challenges with a sense of entitlement and self-recognition. In contrast to my view that there was a sequential aspect to the therapy process, the clients believed that the four concepts they thought were influencing change – addressing identity issues and developing positive self-regard, understanding their relationship with food, developing and applying positivity to wider areas of their lives, and cognitive and behavioural change – were interrelated and concurrent. Their view of the interrelatedness of the concepts was, for example, that understanding the impact of their past on their relationship with food enabled them to focus on relevant cognitive and behavioural change – and/or vice versa, and that

their enhanced sense of self-respect helped them to apply personal strengths appropriately – and/or vice versa. The order of each of these concepts did not seem to be a relevant factor for the clients.

Proposed theory

The findings support a proposed theory to explain how an intervention which includes principles of positive psychology helps to address emotional eating.

There were some differences between how I thought the therapy worked in practice and how the clients thought it worked in practice. The clients expressed that their understanding of how the therapy helped changes to occur was that the four core concepts of positivity, understanding identity issues to develop positive self-regard, relationship with food, and skills for cognitive and behavioural change were interrelated and that each had an impact on the others concurrently. From my stance as therapist-researcher, there were both sequential as well as interrelated aspects to my theoretical model. This reflected my understanding that, following the establishment of a positive therapeutic relationship and then developing positivity, some therapeutic work was then needed understanding and applying positivity to the clients' relationship with food and on their identity issues in order for the skills for cognitive and behavioural change to be effective and long-lasting.

I have developed an explanation of how the intervention based on positive psychology can enable changes to occur by bringing together the different perspectives the clients and I had regarding the therapeutic encounter into one theoretical model (Figure 7).

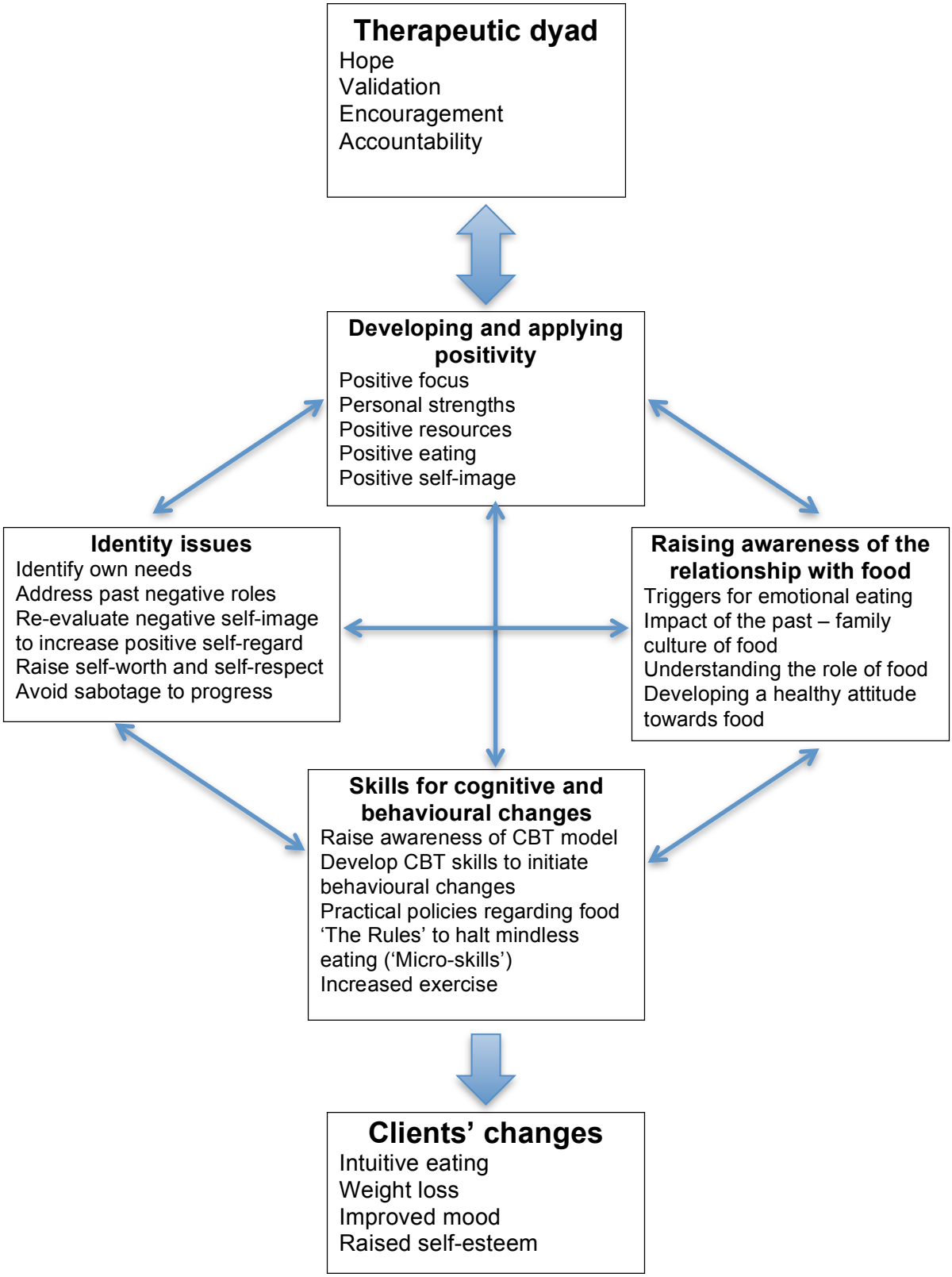

Figure 7 - Joint theoretical model of clients' and therapist-researcher's understanding of how the therapy might have helped to develop a healthier relationship with food

I reviewed both models which I had initially proposed from the findings which explained separately the clients' understanding of how the therapy worked and my own, and attempted to retain the key elements of each in order to produce the proposed theoretical model in Figure 7 above. In order to reconcile differences between the content of the two models, I decided to retain those aspects which appeared in one model and not the other if they were of particular importance to the clients or to myself, and I removed certain elements of each model when I recognised that they were already incorporated into existing aspects, as there was no need to include them as if they represented separate issues. The two separate models expressed the clients' and my own views of the therapy from very different positions. My stance as therapist-researcher enabled me to be both part of the therapy process and also take up an observing position, providing me with an opportunity to reflect on the therapeutic process from a distance as well as being engaged in it. I believe this helped me to notice aspects of the process which were of interest to me in my role as researcher, which in my view included the key role of the therapeutic dyad as well as a sequential aspect to the way I thought the therapy helped changes to occur. I felt it was important to respect and be loyal to my observations of these aspects and incorporate them into the new joint model. Just as my position as therapist-researcher offered me a particular perspective, the clients experienced the therapy from a different stance and I took seriously and respected their views that each core concept had an impact on the others concurrently. Their experience as clients was that the interrelatedness of each element of the therapy was significant and more central to the therapy than I had recognised from my own position. Therefore I concluded that it was important to retain this from the clients' model and incorporate it into the joint theoretical model, as well as including aspects of my own more structured, sequential model.

My proposed theory, based on the findings, to explain how therapy based on positive psychology can help address emotional eating is illustrated in Figure 7. I propose that the therapeutic dyad is the catalyst for changes to occur by providing a collaborative, optimistic and supportive foundation which enables positivity to develop and be applied in various areas of the clients' lives. The positivity reflects back to the therapeutic dyad, strengthening and enhancing the dyad and its usefulness, developing an ongoing two-way effect between the two. Clients are then in a position to draw from the positivity developed in this way and make use of it to address identity issues, raise their awareness of their relationship with food, and to develop and apply skills for cognitive and behavioural change. I suggest that this process of developing and applying positivity triggers the interrelated impact of the four elements within the central diamond in the model on each other. Although each of these four elements are important, I propose that developing positivity, then addressing identity issues and the relationship with food are all necessary for the learned and applied skills for cognitive and behavioural change to become established and applied so they can have long-lasting effect. I suggest that it is essential to have a positive mindset – developed through the therapeutic dyad, by deliberately developing positivity, and by addressing the relevant issues of identity and the relationship with food – as well as applicable skills in order to effect change. It is not sufficient to only develop either a positive mindset or a set of skills; the combination is required for changes to occur. The changes the clients reported and which were measured were that intuitive eating developed and they lost weight, and their self-esteem and mood generally improved. The objective of the intervention was that the clients would develop a healthier relationship with food and lose weight, and as the therapy offered a holistic approach to developing and applying positivity it is perhaps not surprising that other changes also took place.

Methodological aspects of the research

Strengths and limitations of the study

The focus of this study was to explore the therapeutic process, looking through the magnifying glass of case study research to examine in detail how applying principles of positive psychology might enable clients to make changes. Changes did indeed occur during the course of the 20-week intervention, and my interest is in how these changes may have come about, given that during the 20 weeks the clients were exposed to principles of positive psychology and encouraged to apply them to their own challenges.

Strengths

I believe that the complexity and variety of the data in this study is one of its strengths, acknowledging and reflecting that the phenomena under scrutiny are complex, with no simple fit between the clients' psychological experiences I am examining and their representation within the data. By having such a broad palette of information to draw from, it has been possible to make sense of the clients' and my differing perspectives and bring them together into a usable theoretical model.

The exploration process regarding how an intervention based on positive psychology may work is still in its infancy, therefore my choice to collect a wealth of data from a variety of sources reflects this stage of development, as 'it is also possible that different methods tap different domains of knowing' (Mathison, 1988).

By examining the clients' accounts in detail I have gathered knowledge from their perspective and have offered them a chance to express their views, and I have heard

their voices on how they thought the therapy contributed to the changes they made, which is both fascinating and informative. It allows an 'inside view' of the clients' experience of therapy, which is frequently overlooked or not invited at all. Comparing their experiences and understanding of what helped them make changes with my own perspective as therapist-researcher offers an unusual but valuable insight into whether we, as therapists, really understand what clients think we are doing and what they think works in therapy. The varied data collection of this study is fairly similar to that of Julia McLeod (2013) who also carried out case study research on three participants, exploring therapeutic process and outcome. She assembled a rich case record for each client, incorporating therapist notes, transcripts of sessions, scores on standard outcome measures, and a follow-up interview. As in this study, the case materials were analysed to identify key helpful process within the therapy.

Limitations

One limitation of the study is that the quantitative results are simply observations of what has changed from pre- to post-therapy, and I cannot be sure that the changes are directly attributable to therapy. It is possible that there may have been factors external to the intervention which were influential. In their follow-up sessions with me three months after the end of the 20-week programme I asked each client how they thought their changes had come about, and all referred to aspects of the therapy which they believed had helped them. I also asked them whether there was anything outside the programme which they thought had helped them make changes. One client said continued exercise helped, another client said the support from her husband was helpful, and the third client had found having a clearer daily routine helped her. By examining in detail the clients' accounts of their experience of the therapy and their understanding of what helped the changes occur, I hope that I have

gained an accurate impression of the therapeutic process and the elements within it which the clients and I thought helped them make changes.

As with any small-scale qualitative study, it is not possible to generalise the findings of this study to a wider population. The three clients were all women in their 40s and 50s, and they were all happily married with children. It is not possible to know whether women of different age groups, or men, or clients who were childless, single or unhappily married would respond differently. All three clients were psychologically-minded, which drew them to this intervention which was specifically described as a psychological approach to weight loss. It is not possible to know how people without a particular interest in psychology would respond.

Given that I was the therapist for all three clients, it is not possible to know the effect of a different therapist providing the intervention. The therapeutic relationship was unique with each client, who brought her own individuality to the therapeutic dyad. Consequently each client and I co-created both a relational space for the therapy and the therapeutic journey.

Implications of this study for future research

The findings from this study are encouraging - the clients and I have explored how an intervention based on positive psychology may help changes to occur and I have developed a proposed theory supported by these findings. There are a number of aspects of the study which warrant further investigation: to explore the effectiveness of the various elements of the intervention in enabling change regardless of the presenting problem; to explore the effectiveness of this intervention as a therapy

approach to address emotional eating; and to continue with longer term follow-up of clients of this approach. It would be appropriate to incorporate the findings of this study when deciding on which elements of this intervention to include and/or amend in further therapeutic interventions based on positive psychology. Studies with considerably larger numbers of participants would yield useful information, as increased numbers would allow more robust conclusions to be drawn as to the effectiveness of the therapy approach in triggering changes and the potential generalisability of the results of this study. Including a measure of the therapeutic alliance such as the Working Alliance Inventory (Horwath, 1989) would provide interesting data not included in this study. Larger participant numbers are also likely to address some weaknesses of this study relating to the narrow demographic profile of the clients in this study, thereby testing the applicability of this approach to a wider population. Given the current political concern regarding the increasing problem of overweight in the population, further research into the effectiveness and applicability of this intervention to help overcome emotional eating and resulting overweight should be prioritised.

Furthermore, future studies researching the applicability and effectiveness of the proposed theoretical model developed in this study to address psychological difficulties other than emotional eating would be valuable. I suggest that the model be adapted to explore whether it may be relevant to other presenting problems by adapting appropriately the element in the model which is entitled 'Raising awareness of the relationship with food', and also amending the skills to include those tailored to the presenting problem to be addressed.

Personal Reflexivity

Given my combined role as therapist-researcher, I was very involved in both the therapeutic encounter and in the research process. I was the first point of contact for participants when they first showed interest by telephone in being part of the study, I conducted the introductory session with each of them – detailing the intervention and the research study, and I delivered the intervention over 20 weeks of weekly individual therapy sessions.

My part in the process is likely to have impacted on the participants and on the study, therefore some personal reflexivity is warranted to consider how my values, beliefs and interests may have influenced the research (Brewer, 2000). My interactions with the participants will have had some impact on the way they communicated and interacted with me and on the nature of the therapeutic relationship. Furthermore, their perceptions of me may have affected the content and style of their discussions with me in sessions. All the participants and I shared certain personal features, as we are all white, educated women aged between mid 40s and late 50s. The participants may have felt a certain affinity with me because of these similarities, just as I felt a sense of affinity with them. Physically, we were different as I am of a slim build, whereas the participants were overweight, and this difference may have had a bearing on our relationship and on their interactions with me. My experience of the difference in our build was that I felt aware that, as an intuitive eater, I had information and experience regarding developing and enjoying a healthy relationship with food and I hoped this would help me to help the participants to develop the same in order to achieve their aims. However, as we did not discuss this specifically, I can

only speculate as to whether the participants saw me in this regard, or whether they experienced this differently.

I am aware that food and the enjoyment of food plays a large part in my life and in my social and family interactions, as we use food as a vehicle for celebration, as a focus for shared time spent cooking and eating together, as a common interest, as well as enjoying the sensory pleasures of the many varied tastes, textures, smells and visual appeal of food. The importance of food for me as a positive aspect of life means that I am enthusiastic about the enjoyment of food and eating for positive reasons, and it is likely that the participants will have noticed this – in contrast to their experience of being (or of having been in the past) 'a slave to food'. Reflecting on the influence of this on the research, I wonder how this impacted on the participants' experience of our interactions and in turn, how it may have affected their communication with me. Again, we did not discuss this specifically, so I am reluctant to speculate on details, but I acknowledge that aspects of the therapeutic encounter may have been shaped by this.

The therapeutic relationship I had with each of the participants felt collaborative and productive. However, I cannot overlook the potential for a power differential between the clients and myself, as I set the boundaries of the therapy, I determined the framework for the content of the intervention and had set parameters in place, for example obtaining medical clearance, for clients to be included in the programme and in the study. Such decisions made by me as researcher, within the context of the clients being included in the research study, may have had implications for the nature of our therapeutic relationships which developed. In turn, this may have affected research findings by unwittingly encouraging compliance based on the

participants perhaps feeling some pressure to be 'good' clients, as they knew their progress was monitored carefully by me in order for the research paper to be written up.

Holding tensions

I wish to acknowledge and reflect on the complex tensions which were held within this study. In particular, there is a tension in the project between on one hand getting a description of the experience of therapy, and on the other hand getting an explanation from clients of their ideas about how they came to make changes. Also, there is a tension in holding the clients' accounts of their experience and understanding of the therapy process, and my own. Yet another tension is the issue of trying to examine process versus outcome, recognising that both are important. Trying to straddle these polarities when trying to carry out this research was challenging. These issues evoked mixed emotions in me as researcher. I was excited to be hearing about, and examining, the clients' data, representing their views of the therapy - often kept private during the therapeutic encounter. However, at times it felt to me as if I was 'drowning in data' – the sheer amount, variety and richness of data which I wished to try and understand seemed overwhelming. It felt daunting to try and make sense of this volume of data and I also felt a sense of responsibility to the clients to do the best I could to convey their descriptions and understanding of the process of therapy as accurately as possible.

CONCLUSIONS

In this section I describe the contribution and impact of the research on my own therapeutic practice and go on to explore the potential contribution on others' psychological work and to the body of knowledge in this field.

Contribution and impact of the research on my own therapeutic practice

Carrying out this study has had an impact on my own practice of therapy as well as having incorporated a way of researching and evaluating my own practice.

By exploring the role of aspects of positive psychology within the therapy I offered in this study, I have developed confidence in their applicability and relevance within my therapeutic work and to clients who present in my private practice. As the research outcomes and feedback from the clients in this study regarding this approach have been positive, I have been deliberately including in assessments and therapy sessions those elements which seemed helpful to clients in this study. I do so by keeping in mind the model I have developed, which provides me with a loose framework within which to work with clients in the clinic. I keep in mind that the therapeutic relationship offers an opportunity specifically to offer hope, validation, encouragement and accountability. Before I carried out this study these would be included in a less deliberate way within the evolving therapeutic relationship, but the research has helped me to define more clearly those ingredients which I aim to include because they have been identified as helpful. I also keep the 'diamond' shape within the model in mind, which consists of the four therapeutic elements identified by the clients and myself as helpful in enabling change – developing

positivity, addressing identity issues, raising awareness of the presenting problem, and developing skills for cognitive and behavioural change. The clients' emphasis on the interrelatedness of these elements helps me to recognise that each impacts the others. Given my view on the sequential nature of the model, I tend to emphasise developing positivity early on in therapy sessions. Prior to carrying out this research, my therapeutic approach was predominantly based on Cognitive Behavioural Therapy with some aspects of positive psychology and strengths-based therapy included when it seemed relevant to the client. I notice the impact on my practice of having carried out this study as I now incorporate aspects of positive psychology and a strengths-based approach with more structure than previously, using my model to guide the content and timing of such interventions within therapy. Consequently I feel more confident and relaxed about including these elements in my therapeutic work, when such an approach seems to resonate with the client.

Additionally, I also notice that since carrying out this research I am more deliberate than before in inviting my clients to voice their experience of our work together during the course of therapy. I used to include in final sessions a discussion with clients regarding which aspects of therapy they found helpful or unhelpful, when reviewing how they thought progress had come about, but now I incorporate this much more regularly during ongoing sessions, and adapt the emphases in the therapy sessions accordingly. I believe this was part of how I worked collaboratively with clients before, but since the study I feel that I seek clients' feedback not only to guide the therapy, but also to convey to them the importance and value of their voice within the therapeutic encounter, as well as to research my own practice. This offers me the potential to learn about the clients' view of the effectiveness of interventions, as well as to discover whether there are other elements of the therapeutic encounter which

have affected them, and if so, how. It also offers the opportunity to hear feedback on the process of therapy as well as the outcomes. This is an informal and relaxed way of researching my own practice, which can be incorporated into my therapeutic work with clients while keeping their best interests in mind. There is the potential for clients to be selective in their feedback and perhaps omit negative comments, but in my view it is preferable to have an opportunity to hear about at least some of the clients' experience and understanding of the therapy in order to develop my own therapeutic practice.

Potential contribution to others' psychological practice

There are two areas in which this study can contribute to other therapists' clinical work.

Firstly, for therapists with an interest in applying positive psychology to their clinical work, it offers a model to guide the content and timing of interventions. The model developed in this study can be kept in mind as therapy evolves, helping to structure and validate interventions included by the therapist. Principles of positive psychology and the strengths-based approach have so far largely been applied to non-clinical settings such as social work, business and education, but this research study offers information and a practical model, based on the proposed theory, for applying them to clinical problems.

There are a number of reasons underpinned by research why therapists should consider working from a positive psychology and strengths-based approach. Fredrickson (2001) argues that positive psychology principles can enable therapists

to emphasise strengths and positive emotions with their clients. This has several benefits: broadening clients' thinking, counteracting the impact of negative emotions, to increase resilience, build lasting personal resources and encourage greater productivity and well-being.

The potential challenge for therapists who wish to work in this way is that it entails a fundamental shift away from the traditional problem-focused therapy model. The therapeutic emphasis shifts away from problems, deficits and damage to possibilities and strengths. In my view, it is not simply a matter of adding on of set of skills or component to a therapist's existing repertoire, but it requires a fundamental paradigm shift in how we think and view the world, our work, our clients, and ourselves. It is potentially challenging to embrace such a fundamental shift and could feel disturbing and uncomfortable, changing familiar frames of reference.

The positive psychology therapy model developed in this study offers a positivity 'lens' through which we interact with the client, which guides our perceptions, thinking, understanding and practice. It offers practitioners the opportunity to work collaboratively with clients with an egalitarian therapeutic relationship based on the client's strengths and resilience. Saleebey (1996) argues that:

> 'Change can only come when you collaborate with the client's aspirations, perceptions and strengths, and when you firmly believe in them.'

The positivity 'lens' is a powerful way in which to view working therapeutically from a positive psychology perspective, and through which other therapy modalities can be interpreted. It is likely to be more conducive to some approaches than others,

especially solution-focused therapy and cognitive-behavioral therapy, both of which are particularly collaborative.

Secondly, this research makes a methodological contribution as it offers therapists a model for researching and developing their own practice. This can be incorporated in an ongoing manner, seeking feedback from clients more deliberately during the course of therapy by encouraging them to express their experience and understanding of the therapy. Reflecting on the value of understanding how therapy is impacting on clients in order to develop practice, I suggest that there is scope for therapists to more thoroughly audit their clinical work with an emphasis on process as well as on outcomes. This can be included within more formal audit procedures, adding to the richness of feedback from clients that we can use to help them more effectively.

Contribution to the body of knowledge in this field

There are three areas in which this study can add to the body of knowledge in this field.

Firstly, the research offers a theoretical model as a starting point for developing a more thoroughly tested model for incorporating aspects of positive psychology including the strengths-based approach into therapeutic work. Although there are some therapeutic interventions which include principles of positive psychology (Rashid, 2009; Rashid & Seligman, 2013; Sharp, 2011), this study makes a unique contribution in including within the model the clients' understanding of what is helpful in therapy.

Secondly, the study offers a specific model to be explored further for addressing emotional eating, a current challenge with wide socio-political implications relating to overweight in the population. The Positive Slimming Programme offers an approach to weight loss which clients experience as uplifting and encouraging, in contrast to other weight loss approaches they experience as punishing and critical. They benefit from applying the positive psychology based strategies holistically to other aspects of their lives as well as to their presenting problem of emotional eating and related overweight.

Research shows that group therapy can help change eating habits (Buckroyd and Rother, 2007, 2008; Leahey et al., 2008). There is scope to offer the Positive Slimming Programme to group work, which would have some advantages. A group programme would provide a more cost-effective use of therapists' time compared to delivering the programme as a course of individual sessions, as was the case in this study. In my view the group size would need to stay fairly small, perhaps a maximum of eight clients, in order to provide a sense of containment of any personal information shared by clients and to foster a close group dynamic. Another benefit of a group programme would be that it would offer recognition for clients that they are not alone with their challenge to overcome emotional eating. Furthermore, it would provide a forum to share strategies, ideas, experiences and support. It is likely that some clients would welcome this format, but others may struggle with the lack of privacy found in individual therapy work.

The most effective dissemination of the protocol of this approach to help overcome emotional eating can be achieved by publishing details of this study and the Positive Slimming Programme in publications focusing on disordered eating habits such as

'Obesity'. Submitting to such publications would be more suitable than contributing to those focusing on positive psychology, as my primary aim in publication would be to contribute to the currently rather limited literature on psychological influences on eating. In particular, when submitting for publication I wish to emphasise the strength of the therapeutic dyad in helping changes to come about in addressing emotional eating, as it forms the foundation for the therapy, as illustrated in my proposed model.

The approach developed in this study need not be seen as restricted to the client population dealing with emotional eating, however, as the model can potentially be applied to a range of other psychological difficulties by adapting it appropriately, by substituting the element in the model relating to 'Raising awareness of the relationship with food' with an element focusing on raising awareness of the presenting problem. The sequential nature and interrelatedness of the model remain unaffected. The model contributes to the therapeutic options available for therapists to use, providing a structured approach which is a generally uplifting and energising way of working for the therapist and a positive experience for clients.

Lastly, the study offers a model for therapists to research and develop their own practice beyond looking at outcomes, instead including an exploration of their clients' understanding of therapy by encouraging their voices to express their experience of the therapeutic process and hearing directly from clients what was helpful – or not – within the therapeutic encounter.

Concluding comments

This study has been an exploration into the process of therapy from the perspectives of client and therapist, specifically examining how an approach based on principles of positive psychology might help address emotional eating. The clients' understanding of this included elements which I, as therapist-researcher, also shared in my own view. However, there were some differences in our perspectives - the clients emphasised the interrelatedness of the therapeutic elements whereas I accentuated a sequential aspect, as well as the role of the therapeutic dyad which I believed was key to enabling change.

Encouraging the clients to express their voices on what they thought we were doing in therapy, on what they thought was helpful or unhelpful, and on their experience of being clients, has been revealing and will have a lasting effect on my own work. Helping clients to focus on what was right with them, identifying their personal strengths, achievements and resources, as well as acknowledging their problems, was a particularly uplifting, collaborative, optimistic – yet realistic – way of working together. I will use the learning gained from this study to guide my therapeutic interventions as well as more regularly invite the clients to voice their experience of therapy during, not only at the end of, the course of therapy.

I hope the model I have developed can be further tested and refined in order to provide a validated approach incorporating principles of positive psychology into therapy, so that we, as therapists, can tailor our efforts in the consulting room to include focusing on the resources, strengths and positivity available to address the needs of people we try and help and from whom we continually learn so much.

Appendices

Appendix 1

Structure and content of the intervention

Programme structure and content

The intervention programme will be a programme designed to run for a period of 20 weeks. Each participant will have had some information about the strengths-based approach and the nature of the research study before they apply to join the programme, at which time they are screened according to the selection criteria to ensure they are eligible to join the research programme.

Each individual session will be 45 minutes long and will take place once a week over the 20 week duration of the programme.

Most sessions will include common elements and a clear structure. The first and last sessions will differ slightly from sessions 2 – 19.

Session 1:

1. Each participant's weight will be monitored as they arrive to the session each week by being weighed on the same set of scales.
2. The strengths-based approach and the study will be explained again.
3. Psycho education regarding emotional eating and intuitive eating.
4. Discussions of the participant's experiences of emotional eating.
5. Psycho education regarding personal strengths.
6. Discussions of the participant's personal strengths.
7. Participant to identify personal strengths.

8. Discussion of challenges in the forthcoming week which typically trigger emotional eating.
9. Discussion regarding how applying strengths appropriately to such challenges may enable other ways of addressing the challenges.
10. Journal for diary entries to be given and their use discussed.
11. Participant to record in the journal their own potential challenges regarding typical triggers for emotional eating for the week ahead, the relevant strength/s and how they will apply them to these typical triggers to encourage other, more appropriate ways of dealing with them.
12. Reminder to participant to use the journal in the week ahead to record their experiences of applying the strengths-based approach.

Sessions 2 – 19:

1. The participant's weight will be monitored as they arrive to the session each week by being weighed on the same set of scales.
2. Feedback regarding the past week and how the individual has experienced dealing with challenges which typically trigger emotional eating, with particular focus on if and how strengths were applied.
3. Constructive discussion regarding obstacles and whether there was additional scope for strengths to be applied.
4. Each of the sessions 2 – 20 will include one or more of the following topics (some topics may require time in two or more sessions):
    - Raising awareness of the client's relationship with food
    - Defining a healthy relationship with food
    - Using mindfulness to identify cues (situational, emotional, physiological) which trigger emotional or intuitive eating

- Essentials of healthy eating, appropriate portion size and exercise
- Applying strengths to help motivation
- Applying strengths to help self-regulation
- Developing skills for cognitive and behavioural change
- Self-soothing
- Applying strengths to implement and maintain practical alternatives to emotional eating
- Applying strengths to develop and maintain new eating habits
- Increasing positivity
- Goal-setting
- Self-identity issues, past roles, future plans
- Impact of the past on the relationship with food

5. Discussions of personal strengths relevant to session topic.
6. Client to identify relevant personal strengths.
7. Discussion of challenges in the forthcoming week which typically trigger emotional eating and/or relevant to session topic.
8. Discussion regarding how applying strengths appropriately to such challenges may enable alternative, more appropriate ways of addressing the challenges.
9. Client to record in their journal their own potential challenges regarding typical triggers for emotional eating for the week ahead, the relevant strength/s and how to apply them to these typical triggers to encourage other, more appropriate ways of dealing with them.
10. Reminder to each client to use the journal during the week ahead to record their experiences of applying the strengths-based approach.

Session 20:

1. Each participant's weight will be monitored as they arrive to the session by being weighed on the same set of scales.
2. Feedback regarding the past week and how the participant has experienced dealing with challenges which typically trigger emotional eating, with particular focus on if and how strengths were applied.
3. Constructive discussion regarding obstacles and whether there was additional scope for strengths to be applied.
4. Relapse prevention and potential obstacles to maintaining progress.
5. Applying strengths to relapse prevention and addressing potential obstacles.
6. Discussion on participant's strengths and relevance to relapse prevention.
7. Participant to record in their journal their own potential challenges/obstacles regarding maintaining progress and relapse prevention, their relevant strength/s and how they will apply them to these areas.
8. Review of programme.
9. Reminder of post-programme interview and follow-up feedback and arrangements to schedule these.

Appendix 2

Questionnaires

The following questionnaires were used in this study:

Intuitive Eating Scale (IES)

Rosenberg Self-esteem Scale (RSES)

Beck's Depression Inventory (BDI)

A copy of each is included below.

INTUITIVE EATING SCALE© 2006, Tracy Tylka

Directions for participants: For each item, please circle the answer that best characterizes your attitudes or behaviors.

Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agre 5

1.	I try to avoid certain foods high in fat, carbohydrates, or calories.	1	2	3	4	5
2.	I stop eating when I feel full (not overstuffed).	1	2	3	4	5
3.	I find myself eating when I'm feeling emotional (e.g., anxious, depressed, sad), even when I'm not physically hungry.	1	2	3	4	5
4.	If I am craving a certain food, I allow myself to have it.	1	2	3	4	5
5.	I follow eating rules or dieting plans that dictate what, when, and/or how much to eat.	1	2	3	4	5
6.	I find myself eating when I am bored, even when I'm not physically hungry.	1	2	3	4	5
7.	I can tell when I'm slightly full.	1	2	3	4	5
8.	I can tell when I'm slightly hungry.	1	2	3	4	5
9.	I get mad at myself for eating something unhealthy.	1	2	3	4	5
10.	I find myself eating when I am lonely, even when I'm not physically hungry.	1	2	3	4	5
11.	I trust my body to tell me when to eat.	1	2	3	4	5
12.	I trust my body to tell me what to eat.	1	2	3	4	5
13.	I trust my body to tell me how much to eat.	1	2	3	4	5
14.	I have forbidden foods that I don't allow myself to eat.	1	2	3	4	5
15.	When I'm eating, I can tell when I am getting full.	1	2	3	4	5
16.	I use food to help me soothe my negative emotions.	1	2	3	4	5
17.	I find myself eating when I am stressed out, even when I'm not physically hungry.	1	2	3	4	5
18.	I feel guilty if I eat a certain food that is high in calories, fat, or carbohydrates.	1	2	3	4	5
19.	I think of a certain food as "good "or "bad" depending on its nutritional content.	1	2	3	4	5
20.	I don't trust myself around fattening foods.	1	2	3	4	5
21.	I don't keep certain foods in my house/apartment because I think that I may lose control and eat them.	1	2	3	4	5
22.						

TOTAL SCORE_____

(See Scoring Sheet)

Rosenberg Self-Esteem Scale (Rosenberg, 1965)

Instructions: Below is a list of statements dealing with your general feelings about yourself. If you **strongly agree**, tick in the SA column. If you **agree** with the statement, tick in the A column. If you **disagree**, tick D. If you **strongly disagree**, tick SD.

		SA	**A**	**D**	**SD**
1.	On the whole, I am satisfied with myself.				
2.*	At times, I think I am no good at all.				
3.	I feel that I have a number of good qualities.				
4.	I am able to do things as well as most other people.				
5.*	I feel I do not have much to be proud of.				
6.*	I certainly feel useless at times.				
7.	I feel that I'm a person of worth, at least on an equal plane with others.				
8.*	I wish I could have more respect for myself.				
9.*	All in all, I am inclined to feel that I am a failure.				
10.	I take a positive attitude toward myself.				

Scoring: SA=3, A=2, D=1, SD=0. Items with an asterisk are reverse scored, that is, SA=0, A=1, D=2, SD=3. Sum the scores for the 10 items. The higher the score, the higher the self esteem.

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
- 0 I do not feel sad.
- 1 I feel sad
- 2 I am sad all the time and I can't snap out of it.
- 3 I am so sad and unhappy that I can't stand it.

2.
- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel the future is hopeless and that things cannot improve.

3.
- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person.

4.
- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.
- 3 I am dissatisfied or bored with everything.

5.
- 0 I don't feel particularly guilty
- 1 I feel guilty a good part of the time.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6.
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7.
- 0 I don't feel disappointed in myself.
- 1 I am disappointed in myself.
- 2 I am disgusted with myself.
- 3 I hate myself.

8.
- 0 I don't feel I am any worse than anybody else.
- 1 I am critical of myself for my weaknesses or mistakes.
- 2 I blame myself all the time for my faults.
- 3 I blame myself for everything bad that happens.

9.
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10.
- 0 I don't cry any more than usual.
- 1 I cry more now than I used to.
- 2 I cry all the time now.
- 3 I used to be able to cry, but now I can't cry even though I want to.

11.

0	I am no more irritated by things than I ever was.
1	I am slightly more irritated now than usual.
2	I am quite annoyed or irritated a good deal of the time.
3	I feel irritated all the time.

12.

0	I have not lost interest in other people.
1	I am less interested in other people than I used to be.
2	I have lost most of my interest in other people.
3	I have lost all of my interest in other people.

13.

0	I make decisions about as well as I ever could.
1	I put off making decisions more than I used to.
2	I have greater difficulty in making decisions more than I used to.
3	I can't make decisions at all anymore.

14.

0	I don't feel that I look any worse than I used to.
1	I am worried that I am looking old or unattractive.
2	I feel there are permanent changes in my appearance that make me look unattractive
3	I believe that I look ugly.

15.

0	I can work about as well as before.
1	It takes an extra effort to get started at doing something.
2	I have to push myself very hard to do anything.
3	I can't do any work at all.

16.

0	I can sleep as well as usual.
1	I don't sleep as well as I used to.
2	I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3	I wake up several hours earlier than I used to and cannot get back to sleep.

17.

0	I don't get more tired than usual.
1	I get tired more easily than I used to.
2	I get tired from doing almost anything.
3	I am too tired to do anything.

18.

0	My appetite is no worse than usual.
1	My appetite is not as good as it used to be.
2	My appetite is much worse now.
3	I have no appetite at all anymore.

19.

0	I haven't lost much weight, if any, lately.
1	I have lost more than five pounds.
2	I have lost more than ten pounds.
3	I have lost more than fifteen pounds.

20.

0	I am no more worried about my health than usual.
1	I am worried about physical problems like aches, pains, upset stomach, or constipation.
2	I am very worried about physical problems and it's hard to think of much else.
3	I am so worried about my physical problems that I cannot think of anything else.

21.

0	I have not noticed any recent change in my interest in sex.
1	I am less interested in sex than I used to be.
2	I have almost no interest in sex.
3	I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score	Levels of Depression
1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
over 40	Extreme depression

Appendix 3

Post-intervention interview schedule

Post-Programme Interview

Interview Schedule

(Introduction - if not already done – who you are and your role in the programme.)

1. I'd first like to confirm that you have been part of the Positive Slimming Programme and that you have lost weight over the course of the programme – is that the case?
2. On a scale of 1 to 10, when 1 is easy and 10 difficult, how difficult have you found this approach?
3. I'd like to ask you now about changes which you have made over the course of the programme which may have directly – or indirectly – affected your eating habits and weight.

   Can you tell me if any changes come to mind when I ask you that question?

   Check for any changes in:

   Behaviour:

   Eating habits – eg portion size, foods eaten, leaving food on plate, food shopping habits etc

   Responding differently to negative emotions instead of comfort eating – activities/distraction/etc?

   Other behaviours not directly related to eating habits eg pursuing goals defined in the positive slimming programme

Any behaviours related to applying personal strengths (strengths were defined in an early PSP session)

Thinking patterns:

Changes in thoughts about

- Self
- Own appearance
- Own identity
- Own strengths
- Applying own strengths
- Current life
- Own future
- Food
- Eating habits
- Other people
- Positivity

Feelings:

Changes in feelings about

- Self
- Own appearance
- Relationships
- Current life
- Own future
- Food

4. **How** do you think these changes have come about?

What aspects of the Positive Slimming Programme have helped you to make these changes?

Have there been aspects of your life outside the Programme which you think have helped you make these changes?

What has it been like for you to go through the Programme? What can you tell me about your experience of going through the programme?

5. Has there been any aspect of the programme which has been particularly helpful?

Has any aspect been unhelpful?

To what extent do you think the focus on personal strengths and applying them has been helpful in your weight loss?

To what extent do you think the positive focus of the programme has been helpful in your weight loss?

To what extent do you think the focus on developing new thinking skills about food and eating habits has been helpful in your weight loss?

To what extent do you think the focus on your changing sense of identity – from a larger person to a slimmer person - has been helpful in your weight loss?

Are there any improvements in the programme which you can suggest?

6. Any other comments you wish to add?

7. May we re-contact you if there is any more information that we might need?

Appendix 4

Transcript of a post-intervention interview

INTERVIEWER: Ok, umm, I would just like to restate that everything said in the interview is confidential and will be anonymous when written up.

PARTICIPANT 2: Ummhum

INTERVIEWER: I would first like to confirm that you have been part of the Positive Slimming Programme and that you have lost weight over the course of the programme? Is that the case?

PARTICIPANT 2: That's true yes.

INTERVIEWER: Ok, on a scale of 1 to 10, with when 1 is easy and 10 is difficult how difficult have you found this approach?

PARTICIPANT 2: [Pause] Um about a 7 I guess, but that's probably more to do with my motivation levels rather than the approach itself.

INTERVIEWER: Can you tell me a little bit more about that?

PARTICIPANT 2: Um, I **think** I have lost weight in the past and I've used kind of structured schemes to do it through like Rosemary Connelly and things. Um, but this time in the last year or so I have kinda gotten into real emotional eating habits prior to starting this. Um and breaking them has been more difficult I guess, getting motivated to get back to where I wanted to be has been more of a challenge this time but not through the fault of the approach cause I think it has been more effective in the process.

INTERVIEWER: Umm, I would like to ask you now about the changes you have made over the course of the programme which may have directly or indirectly affected your eating habits and weight? What changes come to mind when I ask you this question?

PARTICIPANT 2: Umm, a big one has been getting my exercise routine back into what I consider is normal for me and is healthier for me. Umm, I am really happy that that has changed actually. Umm, I think I was talking to Rose about the nitty gritty skills the kind of umm knowing when to eat or not to eat and how much to eat has been really helpful and being aware of when the high risk times are when I might eat when I am not really hungry. So those things are things that have changed.

INTERVIEWER: Ok, can you tell me a little bit about the high risk situations?

PARTICIPANT 2: Generally, there there seems to be two times of day, one is when I am preparing food for my children and I graze or I was grazing, I haven't I don't do it anymore. Umm, and the other times are if I feel alone in the evening and it's sort of a boredom, alone thing, entertainment I suppose isn't it?

INTERVIEWER and PARTICIPANT 2: [Laugh]

PARTICIPANT 2: Is to eat. And I suppose I have gotten much better at that now.

INTERVIEWER: Ok, so um how have you sort of got better at it? Can you give me an example, the process?

PARTICIPANT 2: Umm, a number of things I guess the main one being focussing on the end goal rather than on the immediate satisfaction I suppose. Umm, wanting to have a healthy diet and be a healthy weight. Umm, ah that's really help feeling like I want to get back to where I used to be umm has been a real motivator when I when it kicked in the motivation it really feel into place.

INTERVIEWER: Ok, ah how do you think these changes have come about?

PARTICIPANT 2: Umm, I think they have come about out of spending a bit more time on myself, focusing on what I need and where I want to be in the future. Umm, and that's motivated me to change things **back** to a healthy balance really. The way I used to be. Umm, they've come about out of sheer grit and determination some of the time, and umm just a a more healthy enjoyment of food and, [phone beeps] sorry, and exercise and bringing everything back more into balance rather than being in extremes.

INTERVIEWER: Ok, can you give me an example of umm how you are bringing things back into balance?

PARTICIPANT 2: Umm, probably by introducing things like exercise and umm I have learnt one of the big things I have learnt is how much I do all or nothing things. So rather than thinking I won't have any of that food or I'll have masses of that food I am a bit better at smaller portions of it within reason, you know within a certain regularity. Umm, and that kind of knocks on onto a social life and things. So rather than thinking I can't go out for a meal I might just do things differently I might socialise with a friend doing exercise or something like that. So just making it not feel punitive I guess. I am trying to do it trying to monitor my foods and foods that I eat without being overly punitive, I can't think of another word. Yeah just not losing the enjoyment of it, not excluding it by being to extreme with all or nothingness.

INTERVIEWER: [Laugh] Ok, what aspects of the Positive Slimming Programme have helped you make these changes?

PARTICIPANT 2: I think having a journal and having weekly appointments with Rose which I want to continue myself um every week looking at the week ahead and reviewing the week just gone and see whether I am on track. Things like weighing and using a hunger scale for only only eating when you're hungry over a certain point. Um, one of the really useful catchphrases has been if you don't love it leave it. So I don't always eat everything on the plate if I've had enough. So, the practical things have been really useful.

INTERVIEWER: Ok, what has it been like for you to go through the programme? What can you tell me about your experiences of going through the programme?

PARTICIPANT 2: It's been really valuable I've really valued having time to consider what the things that I want again. I've kinda had children in the last few years and the focus has been on them. Um so I feel that I am coming back to **me,** this process has been really well timed for that. I have appreciated being able to talk things through with Rose and umm I have appreciated almost the kind of permission to have time to think about things or write in my journal during the week in-between. So yeah.

INTERVIEWER: Ok, so have there been any aspects of the programme which has which have been particularly helpful?

PARTICIPANT 2: I think I think those those practical things and and things that I will continue for myself like trying to make time for myself on a weekly if at the very least basis. Umm and practical things like the rules as it were that sort of stick with you and help day to day with not overeating or eating the wrong things. I think learning about the all or nothing thinking is going to pervade all sorts of areas in my life but it has been one of the most useful things to realise how much I do it and how much that affects my behaviour. So that has been really useful.

INTERVIEWER: Can you give me an example of time when you've used those rules umm that you spoke of?

PARTICIPANT 2: Umm, the rules are the practical rules are like if you don't love it leave it or if your hunger scale is under 6 then I won't eat. But I give myself extra ones like umm like I try to have a treat just at the weekend. A high fat, high sugar treat. Rather than when I started this process I was having them 6 to 7 times a day so I seem to do well with rules probably because of the all or nothing thinking. Umm, but I have also learnt that if it becomes too harsh I can have a little of something and not go crazy with it so um it just keep keeping the balance I suppose between the two things but the awareness of the all or nothing thinking has been really helpful.

INTERVIEWER: Ok, umm has any aspect been unhelpful?

PARTICIPANT 2: I I honestly don't think there has. Umm, there have been points at which I have felt de-motivated but that isn't because of the process that would be more because of how I've been going through it at the time I guess. Umm, I know I found it particularly difficult when Rose sort of suggested that I didn't follow rules very well or take other peoples advice that was a bit of a difficult week. But again a difficult thing to learn but a good to take on board and for me to really think about. But nothing really unhelpful.

INTERVIEWER: Can you tell me a little bit about a time when you felt de-motivated and just how you went through?

PARTICIPANT 2: I think there have been weeks when I have felt I was pretty good both with food and on exercise tracks and the way to handle that is to realise that this is a plateau and to maybe introduce something else that will kick start the following week. Umm, again it's fitted in with the all or nothing thinking cause I've sort of thought I'm in the failure zone umm whereas I have been doing really well but just sort of stalled for a bit so umm I've tried to introduce more exercise or umm been very mindful of what I have been eating in those weeks to sort of move it on again and I am at that point now. So as that process ends I going into a new kick start process for the next stage for a little more weight loss and a bit more careful eating.

INTERVIEWER: Ok, to what extent do you think the focus on personal strengths and applying them has been helpful in your weight loss?

PARTICIPANT 2: It's been really useful, really useful and it was good that it was right at the start of the process I think. Umm, I am very good at using my skills for other people and this process has helped through them back at me really and focus on help me to use them to focus on me really. That's been great.

INTERVIEWER: Can you tell me a little bit about how umm when you have used your personal strengths to help yourself?

PARTICIPANT 2: I think the determination to keep going I am very determined all be it stubborn at times I think this has been a really useful skill to direct in this way. Umm, I am very caring and um good with other people. So using that, what we ended up terming as self kindness um to turn it back onto me and not be so harsh when I am not succeeding or to really feel proud when I am achieving something has really good.

INTERVIEWER: Ok, to what extent do you think the positive focus of the programme has been helpful in your weight loss?

PARTICIPANT 2: I think it is going to be long term in a way that other approaches might not be and has been really for want of a better word positive. I have really appreciated it.

INTERVIEWER: Can you tell me a little bit about umm how you thing the positive approach has helped you?

PARTICIPANT 2: There have been a few occasions in the process where, like it or not, it has been highlighted that I might not always come across with initial positive comments when I am engaging in conversation or um that I tend towards the negative if I am not careful. So it's something that I want to be is much more positive and I think that that's a really good way of achieving things. So it's something that I think will be useful generally in my life as well as with the emotional eating and weight loss.

INTERVIEWER: Ok, [pause] so to what extent do you think the focus on developing new thinking skills about food and eating habits has been helpful in your weight loss?

PARTICIPANT 2: Really helpful, I think Rose pointed out that I wasn't too good at following rules umm or advice from others and this approach means that it comes from you and what you want out of it and your own thinking. So it's a very autonomous approach which I think will suit me and will be a long term help in keeping the weight off.

INTERVIEWER: Can you maybe give me umm a few examples of how you ahh the different thinking skills you developed over the course?

PARTICIPANT 2: Probably the most valuable one is being umm is combating the critical the tendency to be critical of myself I guess. So I will be much more umm able to focus on the positives I have achieved rather than on any kind of stalling in the

process. Umm, I think it its valuable given the point that I am at after my children are just becoming more independent now. Umm that it's really good for me to have time for me and to set goals of where I want to be in the future and the goal setting was really useful in that, so thinking I need to make more space for thinking and jotting things down in the journal was really useful. Umm, so just different approaches to me I guess really are the biggest changes in terms of my thinking.

INTERVIEWER: Can you tell me about a time when you used the goal setting and carried that on?

PARTICIPANT 2: Umm, the there are a few but they are a work in progress I guess. My - we - we are looking at travelling in the future and we are doing little projects in ah to plan that, it's a few years off. But we are definitely moving it on in a way I wasn't at the start of this process. Umm, I have definitely done that with exercise during the process, so I've made the goals I have wanted to achieve, I've made the times in the week where it is convenient and I have committed to doing it and I have done it. So that, I've not really written that in a goal setting sheet but that was definitely something I wanted to achieve when I set out at the start and which I have now achieved and I hope will continue the long term now.

INTERVIEWER: You said that you hadn't written it down in a sheet does it do you feel that it matters if you write it down in a sheet or it's just the process?

PARTICIPANT 2: Umm, at the start of the process I probably would have said not so much, but by the end of it I think it's really valuable have it write things down. I've really found writing things down in a journal helpful and that's something I will definitely do with goals. And even thinking things through where you want your goals to be I will definitely do that in writing now.

INTERVIEWER: To what extent do you think the focus on your changing sense of identity from a larger person to a slimmer person has been helpful in your weight loss?

PARTICIPANT 2: It's been helpful, I think its it needs to continue to be helpful from now on for it to really be powerful. Um, it's something I need to be mindful of and take with me. Umm, I don't feel that I have done enough of it in the last 20 weeks for it to be a permanent change for me probably never is I don't know. But um that's an ongoing thing that I need to keep in mind.

INTERVIEWER: Ok.

PARTICIPANT 2: It's been useful and is definitely something I need to focus on.

INTERVIEWER: Ok, can you give me an example about when it has been useful.

PARTICIPANT 2: Umm, I do tend to, I don't know about a direct example, I do tend to see myself as the biggest person in the room type of thing. Sounds exaggerated but umm, when I'm at what my goal weight would be I don't feel that way I feel quite petite and quite, much more confident and attractive. So, I need to focus on getting there so I don't take the negative stuff with me. Umm, it some days I do it better than others I don't know if it will ever come naturally so it is something I will focus on and keep in mind.

INTERVIEWER: Ok, are there any improvements in the programme which you can suggest?

PARTICIPANT 2: [Pause] I don't think there are. I have wondered if there would be any value being in a group, not not for the whole of the process but some of the process. But I don't think, it would just be another aspect to it rather than an improvement necessarily, because I think for me the one to one nature of it and the regularity and the content of it has all be very pertinent and very useful.

INTERVIEWER: Ok, can you tell me a little bit more about why the group?

PARTICIPANT 2: Umm, because I am curious about other people more than anything else. But I think there might be an aspect of group effort a camaraderie side of it. Umm, I think that has helped me in the past being part of a group effort, specifically with weight loss and exercise. Umm, yeah just think it might talking with other might bring in another experience or open it up in a different way but it would not to the exclusion to the one to one sessions.

INTERVIEWER: Ok, are there any other comments you would like to add?

PARTICIPANT 2: No, other than it has been very timely for me and very useful and I think I shall miss my sessions.

INTERVIEWER and PARTICIPANT 2: [Laugh]

PARTICIPANT 2: Umm, and I hope to keep up the good work. Yes that's the only comments I have I think.

INTERVIEWER: Ok, that's great. Umm, just like to ask if we could, Rose or myself, could we contact you encase there are any questions that have been left off or extra information we may need?

PARTICIPANT 2: Yes that's fine.

INTERVIEWER: Great.

Appendix 5

Medical Clearance Form

Medical Clearance Form

Information for GPs/ and medical advisors

Your patient has asked if s/he can attend the Positive Slimming Programme in order to understand and address emotional eating and lose some weight. Please read the information below and consider whether there are any contraindications to the patient joining the programme.

Programme overview

The Positive Slimming Programme, developed by a Chartered Psychologist, involves attending an individual session on a weekly basis for 20 weeks, with a psychologically trained therapist. Sessions are psycho-educational and involve use of strengths-based techniques from positive psychology to enable participants to change their relationship with food. Participants learn to identify the emotional triggers that lead to overeating and how to cope with them. The patient's height, weight, BMI, and psychological well-being and eating attitudes are assessed at the start and end of the programme.

Programme content

The programme content involves three key components, described below:

1. Intuitive eating
We will be asking participants to use an 'intuitive eating' approach to weight loss. This is a 'no diet' approach that involves asking participants to do the following:
1. Eat only when hungry
2. Stop eating when full
3. Eat slowly and consciously
4. Eat whatever food type they wish

This approach helps people to become attuned to their internal hunger mechanism, and reduce overeating that occurs for emotional reasons. Once intuitive eating has been established, healthy eating choices are discussed.

2. Cognitive skills
Participants are taught how to monitor and recognise the triggers for emotional eating and develop appropriate coping strategies. These strategies are strengths-based and draw from Positive Psychology.

3. Motivation to exercise
We encourage participants to increase their activity levels, including moderate levels of activity such as walking. The strengths-based programme helps them to consider how they can increase their opportunities to exercise and remove obstacles that may de-motivate them to exercise.

PLEASE CONSIDER WHETHER THE PATIENT HAS ANY MEDICAL CONDITIONS THAT MIGHT BE ADVERSELY AFFECTED BY USE OF THE ABOVE APPROACH TO ADDRESS EMOTIONAL EATING

Before we can offer places on the Positive Slimming Programme we ask all clients to visit their G.P. or medical advisor to check their medical suitability for this programme.

Please could you decide in your opinion whether or not this patient is suitable to join this programme. Please complete the slip below, and return it to your patient who is required to provide medical clearance before commencing the programme.

If you would like further details of the programme or have any questions about it, information is available at www.positive-slimming.com or contact Rose Aghdami on 01628 826002 or 07876 212281 or by email info@positive-slimming.com.

Thank you for your assistance.

Yours sincerely

Rose Aghdami Chartered Psychologist
BSocSc MSc DipCoPsych CPsychol CSci AFBPsS

Patient name: **D.O.B.:**

Patient address:

G.P. name:

Surgery:

The above patient is medically suitable / not suitable to join the Positive Slimming Programme.

Signed…….Date:……

Appendix 6

Consent form for participants

Rose Aghdami CPsychol

Participant Identification Number:

CONSENT FORM

Title of Project: Positive Slimming: applying a strengths-based approach to address 'emotional eating'

Name of Researcher: Rose Aghdami

Please initial box

1. I confirm that I have read and understand the information sheet dated .....……for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
3. I understand that my interview may be taped and subsequently transcribed. ☐
4. I agree to take part in the above study. ☐
5. I agree that this form that bears my name and signature may be seen by a designated auditor. ☐

Name of participant	Date	Signature
Name of person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

1 copy for participant; 1 copy for researcher.

Appendix 7

Metanoia Institute Research Ethics Approval

METANOIA INSTITUTE

13 North Common Road
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Telephone: 020 8579 2505
Facsimile: 020 8832 3070
www.metanoia.ac.uk

Rose Aghdami
DCPsych Doctoral Conversion Programme
Metanoia Institute

Our ref: 1/10-11

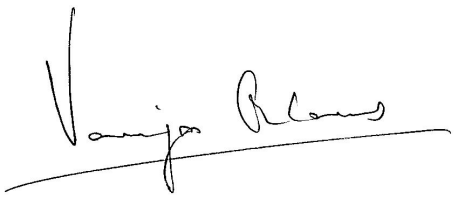
21st December 2010

Dear Rose

RE: *Looking on the bright side in therapy: Clients' and therapist's understanding of the use of positive psychology principles to address emotional eating.*

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as DCPsych representative on the Research Ethics Committee.

Yours sincerely,



Professor Vanja Orlans

On behalf of:
Metanoia Research Ethics Committee

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