

III - Letter of different concepts

Who or what is the gingerbread man?

Dear reader



“Run - run as fast as you can, you can’t catch me, I am the gingerbread man!”

An old nursery rhyme

In this letter obesity is equated to the gingerbread man that is presumably running from someone that can not seem to catch him. An analogy is drawn between the gingerbread man and obesity. Contradictions and assumptions regarding psychological research surrounding obesity and the situation the gingerbread man is in at the moment are investigated in this letter. In search of the conceptualisation of what the research question is asking from literature, the starting point of the race from which women’s relationship with food in excess is captured, begins with certain concepts like obesity, fat women and self-esteem issues surrounding the label of obesity. There have been a large number of research studies on the subject of obesity. In a similar way the gingerbread man has been chased for as long as the nursery rhyme exists.

Rothblum (1999) encourages researchers to ask the following questions: How can psychology take the lead in effecting a paradigm shift about research on weight loss? How many published studies will it take before scientists take a stand that it has convincingly been demonstrated that most people don’t loose much weight and then regain some of this weight when treatment ends? These questions confirm my preliminary question; is weight-loss the only construct in obesity success stories or could there be other constructs? In a similar way, how many times are children taught that the gingerbread man is running all the time without considering any other possibilities? Wiggins, Potter and Wildsmith (2001) state that psychological research into eating practices has focused mainly on attitudes and behaviour towards food, and disorders of eating. Using experimental and questionnaire-based designs, these studies place an emphasis on individual consumption and cognitive appraisal, *overlooking the interactive context in which food is eaten.*

Obesity is not included in the current (fourth) edition of the Diagnostic and Statistical manual of Mental Disorders (American Psychiatric Association, 1994). According to Rothblum (1999) clinical psychologists have a major role in perpetuating errors and inconsistencies related to body weight. As practitioners, they see clients who come to therapy for weight-loss (and eating disorders). As clinical researchers, they study dieting and factors that contribute to weight-loss. As educators in clinical psychology training programs (and related courses in undergraduate psychology programs), they include the topic of obesity, and textbooks reflect this coverage. And the general media interview clinical psychologists when breakthroughs happen in this field, such as the news about identifying the obesity gene in laboratory animals (Rothblum, 1999). When we say obesity, what is it we are describing? For some it could be an explanation of their eating behaviour, for others it could be a label of some sorts.

How is obesity defined according to several experts on the subject?

DiGirolamo, Harp and Stevens (2000) note that obesity has been known to exist for many thousands of years. Obesity is the most common nutritional disorder of recent years in Western societies (Concise Medical Dictionary, 1998). Seidell (1997) states that the estimation of world prevalence of obesity reveals that as many as one billion people are overweight. As a matter of fact obesity seems to be a worldwide problem, especially in South Africa (Schoeman, 1993). DiGirolamo et al. (2000) comment that it seems almost paradoxical that, in the time in history when efforts are made to reduce famine and its consequences worldwide, major health risks are uncovered in the Western world and in some third world countries, that are linked to unlimited food availability, excessive food ingestion, and enhanced fat accumulation in the body. Friedman (1999) states that a wealth of evidence points to the fact that in Westernised countries people suffer from obesity, whereby individually people get fatter as they get older, and collectively the population grows fatter year after year.

Ibson, Crystal and Wells (1987) state that the Latin word for obese is “obesus” which means grown fat by eating, from the past participle of “obedere” that means to eat away. The Concise Medical Dictionary (1998) describes obesity as the condition in which excess fat has accumulated in the body, mostly in the subcutaneous tissues. Obesity is usually considered to be present when a person is 20% above the recommended weight for his/her height and build. The accumulation of fat is usually caused by the consumption of more food than is required for producing enough energy for daily activities. However, recent evidence indicates that a genetic element is involved. Hunger and

satiety appear to be controlled by peptide messengers, encoded by specific genes and acting on the brain (Concise Medical Dictionary, 1998).

According to Schoeman (1993) the diagnosis of obesity is trivial, and is often labelled morbid obesity. Hyper obesity – often called morbid obesity – is defined as being ≥ 100 pounds or (45kg) above ideal body weight (Chandarana, Holiday, Conlon & Deslippe, 1988; Weiss, 1984). There are also two types of obesities, hypercellular obesity refers to grossly obese people due to an abnormal amount of fat cells, while hypertrophic obesity involves enlargement of adipose tissue cells with lipid during adult years and pregnancy (Bray, 1989; Hirsch, Fried, Edens & Liebel, 1989; Björntorp, 1984).

Obesity is seen as a medical problem, as an illness and can be the cause of other diseases. Extreme or morbid obesity is a serious health risk associated with increased mortality and morbidity for several diseases, including coronary artery disease, hypertension, Type-II diabetes, hyperlipidaemia and joint problems (Manson, Colditz, Stampfer, Willet, Rosner, Monson, Speizer & Hennekens, 1990; Must, Jacques, Dallal, Bajema & Dietz, 1992; Gortmaker, Must, Perrin, Sobol & Dietz, 1993). Obesity is linked with an increased incidence of certain types of cancer and musculoskeletal disorders (Van Itallie, 1985; Visscher & Seidell, 2001). Obesity, insulin resistance and diabetes are reaching epidemic proportions (Seidell, 1997).

According to Bosman, Van der Merwe and Hiemstra (1984) illness is defined or labelled as a disorder, affection, disease or ill health. Bosman et al (1984) describe disorder as a person being mentally disturbed or deranged. Anderson and Goolishian (1988) say however, they find that labelling is always a dangerous process, because it connotes problems as fixed or invariant. On the contrary, they believe that systems are fluid, always in change, never stable, and finite. That is, the membership of a system should not be thought of as fixed; as the problem definition changes, so can the membership. For example in this study labels like obesity, fat women and self-esteem issues surrounding the label of obesity are not fixed and could change or evolve during the process of writing this thesis.

Furthermore, being labelled with a mental disorder could have stigmatisation attached to it. Literature conveys that stigma produces prejudice and discrimination (Drury & Louis, 2002). Most people who have a condition that is stigmatised take pains to avoid situations in which they are stigmatised (Hughes & Degher, 1993; Myers & Rosen, 1999). Studies suggest that an obese woman may delay or avoid health care if she feels her health care provider holds a bias against or

berates her because of her weight (Olsen, Schumaker & Yawn, 1994; Packer, 1990). Rodin, Silberstein and Striegelmoore (1984) argue that in our society obesity is met with punishment – psychological, social and economic – and the sanctions appear to be more severe for females than for males. Surely one root of women’s fear of overweight lies in the harsh negative views of society toward obesity – particularly toward obesity in women. According to Molinari and Riva (1995), obese persons may experience emotional distress on encountering the negative feelings of society and can internalise these, modifying their self-images. The question arises, is it possible that stigmatisation of obesity as an unhealthy medical condition, limits health professionals to run after the gingerbread man? Hereby meaning that more holistic ways of helping women with their relationship with food in excess could possibly be explored when health professionals and, in particular psychologists, start investigating the concept of obesity in a narrative therapeutic way within a post-modern context.

Here follows a further description from existing literature on the subject of the origins and nature and relevant aspects regarding obesity.

What are the origins, nature and relevant aspects regarding obesity?

How could we describe the gingerbread man? Similarly, what does a literary overview portray as the etiology of obesity? DiGirolamo et al. (2000) argues that although many strides have been made in understanding the regulation of food intake and utilisation, and in the treatment of obesity, considerably less is known about the etiology and pathogenesis of most cases of obesity. Many classification criteria have been proposed, but there continues to be no consensus reached regarding the best etiological classification for obesity (DiGirolamo et al., 2000).

Friedman (1999) notes that obesity is clearly determined by a great number of factors, other than food intake alone, whereby complex interaction among genetic, physiological and behavioural variables affects both the development and maintenance of the obese condition. In addition, the particular way in which these factors determine the effects of food differs from individual to individual. This statement of Friedman stimulates the question: What is the reason for the gingerbread man to run? In a similar way, what is the reason for a body of literature to describe certain women as being obese or fat? An ongoing debate about the causes and factors surrounding obesity varies from psychodynamic concepts, the regulating of anxiety and dependency on external cues, as well as psychological based arguments and arguments that view socio-cultural factors as part of the development of obesity (Gous, 1995).

The focus of the present study will be on physiological, psychological and socio-cultural factors in the development of obesity.

What are the physiological factors regarding obesity?

Genetic predisposition

Chagnon, Pérusse and Bouchard (2000) state, that the field of the genetic and molecular basis of human obesity is currently receiving a lot of attention from both the research community and the general public. Much of the recent progress has occurred in the identification of new genes and molecules that are involved in the regulation of the energy balance, which may play a role in the obesity phenotype expression. These studies were initiated after it was observed that there is a significant heritability level for human obesity (Chagnon et al., 2000).

The most significant advances in the last few years have been the cloning of the genes that are responsible for obesity and co-morbidities in the single-gene rodent models of obesity. A new biochemical pathway, with a large spectrum of action, has been uncovered from the characterisation of leptin (Chagnon et al., 2000). The Leptin protein is highly similar among species, with 83-84% similarity between rodents and humans (Zhang, Proenca, Maffel, Barone, Leopold, Friedman, 1994; Ogawa, Masuzaki, Isse et al., 1995). Serum Leptin is secreted by the adipose tissue and is highly correlated with fat mass, but also with other adiposity variables such as body mass index (BMI) and percent body fat (%fat) (Rosenbaum, Nicolson, Hirsch et al., 1996; Hickey, Israel, Gardiner et al., 1996). Leptin has also been shown to be synthesised in placenta from pregnant women. There is a gender effect: all the body fat values of women are two to three times higher than those of men (see Considine & Caro, 1997), probably because of the influence of sex steroids such as estrogens, progesterone and androgens (Rosenbaum et al., 1996).

Chagnon et al. (2000) summarises that the identification, in humans, of mutations in two of the genes, Leptin (LEP) and Leptin-Receptor (LEPR) gene, and in the melanocortin receptor 4 gene, represents the first direct evidence of the involvement of genes in human obesity. The results of the two genome-wide scan efforts that have been published so far are disappointing in that they have yielded relatively few new candidate chromosomal regions or candidate genes for the genetic basis of adiposity and obesity in humans. Other scans on different human populations and the cloning of the genes responsible for the quantitative trait loci observed in multigenic animal models of obesity will uncover additional and more promising candidate genes that will contribute to the ongoing

efforts to identify the genetic and molecular basis of the common forms of human obesity (Chagnon et al., 2000).

Stunkard (1993) describes how genetic factors do influence human obesity. Risch (1990) states that the risk of becoming obese when a first degree relative is overweight or obese can be quantified with a statistical value called the lambda coefficient (λ_s) which is defined as the ratio of the risk of being obese when a biological relative is obese compared to the risk in the population at large, regarding the relevance of obesity. Stunkard (1993) highlights a series of family studies that has firmly established the familial nature of human obesity. However, family members share environments as well as genes, and family studies by themselves cannot distinguish between the contributions of these two kinds of influences. An alternative view is that the increases in obesity seen in many Western countries over the past few decades are not reflective of genetic changes but of gene expression, facilitated by the environment (Wardle, 1996). According to Wardle (1996) comparison of twins reared together with twins reared apart also shows how little a shared upbringing contributes to similarity in body size. Most evidence point to environmental effects contributing about one third of the variation in body size in 20th century Western environments.

The most widely held view is that genes confer a susceptibility or predisposition to obesity and genetically predisposed individuals may be especially susceptible to aspects of lifestyle such as low activity and high fat diets, and gain weight more readily (Wardle, 1996). According to Friedman (1999) myths regarding treatment implications of the genetic predisposition must be dispelled, of which one is the idea that obesity is inevitable. Predisposed individuals probably cannot get away with the lifestyle of those without such a predisposition and may find weight-loss harder, but it is not impossible. Similarly, the offspring of the gingerbread man could have a ginger trait or gene, but they don't necessarily have to run or be caught by someone else to be called gingerbread men or women.

Developmental factors

For women, the central event for the development of obesity is pregnancy (Bray, 1989). A woman who becomes pregnant will be several kilograms heavier, two years after the pregnancy than a woman who was not pregnant. The optimal weight gain for pregnant women during pregnancy is 10-12kg. As the body weight increases, the optimal weight gain to minimise fetal loss declines; for women who are more than 50kg above desirable weight, a weight gain of 6 to 8 kg is optimal for fetal survival.

Furthermore, Bray (1989) notes that obesity can begin at any age. During the first year of life, the size of fat cells increases nearly twofold, but there is no measurable increase in the fat cells (Bray, 1989; Gray, 1989). When obesity appears in the age group (4 to 11 years), there can be a progressive deviation of body weight from the upper limits of normal for height and age; this may be called progressive obesity. This obesity is usually life long and is associated with an increase in the number of fat cells. Hypercellular obesity appears along with the onset of menstruation, which usually occurs at an earlier age in obese girls (Schoeman, 1993). Bray (1989) has found that obesity mostly develops after the end of puberty. Estimates from several sources have suggested that less than one third of obese adults were obese in childhood. Thus children who were lean throughout development can become obese in late adolescence or adulthood if they remain in positive energy balance for sufficient periods (Epstein, 1993).

Blackburn and Kanders (1994) conclude that when obesity does develop in individuals below 35 or 40 years of age, it seems to be fraught with greater health risks than when it begins in life. Epstein (1993) concludes that obesity is a developmental disorder. The relative risk of obesity increases with the age of the child, suggesting that the older an obese child, the more likely he/she will become an obese adult. Wadden and Foster (1992) argue that one obvious consequence is that at the same age, obese adults who were also obese as children will have been obese longer, which may have implications for disease and treatment. With regards to the stigmatising effects of labelling, the description of obesity as a developmental disorder could imply that if an individual has the disorder as a child and does not shake it by puberty, an individual will be obese for life even if he/she undergoes treatment. In a narrative therapeutic setting the aim would be to highlight times in an individual woman's life where she did not think of herself as fat or obese, while growing into an adult or times where she could stand up against labels in any preferred way. In this way the women are given a choice to practise the preferred stories against the label of obesity as a developmental disorder. Similarly, the gingerbread man could start realising different attributes he has and start questioning the label of being a man rather than a woman disguised as a man or the label of being made out of gingerbread.

Physical inactivity

Historically, physical inactivity has been seen as playing a major role in the development of obesity, thus obesity developed due to decreased activity, rather than overeating (Johnson, Burke & Mayer, 1956; Rose & Mayer, 1968). Other investigators fuelled the controversy by also suggesting that obese persons did not eat more than non-obese persons, again suggesting that people become obese

as a result of inactivity (Corbin & Fletcher, 1968; Wilkinson, Parken, Pearlson, Strong & Sykes, 1977). Epstein (1993) argues that there is a methodological flaw in concluding that obese children burn fewer calories than non-obese children on the basis of lower activity levels and that these lower activity levels contribute to the development of obesity. Activity measures do not measure caloric expenditure and it must be taken into account that expenditure depends upon both activity and body weight.

The potential role of inactivity in the development of obesity has been revitalised by Dietz and Gortmaker (1985). They showed that television watching, a major source of inactivity in children's lives, was positively associated with obesity. The more television a child watched, the more obese he/she was. Epstein (1993) notes the underlying assumption of the television watching analysis, that excess television watching or engagement in other sedentary activities precludes time spent being more active, such that excess sedentary behaviour becomes a marker for inactivity and a risk factor for obesity. Another example of a sedentary activity is children playing computer games and working on the computer for many hours on end. According to Epstein, Smith, Vara and Rodefer (1991) the observation that obese children are more likely to choose sedentary activities than non-obese children has been replicated in laboratory settings using behavioural economic analyses of choice. Nevertheless, several studies have shown that sedentary individuals are heavier than those who are physically active (Bouchard, Depres et al., 1993; Gortmaker & Dietz, 1990). Very physically active individuals are rarely obese (Williams, 1997). In a narrative therapeutic setting, highlighting sedentary versus physical activities in the participants lives, could give a fuller description of choices they have to partake more in physical activities as to increase their preferred healthy lifestyle. In a similar way the gingerbread man could start running with a specific destination in mind.

Eating style

The stereotype image of the obese person as a glutton who constantly eats with abandon has been repeatedly reinforced by the media (Friedman, 1999). DiGirolamo et al. (2000) describes the underlying cause of obesity in the majority of patients as being one of excess energy intake, inadequate energy expenditure, or a combination of both. Mahan and Arlin (1992) argue that overweight is only partly caused by overeating. Zdrodowski's (1996) notes how the eating behaviour of women classed as overweight is always accounted for in terms of their size. If they ate a lot they were greedy and so it was no surprise that they were fat. Conversely, though, if they ate only a little, it was because they were on a diet – due to their size. Research of this topic is

plagued by poor methodology to measure food intake, because of the tendency of obese individuals to under-report their food intake (Schoeller, 1995) and that only small deviations in energy balance sustained over time are necessary to produce large difference in body weight in the long term (Seidell & Flegal, 1997).

In literature there are controversial debates with regard to the effect of dietary fat on caloric intake and body weight (Popkin, 1998; Willet, 1998). There is evidence to indicate that subjects tend to consume more calories when the diet is higher in fat and this can result in heavier body weights. Nevertheless, many of the long term studies that show associations between fat intake and body weight are confounded by differences in economic development and physical activity level (DiGirolamo et al., 2000). In relation to the life world of an obese person, possible binge-eating episodes, on a daily and weekly basis as well as constantly being on diets could be an integral part of the eating style or pattern. It is difficult to define what constitutes an eating binge, but two proposed criteria provide a reasonable first approximation. They are eating more food in a discrete period of time than most people would eat, combined with a reported lack of control during the binge. Whatever refinements in the diagnosis may occur in the future, the definition of binge eating disorder has had the valuable result of characterising a group of distinctively different obese persons (Wadden & Stunkard, 1993).

Nauta, Hospers and Jansen (2001) note that several researchers have found that dieting itself has negative effects as well. Frequent dieting might be associated with increased cardiovascular and all-cause mortality (Blair, Shaten, Brownell, Collins & Lissner, 1993; Lissner, Odell, D'Agostino, Stokes, Kreger, Belanger, & Brownell, 1991), that results in pathological changes in cognition and affect (Brownell & Rodin, 1994; Foreyt, Brunner, Goodrick, Cutter, Brownell, & Jeor, 1995; Friedman & Brownell, 1995; Polivy & Herman, 1992). The literature is inconclusive as to the causal role that dieting plays in the development of binge eating in obese people (Howard & Porzelius, 1999). However, in a study of Telch and Agras (1993), it was found that caloric restriction leads to binge-eating episodes in obese people.

In the eating style context, the gingerbread man analogy could simply be deconstructed in changing the running verb with eating as verb and the catch verb with swallow as verb, thus “eat, eat as fast as you can you cannot swallow me I am the gingerbread man”. Similarly, the above research highlights important trends, but fails to explore women’s relationships with food in excess; especially the when, what, how and how much food intake and the function of the eating process for an individual woman. In White’s (2002) South African study, a group of matric girls made lists of

reasons why people might decide to eat as follows: for comfort, for fun, for company, for a healthy diet, for energy, because they were lonely, feeling bored, to try things they saw advertised, to punish critics, because they are angry, to please other people, to celebrate, to show appreciation, to show love, to spite someone who has criticised them, to show someone they cannot control them. White (2002) continues by saying that results in obesity and is by itself not generally considered to be an emotional illness, but when everything is considered the sufferer almost always finds a lot of feelings mixed up in his or her reasons for eating too much. The question remains as to the psychological factors regarding obesity?

What are the psychological factors regarding obesity?

Rodin, Silberstein and Striegel-Moore (1988) suggest that while daily conversations and popular press clearly indicate the importance of weight in women's lives, psychological research has largely neglected the issue. For many years obesity was ascribed to psychopathological determinants, such as low frustration tolerance and lack of will-power (Stunkard & Wadden, 1993; Wadden & Stunkard, 1985). However, further research has changed our understanding of obesity, and psychopathology is now seen more as a consequence, rather than a cause, of obesity (Rand & Macgregor, 1990).

Consequently, the concept of psychological distress requires clarification. Obesity has consequences for physical morbidity via different physical complications and diseases, and so do psychological morbidity, therefore it is not a unitary concept. Common place assumptions of psychological distress and of the contribution of psychological factors to the state of obesity are not supported by consistent research evidence (Friedman & Brownell, 1995). In this study the following psychological factors are discussed, namely: psychological disturbance, intrapsychic- and interpersonal factors.

Psychological disturbance specific to the obese

Although weight dissatisfaction is common among adolescent girls so as to approach a normative discontent (Rodin et al., 1984), it is more severe in obese girls. With the problem of body-image disparagement, many obese feel that their bodies are ugly and despicable and that others view them with hostility and contempt (Stunkard & Mendelson, 1961). Body-image disturbance is the mental picture that an individual has of his/her physical appearance (Gardner, Morell, Urrutia & Espinoza, 1989). Freedman (1988) states that body-image consists of the following aspects: visual, cognitive,

emotional, kinaesthetic, historical and more especially a social aspect; therefore an obese person sees herself as she thinks others see her. There is a general consensus in literature that obese persons have a disturbance in their accuracy regarding their body size. They often block their own reactions towards their own body-image, inner needs and feelings (Gous, 1995). The perception of women regarding their body-image and especially their weight is a highly emotional issue. Stunkard and Mendelson (1961) further say that it makes no difference whether the obese is also talented, wealthy or intelligent; their weight is their only concern, and they see the whole world in terms of their weight.

The obese have disturbances in self-evaluation also; therefore feelings of guilt and shame over their inability to control their weight are likely to diminish their self-esteem in some areas of functioning (Wadden & Foster, 1992). From adolescent to womanhood it seems that the obese experience a sense of personal ineffectiveness that is intricately tied in with their own distorted evaluations of self and personal standards, including, but not limited to, distorted evaluations of physical body. Related to this, one would expect that sense of personal effectiveness is less related to generalise expectations. These expectations concern one's control over reinforcements and are conceptually associated with self-concept and ego-strength, especially as defined by subjective perceptions of what one is vis-à-vis what one believes to be the ideal standards (Woods & Heretick, 1983-1984).

Within a feminist theoretical framework the feminine body is constructed as an object to be looked at (McKinley & Hyde, 1996) and because of this construction; women learn to view their bodies as if they are outside observers. They internalise cultural body standards so that the standards appear to originate from the self and believe that achieving these standards is possible, even in the face of considerable evidence to the contrary. This experience of the body as an object and the beliefs that support this experience is called objectified body consciousness (McKinley & Hyde, 1996). The gingerbread man analogy could be that the female gender of the gingerbread man is observing herself as being unacceptable, without considering others positive feedback and therefore she continues to run.

Intrapsychic factors

Here follows some intrapsychic factors from literature as a possible cause or consequence of obesity:

- *Depression*: Low self-esteem, social avoidance and body-image dissatisfaction may need to be included alongside clinical states of depression and anxiety, as significant symptoms of psychological distress (Hill & Williams 1998). According to Smith and Petty (1995) a

variety of behaviours have been associated with mood regulation, one example being overeating (Frost, Goolkasian, Ely & Blanchard, 1982).

- *Anger and frustration*: As stated above the emotion of anger and feelings of frustration with regards to an obese women's dependence upon people or situations are replaced with feelings of hunger (Gross, 1983).
- *Anxiety*: Wise (1981) explains that the eating situation is filled with tension and anxiety. The act of overeating helps to relieve the person of his/her tension and anxiety.
- *Self-nurturing*: Obese people often feel that some types of food or all types of food have the power over them and can force them to overeat, even though rationally they do not want to. Wise (1981) further suggests that when a child experiences a lack of nurturing from the mother figure, the child could start overeating to nurture him or herself.
- *Locus of control*: Obese women are more prone to have an external locus of control, possibly because they feel that they have less personal control over their social environment and over their impulses and desires (Rodin, Schank & Striegel-Moore, 1989). Rotter (1975) distinguishes between an internal or external locus of control. In the first case, individuals believe that they are personally responsible for and in control of the choices they make in different circumstances. In the second case, individuals believe that external forces or circumstances are to blame or as the saying goes "it is out of my control, so I can't help it, whatever will happen, will happen". However, with relation to weight reduction, controversial findings have been reported. Some support the superior ability of internals to lose weight, while others found no difference between internals and externals, at least in the short term (Nir & Neuman, 1995). Friedman (1999) reasons that the obese state may be followed by an external locus of control orientation rather than precede it.
- *Gender role identity*: Roden et al. (1988) propose that maternal modelling of a highly appearance-invested mother or one who worries about, or disparages her own looks, may abet a daughter's development of disturbances in body-image and eating.

Interpersonal factors.

Here follows some interpersonal factors from literature as a possible cause or consequence of obesity:

- *Family dynamics*: Gous (1995) states that there is a minimal amount of literature available focussing on the family dynamics of obese persons. A possible reason for this according to Louw (1989) is that obesity is not necessarily related to specific pathology in a family. Although it is theorised that a focus on female appearance starts in childhood through

parental commentary and continues to impact a woman's body and psychological functioning in her adult life (Swartz, Phares, Tantleff-Dunn & Thompson, 1999).

- *Intimate relationships*: Gous (1995) states that obese persons may possibly lessen their activities, because of their fear of handling certain stressful situations. To become obese, could be a possible defence against their fear of sexual functioning or a fear to partake in intimate relationships with significant others.
- *Traumatic incidents*: It could be a cause of obesity (Gross, 1983). For example, an adult survivor of sexual abuse in childhood, where the woman has an unconscious need to be strong and large to protect herself, obesity is a means to an end in itself. Another example is the loss of a loved one at an early age, where obesity becomes a way of dealing with the grief the woman experiences at certain points in her life.

Furthermore, in search of different contexts in which obesity is placed, one of the salient concepts used in literature studies with regards to obesity are women's self-esteem issues.

How are self-esteem issues regarding obesity defined according to several experts on the subject?

The question arises as to the origin of the word self-esteem. Let us start with self as the base word in self-esteem. Many psychologists refer to William James (1890) when talking about self-components. The important issue is James's answer to the question, "What self is known?", and here we see that the self is easy to recognise; it consists of material components, others' evaluations, and inner psychological mechanisms. More than 100 years later Bruner and Kalmar (1998) describe self as being somewhat unstable over extended time – a fact that should not be overlooked. Autobiographies are typically full of turning points featuring presumably profound changes in selfhood. Our fixed identity in the eyes of the law is not matched psychologically by the subjective twists and turns in our self-conceptions, perhaps the more so under conditions of rapid cultural change (Lifton, 1993).

Within a post-modern context self grows in an environment of its own making. The events and circumstances that shape it are themselves constructed, products of self-generated meaning making shaped to fit our growing conceptions of selves (Bruner & Kalmar, 1998). The events we encounter are coded and filtered at the very entry port by our perception of the world (Bruner, 1973, 1992; Neisser, 1988; Niedenthal & Kitayama, 1994). So while the experienced world may produce self, self also produces the experienced world, all of which suggests that the self is not only constructed,

but also that its mode of construction is massively hermeneutic. Perhaps it is this interpretive feature of self-construction that imposes certain conceptual structures upon self (Bruner & Kalmar, 1998). In this study the defining process of women's selves is co-constructed between the therapist and an individual woman. The subjective nature of conversations allows for unique constructions of selves, which in itself is possibly larger than the description given regarding an obese person or obesity. Within a post-modern context the assumption of human nature is that an individual has more stories than just an obese story and that the obese story could be part of the fuller description of the individual's self. Furthermore the combination of the words self plus esteem will be described according to experts on this subject.

Brown and Dutton (1995) address the fact that numerous theorists have attempted to define self-esteem. These attempts have ranged from an emphasis on primitive libidinal impulses (Kernberg, 1975) to feelings of existential security in a meaningful universe (Solomon, Greenberg & Pyszczynski, 1991). Brown and Dutton (1995) take a less exotic approach and define self-esteem in terms of feelings of affection for oneself, no different in kind than the feelings of affection one has for others. Brown (1996) questions the assumption made in research with regards to improvement of self-esteem (Mruk, 1995), that people's feelings about themselves depend on what they think about themselves, and that self-esteem can be improved by thinking you have many positive qualities. Brown (1996) argues that many people with low self-esteem believe they have many positive qualities, but they still do not feel good about themselves. In this study the therapeutic intervention – narrative conversations, include women's verbal accounts of their feelings and thoughts about themselves and others, as well as thoughts and feelings of affection. Rather than separating these two levels of self-affection, thoughts and feelings could have an effect or influence on each other at any given point in time and situation, thus being interwoven with one another. Furthermore, negative feelings do not necessarily cause negative thoughts and visa versus. The same could be said for positive thoughts and feelings. Supporting research regarding the interplay between affective and cognitive processes has been done (see, Erber & Tesser, 1992; Parrott & Sabini, 1990; Petty, Schumann, Richman & Strathman, 1993; Smith & Shaffer, 1991).

Further Smelser (1989) identifies the almost universally accepted components of the concept of self-esteem as follows:

- There is first a cognitive element; self-esteem means characterising some parts of the self in descriptive terms; power, confidence, agency. It means asking what kind of person one is.
- Second, there is an affective element, a valence of degree of positiveness or negativeness attached to those faces identified; we call this high or low self-esteem.

- Third, and related to the second, there is an evaluative element, an attribution of some level of worthiness according to some ideally held standard.

Within normal populations, high self-esteem is characterised by general fondness for oneself; low self-esteem is characterised by mildly positive or ambivalent feelings toward oneself rather than excessively negative feelings toward oneself (Baumeister, Tice & Hutton, 1989). According to Abell and Richards (1996), researchers have begun to look at the specific issue of thinness versus fatness, and at how satisfaction with the shape of one's body can affect self-esteem. This has been a particularly salient aspect of body-image for psychologists to investigate, since our society has often been described as one that is obsessed with the issues of weight and body shape (Faust, 1982; Mintz & Betz, 1988). In general, researchers have found that women who express greater dissatisfaction with their weight and body shape tend to have lower self-esteem scores than women who have a healthier body-image. This difference tends to be true for pre-pubescent girls (Fabian & Thompson, 1989; Mendelson & White, 1982, 1985), for adolescent females (Fabian & Thompson, 1989; Martin, Housley, McCoy, & Greenhouse, 1988), and for adult females (Mintz & Betz, 1988; Thomas, 1989). A woman's feelings about her weight may be a particularly crucial aspect of her body-image (Abell & Richards, 1996).

Body-image may be understood as a multidimensional self-attitude toward one's body, particularly its appearance (Muth & Cash, 1997). Body-image is associated with how people think, feel and behave with regard to their own physical attributes (Rosenblum & Lewis, 1999). Across the life span, body-image can be seen as a vital aspect of self-worth and mental health (Potash, 2002). Potash (2002) notes that body-image undergoes change during adolescence. The combination of adolescents' changing physical appearance, their increasing cognitive abilities, and their capacity for introspection may render them particularly vulnerable to excessive and negative preoccupation with their own and others' perceptions of their bodies (Rosenblum et al., 1999). Body-image lies at the heart of adolescence as it is an important part of identity development, particularly at the stage of adolescence when accommodation to pubertal change is a key developmental task (Ferron, 1997).

Molinari and Riva (1995) further state that obese women feel themselves socially undesirable and consider obesity as a largely negative condition. An obese person was described as heavy, slow, unhappy, unlikeable, crude, nervous, tense, introverted, stupid, pessimistic, fearful, weak, indolent, insecure, static, passive and inconsistent. Obese people are typically characterised as physically unattractive, flawed in character and personally responsible for their overweight condition (Lewis,

Cash, Jacobi & Bubb-Lewis, 1997). Furthermore they are commonly described as lazy, ugly, stupid, lacking will power, incompetent and indulgent (Richardson, 1971; Larkin & Pines, 1979). The consequences of such stereotypes have been shown in many studies. For example, some results showed that obese people are less likely to be hired for jobs or positively evaluated compared to non-obese candidates (Rothblum, Miller & Carbutt, 1988; Jasper & Klassen, 1990), obese people were less likely to receive a service, help or advice than their non-obese counterparts (Steinberg & Birk, 1983; Pauly, 1988).

Existing self-esteem literature supports the proposition that people low in self-esteem are generally more dependent on and more susceptible to external cues that carry self-relevant implications (Campbell & Lavalley, 1993). Of particular relevance is the research that has examined self-esteem differences in reactions to self-relevant feedback or information (Jones, 1973; Shrauger, 1975; Swann, Pelham & Krull, 1989). Campbell and Lavalley (1993) propose that low self-esteem people tend to be more threatened by negative feedback and more gratified by positive feedback and that such individuals are more reactive to their social environment. Drury and Louis (2002) balance the literature proposing that obese people have low self-esteem by stating that the obese are not a homogenous group. Although body-image dissatisfaction is correlated with Body Mass Index (BMI) (Hill & Williams, 1998; Sarwer, Wadden & Foster, 1998), low self-esteem is not always the inevitable result. Obese women who reject the cultural standard of thinness equalling beauty report higher levels of self-esteem and self-confidence (Fuller & Groce, 1991; Packer, 1990). However, both groups of obese women – those with low self-esteem and those with high self-esteem – have been found to delay or avoid health care (Packer, 1990).

Within a narrative therapeutic framework, women having a high or low self-esteem have choices in any given social environment and their choices have certain consequences. According to Phillips (2001) the powerhouse in any story is the will of the characters to get or do what matters to them. So they need to know what matters; it needs to matter enough that they are prepared to work for it, and they need to understand what it would take to get what they want. In this study the aim is to allow a space where women become aware of their choices regarding a low or a high self-esteem which could have an effect on their self-awareness as individuals, thus knowing oneself and exploring one's own feelings and thinking about oneself.

Conceptualising the concept of self-awareness follows. Self-awareness is internally focused attention and may increase the accessibility of one's general self-schema or self-concept, which in turn can influence collecting and processing self-relevant information (Carver & Scheier, 1981;

Carver, Lawrence & Scheier, 1996). According to Natsoulas (1998) a person's self-awareness must take place in any instance of consciousness that is based on evidence from the past. Natsoulas (1998) describes several kinds of self-awareness as follows and states that one cannot be conscious in their absence:

- Self-witnessing is the relevant outcome to which factors like one's intellectual, moral, or religious powers, abilities, traits, dispositions or tendencies as well as spiritual, social and material facts about oneself, may have contributed, such as a habitual way of thinking about the world or treating other people.
- Appropriation to oneself is to be not only aware firsthand of the particular piece of one's behaviour or segment of one's stream of consciousness that would serve as evidence, but also to be aware of that piece or segment as being one's own.
- 'Retrowareness' of oneself involves concurrent awareness, now, of a past happening or state of affairs.
- Inner awareness is the act of remembering something in particular. One must be concurrently aware now of oneself as now apprehending that which one had earlier apprehended.
- With consciousness extended backward, a present 'retrowareness' of one's past experiences occurs. Past experience meaning, for example, one perceiving, emoting over, particular that was taking place, had taken place, or was going to take place.
- One must have thoughts regarding one or more characteristics that may belong to the intellectual, moral, or religious dimensions of one's personality, and one must make judgments regarding how the remembered evidence bears on whether those characteristics do so belong.

Following the analogy of the gingerbread man; are the ginger bread man and the obese women being self-aware and if so what are they aware of themselves? The assumption in this study is that women's obese story is possibly the story that overshadows women's thoughts and feelings about themselves. Bruch (1962, 1969) states that obese patients fail to discover or tend to block their awareness of impulses, feelings and needs that originate within themselves. The failure to respond to external and inner cues is the central core of their psychopathology. The inability of obese patients to respond to their body-image, inner needs, impulses and feelings stems from their tendency to block them. The obese patients substitute feelings of anger or frustration or dependency needs for feelings of hunger. They tend to distort their own body-image by changing the visual stimuli from their own bodies (Gross, 1983). Alternatively, Phillips (2001) notes with regards to self-awareness that if you are more aware of where you're reasoning comes from, you

become more aware of how important it is to your thinking in the future. It allows you to see what impacts on you and what you may have missed. In the narrative therapeutic context of this study, women in relationships with food in excess could become self-aware or more self-aware in the process of the therapeutic conversation and this is part of their realisation of preferred narratives they could choose to live by. Therefore self-awareness is an important ingredient in finding new-old stories in a person's past which could be relevant in one's future becoming the preferred narrative for one to live by.

From above mentioned literature, the conclusion could be drawn that obese patients are depicted, at a self-awareness level, as being pathological in nature, thus being branded with a label that they cannot be self-aware like normal people. Brown (1993) is of the opinion that the definitions of obesity and overweight have been the subject of substantial medical debate, in part because they must be based upon inferred definitions of normality or ideal body proportions. Further Brown (1993) states, that cultural beliefs define what is normal and therefore constrain the choices of behaviours available to an individual. In this study, within a narrative therapeutic framework, women in the obese category could become self-aware or more self-aware during questioning of the discourses in their obese story. The aim of facilitating self-awareness is for the purpose of collecting and processing self-relevant information for a fuller description of an individual woman's life world of obesity and beyond.

After exploring self-esteem issues surrounding obesity as a starting point for a fuller description of the context in which obesity is researched in this study, there follows a description of the socio-cultural context in which the gingerbread man or obese person is running.

The socio-cultural context regarding obesity

Is the socio-cultural context with regards to obesity and the gingerbread man a marathon, a chase or a quest or something else and for what reason? Here follows some socio-cultural factors:

Cultural factors

Cultural stories determine the dimensions that organise people's experience (Zimmerman & Dickerson, 1994). Cultural stories are not neutral (Bruner, 1990). They lead to constructions of a normative view, generally reflecting the dominant culture's specifications, from which people know themselves and against which people compare themselves (Zimmerman & Dickerson, 1994).

Culture refers to the learned patterns of behaviour and belief characteristics of a social group. A cultural system of thought and behaviour may be shared by an isolated tribe or in a complex society, an ethnic group or social class. Culture includes directly observable material aspects, like diet or productive economy, as well as important ideological components, such as aesthetic standards of ideal body type; the relationship of the material aspects of culture to the etiology of obesity may be directly demonstrated while the relationship of ideological components and obesity remains more speculative (Brown, 1993).

While cultural influences may be less important than genes in a statistical sense, they are more important in terms of the treatment and prevention of obesity. This reason is simply that cultural predispositions to obesity are changeable. A culture is an integrated system, so that a change in one part causes changes on the other levels (Brown, 1993). In fact, culture is the primary reason for the evolutionary success of humans because of its distinct advantages of greater speed and flexibility over genetic evolution (Brown, 1986). Braten (1984) defines a socio-cultural system as a “meaning-processing system of interacting participants who maintain and transform the identity of themselves and of their network through a more or less shared understanding of both themselves and the world” (p. 193). He further states that this shared understanding is neither subjective nor objective, but that it is intersubjective, generating the subject complementarity.

According to Sarlio-Lahteenkorva, Stunkard and Rissanen (1995), of all conditions for which a person may be stigmatised in our culture, the stigma of overweight may be the most debilitating. Research in obesity demonstrates that there is a widespread, culturally acceptable stereotype and negative attitude of obese people (Jasper & Klassen, 1990; Lewis et al., 1997). These stereotypes may stimulate prejudices and poorer treatment of obese people (Jasper & Klassen, 1990), thereby potentially limiting their social and economic success. Since obesity is immediately visible to others, it can affect most social interactions. The stigma of overweight has two aspects: stigmatisation of appearance of the body and the stigmatisation of the character of the person for the moral failure of not controlling one’s weight. Fatness is symbolically linked to psychological dimensions such as self-worth and sexuality in many societies in the world; but the nature of the symbolic association is not constant (Brown, 1993). Friedman (1999) states that cultural artefacts are clearly constructed with the thin person in mind, narrow supermarket aisles and seats in buses, planes and theatres are all designed to accommodate the thin person. Restaurant booths, telephone booths and conventional furniture all tend to pose difficulties for the obese members of society, potentially denying them from full participation in the culture. English (1993) highlights the fact that obese people are culturally isolated in subtle and not so subtle ways.

South Africa is a mixture of cultures pertaining to traditional and developed societies within a multi-cultural context. In the context of this study the participants are women, from a traditional and developed white, Afrikaans speaking society. According to Dollan (1991) white women are under cultural pressure to value thinness and thus to diet for the sake of appearance (Melnik & Weinstein, 1994). Senekal, Steyn, Mashego and Nel (2001) conclude that their research results indicate that the weight pattern of black South African students follows the pattern found in black American females, while whites in this country follow the pattern of white westernised groups. In America, in traditional societies in which women attain status primarily through motherhood, the symbolic association increases the cultural acceptability of obesity. A fat woman, symbolically, is well taken care of, and she in turn takes good care of her children. The cultural ideal of thinness in developed societies, in contrast, is found in societies in which motherhood is not the primary means of status attainment for women (Brown, 1993). In this study the participants are a mixture of both abovementioned symbolic associations, thus being career women and caregivers at the same time. In a narrative therapeutic framework, women's feelings and thoughts could be explored regarding their possible mixed symbolic associations of what makes a culturally perceived good enough or healthy woman.

Societal expectations

Despite societal expectations of slimness, the prevalence of obesity is increasing (Kuczmarski, Flegal, Campbell & Johnson, 1994; Lyznicki, Young, Riggs & Davis, 2001). Freedman (1988) refers to the social norms that are neurotic in nature and they set impossible standards for female beauty, resulting in body-image disturbance and the destruction of women's self-worth. During the 20th century, the ideals of beauty for women, and to a lesser extent for men, have increasingly emphasised slimness. The increasing discrepancy between actual versus desired body weights has led to normative discontent with weight among women and has promoted efforts to lose weight (Friedman, 1999).

Blackburn and Kanders (1994) state that in industrialised societies, social epidemiologists find that *fatness varies in relationship to many different roles*, including gender (women are fatter), life course position (fatness increases until people become elderly, then declines), ethnicity (African American women in the United States are fatter), socio-economic status (lower socio-economic status women are fatter), marriage (married men are fatter), parenthood (the more children a woman has the fatter she is) and residence (people living in rural areas are fatter). Concluding that specific mention of the female gender regarding obesity is more prevalent in literature than that of the male

gender. The question arises as to the power relations men, the media, and health businesses portray with regards to societal expectations of women forced to be thin in order to be regarded as beautiful.

Rothblum (1999) argues that the power relations at play are nested in the billions of dollars that are at stake and many companies would lose revenue or go bankrupt if women became satisfied with their bodies to the point of not joining health clubs, not undergoing plastic surgery, or wearing comfortable clothing that was unrelated to the annual changing fashion dictates. Furthermore, Rothblum (1999) predicts a rapid and vicious backlash on the part of the corporate sector and related institutions, such as the media and medical establishment. Rothblum proposes that the health professionals with specific mention of psychologists should predict this backlash. Questioning this situation would mean berating the intimate relationship between research and politics.

Could we be certain beyond a shadow of a doubt that the gingerbread man or obesity is who society, literature and media say he or it is? Could walking instead of running after the gingerbread man lead us to a slower search or lead us astray in trying to understand him or it? Thus, is it possible to approach the description of the concept of obesity differently than what the medical model has defined it to be? Could the deconstruction of the label of obesity lead health professionals and women to a fuller understanding of their experiences with food in excess? Consequently, could the treatment of obesity as literature depicts it lead health professionals on a different path of healing methods for women?

Treatment in reflection

Here follows a description of the concept of physical and psychological health regarding obesity:

The concept of physical health regarding obesity requires clarification

Rothblum (1999) states that obesity is usually presented as a condition that correlates with, or leads to, physical health problems, and this fact is sighted in many of the weight loss treatment studies as the reason for attempting to lower body weight. It is important to point out that the association between obesity and physical health problems is based on studies of obese and non-obese people, not on obese and formerly obese people.

In other words, the fact that thin people are healthier than fat people does not mean that formerly fat people (successful dieters) necessarily will also be healthier than fat people who have not dieted or who can not lose weight. For example, obesity and physical health risks may be due both to genetics, or to a third variable, so that changing one of these factors (weight) may not change the other (health) (Rothblum, 1999). Treatment, with the goal of a long-term successful outcome would be more complete once the psychological impact of obesity is understood and focused on (Friedman, 1999).

The concept of psychological health regarding obesity requires clarification

While the links between obesity and physical health problems are well established, the same is not true of those between obesity and psychological health (Hill & Williams, 1998). This apparent preservation of psychological health is all the more surprising given the stigma attached to obesity (DeJong & Kleck, 1986) and the measurable social and financial penalties of obesity (Gortmaker et al., 1993; Sargent & Blanchflower, 1994). The concepts of disease prevention, wellness, and health promotion are basic and common-sensical in theory, however in practice they are anything but basic or simple to enact. Barriers to health care utilisation exist and health care providers, including nurses, need to be aware of these barriers, particularly those associated with weight as overweight and obesity contribute to much morbidity (Drury & Louis, 2002). Psychologists also need to be aware of these barriers and they need to be part of a multi-disciplinary team effort in helping people who are struggling with overweight.

On an individual level self-esteem appears to be related to positive mental health or psychological well-being (Mruk, 1995). As Bednar, Wells and Peterson (1989) say, for instance, “It has been repeatedly demonstrated that self-esteem and psychological health are related to favourable psychological consequences in a variety of psychological situations” (p. 190). Colvin, Block and Funder (1995) note that traditional conceptions of mental health have held that well-adjusted people perceive relatively accurately the impact and ramifications of their social behaviour and possess generally valid information about the self. Therefore, it is not surprising that when individuals are asked to recall self-defining characteristics, mentally healthy people recall positive traits with greater ease and frequency than do people lacking in mental health (Kuiper & Derry, 1982; Kuiper & MacDonald, 1982). In a narrative therapeutic setting, being self-aware of one’s self-esteem could open up an understanding of the possible choices and consequences of those choices women have with regards to their relationship with food in excess or not in excess.

A holistic approach to the care being provided to the client should include a focus on health and well-being, not weight. This approach needs to encompass not only health outcomes, but also needs to take into account each individual's perspective on success, health status, weight history and goals related to appearance and body size, and that nurses must refuse to participate in cultural stereotypes related to fatness and challenge the sexist bias inherent in the cultural ideal for women's bodies (Allan, 1994). Culture is the key to prevention; the existing beliefs and practices of populations at greater risk for obesity must be understood if appropriate and effective health intervention is to be designed (Brown, 1993). Drury & Louis (2002) suggest that emphasis needs to be placed on evaluating and optimising life style patterns such as stress reduction, exercise and healthful eating habits.

An alternative exploration in a narrative therapeutic setting could be the deconstruction questioning process itself in search of treatment, intervention or conversations regarding obesity. According to the analogy, does the gingerbread man understand his quest? Could he be after happiness, health, quality of life or something else? What other possibilities are there? In a similar way, having narrative conversations and discovering new meanings, could open up alternative ways of treatment, rather than using a general set of symptoms and treatments clarified and categorised as in literature. For example, weight reduction can be approached as a partnership between the client and providers (multi-disciplinary team), rather than a directive such as weight-loss aimed at the client (Drury & Louis, 2002). Here narrative therapists/ psychologists could play a major role in helping the other health providers as members of a multi-disciplinary team and the clients in challenging cultural stereotypes related to fatness, finding discourses and new-old stories or alternative stories for individual and team success in treatment.

Concluding reflections

Upon reflection, a new phrase of this letter's nursery rhyme comes to mind: "*Eat, eat as slow as you can, then you will taste me, I am the gingerbread woman*". In explanation of this reflection, the *eating metaphor* in the label of obesity could be more appropriate than the running. Where as the *slow paced metaphor* allows for a slower pace where the narrative researcher-therapist in collaboration with the participant-women could explore their verbal meaningful accounts with regard to their relationships with food in excess. The *taste metaphor* could refer to an evaluative experience of how good or bad the gingerbread woman tastes or how destructive the label of obesity could be versus the deconstruction of the label of obesity in being constructive through the use of narrative conversations. The *gingerbread woman* metaphor could refer to the feministic viewpoint

of women being more obese than men and as stated that the specific mention of the female gender is more prevalent in literature than that of the male gender and the power relations this entails.

In conclusion, regarding the etiology of obesity the question remains; what makes this, already well-trodden subject important to research again? Stunkard's (1993) perspective is that at the present time, however, we know enough to help patients to a better understanding of their obesity. The information about the influence of genetic factors, for example, can help to relieve the shame and guilt that so many obese people feel about their weight, while the importance of environmental factors provides them with the hope that they may be able to control their weight. Once again this is the perspective of a professional or expert on obesity.

How does the gingerbread woman or obese person construct meaning to the description of the etiology of obesity? This study proposes in Letter of the research method–IV that women talking about their relationship with food in excess will give some understanding of what meanings they attach to their experiences and knowledge about obesity. A shift is made from the experts seen as the health professional's knowledge *to also incorporating the experiences and knowledge of so called obese women at grass roots level.*

With careful exploration

Co-author and researcher