

# Obesity: Open Access

Research Article

Volume: 3.2

Open Access

## Assessing Body-Centered Educational Approaches to the Management of Obesity

**Bertrand I<sup>1</sup>, Bois D<sup>1</sup>, Fédor MC<sup>2</sup>, Leyssene-Ouvrard C<sup>2</sup>, Miolanne M<sup>2</sup> and Boirie Y<sup>2,3,4</sup>**<sup>1</sup>CERAP, Universidade Fernando Pessoa, Sciences sociales Department, P-Porto, Portugal<sup>2</sup>CHU Clermont-Ferrand, Clinical Nutrition Department, Clermont-Ferrand, France<sup>3</sup>Clermont Université, Université d'Auvergne, Unité de Nutrition Humaine, Clermont-Ferrand, France<sup>4</sup>INRA, UNH, CRNH Auvergne, Clermont-Ferrand, France**Corresponding author:** Isabelle Bertrand, CERAP, Universidade Fernando Pessoa, Sciences Sociales Department, P-Porto, Portugal, Tel: +33-6-82-30-86-09; **E-mail:** isa.bertrand.spp@gmail.com**Received date:** 27 Jun 2016; **Accepted date:** 29 Jun 2017; **Published date:** 06 Jul 2017.**Citation:** Bertrand I, Bois D, Fédor MC, Leyssene-Ouvrard C, Miolanne M, et al. (2017) Assessing Body-Centered Educational Approaches to the Management of Obesity. *Obes Open Access* 3(2): doi <http://dx.doi.org/10.16966/2380-5528.130>**Copyright:** © 2017 Bertrand I, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

### Abstract

**Background:** In accord with international recommendations, the management of patients suffering from obesity is based on a multidisciplinary approach. The body-centered educational approaches (approaches aimed at educating people to have a perceptual relation with their body) are hardly developed in monitoring this type of patient. However, the problems in obese patients' relationship with their own bodies, their "social bodies", their subjective and self-experiencing bodies are indeed real.

**Objective:** The present research aims to assess the effects of body-centered educational approaches, within a multidisciplinary approach, for obese patients monitored in a hospital in France.

**Design:** Our observational study was a group of 18 obese patients (average age 42, body mass index 39 kg/m<sup>2</sup>) randomly selected during a nurse consultation. After transcribing their consultation files, an analysis of 95 consultation sessions was conducted using a framework of reference with criteria relevant to the management of obesity.

**Outcome:** Obese patients express a real interest in body-centered educational approaches due to the benefits to their well-being and to helping their relaxation. The benefits concern their relationship with their body, quality of life, personal motivation, self esteem, adaptation to stress, eating behavior, and the interaction between patient and caregiver.

**Conclusions:** These results show that body-centered educational approaches constitute a new tool for the management of obesity, within the multidisciplinary health care pathway of obese patients.

**Keywords:** Obesity; Body shape; Body educational approach; Perception

### Introduction

Obesity is a worrying phenomenon acknowledged worldwide. The International Obesity Task Force (IOTF) and the World Health Organization (WHO) [1-3] have laid out elements of diagnosis, prevention and management of obese patients in order to respond to this epidemic. The issue of obesity has been targeted in a joint consultation by the United Nations member states, civil society, and the private sector. Worldwide, obesity has almost doubled since 1980, and more than 3.4 million people die each year from obesity, making it one of the leading causes of global mortality [4]. The present situation is that being overweight and obesity are increasingly prevalent in developing countries, and among the socially disadvantaged classes of wealthy countries [5].

Since 2004, the WHO has implemented an action plan called "World Strategy for Eating, Exercising and Health" in which they describe obesity management directed towards regulating patients' behavior (eating habits and life style). In this plan physical activity and healthier eating habits are presented as a unique opportunity to impact health effectively, provided it becomes a lifetime commitment [1,4]. The proposition of body-centered management is described in an over-simplified way through a spectrum of physical activity, although physical activity can be difficult, and even painful.

Obese people suffer in their body [6,7]. They often describe body image distress (ill-defined, confused, contourless, distorted body). The body as

a social representation is often addressed by researchers [8]. This clearly shows the stigmatization problem faced by these patients. In the literature, there are hardly any studies on these body-based educational practices, which address the relationship with the body through body perception. Through this, they allow obese people to reconsider their negative relationship with their body, and to identify new effects such as body-image, self-esteem, and quality of life.

In this study, we analyzed the somato-psychic effects of an educational management of the patients' relationship with the body through perception. This research is a contribution to the assessment of the importance of subjective and self-experiencing body works in the management of obese patients.

### Equipment and Methods

#### Nutrition clinic unit of Clermont Ferrand's hospital

The nutrition clinic unit of Clermont Ferrand's hospital in France treats patients with severe obesity. It offers multidisciplinary care to ensure a global monitoring of obese patients: therapeutic, psychological and educational.

#### Selected body-centered educational approaches

These body-centered educational approaches are integrated in the care pathway of patients. The techniques were chosen according to a

multidisciplinary assessment based on a precise diagnosis of the patient's relationship to the body disorders, stress-related adaptive process problems, lack of self-esteem, and psychological problems related to obesity, such as cognitive limitation.

Two clinical nurses performed these techniques, which included relaxation, non-directive verbal dialogue, and, Qi Gong exercises for treatment practice referred to as Practice 1, and somato-psycho education for treatment practice referred to as Practice 2.

Relaxation permits an enrichment of body sensations associated with visualization. We anticipated the following sensations: wrapping (being aware of one's body contours), inner scanning (including each part of the body), perception of body weight bearing zones (more or less weighted down) [9]. The Qi Gong exercises used are essentially the "tree" technique (feeling rooted within one's body and to the ground) and movements aiming at defocusing thought [10]. The non-directive dialogue, as defined by Carl Rogers in his works [11,12] permits exploration of different thoughts, to value the improvements made, to analyze the problem of obesity as well as other occasional problems, to put into words and link up the sensations and emotions experienced, to let the present priorities in terms of projects and objectives rise to the conscious.

*Somato-psychoeducation* combines different body and verbal approaches [13]: manual touch, informative directional dialogue, sensorial gestural gymnastics, and introspection. It is patient-centered, following a humanistic approach. Manual touch allows the obese patient to reconnect to his/her own body by developing his/her perception of inner movements and manual supporting points. The supporting points are directed at peacefulness (perceiving a pause in one's too often restless body), presence of oneself (experiencing parts of one's body which are often felt as distant), neutrality (soothing the patient in his/her own judgment of his/her body), self-confidence (regaining self-confidence by trusting one's body), revitalization (finding within oneself a space to regenerate one's body and thoughts, a place safe from troubles and judgments). Sensorial movement, practiced in a sitting or standing position aims to sustain a perceptive relationship with one's body while moving slowly, this technique must be performed without pain. Sensorial introspection, practiced in a sitting position, allows the patient to scan and register his/her own inner body perceptions, and their related thoughts. The informative directional dialogue allows putting into words the perceptual lived experience during and after the session. Direction and directional information allow the patient to remain focused on his/her own body experience and its effects (awareness, motivation, decision).

### Epistemological position and patient selection

This study is a qualitative and interpretive work and is in the field of observational health survey, it was performed within the framework of existing practices. It was submitted to the ethics advisory board of Clermont Ferrand's hospital. Patients were incorporated in the survey from an alphabetical classification of patient files (n=90 per practitioner) and the sampling was done randomly. Each nurse selected one file out of every ten patients being monitored in May 2013. The survey concerns 18 patient files (9 for each nurse), and each patient signed an informed consent. The population was composed of 16 women and 2 men divided up as follows:- for Practice 1-7 women and 2 men, for Practice 2-9 women. The studied population had an average age of 42. The average body mass index was 39 kg/m<sup>2</sup>. The patients' BMI had led to the monitoring in the Nutrition Clinic service. The number of sessions performed was 43 for Practice 1 and 52 for Practice 2.

The patients were not given the exact same number of sessions in order to respect the scope of an observational health survey and to not influence the treatment. The patients had an average of 1 session every 5 weeks; the sessions were all in the form of an individual consultation.

The data come from the patient files, which report the accounts of patients transcribed by the practitioners at the end of the body-centered sessions.

### Measurement of the outcome

The results highlight many points of interest, in particular the patients' interest in these body-centered approaches, and the reports they gave of the effects of these nursing sessions. Eight effects were studied, they were all connected to the patient's relationship to their body, the quality of life of the patients, their self-esteem, their adaptation to stress, their eating behavior, their motivation, the interaction between the patient and the caregiver, and the relation to surgery.

The results come from a review then a cross-analysis of data from Practice 1, Practice 2, and both practices together to better understand the patients' need to be monitored via a body-centered approach, to go into depth on the outcome of the practices, and to better understand the nature of the benefits thus obtained.

### Results

#### Interest shown by the patients in regard to body-centered educational approaches

The study of the patients' files enabled us to define the interest shown by the patients for these approaches. We were able to categorize 9 different types in Table 1. Self-reflection and eating behavior disorders (n=11), stress management, fears (n=7) and pains (n=6) are the most frequently mentioned.

#### Reports given by the patients of the body-centered educational approaches

The analysis of the patients' data enabled us to see the different effects, perceived and attributed to body educational approaches by the patients studied. We noted some nuances in the benefits, depending on the practice used in Table 2.

For Practice 1, all the patients report at least one positive effect on the relationship to their body: calm and peacefulness (n=4), physical relaxation (n=3), rest (n=3), decrease of pressure (n=1). All the patients relate effects linked to their quality of life: feeling better (n=4), fewer pains (n=3), new engagement in leisure activities or walking (n=3), vitality (n=1), smiling again (n=1). Seven patients testified to at least one benefit to their personal motivation: discovery of new possibilities for self (n=3), personal practice of the exercises experienced (n=2), demand for psychological follow up (n=2), sensation of being responsible for one's life and one's health (n=2), fewer expectations for surgery (n=2), looking for professional training (n=1), regained concern for eating behavior (n=1). Six patients reported benefits to their self esteem: improved self-confidence (n=3), better self-knowledge (n=1), desire to hide less (n=1), desire to take better care of self (n=1). Five patients reported benefits to their adaptation to stress: less anxiety (n=3), fewer fears (n=1), keeping emotions at bay

**Table 1:** Patients' interest in body-centered educational approaches.

Practice 1 (n=9)	Practice 2 (n=9)
Weightloss (n=3)	Fears and stress management (n=5)
Help from surgery (n=2)	Work on food compensations (n=5)
Stress management (n=2)	Pain relief (n=4)
Support (n=2)	Taking care of oneself, being oneself (n=3)
In need of framework, of space for oneself; working on compulsions; changing the relationship to the body; well-being (n=1)	Fatigue management (n=3)

**Table 2:** Analysis of the effects of body-centered educational approaches for Practice 1 and Practice 2 on 8 criteria.

	Relationship to the body	Quality of life	Motivation	Self-esteem	Coping with stress	Eating behavior	Treatment	Patient-carer relationship
Practice 1	All calm and peacefulness (n=4) physical relaxation (n=3) rest (n=3) pressure release (n=3)	All well-being (n=4) pain decrease (n=3) resumingleisures activities (n=3) increase of energy (n=1) being happier and smiling (n=1)	7 patients Discovering new possibilities (n=3) personal practice of the exercises (n=2) psychological follow-up (n=2) feeling responsible (n=2) looking for vocational training (n=1) motivation/ dietary behavior (n=1),	6 patients self-confidence, (n=3) self-knowledge, (n=1) hide less (n=1) Taking care of oneself (n=1)	5 patients less anxiety (n=3) fewer fears (n=1) distancing emotions (n=1)	4 patients less binge eating and snacking (n=2), perception of compulsion warning signs (n=1) perception of risky situations. (n=1)	2 patients Less dependent on surgery (n=1) Thought about surgery (n=1)	
Practice 2	All relaxation (n=9) body warmth (n=5) Suppleness (n=4) fluidity, easiness and pleasure to move (n=4) physical relaxation (n=3), lightness (n=3) Freedom (n=3) unknown height (n=2) peacefulness, (n=2) wholeness, (n=1)	All less pain (n=6) resuming leisure and activities (n=4) smiling again (n=2) Tonicity (n=1) sleep (n=1)	7 patients personal practice of exercises (n=4) Less punctual motivation (n=3) psychological follow-up (n=2), discovery of their own active part (n=2) take greater care of oneself (n=1)	7 patients different kinds of thoughts (n=5) self-valuation (n=1) accuracy in process (n=1) Inner conflict (n=1),	7 patients Less stress (n=3) Fewer nightmares (n=1) Fewer fears (n=1) Anxiety of letting go (n=1) Fear of losing too much weight (n=1)	6 patients Acknowledgement of the causes of snacking (n=2) Altering eating behavior (n=2) Slowing down when eating (n=1) Fewer thoughts about food (n=1) Perception of fixed relation to food (n=1)		6 patients Safety feeling (n=5) Allowing oneself to confide, to speak (n=4) Trusting relationship (n=2)

(n=1). Four patients described improvements in their eating habits: fewer bulimia fits (less binge eating) or snacking (n=2), perception of signs leading to compulsion (n=1), better perception of risky situations (n=1). Two patients described benefits concerning their reflection on surgery: less concerned by surgery (n=1), thinking about surgery (n=1).

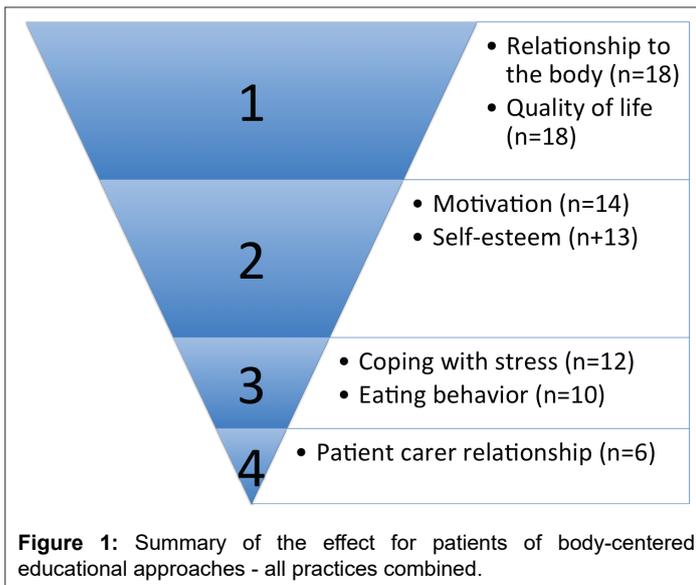
For Practice 2, all the patients report at least one positive effect on their relationship to their body: relaxation (n=9), body warmth (n=5), suppleness (n=4), fluidity, easiness and pleasure in moving (n=4), physical relaxation (n=3), surprising lightness (n=3), freedom (n=3), size never experienced before (n=3), rest (n=2), new wholeness (n=2). All patients related effects linked to their quality of life: fewer pains (n=6), resumption of leisure activities, holiday plans or sport (n=4), smiling again (n=2), tonicity regained (n=1), improved quality of sleep (n=1). Seven patients reported at least one effect on their personal motivation: personal practice of exercises experienced (n=4), demand of psychological follow up (n=2), discovery of self-motivation (n=2), choice made to take better care of self (n=1). Seven patients reported benefits for their self-esteem: discovery of nuances of thought (n=5), self-approval (I feel proud of myself for the first time) (n=1), sensation of the correctness of one's meaning (n=1), awareness of one's inner conflict (n=1). Seven patients reported benefits to their adaptation to stress: less stress (n=3), fewer nightmares (n=1), fewer fears (n=1), less anxiety in letting go (n=1), less fear of losing too much weight (n=1). Six patients noticed changes in their eating habits: understanding of the causes of their snacking (n=2), changes in their eating habits (less hunger) (n=2), slowing down the speed of eating

(n=1), fewer thoughts about food (n=1), a perception of their inflexible relationship to food (n=1). Six patients commented on the importance of their interaction with the caregiver: sensation of security (n=5 comments), feeling authorized to speak (n=4), confiding without being judged (n=2), trusting relationship (n=2).

To summarize, the benefits reported by the patients with the two methods clearly show that firstly body-centered educational approaches affect the patient's relationship with their body, and the quality of life for all patients. (Figure 1). Secondly, these approaches enable the patients to regain motivation, self-esteem, adaptation to stress, and eating behavior. It can be noted that the patients of Practice 1 address the question of surgery, which is not the case for the patients of Practice 2; and that the patients of Practice 2 emphasize the importance of the caregiver/patient relationship, which is not mentioned by the patients of Practice 1.

## Discussion

This study reveals the interest shown by obese patients for body-centered educational approaches (working on self, stress, and fear management), and the benefits of these practices on the relationship of the patient with his/her own body (relaxation, rest, tension release, warmth, suppleness), but also on other sectors of one's life (quality of life, motivation, self-esteem, adaptation to stress, eating behavior). It highlights the relevance of introducing these approaches in the multidisciplinary management of obese patients. Besides their complementary large benefits on well-being and relationship to the body, these new approaches could eventually allow



a reduction in the use of other health solutions, such as invasive techniques like bariatric surgery which is presently booming in France (the number of operations tripled between 2006 and 2013 [14]). It would be interesting to follow the patients in our study in the longer term in order to know how the regular practice of the body educational approaches we offered impacts further on the need for invasive surgery.

Concerning the various body-centered approaches in the two practices, we observed what was practiced within the hospital unit. Future research could also be broadened to other body techniques (such as meditation and yoga) which have already shown similar benefits in other patients.

As for the research methodology, it is important to note that due the fact that management of obese patients is multidisciplinary, our results might lack transparency. This is the reason why we took great care in isolating the results clearly expressed by our patients as being directly related to the body-centered approaches.

Some weaknesses still remain in our study. First, only a few patients took part in it, thus it seems important that this research should continue on a larger sample of representative patients among this population. Moreover, the male/female ratio in each group was unbalanced. Women were over-represented (88%), which could potentially lead to a bias in our results for various reasons: a) emotional responses are different between men and women, b) cultural/social beliefs could lead men to resort to

these approaches later than women for fear of stigmatization or damage to their self esteem. Our study definitely deserves to be repeated on a more balanced sample of men and women.

The strength of this study stems from its innovative character, because few scientific researches have addressed the disturbances in the relationship of the patient with their body for obese patients and the monitoring of these disturbances. In spite of the weaknesses of our study, its originality lies in that it opens new ways for managing obese patients. The complementary approach we offer tends to consider the body of the obese person from the angle of subjectivity and uniqueness.

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