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Leslie Rosenberg
Maybe We Really Are What We Eat:
Implications of Nutrition and Mental
Illness Research for Clinical Practice

ABSTRACT

In light of our nation's growing obesity epidemic, this paper will explore the growing body of research indicating clear links between nutrition and mental health, and the implications for clinicians treating mental illness in chronically ill clients who are overweight or obese. I will analyze the intersection between nutrition and mental illness according to the concepts of motivational interviewing (MI) and Irwin Yalom's group therapy theory in order to inform social work practice with these adults. Medical professionals who tend to shoulder the responsibility of addressing diet concerns in mentally ill patients rarely have adequate time nor training to fully examine the evolution of their patients' complex relationships with food. As a result, well-intentioned physicians, nurses, dieticians, and nutritionists may unintentionally be insensitive or ineffective in their attempts at these dialogues, and they may miss critical emotional pieces of their clients' weight-loss puzzles altogether. In this way, clinical social workers - particularly those working in teams with medical staff - can fill this void through implementing holistic treatment approaches which aim to integrate health and wellness goals into psychotherapy.

**MAYBE WE REALLY ARE WHAT WE EAT: IMPLICATIONS OF NUTRITION AND
MENTAL ILLNESS RESEARCH FOR CLINICAL PRACTICE**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Leslie Rosenberg

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2014

“Mental and physical health is fundamentally linked. There are multiple associations between mental health and chronic physical conditions that significantly impact people’s quality of life, demands on health care and other publicly funded services, and generate consequences to society. The World Health Organization (WHO) defines: *health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*. The WHO states that “*there is no health without mental health*” (Canadian Mental Health Association, 2014).

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CHAPTER I

Introduction

Few people are aware of the connection between nutrition and depression while they easily understand the connection between nutritional deficiencies and physical illness...Nutritional neuroscience is an emerging discipline shedding light on the fact that nutritional factors are intertwined with human cognition, behavior, and emotions (Rao et al., 2012, p. 77).

In light of our nation's growing obesity epidemic, this paper will explore the growing body of research indicating clear links between nutrition and mental health, and the implications for clinicians treating mental illness in chronically ill clients who are overweight or obese. I will analyze the intersection between nutrition and mental illness according to the concepts of motivational interviewing (MI) and Irwin Yalom's group therapy theories in order to inform social work practice with these adults. Through this project, I will critique and analyze existing research which examines proven benefits of nutrition counseling to chronically mentally and medically ill populations.

Given the extensive amount of attention American media has paid in recent years to issues of nutrition and obesity, and particularly in light of First Lady Michelle Obama's "Let's Move!" campaign, social work lags significantly behind the fields of medicine and public health in its empirical research on the topic. I attribute this difference at least in part to social work's emergence as a unique discipline, which depended to some extent on a mind-body split. Social work has historically emphasized person-in-environment approaches to treatment as opposed to

research-based trials as in psychology or the medical model of psychiatry. In fact, the stark division between psychiatry and social work remains apparent today at every level of the field, from undergraduate and graduate coursework to interactions between therapists and psychiatrists in professional settings. Social work has prioritized distinguishing and distancing itself from diagnosis, the DSM, and medical models of conceptualizing and treating clients. Even the word “patient” in itself is controversial in many clinical social work circles due to its association with medicine. Meanwhile, American medical ideology and culture typically isolates itself from the work of therapists. Physicians refer mental health issues out to clinicians rather than treat them. As a result, somatic symptoms tend to end up in the domain of medical staff, whereas mental illness is directed towards social workers. I believe, however, that the two are so interconnected that they simply cannot be separated, particularly when it comes to nutrition and diet and their interface with mental health.

A fact sheet produced by HHS’s Center for Integrated Health Solutions emphasizes the importance of specific, demonstrative, long-term (over six months) nutrition counseling in conjunction with fitness education when treating the seriously mentally ill due to their susceptibility to poor physical health (Bartels & Disilets, 2012, p. 2). As a substance ripe with emotion, culture, memory, and gratification, food deserves the same level of attention that social work theory and practice pays other substances and behavioral health issues. Yet, a close reading of the field’s literature reveals a dearth in the discourse of the intersection between individual nutrition goals and psychotherapy, particularly outside of the realm of articles addressing eating disorders. Now more than ever, as many social work settings find themselves increasingly faced with major institutional and structural shifts generated by the effects of the recession and healthcare reform, providers must be prepared to think more broadly about clients’ health needs.

By applying external theoretical constructs to this dialogue, we may begin to appreciate how to better integrate medical goals into psychiatric treatment.

There also exists sparse social work literature on effective cross-cultural nutrition counseling and nutrition education with clients of color. Similarly, the issues of health disparities, barriers to access and resources, and food deserts in low-income areas lack emphasis in most current social work literature on nutrition and depression. These barriers to eating well, however, are especially significant, because minority populations continue to suffer disproportionate burdens of morbidity and mortality (Hulme et al., 2003, p. 244). To ignore this fact in this study would be a gross oversight, particularly because the clients social workers serve constantly face these obstacles.

Every year, statistics reveal greater and greater health disparities among racial, ethnic, and socioeconomic minority populations who remain chronically underserved by our health care system. Cardiovascular disease, for example, is the leading cause of death among Americans, and it most adversely impacts racial and ethnic minorities and individuals with low-socioeconomic status (National Institutes of Health, 2010, p. 1). Furthermore, individuals living with serious mental illness risk premature death, largely due to complications from untreated, preventable chronic illnesses like obesity, hypertension, diabetes, and cardiovascular disease, which are aggravated by limited health choices associated with poverty, including poor nutrition, lack of exercise, and smoking (Bartels & Disilets, 2012). Social work has long taken pride in its extensive treatment of underserved and disadvantaged populations, and the profession therefore must address these health disparities in its clinical work.

Following the implementation of the Affordable Care Act, Medicaid reform, and the “Health Homes” movement, insurance companies are incentivizing behavioral health providers

to move towards more comprehensive and coordinated approaches to care in conjunction with their medical colleagues. Rarely do insurance companies cover nutritionist visits, for example, yet they approve behavioral health care requests at much higher rates. Clients seldom present exclusively with mental illness, but rather with additional chronic medical conditions. Social workers have found themselves on the front lines of the new “polydiagnosis” category of clients who present not simply with one or two diagnoses, but rather with multiple medical and psychiatric conditions, often including substance abuse. Therefore, psychotherapy is no longer strictly limited to treating issues of the mind as it once was. Just as physicians must consider psychiatric symptoms in their treatment methods of medical conditions, so too, must social workers consider the implications of physical health in psychotherapy. The mind and body connection is no longer just a myth; it is policy, and social work must embrace this new world in order to achieve exceptional client care.

As a result of this shift, virtually every clinician practicing in the field today will encounter clients whose lives may be in jeopardy as a result of their weight. Medical professionals who tend to shoulder the responsibility of addressing diet concerns rarely have adequate time or training to fully examine the evolution of their patients’ complex relationships with food. In this way, well-intentioned physicians, nurses, dieticians, and nutritionists may unintentionally be insensitive or ineffective in their attempts at these dialogues; they may even miss vital emotional pieces of their clients’ weight-loss struggles altogether.

There exists, then, a critical need for clinical social workers - particularly those who practice in teams with medical staff - to fill in these gaps through implementing holistic treatment approaches which aim to integrate health and wellness goals into psychotherapy. I propose, therefore, that social work training programs incorporate basic principles of nutrition

and health into their curriculum in ways relevant to our unique perspective on the client. Rather than strictly distinguishing treatment plans along mind/body lines, social workers should draw connections between diet and their clients' psychiatric symptoms. Through my research I will address the question: How can clinical social workers work in conjunction with their medical colleagues to effectively apply culturally competent and therapeutic nutrition interventions to practice with clients who struggle with poor eating habits?

Specifically, I hope to demonstrate the usefulness of the theory of MI as a motivator of change when working with clients for whom weight-loss would likely extend quality and length of life. The theory, once primarily associated with substance abuse, can also be effectively applied to initiating healthy eating habits. Evidence clearly supports its technique of engaging clients in such a way that they hear themselves argue in favor of a positive change rather than expressing ambivalence or resistance to it. In addition to MI theory, Yalom's writings on group therapy can be applied to health and wellness or weight-loss support groups of the type that are cropping up in social work settings all over the country. As Yalom argues, when individuals have accountability to and strong relationships with each other, they feel more supported and motivated in their change behavior.

I argue that clinical social workers have a moral obligation in this national health crisis to educate themselves on basic principles of nutrition in order to incorporate them into practice. Even for those clients whose weight alone does not place them in grave danger, but whose quality of lives may be considerably ameliorated by certain lifestyle adjustments, the field of social work must consider what current research reveals regarding potential psychiatric benefits to healthy eating. This project aims to improve the capacity of social work as a field to attend to the physical as well as the emotional needs of clients working on weight-loss goals. It is intended

to be useful for all social workers, but I hope that it will also serve as a contribution to other health fields that work clinically with diet and nutrition goals. I imagine this paper as an opening to a much larger conversation about how our field approaches its work across disciplines.

Conceptualization

In this section, I will introduce the evolution of the study's major concepts, as well as several key definitions and its potential biases resulting from my personal and professional experience. Given that it would be unrealistic to address each individual concept and phrase in great detail, I acknowledge that this section focuses only on those terms that I have identified as being imperative. That said, they will be expanded upon in further sections.

By way of introduction to my analysis and for the sake of clarity, I will begin by defining those terms which reappear throughout this chapter. First of all, the National Alliance of Mental Illness (NAMI) defines *serious mental illness* (the population I address more than any other) as:

serious medical illnesses which cannot be overcome through “will power” and are not related to a person’s “character” or intelligence. Serious mental illness diagnoses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD) and borderline personality disorder and they affect one in seventeen Americans (National Alliance of Mental Illness, 2014).

Secondly, the phrase *polydiagnosed* patients is relatively new to the field of social work and is still largely unknown to most practitioners but is quickly gaining ground as Health Homes expand to more and more social work settings across the country. Whereas “dually-diagnosed” is a term widely used in social work to describe individuals who struggle with a combination of substance abuse and mental illness, “polydiagnosed” refers to a category of patients who struggle with substance abuse, mental illness, and one or more chronic health conditions such as diabetes, high blood pressure, and/or high cholesterol. The combination of these diagnoses puts these

clients at particularly high risk for early death, often identifying them as prime candidates for participation in a *Health Home*, a term Medicaid.gov explains:

the Affordable Care Act of 2010, Section 2703, created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions by adding Section 1945 of the Social Security Act. CMS expects states health home providers to operate under a "whole-person" philosophy. Health Homes providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person (Medicaid.gov, 2010).

Many Health Homes implement groups as a tool for practicing preventative healthcare with patients. Yalom writes extensively of the various types of group leadership, and I focus primarily on what he terms the "*leadership function of caring*" which Polcin (1991) describes as the implementation of the leader's expression of warmth, acceptance, genuineness, and concern. The leader, he explains, is open and honest with group members and seeks to facilitate the growth of trust in the group. When effective, caring functions result in group members being able to increasingly give and receive emotional support and nurturance (Polcin, 1991, p. 10). In particular, I focus on applying this form of leadership to nutrition and wellness groups.

The World Health Organization (WHO) defines *nutrition* as "the intake of food, considered in relation to the body's dietary needs." WHO asserts that poor nutrition can lead to reduced immunity, increased susceptibility to disease, impaired physical and mental development, and reduced productivity (WHO, 2014). Finally, "*nutrition/al counseling*" is a reoccurring phrase in the study referring to any attempt made by a clinician to educate, motivate, or explore with a client how to improve their general health through diet.

Methodology

The following sections of the study will analyze the phenomenon of integrating nutrition counseling into psychotherapy through a theoretical comparison of MI and Yalom's group therapy. Each individual theory will be evaluated consecutively, according to its history, trends,

key features, and orientation. The existing body of literature on each will serve as the basis for a discussion of their respective evolutions: how they came to be, why they were developed, and for whom. Finally, I will examine how the theories individually and together relate to the phenomenon as well as their relevant clinical implications and broader connection to the field of social work. To begin, I will address the background and development of the study's major concepts.

My conceptual framework for this thesis originated both from my passion for the power of group therapy in generating behavioral modifications as well as my own desire to competently serve those clients of mine who seek motivation to lose weight from their therapist. MI seemed to be everywhere I turned at both placements and was often discussed in the same breath as the new integrated model of care coming out of healthcare reform. It was evidence-based, and broadly effective for substance abuse. I imagined then, that its concepts could also translate to health and wellness changes. In fact, I came to realize through my clinical practice that psychodynamic explorative psychotherapy alone was not suitable for the shorter-term relationships dictated by the nature of a graduate internship placement. When combined with MI, however, progress suddenly shifted for my Yalom-informed Health and Wellness support group members. I became fascinated as to the how and why traditional support group theory combined with MI techniques seemed a magic combination when it came to improving their healthy living behaviors.

I prefer to use Yalom's theory of "leadership function of caring" to examine how clinicians can best support clients by running Health and Wellness groups (Polcin, 1991). I use MI/transtheoretical literature to interpret the phenomenon of nutrition counseling in psychotherapy as well as applying it, point by point to unhealthy eating practices. Components in

Yalom's therapeutic processes, which emphasize experience and reflection on that experience, will illuminate what occurs in health and wellness therapeutic interactions. Ultimately, the significant areas of overlap between MI and Yalom's group theories are revealed, and I argue that they can be combined for prime efficacy.

Motivational interviewing (MI) and *Stages of change/transtheoretical* theory often appear in the literature interchangeably because the former is a practical clinical application of the latter. According to SAMHSA (Substance Abuse and Mental Health Services Administration), "motivational interviewing is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change." It is an empathic, supportive counseling style that supports the conditions for change. Practitioners are careful to avoid arguments and confrontation, which tend to increase a person's defensiveness and resistance (SAMHSA, 2014). Almost 20 years ago, two well-known alcoholism researchers, Carlo C. DiClemente and J. O. Prochaska, introduced a five-stage model of change to help professionals understand their clients with addiction problems and motivate them to change. Their model is based not on abstract theories but on their personal observations of how people went about modifying problem behaviors such as smoking, overeating and problem drinking. The six stages of the model are: precontemplation, contemplation, determination, action, maintenance, and termination (Gold, 2013). Coleen Dobo, Psy.D defines *precontemplation* as the point at which the "consumer knows substance abuse or mental illness is a problem and feels unable to change," and *contemplation* as when the "consumer is ambivalent about change". The *determination* stage is marked by realistic goal setting often with the help of a treatment professional (Gold, 2013). Dobo explains the *action* stage as the point at which the consumer takes steps to implement a plan and the *maintenance* phase as the consumer being committed to the change. Of *termination*, Gold (2013) writes, "At

this stage, the alcoholic no longer finds that alcohol presents a temptation or threat; he has complete confidence that he can cope without fear of relapse.” For the purposes of this project, however, MI will be discussed in reference to healthy eating changes rather than substance cessation. These definitions will serve as a reference guide for all following chapters.

Biases

As I explore the relationship between mental illness and nutrition counseling in social work and its related fields’ literature, my biases towards incorporating health and nutrition in therapy will emphasize literature supporting this framework. Coming from generations of health professionals, I have strong personal ties to the medical field and therefore very much believe in Western medicine and its possibilities, as well as in the fact that there are many capable physicians in the U.S. practicing effective and compassionate care daily to diverse populations. In this way, I do not share the skepticism of medicine as a field that is prevalent among therapists who promote alternative and holistic approaches. In particular, I very much support the use of psychiatric medication in conjunction with talk therapy when deemed necessary by the client and a multidisciplinary team of professionals. However, if research continues to support the idea that there is a portion of individuals with mental illness who can safely have their medication levels reduced in conjunction with nutrition counseling, I would embrace this approach.

While I certainly believe in the power of nutrition and diet to help manage emotional and physical health, I find myself also somewhat skeptical that we can literally change the brain chemistry of a seriously mentally ill individual through diet. I am more inclined to support nutrition counseling in addition to rather than as a substitute for SSRI’s or other medications that could be potentially beneficial, particularly when those medications have significant weight gain as a known side effect. Unlike many in the social work field, these connections have strongly

influenced my attitudes towards psychiatric medications which I believe are critically necessary for many clients.

I have also witnessed both personally and professionally how prevalent is the problem of physicians whose bedside manner lacks sensitivity and care. I have noticed this particularly when the conversation between doctor and patient steers towards the topic of weight loss. My high expectations set by my parents of how to thoroughly and carefully address this type of health concern with patients in a direct, yet sympathetic fashion are all too rarely met according to the experiences of my friends, family, and clients. I believe that social workers then can be particularly valuable in follow-up with patients on weight-loss and nutrition goals.

Like all research projects, mine has certain strengths just as it has biases. First of all, the topic of how to treat polydiagnosed individuals most effectively and efficiently in healthcare today is extremely timely and relevant given the trickle-down effects of the Affordable Care Act. Secondly, I bring two years of practical experience in both a Health Home and an outpatient medical setting to this research. Having worked extensively with clients who are struggling with the combination of health problems examined in this paper, I am able to see its research questions not simply as theoretical or hypothetical, but as very pertinent to my work and to their well-being. In this way, my placements offered a daily catalyst for this project and contributed positively to its inception and execution. Of course, this sense of “knowing” can also serve as a limitation to the project in that it could potentially lead to false broad assumptions based on the unique experience of one or a few of my clients. Resisting the temptation to apply my anecdotal clinical observations to a large sample of this population will be important to maintaining objectivity in my evaluation of existing research and my chosen theories.

In addition, other limitations to my study include the fact that I am not formally medically trained, nor am I a certified nutritionist or dietician. The topic of food and its health benefits and pitfalls is primarily a personal passion of mine on which I have educated myself extensively over the past five years, but am not an authority. That said, this acquired proficiency has slowly crept into my professional life such as in the case of the health and wellness group I co-facilitated this year with a Johns Hopkins Nurse Practitioner. Such examples of coordinated practice between medical and mental health clinicians are becoming commonplace as integrated care settings spread across the country.

Another limitation of my plan is in the lack of control for medication use in clients, as many carry the side effect of significant weight gain and/or increased appetite and may even overpower users' attempts at dieting. Similarly, much variance exists culturally among clients with regard to norms and expectations of food, cooking, portion sizes, as well as body size. As a white upper middle-class clinician, I am aware that I likely exhibit blindness and privilege whenever writing about issues which disproportionately affect populations of color and lower SES status than my own. Although I attempt throughout the project to be hyper-aware of not imposing my own values of the importance of nutrition and health onto my interpretations and findings, I cannot ignore that they stem from my life experience of access to resources which offered me the opportunity to maintain my own health.

Similarly, Yalom's theories of group therapy stem from a white European psychoanalytic tradition of practice with mostly white clients. I fully consider that his practice may not have ever benefited from a critical examination of his own privilege or his theories' efficacy cross-culturally and in diverse settings. Clinical social work and psychotherapy value flexibility. No single approach can serve as a panacea for every client. I certainly do not expect that the

conclusions I draw from this project will be applicable across the board in every case. I merely intend to arrive at some general guidelines to inform practice with a rapidly growing population of clients being served in settings across the country.

In the following chapters, I will explore existing approaches to treatment examined in the literature with seriously mentally ill populations in order to more broadly apply them to a wider a range of clients who have similar nutrition goals. After fully addressing the past and present body of relevant research on this topic, I will examine how the major concepts of the transtheoretical theory of change/MI and Yalom's group therapy writings can be useful in considering the integration of nutritional counseling into psychotherapy. In my final chapters, I will analyze and synthesize my key findings and discuss their implications for clinical social work practice, as well as for other human service professionals who serve as collateral in the lives of our clients.

CHAPTER 2

The Connection Between Nutrition and Clinical Social Work Practice

Introduction to the Literature Review

In this chapter I analyze existing social science and medical literature that examines the link between an individual's diet and his or her mental health as well as what implications this research has for both individual and group interventions in social work practice. It is my goal then to avoid privileging any one study or intervention strategy but rather to critique existing discourses according to their applicability to communities of color as well as to those who hold lower socioeconomic status. Just as in psychotherapy, if nutrition counseling is not conducted in a "culturally competent" manner, the work is not only ethically questionable - it will likely be ineffective. Hulme et al. (2003) write, "Familiarity with cultural values and beliefs can help with" the process of guiding clients through their weight-loss journeys (p. 258). Finally, I will briefly address some ways in which social workers may leverage their unique position within multidisciplinary treatment teams in order to integrate their expertise into effective weight-loss interventions with polydiagnosed individuals. This discussion will set the stage for the Chapter Three, which will provide a careful analysis of Motivational Interviewing/Stages of Change theory as it relates to practice with overweight and obese clients.

Research on the connection between nutrition and mental illness has intensified in the past decade, and study after study shows clearly that the two are inextricably linked. Evans and Burghardt (2011) discuss this growing body of evidence in mental health literature, writing,

“Nutritional factors affect brain function. The simple concept of ‘you are what you eat’ applies” (p. 243). They offer,

“clinicians would do well to consider incorporating lifestyle approaches in their treatment strategies, most frequently as complementary approaches to pharmacological or cognitive therapies, and in appropriate cases as stand-alone paradigms...Emerging data indicate that specific nutrients...influence the course of clinical depression and bipolar disorders and may play roles in the alleviation and prevention of treatment resistance” (p. 237).

Gerden et al. (2011) echo this sentiment: “Patients would likely benefit from interaction with nutritional consultants as a standard component of depression therapy” (p. 248). I posit that therapists themselves, once substantially trained in the basics of nutrition counseling, should serve at least partially, as these “nutritional consultants.”

The Link Between Nutrition and Mental Health

I would argue that it is fundamental to situate a paper which explores the association between nutrition and mood within the context of the United States’ capitalist and often oppressive society. That is to say that issues of obesity, chronic illness, and lack of access to affordable healthy food disproportionately affect those living in poverty and people of color. Many of America’s most profitable corporations have achieved their wealth and power on the basis of marketing addictive, inexpensive, and unsafe food products to vulnerable populations such as these and they therefore have no incentive to educate their consumers on the very real health consequences of overindulging in their product. The symptoms individuals living with serious mental illness experience make them particularly susceptible to such advertising tactics, complicating their weight loss efforts. As I critique the existing body of research on nutrition and mood, I intend to hold in mind this national setting in which it has been conducted and published. Our understanding of the role of nutrition in mental health dates back a couple of

millennia; Dr. T.J. Ritter's (1910) popular *The People's Home Medical Book* cited "imperfect nutrition" as a cause for "temporary insanity" (Evans and Burghardt, 2011, p. 245). Evans and Burghardt (2011) also note that in the 1970's some significant gains were made in our understanding of food's impact on mental illness but that then, "lithium and other antidepressants withdrew focus on nutritional factors as direct contributors to mood regulation" (p. 245). The current lack of focus on nutritional factors as major contributors to mental health status is a relatively new direction (Evans and Burghardt, 2011). Recent literature on the relationship between diet and mental illness tends to explore one of two types of fundamental research questions: an examination of specific nutrient therapies as an alternative or adjunct to psychiatric medications, or exploring whether broader diet modifications such as eating healthier and in smaller portions may alleviate depressive symptoms. I will consider both categories of study in this analysis.

Rao et al. (2008) write that "nutritional neuroscience is an emerging discipline shedding light on the fact that nutritional factors are intertwined with human cognition, behavior, and emotions" (p. 77). They go on to argue that depression is more typically thought of as strictly biochemical-based or emotionally-rooted (Rao et al., 2008). "On the contrary," they explain, "nutrition can play a key role in the onset as well as severity and duration of depression" (p. 77). In studies of how to influence mood either positively or negatively through foods, certain specific nutrients have emerged as being particularly relevant. According to Rao et al. (2008), for example, carbohydrates, which have been vilified by a series of "fad diets" in recent decades, are actually critical to mood. They write:

Consumption of diets low in carbohydrate tends to precipitate depression, since the production of brain chemicals serotonin and tryptophan that promote the feeling of well being, is triggered by carbohydrate rich foods. It is suggested that low glycemic index (GI) foods such as some fruits and vegetables, whole grains,

pasta, etc. are more likely to provide a moderate but lasting effect on brain chemistry, mood, and energy level than the high GI foods - primarily sweets - that tend to provide immediate but temporary relief (Rao et al., 2008, para. 9).

Evans and Burghardt (2011) also discuss this issue of carbohydrates' relationship to folate and brain chemistry by offering a case example of a forty-year old woman who came to treatment after a sudden increase in depression that had previously remained steady and manageable throughout her adult life. After a month of antidepressant treatment which yielded no significant improvement, further consultation revealed that she had abruptly begun a low-carbohydrate diet to lose weight a few months prior. It became clear to her doctor that the cereal and bread her body had been accustomed to was suddenly eliminated from her diet, and with it, her daily dose of folic acid. Rather than try her on a new antidepressant, the psychiatrist merely added a folate supplement to her daily medication regimen as well referring her to a nutritionist with the goal of ensuring that she was obtaining the appropriate B-complex vitamins involved in the synthesis and proper balance of monoamines (Evans and Burghardt, 2011). Ultimately, the treatment was effective, and at the time of publication, the patient was tapering off the antidepressants as a result.

Peedicayil (2012), expands on this connection between folic acid and mood, writing:

It is known that severe folic acid deficiency can result in depression and that depressive symptoms may be associated with antiepileptic-induced folic acid deficiency. Previous surveys have found that up to one-third of psychiatric inpatients had folic acid deficiency which was associated with the presence of depression and dementia. Moreover, these surveys found that depressed patients who were treated with folic acid had significantly better clinical outcomes than those in which the folic acid deficiency was uncorrected (p. 500).

Unlike the majority of psychotropic medications, folic acid has the added clinical advantage of being inexpensive and over-the-counter when taken in moderate doses. Furthermore, the supplement is not harmful when taken once daily, so it offers significant chance of benefit without the risks of side effects posed by many antidepressants or mood stabilizers. For these

reasons combined with the growing body of compelling research about its benefits, Evans and Berghardt (2011) write of folic acid, “clinicians would do well to consider this as an adjunctive treatment” (p. 247). They continue:

Folic acid and B vitamins (B12 especially) also seem to correlate to depression when their levels are low, probably because they are involved in the synthesis of dopamine, serotonin and norepinephrine...It has been observed that patients with depression have blood folate levels, which are, on an average, 25% lower than healthy controls. Low levels of folate have also been identified as a strong predisposing factor of poor outcome with antidepressant therapy (p. 247).

Another focus of nutrition and mental health research examines ratio and levels of omega fatty acids in diet. Accumulating evidence from demographic studies indicates a link between high fish consumption and low incidence of mental disorders directly resulting from omega-3 fatty acid intake (Rao et al., 2008). Lakham and Vieira (2008) write, “Since the consumption of omega-3 fatty acids from fish and other sources has declined in most populations, the incidence of major depression has increased” (p. 2). Evans and Burghardt (2011) add to these findings:

Societies that eat more fish which are high in omega-3's, have less depression. Seasonal variations in suicidal behavior correlate with fish intake as well – in Scandinavia, when fish intake is lower, violent suicides increase. In some studies, people who attempted suicide had lower blood levels of omega-3 fatty acids, and those who did not eat much fish were more depressed (p. 246).

Rao et al. (2008) expand on our understanding of omega's association with mood by addressing the ratio of omega-6 and omega-3 fatty acids in diet:

The quantity and ratio of omega-6 and omega-3 polyunsaturated fatty acids (PUFA) that affect serum lipids and alter the biochemical and biophysical properties of cell membranes has also been found to have a clear impact on depression levels...Research findings point out that an imbalance in the ratio of the EFAs, namely the omega-6 and omega-3 fatty acids, and/or a deficiency in omega-3 fatty acids, may be responsible for the heightened depressive symptoms associated with low plasma cholesterol. These relationships may explain the inconsistency in the results of trials on cholesterol-lowering interventions and depression (para. 11).

Evans and Burghardt (2011) explain that “today’s western diet has deviated from the preferred ratio, which was maintained for most of human evolution,” and that this shift correlates with increased incidence of depression in our society (p. 246). Two analyses from high-quality cohort studies, and one high-quality cross-sectional study also reported significant associations between reduced consumption of Western foods/less healthy diets and a decreased likelihood of depressive symptoms (Quirk et al., 2013). Several studies have documented alterations in dopamine and serotonin activity in the brain’s frontal cortex after omega-3 manipulation; this kind of change affects the metabolism including signaling related to depression and the limbic system that controls mood (Evans and Burghardt, 2011).

The latest relevant study of the implications of diet on the mind indicates that an increase in “gut bacteria” or probiotics like those found in most yogurts may ease psychiatric symptoms such as anxiety and bipolar manic episodes. *National Public Radio*’s Rob Stein reported on the revelation in November 2013:

Along with his colleague Kirsten Tillisch, Mayer gave healthy women yogurt containing a probiotic and then scanned their brains. He found subtle signs that the brain circuits involved in anxiety were less reactive, according to a paper published in the journal *Gastroenterology* (National Public Radio, 2013).

According to Kirsten et al. (2013), a four-week intake of a fermented milk product probiotic (FMPP) by healthy women affects activity of brain regions that control central processing of emotion and sensation. They write, “In healthy women, chronic ingestion of a fermented milk product with probiotic resulted in robust alterations in the response of a widely distributed brain network to a validated task probing attention to negative context” (Kirsten et al., 2013, p. 1397).

Stein’s article on the study continues,

“I’m actually seeing new neurochemicals that have not been described before being produced by certain bacteria,” says Mark Lyte of the Texas Tech University Health Sciences Center in Abilene, who studies how microbes affect the

endocrine system. ‘These bacteria are, in effect, mind-altering microorganisms’” (National Public Radio, 2013).

Such studies indicate that dietary shifts beyond simply specific nutrient alterations can impact the mental health of the clients social workers serve.

Dietary interventions are a low-cost, low-risk treatment strategy that yield almost no side effects in comparison to psychiatric medications. I therefore echo the sentiments of Lakham and Vieira (2008) who argue, “Psychiatrists treating patients with mental disorders should be aware of available nutritional therapies, appropriate doses, and possible side effects in order to provide alternative and complementary treatments for their patients. This may reduce the number of noncompliant patients suffering from mental disorders that choose not to take their prescribed medications” (p. 6). I also share in the call by Quirk et al. (2013) for more research on this and other related topics. They write, “to our knowledge, this is the first review to synthesize and critically analyze evidence regarding diet quality, dietary patterns and depression...Further studies are urgently required to elucidate whether a true causal association [between diet quality and depression] exists” (p. 1).

Nutrition Counseling in Therapy

The second major focus of the existing research on nutrition interventions as a component of depression treatment is in more general (not nutrient-specific) healthy eating and wellness counseling through individual and/or group therapy. Although the literature is somewhat divided on what approaches to incorporating nutrition into mental health services are most effective for different client populations, one universal finding is clear: any diet intervention, regardless of type, is far superior to none. Avoiding the topics of preventing weight gain, or promotion of weight loss with obese or overweight clients typically leads to no weight

loss, or worse, weight gain and a correlating worsening of both psychiatric and somatic conditions.

Much is made in the literature of the particular vulnerabilities to weight gain that clients with severe mental illness face as well as the many obstacles that exist in this population when trying to promote weight loss. These challenges are due primarily to the combination of side effects from psychiatric medications (especially antipsychotics), which are well known to cause weight gain, as well as those of the disease such as lack of motivation, disorganization, or overeating in an attempt to self-soothe. Evans et al. (2005) write, “The clinical importance of preventing weight gain in this population cannot be understated given that the rate of obesity among people with schizophrenia even before starting antipsychotic medication is two to three times greater than the general population” (p. 484). Yet, providers should certainly maintain hope rather than dismiss these clients as unable to make positive diet and wellness changes, as study after study reveals their responsiveness to interventions. Hoffmann et al. (2005) report, “Survey results...demonstrated that individuals with serious and persistent mental illness were able to make healthy lifestyle changes, which helped them to lose weight and gain self-confidence” (p. 1578).

In Brown et al.’s (2011) study of the RENEW program, individuals with serious mental illness clearly benefited from weight loss programs. They write:

The results indicate the RENEW (Recovering Energy Through Nutrition and Exercise for Weight Loss) program was successful in achieving modest weight loss for individuals with serious mental illness. Unlike many previous studies, this multisite randomized controlled trial included a significant number of participants from minority groups and promoted changes in both nutrition and physical activity (Brown et al., 2011, p.803).

Jean-Baptiste et al.'s (2007) study also serves as evidence that not only are the seriously mentally ill by and large responsive to initial weight loss interventions, but these individuals can also maintain it months later in follow-up interviews. Jean-Baptiste et al. (2007) write:

The program not only arrested weight gain, and produced meaningful weight loss, but also weight loss continued 6 months after the intervention is completed. Cognitive impairment had no bearing to the extent a participant benefited from the program. As a conclusion, well designed simple behavioral programs can produce lasting weight loss for patients with schizophrenia and comorbid obesity, improve metabolic indices, and possibly decrease significant medical risks associated with obesity (p. 204).

Relatedly, Vreeland et al. (2003) investigated atypical antipsychotics' propensity to cause weight gain in their research. They assert, "On the basis of our results we believe that professionals treating persons who are taking atypical antipsychotics should educate patients and encourage them to engage in weight control activities" (p. 1157). Evans et al. (2005) focused specifically on the drug olanzapine to see whether individual nutritional intervention helped to assuage weight gain among those patients to whom it was prescribed. They, too, found that "individual nutritional intervention" was "highly successful at preventing olanzapine-induced weight gain" (Evans et al., 2005, p. 479).

Bassett, Llyod, & King (2003) address McDougall's call for the education process with seriously mentally ill clients to be strengths-based and to focus on the social and environmental determinants of health and healthy eating. Kennedy et al. (1998) believed that inherent in this process was the need for educators to acknowledge the additional effort and forethought required to make even a simple dietary change while also battling the serious symptoms of mental illness and circumstances of living in unhealthy environments. Palmeri et al. (1998) discuss the additional value, particularly in communities of color, of showing clients how to make changes through activities such as healthy cooking classes and grocery store shopping trips rather than

just “telling” clients how and what to eat and where to buy it (p. 314). Bassett, Llyod, and King (2003) write:

The literature has shown that encouraging the active involvement of participants in nutritional programs influences behavior change. It would appear that learning by doing is one of the most important aspects of the Food Cent\$ program and one that distinguishes it from many other nutritional educational approaches. It is therefore believed that since people with a mental illness often have difficulty with translating concepts into practice, this approach is particularly valuable (p. 374).

Findings such as these support nutritional interventions which approach working with clients on what they already have, such as researching what healthy and affordable foods are covered by WIC or food stamps, for example.

Noticeably absent from the prevailing literature on nutrition interventions and mental health outcomes are studies including people of color. In one of the only current articles on the need for coordinated mental and medical healthcare in Native American communities, Harper (2010) writes, “research has indicated a strong link between mental health and physical health issues for this population, so authors suggested paying particular attention to integrating care and operating under systems theory approaches when implementing interventions with this population” (Harper, 2010, p. 286). Mental health practitioners must be aware of the particular implications of different diagnoses on diverse clients culturally and medically, but without literature on different groups, sensitivity training materials are scarce. Like Hulme et al. (2003), I am calling for further study of how traditional health-promoting lifestyle behaviors change in the United States when thwarted by lack of money, friends, and family or by unfamiliarity with potential resources, barriers which disproportionately exist in communities of color.

Existing research indicates that nutrition and wellness groups are the most successful and widely implemented type of intervention in clients with comorbid mental health and medical conditions. Bahr et al. (2009) write, “With any intervention, social forces have an exponentially

greater influence than pinning the weight of individuals” (p. 728). Perlman et al. (2010) evaluate a VA program in their pilot study which confirms this notion. They write,

This study demonstrates the feasibility of implementing a comprehensive health-oriented wellness group intervention, encompassing both interpersonal and bodily domains, with the predominantly chronic patient population of a VA mental health clinic. These are extremely challenging older patients with many comorbid psychiatric and medical conditions. The willingness of the patients to try out new behaviors...their reported health improvement, and their overwhelming satisfaction suggest that such a program can be effective in improving overall health (p. 125).

Lawrence and Azhar (2010) add that social workers are in a unique position to provide interventions of this sort not only on a micro level (educating individual clients) but also on a macro level in terms of large-scale education campaigns and knowledge dissemination efforts focusing on nutrition and exercise both in children and adults. Perlman et al. (2010) evoke their findings to urge health fields to support group interventions like the one in their pilot study. They write, “future directions include the development of additional support structures, such as an advanced-level group and a peer support network, to help patients maintain the skills that they acquire in the program” (p. 126).

Mental health practitioners have a unique opportunity to increase their impact by becoming proficient in treatments that can affect both mental and physical health outcomes (Pagoto et al., 2008). That said, the body of research examined in this paper indicates that clients must be motivated to change for wellness interventions to be most effective. According to Hoffmann et al. (2005), the success of polydiagnosed individuals in making healthy lifestyle changes was significantly associated with their readiness to do so, a finding which was consistent with other studies’ results. These findings underscore my argument for MI as a relevant theoretical construct from which to explore integrated mental health and medical care. In the

next chapter, I will examine MI and Stages of Change theory in depth and apply it to the phenomenon of diet's impact on mood.

CHAPTER 3

Stages of Change Theories

In the following chapter I will review the transtheoretical theory of stages of change and MI and discuss how they have been elaborated beyond the field of substance abuse, and into broader behavioral health applications. It is my hope that this chapter will move beyond an individualized notion of MI as exclusively treatment for alcoholism and provide the reader with an opportunity to explore the possibility that this technique is also a productive force for instigating lasting meaningful behavioral changes in clients' lives. This argument will introduce

a harm reduction approach to clients struggling with numerous medical and mental health risks such as diabetes, obesity, hypertension, bipolar disorder, tobacco addiction, and/or drug abuse.

This chapter, then, will serve as a foundation for the discussion chapter, wherein I will apply these understandings to practice with polydiagnosed individuals and elucidate how these theoretical constructs can provide social workers with a more complex understanding of this population's needs than is offered by the traditional "evidence-based practice vs. insight-oriented interventions" debate. This discussion will argue that this internal debate within the field may be counterproductive to the goals of social work; that in fact, weight loss promotion in polydiagnosed clients requires a combination of the two approaches such as in the case of the health and wellness groups. My hope is that these insights will redress the ways in which social work practice can marry its two competing camps in order to significantly impact and better serve one of its highest-need populations.

Defining Motivational Interviewing

I will begin this chapter by offering a history and background of MI including its trends, principles, and key features. I will then briefly summarize the relevant existing empirical studies which investigate MI's usefulness in addressing behavioral health issues. While the majority of the literature is supportive to my argument that MI is a valuable technique for weight-loss interventions with polydiagnosed individuals, I will also present the most common critiques of MI offered in studies whose findings are contradictory to my argument. The conclusion highlights the research's implications for clinical practice with clients suffering from chronic health problems and poor mental health, a combination which so often plagues social work clients.

First of all, a motivational intervention is any clinical strategy designed to enhance client motivation for change. It can include counseling, client assessment, multiple sessions, or a 30-minute brief intervention (SAMHSA, 2013). According to Rollnick, Miller, & Butler (2008), the clinical method of MI, initially described in 1983 by one of the book's authors, William R. Miller, was developed as a brief intervention for problem drinking, in which patient motivation is a common obstacle to change. Over the last two decades, there has been a growing trend worldwide to view substance-related problems in a much broader context than diagnosable abuse and dependence syndromes (SAMHSA, 2013) which has further contributed to the rise and value of MI techniques. Starting in the 1990's, medical and social science researchers, including these same authors Rollnick, Miller, and Butler, tested MI with other health problems, particularly chronic diseases in which behavior change is key and patient motivation is a common challenge (Rollnick, Miller, & Butler, 2008). Until recently, clinicians and researchers in the addiction field viewed motivation as a static trait or disposition that a client either did or did not have. Now, as a result of the shifting literature, it is understood by social work, addiction, and their associated fields to be far more multidimensional in that it may be influenced by social factors or by a clinician's style. In this way, it becomes their task to elicit and enhance their client's motivation (SAMHSA, 2013). Therefore, more recent conceptual models emphasize the need to address broader social, environmental, and policy factors to promote individual behavior change (Hyman et al., 2007).

Today, following the Affordable Care Act's emphasis on integrated care and its implementation of Health Homes, the broad use of MI has "highlighted a growing trend to favor effective outpatient care over less effective or less studied—but far more expensive—inpatient, hospital-based, or residential care" (SAMHSA, 2013, p.147). Part of this new push away from

reactive treatment and more towards preventative and outpatient care also embraces a more positive, narrative approach when evaluating clients. Rather than “telling” clients what to do, be it quit smoking, to get sober, or to lose weight, the fields of medicine, psychology, and social work have learned that allowing the individual to articulate their own case for change is far more effective. Generally, clients are already quite experienced at defending their unhealthy behavior(s) against the pleas of loved ones or others in their lives who are requesting that they change. Since MI technique demands that the clinician collude with the stasis, it offers the client a rare opportunity to be put in a position where they must advocate for their own change and hear themselves articulate its potential benefits in their own words.

Whereas the treatment field has historically focused on the deficits and limitations of clients, there is a greater emphasis today on identifying, enhancing, and utilizing clients’ strengths and competencies. This trend parallels the principles of motivational counseling, which affirm the client, emphasize free choice, support and strengthen self-efficacy, and encourage optimism that change can be achieved (SAMHSA, 2013). As SAMSHA’s (2013) research paper proves, “clinicians who use a motivational style avoid branding clients with names, especially those who may not agree with the diagnosis or do not see a particular behavior as problematic” (p. 11). In this way, MI has given birth to whole new segment of the obese and chronically ill client population with whom clinicians now have an opportunity to influence change in a way which would likely not have succeeded in decades past.

In her article, Hardcastle (2013) clarifies some of the key features of MI, writing that at its heart is the “spirit” or “the style of interaction between the practitioner and client which should be one of collaboration, evocation, and autonomy” (p. 2). By collaboration, Hardcastle refers to the practitioner as a ‘supportive partner’ rather than a ‘persuasive expert’ who remains

nonjudgmental of the behavior throughout the conversation. The collaborative component of MI stands in contrast to more prescriptive, expert-driven interventions that are commonly implemented in the dietary and physical activity domains by medical practitioners. “Evocation” denotes the practitioner drawing out the client’s personal motives for behavior change by alluding to their stated perceptions and values. Finally, the emphasis on autonomy and personal choice in MI offers the client the opportunity to be in total control over the responsibility, ability, and decision to change (Hardcastle, 2013, p. 2). Specifically, motivational interviewing provides three of the key components that support psychological needs with one based on self-determination theory to enhance self-efficacy from social cognitive theory and the other from the theory of planned behavior to increase attitudes and perceived behavioral control (Hardcastle, 2012). These concepts will be expanded upon and evaluated in the following literature review.

Motivational Interviewing: A Discourse Analysis

While a far greater body of research exists on MI than I will be referencing, I have focused my brief review on that literature which examines the model objectively and is most relevant to its application with clients for whom weight-loss is a health necessity. Recent studies indicate the usefulness of the MI model, even contending that it has been the most valuable theoretical health promotion development of the decade (Bunton et al., 2000; Hoffman et al., 2005). One study in particular offers a supportive view of Stages of Change theory’s effectiveness for inducing weight loss in clients with serious and persistent mental illness (Hoffmann et al., 2005). In their one-year survey study of this population, Hoffmann et al (2005) find that participants who responded affirmatively to the readiness for change questions were significantly more likely to complete the program and experience positive results. This finding serves as an important reminder to clinicians that when multiple attempts at MI sessions fail to

move a client forward towards change, it is probably best to steer treatment towards a more realistic goal until the individual is more prepared to try again. Furthermore, it underscores MI as an important tool in determining an individual's readiness for change and whether or not he or she is a strong candidate for working on health and wellness goals in group and/or individual therapy.

Additionally, Hardcastle's (2012) research buttresses the effectiveness of the MI approach for promoting physical activity amongst lower socio-economic status groups (p. 318). Her study was one of the first to clearly delineate a robust relationship between MI and exercise, but it was in no way the last (Hardcastle, 2012, p. 330). This finding is particularly useful in the context of health and wellness interventions such as weight-loss groups which typically encompass issues of fitness and physical activity in addition to nutrition and diet. In a later article, Hardcastle (2013) writes of her most recent study, that it "suggests that a low-intensity MI counseling intervention is effective in bringing about long-term changes in some, but not all, health-related outcomes (walking, cholesterol levels) associated with cardiovascular disease (CVD) risk" (p. 1). The intervention was particularly effective for patients with elevated levels of CVD risk factors at baseline (Hardcastle, 2013, p. 1).

In fact, SAMHSA's study also identifies MI's effectiveness beyond just medical behavioral changes such as with substance abuse, smoking cessation, fitness, and weight-loss and applies it more broadly to enhance client commitment towards their own mental health care. The SAMHSA (2013) paper explains, "simple motivation-enhancing interventions are effective for encouraging clients to return for another clinical consultation, return to treatment following a missed appointment, stay involved in treatment, and be more compliant" (xviii). In this way, MI's benefits can be felt by even those social workers who do not work in healthcare settings or

have any passion for health and wellness promotion with clients, but struggle instead with no-shows, poor client attendance, or passive participation in therapy.

Any literature review would be incomplete, however, without a presentation of views counter to those with which I have aligned myself. I therefore, point first to Bunton et al. (2000) who argues of MI, “despite the apparent popularity of the model...there appears to have been little overall evaluation or assessment of the efficacy of this approach. Similarly, conceptual critiques that have been developed have received little explicit coverage” (p. 56). Their review of the studies prior to publication in 2000 finds, “serious internal and external validity problems in Stages of Change (SoC)” (p.66). They argue, “there has been insufficient and inconclusive outcome evaluation of SoC and its use in the fields of public health and health promotion. The model occupies a status unwarranted by the conventions of scientific outcome evaluation (Bunton et al., 2000, p. 66). While this review contains valid critiques, it is worth noting that MI has evolved greatly since 2000 following research discoveries about whom it benefits most and what specific conversation styles tend to have the greatest effect (SAMHSA, 2013). I therefore consider Bunton et al.’s arguments to be outdated and antiquated at this point.

Other critiques of MI have focused on its limited worth given its status as a short-term intervention. For example, Hyman et al. (2007) write of transtheoretical methods, “although these models have been widely applied in health behavior research, they may have inherent limitations as frameworks for effecting significant behavior change in a relatively brief time span” (p. 1157). Hardcastle (2013) adds to this critique by arguing that the majority of research on MI examines short-term rather than long-term behavioral and biomedical outcomes for overweight or obese people, noting that only two previous studies reported weight loss beyond six months (Hardcastle, 2013, p. 3). I echo these calls for more research on MI and behavioral

change, particularly with regard to its lasting effects over the long-term. The more information we have about when and with whom MI is most successful, the better off the field of social work will be in its targeted implementation of the technique. Furthermore, the research seems united in its findings that MI is largely ineffective in those clients who are totally apathetic with regard to change. Rather, it serves a critical purpose in cases where the client is ambivalent and the clinician's skill is the push necessary to move them from readiness to action.

Transtheoretical Clinical Implications

Out of my analysis of the Transtheoretical model and MI emerge several clinical implications for social workers that seek to inspire weight-loss promotion in their overweight and medically ill clients. For example, SAMHSA (2013) reports, "In the past, especially in the medical model, clients passively receive treatment" (p.11). The article continues:

Today, treatment usually entails a partnership in which the client and the clinician agree on treatment goals and work together to develop strategies to meet those goals. The client is seen as an active partner in treatment planning. The clinician who uses motivational strategies establishes a therapeutic alliance with the client and elicits goals and change strategies from the client. The client has ultimate responsibility for making changes, with or without the clinician's assistance. (SAMHSA, 2013, p.11)

In this way, MI has helped to fuel a move by the medical field towards implementing longstanding social work values of integrating the client or patient into treatment beginning with its planning and goal setting. That said, when it comes to issues of obesity and weight, many physicians simply do not have the training to compassionately and delicately address these topics with their patients. Alexander et al. (2007) discuss the possible reasons for this phenomenon:

Although obesity is ubiquitous, research shows that many physicians do not talk with their overweight and obese patients about weight loss. The results from this qualitative analysis suggest that physicians perceive many significant barriers that hinder these discussions. Societal factors such as the sedentary nature of work and the role of the family and other social groups interfere with these discussions. For physicians, scarce resources, low outcome expectancies, and lack of training may

be important factors that influence their ability and willingness to talk about obesity and weight loss (p.500).

Clinical social workers, however, offer their niche experience and skill in broaching difficult topics with clients while ideally avoiding “shaming” them for their body and/or behavior. Perhaps more importantly, social workers are trained extensively in how to acknowledge their own discomfort with this type of conversation, while simultaneously not allowing it to silence them and therefore shy away from the topic altogether. Finally, MI literature clearly makes the case for multiple rather than one isolated intervention attempt.

Hardcastle (2012) writes:

Although the current research suggests that any exposure to the intervention promoted increased physical activity, an important implication of the current study is that attendance to multiple sessions, with an optimal number appearing to be four to five sessions, leads to significantly greater physical activity participation relative to fewer sessions. Practitioners delivering motivational interviewing should, therefore, encourage patients to attend multiple sessions in order to maximize potential gains (p. 330).

This particular finding further makes the case for the value of merging group theory and MI together to form Health and Wellness meetings, so that each member would benefit from multiple interventions, particularly in the early phases of a group.

One area which remains unexplored in MI both in the research and clinically, is in its application to groups in addition to simply individual therapy sessions. Part of the impetus for this project stems from my curiosity regarding how the principles of MI in primary care for example, could be applied to and enhanced in a group therapy context. What would Yalom, “God of group therapy theory,” say, I wondered, about MI? I am particularly interested in the possibility that when combined, these two theoretical contexts could complement each other for maximum results in the health of group members. Although MI and psychodynamic theory are

rarely ever discussed in the same breath, I argue short-term/long-term divide in therapies serves only to exclude potential benefits to practice.

CHAPTER 4

Yalom's Group Therapy Theories

In this chapter I will review Irwin Yalom's theories of group therapy and discuss how they relate to many different contexts: inpatient, outpatient, long-term, short-term, supportive, and skills-based groups, as well as how they can be applied to health and wellness weight-loss promotion groups. It is my hope that this chapter will move beyond an individualized notion of Irwin's psychodynamic group therapy theory as exclusively applicable to insight-oriented treatment for managing psychiatric symptoms related to mental illness, grief, trauma, and/or

environmental stress and consider its relevance to health and wellness groups for polydiagnosed adults. Yalom believes in the power of groups as agents for change which he says occurs through sharing, involvement, and belonging (Jacobs, Harvill & Masson, 1994, p. 21). Through these “curative factors”, as Yalom refers to them, clients who are trying to lose weight alone, may find a group to be a useful agent for change in a way that individual therapy is not, particularly if they have had previous unsuccessful attempts. This argument will introduce a group theoretical approach to clients struggling with numerous medical and mental health risks such as diabetes, obesity, hypertension, bipolar disorder, tobacco addiction, and/or substance abuse.

This chapter, then, serves as a second foundation for the discussion chapter, wherein I will apply these understandings to practice with polydiagnosed individuals and elucidate how these theoretical constructs can provide social workers with a more complex understanding of this population’s needs than is forced by the traditional “evidence-based practice vs. insight-oriented interventions” debate. The discussion will argue that this internal debate within the field may be counterproductive to the goals of social work; that in fact, weight loss promotion in polydiagnosed clients requires a combination of these two approaches such as in the case of health and wellness therapy groups. These insights will redress the ways in which social work practice can combine MI and traditional group therapy theory in order to significantly impact and better serve one of its highest-need populations.

Defining Yalom’s Group Therapy Theory

I will begin this section by offering a (historical) background of group therapy, and Yalom’s theories, in particular, including their trends, principles, and key features. I will then briefly summarize the relevant existing empirical studies which investigate group therapy’s usefulness in addressing behavioral health issues as well as those whose findings counter my

argument and critique its effectiveness with certain populations. The conclusion highlights the implications of Yalom's principles for clinical practice with clients suffering from chronic health problems and poor mental health, a combination which so often plagues social work clients.

One of the earliest examinations of group dynamics was Freud's 1922 publication *Group Psychology and Analysis of the Ego* in which he emphasizes the leader's function as a parent figure in the group as well as how it functions as a reconstitution of the family unit (Polcin, 1991, p. 9). Polcin (1991) explains that many early psychoanalytic group therapists saw the key function of the leader to be interpreting individual transference dynamics of group members (p. 9). Other psychoanalytic workers such as Bion (1959) and Durkin (1964) felt that the function of the leader was to interpret forces at work within the entire group, rather than within individual members (Polcin, 1991, p. 9). Later, in 1969 when Yalom begins writing on his group therapy philosophy, he refers to the field as having become "ideologically cosmopolitan" in its varied approaches and expert perspectives (Yalom, 1970, p. x). Embracing rather than rejecting this diversity of methods among group theorists, Yalom addresses his many influences in the introduction of his book *The Theory and Practice of Group Psychotherapy*:

This book reflects my own eclectic ideological background beginning with a grounding in Freudian psychoanalytic theory and technique which was, over the years, complemented by a series of other influences: neo-Freudian theorists (especially Sullivan and Horney), brief-therapy approaches including behavior and somatic therapy, in-patient therapeutic community groups, conjoint family therapy with a period of valuable collaboration with the late Don Jackson, social psychology and small group dynamics, and sensitivity group work and affiliation with the National Training Laboratories" (Yalom, 1970, p. x).

Yalom also cites the impact of behavioral scientists on his theories whose research, he argues, allowed him to establish a scientific basis for the methods already being practiced by most American group therapists (Yalom, 1970). Yalom asserts that his writings on his group practice theories are directed towards therapists themselves, rather than clients of group therapy. He

asserts that his intention in writing this book is “to provide a guide for the training of group therapists” (Yalom, 1970 p. xi).

Today, psychodynamically oriented group leaders tend to concentrate on both group and individual processes (Polcin, 1991, p. 9). Yalom's therapeutic processes, in particular, emphasize experience and reflection on that experience (Dayus, 2001, p. 2). Yalom (1970) notes the similarities between this dynamic in individual as in group treatment, arguing that in both scenarios, the intellectual task is the exploration and integration of the past, which serves primarily as cement to keep therapist and patient tied together until the relationship solidifies and its subsequent exploration becomes the paramount mutative force (p. 123). Another example of individual psychotherapy theory percolating into that of groups is in the case of Carl Rogers's client-centered approach which eventually evolved into the popular “encounter groups” of the 1960s and 1970s (Polcin, 1991, p. 9). Polcin (1991) explains that consistent with the therapy of individuals, encounter group “facilitators” functioned in a nondirective, empathic manner that accepted the group unconditionally (p. 9). Likewise, rational approaches to counseling such as Glasser's “reality therapy” and Ellis's “rational-emotive therapy” developed group counseling approaches that were based on individual treatment. The essence of counselor functioning in both individual and group settings is to point out dysfunctional ways of thinking and behaving in order to help clients meet their needs more effectively (Polcin, 1991, p. 9).

Yalom indicates that interpersonal learning is another key therapeutic factor in group psychotherapy (Gallagher et al., 2013, p. 1) which he defines as “a broad and complex curative factor representing the group therapy analogue of such individual therapy curative factors as insight, working through the transference, the corrective emotional experience, as well as processes unique to the group setting” (Yalom, 1970, p. 16). Gallagher et al. (2013) assert,

“group therapists may facilitate such interpersonal learning, especially for those higher in attachment anxiety, by noting discrepancies and then encouraging convergence between an individual and the group in their perceptions of cohesion to the group” (p. 1). Yalom’s research demonstrates that interpersonal learning is an important and dynamic factor in group-based psychotherapy that allows participants to share aspects of their emotions, thoughts, and perceptions while receiving feedback from fellow clients in a safe and collaborative setting such as, I argue, in the case of a health and wellness and/or weight-loss support group (Gallagher et al., 2013, p. 1). Yalom (1970) explains that this process allows individuals to challenge their interpersonal distortions which tend to be self-perpetuating, and to improve their awareness of the self, and of the dynamics in their interpersonal relationships.

Among the most commonly referenced of Yalom’s principles of group therapy are his descriptions of the various schools or orientations from which group leaders operate, what he dubs “leadership functions” (Polcin, 1991, p. 10). According to Polcin (1991), Yalom distinguishes these “fronts” or “outer trappings” from “core” mechanisms of group process and change which go beyond specific orientations and are the real, central factors in whether groups are productive or not (p. 10). Yalom’s research on encounter groups identifies and describes four major leadership functions which all prove equally effective in their implementation: emotional stimulation, caring, meaning attribution, and executive function (Polcin, 1991, p. 10). Block & Llewelyn (1987) explain the former style as leader behavior which places emphasis on revealing feelings and challenging members about their attitudes and beliefs during meetings, particularly through questions which may yield cathartic responses for participants (p. 262). Polcin (1991) writes of the second category, the “leadership function of caring” that:

it is implemented by the leader’s expression of warmth, acceptance, genuineness, and concern. The leader is open and honest with group members and seeks to

facilitate the growth of trust in the group. When effective, caring functions result in group members being able to increasingly give and receive emotional support and nurturance (p. 10).

Thirdly, “meaning attribution” includes behavior which helps members clarify and interpret their situation in order to provide a framework which promotes change or acceptance by labeling behavior so that feelings can be discussed in the group setting (Block & Llewelyn, 1987, p. 262). Finally, Block & Llewelyn (1987) write that Yalom’s “executive function” refers to a particular style of management which involves the leader in setting limits and rules for the group, directing them towards certain goals, and organizing the discussion (p. 262). Yalom (1998) has commented on this style of leadership as being most common among CEO’s and in business settings where the appearance of confidence must be constantly maintained at all costs. In assessing the effectiveness of these functions, Yalom concludes that the most effective styles of leadership involved the following: (a) moderate amounts of emotional stimulation, (b) moderate amounts of executive direction, (c) frequent use of caring functions, and (d) consistent use of meaning attribution (Polcin, 1991, p. 11).

Yalom's theory and principles of group psychotherapy suggest that the process leading to therapeutic change is very complex. According to Dayus (2001), the basic premise of change in Yalom’s findings lies in the fact that human experience can be therapeutic to our lives. Jacobs, Harvill & Masson (1994) note that Yalom uses the term *universality* when discussing the value of getting people together in a group therapy setting (p. 3). This feeling of commonality offered by groups, which Yalom also refers to as the “sense of belonging” is helpful and therapeutic for most individuals and cannot develop in individual counseling (Jacobs, Harvill & Masson, p. 3, 1994). He also discusses the positive value of vicarious learning, which includes both the lessons offered by fellow group members rather than the therapist and the phenomenon of benefitting from observing the therapy of another patient with a similar problem constellation (Yalom,

1970). Concepts related to Yalom's theory have been expanded upon and evaluated in the literature review.

Yalom's Group Therapy Theory: A Discourse Analysis

Unlike in the case of MI, a massive body of research evaluating Yalom's group therapy theory is not present in the literature. Far more studies on the topic evaluate group therapy more generally, rather than focusing on Yalom's principles in particular. Polcin (1991) addresses the dearth of research in this area, writing:

Several broad, general examples of how to consider the use of various functions in light of clinical setting and client population factors have been described. More specific suggestions for a prescriptive use of functions await further research. The area of group counseling is in critical need of empirical studies documenting the effective use of different leadership functions under different counseling conditions (p. 11).

I have therefore been able to focus my brief review on those few articles which do examine Yalom's model objectively and are most relevant to its application with clients for whom weight-loss is a health necessity.

A Dayus (2001) study indicates the usefulness of Yalom's theories when applied to support group therapy with infertile couples. The group treatment, which followed his principles, allows the couples to promote their health and well-being and support each other through the emotionally challenging experience of failing to conceive (Dayus, 2001). Dayus (2001) finds that Yalom's techniques are all "adjuncts to holistic healing or ways that we use our minds to change behaviors to promote health" (p. 4). This description of the benefits of Yalom's methods when applied to behavior change is reminiscent of those offered in the literature on MI, further demonstrating their unlikely similarities and potential for combined efficacy. I therefore argue that these applications of Yalom's "adjuncts to holistic healing" and focuses on coordinating the mind and body can inform health and wellness, as well as supportive infertility groups.

A more recent study of a binge-eating disorder group verifies Yalom's assertion that interpersonal learning and cohesion serve as cornerstones of positive outcomes in group psychotherapy (Gallagher et al., 2013). Gallagher et al. (2013) confirm this idea of Yalom's, stating, "groups offer a unique context for interpersonal learning given the opportunities for immediate feedback from peers and therapists" (p. 9). Results of this study suggest that clinicians may even improve the effectiveness of group-based interventions by encouraging interpersonal learning through helping individuals work toward convergence between their own and the group's perceptions of the individual's cohesion to the group (Gallagher et al., 2013).

Polcin (1991) expands on these findings in his paper, explaining that for the most part, counselors have tended to rely on theoretical orientations developed from individual therapy as a guide for group leadership, such as in the cases of psychodynamic, behavioral, and client-centered. He continues:

The application of these theories to group treatments, however, has been somewhat awkward and has required substantial modification. Furthermore, as Lieberman, Yalom, and Miles (1973) have shown, the actual behaviors of group leaders do not seem to be determined by theoretical orientation. In fact, the "leadership functions" that they found to have a therapeutic effect on groups were not related to specific orientations or schools of thought (Polcin, 1991, p. 8).

Yalom, himself, addresses the limitations of his theories, warning his readers that group counseling is "not for everyone," and that in fact, it can be harmful to individuals who do not want to be in, are not ready for, or may disrupt the group (Jacobs, Harvill & Masson, 1994, p. 22). In these cases, write Jacobs, Harvill & Masson (1994), Yalom advises his readers that individual counseling is likely more appropriate. An examination of the group counseling literature, however, reveals that minimal attention has been paid to this work (Polcin, 1991). Polcin (1991) writes:

Counselors therefore continue to rely too heavily on individual treatment models as a guide for group work. Furthermore, the literature has not sufficiently

expanded on this important research by examining when to use various leadership functions under different counseling conditions (p. 8).

The lack of literature on the efficacy of Yalom's group therapy techniques further support my argument that more research is required in this area of social work, particularly with regard to his theories' relevance to health and wellness groups.

Yalom's Clinical Implications

Out of my analysis of Yalom's group therapy theory emerges several clinical implications for social workers that seek to inspire weight-loss promotion in their overweight, obese, and/or medically ill clients. For example, his assertions that not all members of this population necessarily should participate in a health and wellness group, support pre-screening clients in order to evaluate their suitability prior to the first meeting. MI could potentially be useful in this process as an interview strategy for identifying an individual's stage of change and readiness for the significant effort entailed in weight-loss and other healthy lifestyle modifications.

Yalom also illuminates the value of the sense of belonging that group therapy offers clients which can be beneficial above and beyond what members may experience in individual therapy. Furthermore, the vicarious learning that occurs in a group context often outweighs what clients may gain simply from the clinician who may or may not authentically connect to their struggle of healthy living. Fellow group members offer not only accountability to each other in their goal setting, but also multiple levels of support and understanding emanating from their shared experience that reaches beyond simply the group therapist's leadership ability, wisdom, or skill. It would stand to reason then, that health and wellness groups should be closed rather than open, as the earned trust and consistency of members are more likely to flourish when predictability of members is present. These concepts are particularly pertinent when considering

the value of groups promoting health behavioral changes, which so critically rely on the cohesiveness and openness of their members for success.

The major contribution of Yalom's research is that it provides group practitioners with guidelines about what to actually do in groups to be effective (Polcin, 1991). Health and wellness group leaders have much to gain from reading Yalom's discussions about diverse leadership styles. He advises that the facilitator as "processer" - making connections between what happens in group and what may be happening out in the world – rather than as evaluator, yields optimal results for client improvement over time (Yalom, 1970). In the case of health and wellness groups, this seems particularly relevant when these connections are made by the leader in the form of observations of resistance that may be mirroring the challenges clients are experiencing in achieving their goals outside of meetings. Furthermore, Yalom highlights the importance that the genuine caring of the clinical leader comes across to members (Polcin, 1991). In the context of a health and wellness group, perhaps the leader's initial introduction to the group would be one important way to begin demonstrating this principle. For example, he or she may choose to share how and why they came to be interested in working on these issues with clients, as well any personal connection that they may have to them. In addition, an assertion of the leader's strong belief in their clients' abilities to make the changes they seek could likely go a long way towards setting the tone for caring leadership throughout the group process.

In the same vein, Yalom argues in favor of leadership which makes space for emotional expressions and processing of feelings related to the group topic such as fear. In the case of a health and wellness group, discussions related to barriers to change or even the complexities of what may be lost through a body's transformation, would be an appropriate form of promoting emotional processing. Typically, society only considers the positive outcomes of weight-loss, but

some clients in health and wellness groups may be clinging to their size for a variety of conscious or unconscious reasons as a protective factor for their survival. For example, much has been written about formally sexually abused women who become overweight or obese later in life as a subconscious form of repelling potential future perpetrators (Lobraco, 2014; Noll et al., 2007; Chartier, 2007). My interpretation of Yalom's theories is that he would favor bringing these types of analyses into the room of a weight-loss group, rather than strictly adhering exclusively to CBT or short-term goal-based interventions.

Conclusion

During this time in our healthcare system when budget, cutting costs, and profit margins are the top priorities of most hospital and agency administrators where social workers provide services, group therapy also offers increased efficiency by billing for multiple clients simultaneously. Even in 1969, Yalom noted this benefit, "Group therapy has had a succession of attractive wrappings: it was, during World War II, the economical answer to the shortage of trained therapists; later it became the logical treatment arena of the interpersonal theory of psychiatry; and currently it is a medium for alleviating individual and social alienation" (Yalom, 1970, p. 385). These benefits all still ring true today, including the latter which is being broadly discussed particularly with regard to clients with serious mental illness. Finally, the funders of our healthcare are prioritizing preventative care by investing in eliminating social isolation among the chronically ill, motivating clients to change before their health deteriorates, and evidence-based techniques such as MI. When Yalom's group therapy theories are combined with MI and these other benefits offered by health and wellness groups, the result would clearly be a worthwhile investment for insurance companies and other payers. For all of the stark differences between MI and Yalom's theories of which there are many (short-term vs. long-term, individual

context vs. group context, twenty-five years old vs. fifty-five years old), each has a body of persuasive literature referring often to its respective efficacy as an agent of change. Jacobs, Harvill & Masson (1994), for example, argue that the “power of groups is that both the fellow members and the group leader can combine together to be agents of change” (p. 295). This bit of commonality between these two differing perspectives will be further examined in the following discussion chapter in order to conclude my argument in favor of merging both theories in social work practice with polydiagnosed clients.

CHAPTER 5

Discussion and Case Study

Mind and body dualism was a convenient philosophy that used the “divide and conquer” strategy to cope with prevalent religious thinking, and subsequently fitted well to deal with the complexity of human nature. It, however, cost us dearly, as it took our focus away from the dynamic nature of human beings, their relationship with the environment and their real health concerns, and to that extent blocked the development of effective interventions.

Mehta, 2011, p. 209

In the last chapter, I will employ the previous discussion of MI and Yalom's group therapy theories to practice with polydiagnosed individuals and elucidate how these theoretical constructs can provide social workers with a more complex understanding of this population's needs than is offered by the traditional "evidence-based practice vs. insight-oriented interventions" debate. I will argue that this internal debate within the field may be counterproductive to the goals of social work; that in fact, weight loss promotion in polydiagnosed clients requires a combination of these two approaches such as in the case of the health and wellness therapy groups. My hope is that these insights will redress the ways in which social work practice can marry MI and traditional group therapy theory in order to significantly impact and better serve one of its highest-need populations. What follows is an attempt to extract some of the key features of these two differing perspectives through the case study of Rachel in order to conclude my argument in favor of merging both theories in social work practice with polydiagnosed clients. I undertake the following exercise in critical analysis, therefore, with every effort to hold and identify implications for clinical practice.

Review of the Major Constructs

The layered complexities of somatic and psychiatric symptomology that shape the experiences of polydiagnosed individuals are vast. Further impacting this population's mental and medical health are the many barriers they face in our society. Many of these clients are unable to work and are therefore stigmatized, isolated from potential social supports, reliant on fixed incomes, and residing in food deserts or similarly limited areas. Negotiating nutrition education and counseling in therapy amidst these significant barriers is by no means a simple task, but it is a necessary one for those social workers who practice with this population. There is

a paucity of previous research that examines this experience through a theoretical orientation and clinical lens. However, those empirical research studies that do exist continue to explore the intersection of diet and mental health and the best practices in implementing nutrition counseling as a part of social work practice with individuals and groups (Bartels & Desilets, 2012; Bassett, Lloyd, & King, 2003; Brown, Goetz, & Hamera, 2011; Evans & Burghardt, 2011; Evans, Newton, & Higgins, 2005; Harper, 2010; Hoffman et al., 2005; Hulme et al., 2003; Hyman et al., 2007; Jean-Baptiste et al., 2007; Lakhan & Vieira, 2008).

Chapters III and IV examined MI and Yalom's group therapy theories. MI, which emerged from the transtheoretical theory, is a clinical interviewing strategy designed to enhance client motivation for behavioral change. It is generally considered to be an "evidence based" short-term intervention and can include counseling, client assessment, multiple sessions, or a 30-minute brief interview (SAMHSA, 2013, p. xviii). In recent years, physicians have discovered and embraced MI as a means of identifying and pushing those patients who are ambivalent about healthy behavior change from readiness to action. In this way, the theory has helped to fuel a move by the medical field towards implementing longstanding social work values of integrating the client or patient into treatment beginning with planning and goal setting.

Yalom's theories emphasize therapeutic process of and reflection on experience (Dayus, 2001, p. 2). He indicates that interpersonal learning, which he defines as "a complex curative factor representing the group therapy analogue of such individual therapy curative factors as insight, working through the transference, the corrective emotional experience, as well as processes unique to the group setting" is a key therapeutic element in group psychotherapy (Gallagher et al., 2013, p. 1). Lastly, Yalom's theories examine his identified four major leadership functions (emotional stimulation, caring, meaning attribution, and executive function),

which, according to his research, all prove equally effective in yielding therapeutic change (Polcin, 1991, p. 10).

The theories—MI and Yalom’s group therapy theory—are in line with my investigation of the connection between diet and mood that may impact the experiences of polydiagnosed individuals whose improved health is dependent on their ability to lose weight. Furthermore, these theories can provide a more pertinent and constructive framework for clinical social work practice with these individuals. The next section presents an in-depth analysis of the present phenomenon and theories through a composite case of Rachel.

The Case of Rachel

The following case study is a composite case of several clients from my past clinical work. All identifying information has been modified to ensure confidentiality for the purposes of this study.

Rachel is a 42-year-old female who self-identifies as a single Puerto Rican heterosexual woman. She has been on disability for thirteen years due to mental health issues including a bipolar diagnosis characterized by chronic depression as well as an anxiety disorder which produces frequent panic attacks. She is the single mother of one fifteen-year-old daughter with whom she has a tense relationship. Rachel was never married and she reported that her daughter’s father “bounced the second he heard I was pregnant.”

When Rachel first began treatment, she expressed how concerned she was about feeling so depressed and unmotivated, particularly considering her recent medical hospitalization which revealed that she had developed diabetes. She reported, “almost caring less now about getting healthy than before this news,” because her new diagnosis was such a blow and made her feel

like “what’s the point in even trying?” At the same time, she articulated strong reasons for this “wake-up call” to serve as motivation to her to make some lasting lifestyle changes. In discussing her health, she noted that she used food to fight boredom and unbearable feelings of hopelessness and helplessness, and that eating was the only experience in her daily life to which she looked forward. Since the most recent bout of this depression had worsened about eight months prior, she had gained eighty pounds. Suddenly being “fat,” as she described herself has been quite the shock for her considering her history of being normal weight for most of her life prior to this period.

Rachel also revealed several past hospitalizations for suicidal ideation and said that at these points in her past she “really needed help” and appreciated the safety the hospital offered. Her trauma history includes a childhood rampant with witnessing domestic violence between her parents, emotional abuse from her family members, bullying and beatings at school, and sexual abuse by a perpetrator whom she never revealed to me. Recent traumatic losses of hers included a relationship that ended a year ago after she learned that her boyfriend had cheated on her with multiple women, the friends she had obtained through this relationship, relational difficulties with her immediate and extended family members, and financial strains given her limited fixed-income.

Rachel has expressed her shock upon learning that her ex-boyfriend was cheating on her exclusively with overweight and obese women, which at the time, she was not. She and I talked about the possibility that her recent extreme weight gain could be a subconscious attempt at getting his attention. Rachel did not see this connection and was somewhat reserved when I would bring it up.

Rachel occasionally presents with a labile mood but her overall affect is sad. On particularly hard days, Rachel would describe herself as "overwhelmed and useless, just a very depressed human being." She always made a point to note that if she had more friends or supportive people in her life that understood her plight, she felt that she would be better equipped to make progress towards her health goals. On some days, however, Rachel seemed to gloat in her descriptions of how successful she once was in the past, especially in terms of her previous weight-loss experience ten years prior when she lost 100 pounds. She sometimes struggled to balance these feelings and make sense of what she felt especially during her more difficult days. Rachel relied heavily on feedback from others while also struggling to accept praise of any sort.

Rachel utilized her individual therapy sessions to process her feelings of low self-esteem and "stuckness" and explore the source of her resistance to improving her diet and physical activity level. She agreed to attend weekly individual sessions as well as a weekly health and wellness group for clients battling both mental and medical chronic illness in order to take control of her health and weight "once and for all," which she reported she could not do without help from professionals. She will also continue teaching her aqua aerobics class to senior women once a week at the local YMCA on which, even throughout the worst of the depression, she has always managed to follow-through.

Analysis

There are many ways to explore the present case study in thinking about Rachel's clinical treatment and prognosis after therapy. An MI paradigm combined with a Yalom-informed health and wellness group may best benefit this client in terms of understanding the interplay of her depressive symptoms such as lack of motivation and relational difficulties, and her diabetes and

recent weight gain. Identifying the client's existing resources and resiliencies will serve her in setting realistic goals towards improving her overall health. I will first explore Rachel's case through the theory of MI to begin this analysis. I argue that a clinical application of MI asks that practitioners understand the meanings and experiences of the patient's ambivalence regarding making healthy lifestyle changes and also include an examination of the existing barriers posed by the client's mental illness.

A Motivational Interviewing Analysis of the Case of Rachel

I have explored a clinical MI analysis through the case of Rachel. In the next section, I will apply Yalom's group therapy theories in order to explore clinical treatment approaches with this client. MI and the transtheoretical model of change offer a theoretical basis for Rachel's fluctuation between her desire to improve her health following her recent diagnosis of diabetes and her despair at the somatic and psychiatric symptoms she experiences, the combination of which leads to an incentive paralysis exacerbated by her social isolation. Ideally, some sort of therapeutic alliance should be established within the relationship before the MI takes place, even if that trust building process is built into the first session.

Assessing a person's readiness for change, especially in an individual with serious and persistent mental illness, is an important but critical challenge in order to identify the most appropriate intervention for their stage of change (Hoffman et al., 2005). A practitioner therefore might begin with Rachel by using brief MI techniques in order to empower her to articulate her own reasons for wanting to change. The clinician's tone during this interview should be nonjudgmental, empathetic, and encouraging (Hyman et al., 2007). Understanding her vacillation may also lead to a beneficial exploration of her mental health issues.

Once Rachel can be identified as ready for change according to principles of MI, Hardcastle, Blake, & Hagger (2012) conceptualize that her therapist might examine her ambivalence and elicit self-directed “change talk” as well as employ strategies to build her autonomous motivation such as agenda setting, decisional balance, and negotiating a transformation plan (p. 322). It would be important for the clinician to avoid the temptation to tell her all the reasons that she should make lifestyle changes, but rather to assume that she knows them and has been informed of them previously by physicians, loved ones, and/or society (Hardcastle, Blake, & Hagger, 2012). Specifically, in the case of Rachel, a practitioner might take a patient-centered MI approach including agenda setting for a typical day, an exploration of the pros and cons of change, an examination of the importance and confidence rulers, and the ‘two possible futures’ strategy (looking over the hypothetical fence) (Hardcastle, Blake, & Hagger, 2012). Discussion around planning would involve considering potential obstacles and barriers to change as well as enlisting social support to help advance efforts towards the behavior change. I have explored a clinical MI analysis through the case of Rachel. In the next section, I will apply Yalom’s group therapy theory in order to explore clinical treatment approaches with this client.

Yalom’s Group Therapy Theories and the Case of Rachel

Yalom’s theories investigate the ways in which group therapy has tremendous benefits for the majority of its participants through what he calls “curative factors”. Furthermore, he addresses the various “leadership functions” he observed in his research, and his observation that they each have widespread therapeutic effects unrelated to specific orientations or schools of thought (Yalom, 1975). In this section, I will explore Yalom’s theories through the case of

Rachel. I argue that these theories can be applied in clinical practice to combat the ways in which the combination of mental illness, obesity, and social isolation encourage disconnection and a negative spiraling of health status. Additionally, I argue that Yalom's theories, in their exploration of group curative factors and leadership styles, encourage healthier living, motivation, and resiliency by transforming human bonds and connections.

Yalom studied the therapeutic factors operative in group therapy, and developed a taxonomy of twelve factors, which have been used with a variety of groups in a wide range of settings (Block & Llewelyn, 2007). In Block & Llewelyn's (2007) study, participants overwhelmingly ranked the factor of leader "guidance" as the "least helpful" technique, confirming Yalom's suggestion that therapists may withhold giving advice to patients in the belief that this would serve their best interests (p. 268). What is so striking about this finding of Yalom's, is its resemblance to the teachings of MI in which clinicians are instructed never to "tell" patients to make changes but rather to empower them to discover them for themselves. This area of overlap between MI and Yalom's theories further endorses my argument that the two can work effectively together in cases such as Rachel's.

Rachel is an individual who seeks meaningful connections as exhibited by her fostering of relationships with her therapist, her "old ladies" (her reference to the senior students of her water aerobics class), and her history of long-term romantic relationships. However, she has expressed feeling less and less connected to her family and friends as characterized by her depressed and isolated feelings. Under these circumstances, independently motivating to exercise and eat better is going to be exceedingly difficult. In this way, a group may offer supplemental support both for her depressive isolative symptoms and as additional motivation from others who deeply understand her experience given its similarity to theirs.

Moreover, Yalom wrote of the value of “interpersonal learning” in group psychotherapy which he explained is an important and dynamic factor that allows group members to share aspects of their emotions, thoughts, and perceptions while receiving feedback from fellow group members in a safe and collaborative setting (Gallagher et al., 2005, p. 1). This process allows individuals to challenge their interpersonal distortions and improve their awareness of the self, and the dynamics in their interpersonal relationships (Gallagher et al., 2005). Once adjusted to the group, Rachel may therefore be able to utilize her newly found meaningful relationships with other group members to foster self-esteem, confidence, and inner strength – all prerequisites for a successful weight-loss experience. The group psychodynamic therapeutic process offers a unique opportunity for Rachel to confront and further process her experiences of early childhood abuse and neglect and their connection to the comfort food now offers her.

Yalom (1970) writes, “a focus upon the here-and-now process is, to my mind, fundamental to effective group therapy technique” (p. 109). A health and wellness group therapist may employ this strategy as a means of suggesting that members wipe their slates clean of past unhealthy behaviors and use the group as an opportunity to “start fresh”. The leader of Rachel’s group therefore might use one member’s report that he does not want to participate in the walking activity that day as an opportunity to examine the sources of his present state of resistance. By using one group member as an example of how to overcome feelings of sluggishness and lack of motivation, everyone can benefit by relating the present moment to their own similar struggles. As the Perlman et al. (2010) study of health and wellness group treatment with a “highly comorbid, chronically ill” population found, group process is “quite effective in encouraging change” (p. 120). Perlman et al.’s (2010) research further underscores the feasibility and importance of integrating psychosocial and physical interventions in cases such as Rachel’s.

Synthesis

Clinical practitioners can benefit from utilizing the combined approach of MI and Yalom's group therapy theory when leading health and wellness groups, as well as in individual nutrition counseling as a component of psychotherapy. MI techniques may be used as a means of identifying appropriate members or as a supplement to groups in individual psychotherapy as a brief or short-term intervention to support identified behavioral health goals. Additionally, clinical treatment plans which include group therapy opportunities seek to encourage strength, empowerment, and resiliency beyond what is learned in individual psychotherapy through the curative factors Yalom examines in his research.

Uniting MI techniques with Yalom's theoretical frameworks supports a working paradigm for clinical practice that encourages holistic and integrated culturally responsive healthcare as well as mutual empathy in the struggles inherent in weight-loss. These theories ask clinical practitioners to acknowledge that mental health and physical health are clearly connected, and to improve their services by paying closer attention to how mental health care and general medical health care interact (Jensen, Decker & Andersen, 2006). Clinical practitioners must also be prepared to question their own biases and assumptions about their clients' behaviors. MI and Yalom's group therapy theories provide clinical practitioners with an opportunity to challenge the traditional notion that the two primary schools of thought in social work (short-term versus long-term treatment modalities) cannot be merged.

The analysis presented through the case of Rachel highlights interventions that may benefit the therapist in understanding how to approach clinical treatment with clients working towards weight-loss and nutrition goals as well as on mental health problems. The case analysis

is intended to provide further insight of MI and Yalom's group therapy theories as relevant frameworks for clinical practice. Next, I will explore the strengths and weaknesses of the framework presented.

Strengths and Weaknesses

A MI and Yalom-informed group therapy approach yields several strengths in addressing the connection between poor diet and psychiatric symptoms such as depression and anxiety. The current study utilizes a theoretical approach to explore, analyze, and recontextualize the complex medical and mental health needs of polydiagnosed individuals seeking treatment in today's healthcare system, moving away from past practice modalities and frameworks that have consistently kept separate medical and mental health care to the detriment of this population. Traditional scholarship has by and large overlooked health and wellness groups as a model for merging the two competing disciplines of nursing/medicine and social work in order to deliver holistic clinical care that combines the skills of each practitioner. When united, MI and Yalom's theories offer a clinical assessment and treatment plan that attempts to encompass the entirety of an individual—including their somatic, psychiatric, and intrapsychic worlds.

However, it is also important to note that not all clients who experience both mental and medical illness are ready to discuss or even should attempt to engage in healthy lifestyle changes. Additionally, every individual's experiences are unique to their particular medical and mental health needs as well as their background and environment. It is difficult to generalize across one diverse population to find a clinical treatment model that addresses most issues and concerns inherent in integrated healthcare. Furthermore, as my project required a limited scope due to the requirements of a master's thesis versus a doctoral dissertation, I did not address exercise as a

mitigating factor of poor diet and nutrition. Clearly exercise or lack thereof can have grave effects on a person's health which is a critical variable when considering weight-loss interventions. That said, these treatment recommendations offer vast clinical implications in working with polydiagnosed individuals and ask that practitioners utilize a combination of theoretical frameworks that can address multiple issues and concerns of this population.

Consideration of Implications for Field of Social Work

MI and Yalom's group therapy theories provide a contextual analysis of micro and macro level systems that strengthen social work practice, policy, and research. Combining these theories promotes a paradigm shift in expanding the knowledge base of the social work field as highlighted in the profession's core values and mission statement. Social work practice, policy, and research have been limited to traditional psychodynamic, and more recently, shorter-term, evidence-based therapies as opposed to a broader view of mental health that includes issues of physical health and illness as well. I propose that social work training incorporate basic principles of nutrition and health into its bachelor and masters curriculums just as nursing, and other medical curriculums touch on mental health care in theirs.

Furthermore, I would like to restate my earlier call for additional research on topics related to nutrition counseling in psychotherapy, particularly with regard to communities of color and clients of lower SES. Hoffman et al. (2005) echoes these sentiments, writing:

“Although studies of weight gain intervention in persons with mental illness are limited, results consistently support at least moderate effectiveness of nutritional education and mild exercise, like walking, on weight loss. Clearly, there is an unmet need for prospective, randomized trials to determine the effectiveness of weight intervention programs that could promote weight loss and perhaps even prevent weight gain in persons with serious and persistent mental illness” (p. 1579).

Unfortunately, the disparities in the present literature also reflect those of the health status of many underserved populations that social workers tend to treat. Hardcastle, Blake, & Hagger (2012) write, “little research exists on the impact of behavior change interventions in disadvantaged communities” (p. 318). Public health literature has documented extensively that obesity and other chronic health problems disproportionately affect people of color, those living in food deserts, and folks who are low and fixed-income (Atdjian & Vega, 2005; Kaplan 1996). The field of social work need not fall behind on its tackling of these important and difficult issues, particularly given its emphasis and historical basis on the person-in-environment perspective.

Relatedly, therapeutic nutrition interventions are worthless if they are not culturally sensitive and catered to the individual’s context in society. Reframing as opposed to blaming clients for their unhealthy learned and adapted behaviors is a critical piece of culturally competent nutrition counseling. Removing the individual from the greater picture of their poor health and addressing its structural causes such as a lack of available and accessible preventative care resources can help clients to relieve themselves of guilt and shame they may feel about their weight problem. This can be particularly important when the client has been taught to cook or prepare certain high-fat, high-carbohydrate dishes from their culture that are unfortunately contributing to their poor health. I would strongly urge social workers, particularly those with many areas of privilege, to be aware of these types of nutrition dilemmas in their work with clients from cultures that are different than their own. I will never forget my rookie error during my first year placement when I questioned a client about her willingness to attempt a vegetarian diet for health reasons and was scoffed at endlessly considering her Jamaican culture’s emphasis on meat. She graciously informed me that “a Jamaican who doesn’t eat chicken or goat ain’t no

Jamaican at all”. In incorporating nutrition counseling into social work practice, we must preserve clients’ culture and traditions through the adaptation of recipes to their individual health needs by reducing fat and/or sugar content, or promoting smaller portion sizes or increased vegetable volume rather than eliminating dishes all together. By instructing a client not to eat foods central to their identities, we may unintentionally be invalidating the family members who taught them the culinary lessons they hold dear, or key pieces of their lived experience.

For example, in the case of Rachel, Spanish beans and rice was a staple of the diet on which she was raised, and to this day it is served every Sunday evening at her family’s weekly post-Church gathering. In our work together, I was conscious of not directing her to avoid these gatherings or refuse her family’s cooking, but rather to approach the food from a strengths-based perspective, noting first how nutritional, cheap, and beneficial beans are, and then to examine healthier preparation techniques for the rice. Eventually, through our nutrition counseling, she came up with a new version of an old favorite family recipe in which she prepared the rice using olive rather than vegetable oil and substituted smaller portions of brown rice for endless heaps of yellow rice. These types of conversations can be particularly well executed in the context of health and wellness groups where multiple members can weigh in based on their own experiences with making diet modifications sensitive to their respective cultures. It is my hope that the trajectory of this research sparks similar investigations into the role of social workers, particularly medical social workers, in fighting our nation’s obesity crisis.

Although much was made in this project of the value of group work, particularly those with a health and wellness focus, as a means to employ many of the findings in this project, I do not mean to imply that it is the only one. Many opportunities also exist in individual therapy to practice holistic, mind/body, and medically integrated mental health care with clients one-on-one

through nutrition counseling, logistical and psychological barrier breakdown activities, MI, and other similar interventions. Ideally, I would like to suggest that social workers be trained and prepared to tackle these issues with clients in both mediums of treatment.

This paper clearly demonstrates that health and mental status are, in fact, linked. Clinicians must be mindful then in their treatment and diagnosis of their clients' total health pictures. They must take into account such factors as the conditions in which those they treat live, the culture of which they are a member, and genetic predispositions they may be at risk for depending on their particular family history and/or various racial, ethnic, and gender identities. The burden does not lie simply with the medical profession to value the contributions of social workers more, but also with social workers to not dismiss and distrust the field of medicine. When collateral healthcare providers battle each other even subtly, just as when social workers split themselves along strict theoretical lines, it can hurt those whom we are trying to help. Often, in an attempt to align with their clients, social workers unintentionally alienate physicians, particularly psychiatrists, who can bring another useful perspective to the client's treatment.

Conclusion

As healthcare, particularly preventative measures, become more and more integrated in a variety of medical settings in this country following the implementation of health homes and the Affordable Care Act, the lines of medicine and social work continue to blur. Clients present to both therapists and physicians with confusing symptomology originating from both psychiatric and somatic causes, yielding more teamwork and care coordination across disciplines. Throughout this study, I have argued for a theoretical stance that examines the impact of obesity and poor physical health on the psychiatric symptoms experienced by those living with chronic

mental illness. I have presented frameworks—MI and Yalom’s group therapy theories—that question a rift in the field of social work between evidence-based shorter-term behavioral strategies versus traditional psychodynamic long-term process-oriented work. However, it remains in the hands of social work practitioners, researchers, and advocates to take up the challenge and move beyond notions of the medical versus mental health binary and embrace practices that value truly integrated healthcare.

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