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OBM Integrative and Complementary Medicine

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Short Report

The Heavy Burden of Judgement: Cultivating Compassion with People Accessing Healthcare Services for Support with Weight Management

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Academic Editors: Neil Clapton and Syd Hiskey

Special Issue: Compassion Focused Therapy (CFT) – Advances and Innovations

OBM Integrative and Complementary Medicine
2024, volume 9, issue 1
doi:10.21926/obm.icm.2401020

Received: October 16, 2023
Accepted: March 19, 2024
Published: March 20, 2024

Abstract

Compassion focused therapy concepts and techniques are explored in the context of weight management efforts within community, specialist and surgical settings. Living at higher weights within a culture that over-values life at low weights can induce feelings of shame, self-loathing and hypercriticism. This article examines points at which individuals engaging in weight management may experience heightened distress and describes some of the ways that the model has been applied with this population. An outline of the way that CFT could be used to inform service delivery and development is proposed, from first contact through assessment, interventions and wider aspects such as staff well-being.

Keywords

Compassion focused therapy; weight management; shame; self-criticism; internalized stigma

1. Introduction

Compassion Focused Therapy (CFT) is a biopsychosocial psychotherapy approach well suited to addressing the challenges commonly encountered by people trying to manage their weight. It has been developed and refined over the past 20 years and draws from evolutionary science and therapeutic models including attachment theory and cognitive-behavioural therapy, as well as from philosophies that explore the nature of suffering such as Buddhism. This synthesis has created an approach that offers an in-depth analysis of compassion and how it may be applied to all forms of distress, in particular those that involve aspects of self-attacking and a resistance to self-compassion [1].

CFT emphasises the importance of social connectedness and interpersonal contexts. There is a focus on 'social mentalities' which describe biological systems associated with specific relational tasks; for example, caregiving/seeking, cooperating, competing [2, 3]. Social mentalities influence our attentional, memory, affective, cognitive and physiological processes, which therefore means that they can be experienced as very compelling and may be focused on either internal or external targets. A person might demonstrate sensitivity to the distress of another and feel motivated to alleviate it, while also being able to direct this sensitivity towards their own pain. In addition, CFT outlines an emotional regulation model that is linked with basic life tasks of threat/loss detection, resource acquisition and resting/digestion [4].

The current article aims to consider the ways in which CFT may be a valuable model when working with people engaging in weight management strategies. Within the current paper, this refers to those who are hoping to lower or maintain their weight, as opposed to increase it as may be the case with some forms of eating disorder or malnutrition. The article identifies common types of distress and psychopathology within this population, across the spectrum from community settings to specialist weight management services, exploring some of the relevant research into CFT and offering possible ideas for using the model within clinical practice. A broad perspective is applied, in that CFT is not purely viewed as a strategy to address internalized stigma, since this places the burden on people living at higher weights to take responsibility for resolving the discrimination they have faced, and in addition there are other well-being outcomes worthy of consideration. The article considers how the CFT model may be helpful with staff working in weight management services and also how compassionate action more generally may involve developing better-informed services that are less likely to trigger or strengthen that internalized stigma.

1.1 Weight Management in Community Settings

Living at a higher weight within a culture that overvalues thin-ness and stigmatises overweight can induce feelings of shame, self-consciousness and body image disturbances [5], and those individuals who already perceive themselves to be of a lower social rank may be particularly prone to body dissatisfaction and striving towards being thin [6]. The dieting and fitness industries invest vast sums of money promoting products which promise a particular size and shape which, for many reasons, is unattainable for the majority of people [7]. Without specialist education regarding the science of weight, people may end up setting unrealistic goals for their appearance and hold disproportionate responsibility for achieving them.

The concept of a 'set-point' for weight is not widely known among the general public and relates to an, often narrow, range of weight that the body's homeostatic systems try to maintain [8]. A

person's weight may be influenced by factors such as genetics, hormonal changes, mobility levels, medication side-effects, sleep quality and is not solely down to behavioural management [9]. In addition, recent research also highlights the role of epigenetics [10] as well as the gut microbiome [11]. An individual's set-point may drift over time and the body will tend to work to defend it's highest weight, e.g. by decreasing metabolism levels and increasing hunger hormones. Therefore there are various physiological forces operating against weight loss which means that long-term, sustainable weight management is not necessarily as simple as 'eating less, moving more'. This lack of education is widespread among healthcare professionals, which reinforces the idea that the key reason for living at a higher weight, as well as experiencing any related co-morbidities (or even unrelated health conditions), is a lack of self-control or inadequate motivation [12].

Under pressure from social norms, and without adequate knowledge, people may feel as though their only effective weight management option is to attempt drastic action to reduce their food intake and increase their movement. This can be a challenging task within an 'obesogenic' environment [9], in which ultra-processed foods are easily accessible, and sedentary work roles are common, particularly post-Covid. The interaction between the stimulation of reward pathways in the brain by high-sugar, high-salt energy-dense foods and the body's evolved homeostatic processes can lead to intense cravings and potentially to compensatory behaviours, such as over-eating or even binge-eating [13]. Consequently, there are multiple points at which people living at higher weights might experience acute feelings of self-contempt.

When trying to manage their weight, people may initially seek support from commercial diet clubs or be referred to other community initiatives by their GP [14]. Much of the advice is focused on a combination of a reduction of calorie intake and an increase in movement. Although this model has intuitive appeal, it may not take into account the different ways that people metabolise food and build muscle, or the impact of physical conditions (such as those that dysregulate insulin) and stress on hunger/fullness hormones and energy levels. It also neglects to address the complex interplay of psychological factors, such as negative affect, self-hatred and self-reassurance which can impact on hunger susceptibility and behavioural disinhibition [15]. Thus the evidence for the efficacy of commercial weight loss programmes is not strong [16].

For some, the commercial diet club environment may provide helpful motivation for weight loss and maintenance. The sense of connection with peers who are also engaging in active weight management and encouragement from group facilitators who may have been through a similar process could foster a sense of common humanity. For others, this type of setting may stimulate a competitive social mentality, whereby people are potentially ranked in terms of how much weight they have lost over a particular time period. The process of being witnessed while being weighed could trigger high levels of shame, especially if there has been weight gain. The sometimes non-linear trajectory of weight loss, which can be affected by non-obvious factors such as water retention, might lead people to feel frustrated, hopeless and prone to self-attacking. Patient experience of commercial weight loss programmes may therefore be quite mixed [17].

Another potential source of self-criticism can be the times where people have experienced a slip or lapse in their weight management behaviour [18]. This may be precipitated by a period of reward deprivation or rigid control of calorie intake which becomes unsustainable and leads to impulsive over-eating. A brief period of pleasurable feelings can give way to extreme feelings of self-loathing, shame and self-conscious distress. Over time, the oscillation between 'good' eating episodes and 'bad' eating periods, sometimes described as 'yo-yo dieting', can fuel low mood and depression [19].

1.2 Weight Management within Specialist Services

At some point, people living at high Body Mass Index (BMI) levels who have spent a period of time trying to manage their weight in the community, may become eligible to receive support from a specialist weight management team. These teams are sometimes based within hospital settings and are generally multidisciplinary, including staff such as endocrinologists, dietitians, psychologists, pharmacists and physiotherapists. Their aim is to offer both group and individual support to individuals which may include a range of behavioural and medical interventions for obesity [20]. They are likely to have links with bariatric surgery services too and therefore might also provide additional preparatory work for surgical weight management services.

There is great potential for de-shaming work within these settings, either within group programmes where people often have the opportunity to share experiences of weight stigma or during individual appointments with professionals who have specialist knowledge of obesity. The World Obesity Federation [21] describes how weight stigma may manifest within education, healthcare settings, workplaces, personal relationships and in the media, and at the time of writing was listed as one of their key policy priorities. Internalised weight bias or stigma has been linked with low self-esteem and disordered eating behaviours [22] and may require empathic confrontation in order for patients to achieve positive outcomes.

Compassion Focused Therapy techniques are likely to be useful for addressing relevant issues such as internalised weight stigma, emotional eating, secret eating, self-neglect and low self-esteem using concepts such as CFT case formulation, compassionate letter-writing, compassionate imagery work and general psychoeducation regarding emotional regulation and self-compassion [23]. A focus on fears, blocks and resistances towards compassion is likely to be needed, since people may have spent many years feeling unworthy of care and respect so it may feel unnatural to connect with a sense of inner value and safety [24, 25]. Consideration of the 'three flows' of compassion could also be helpful, given that individuals may be highly empathic and skilful when caring for others but feel unable to direct the same form of kindness towards themselves. The concept of 'three flows' refers to the direction in which a compassionate motivation may move, i.e. from self to other, from other to self, and from self to self [26-28]. In practice, the 'three flows' may be explored using imagery exercises and strengthened through tasks that allow for monitoring of their frequency and intentional scheduling of activities that encourage rehearsal either in solitude or with others.

Studies looking at how CFT might be included in clinical service provision have found some modest positive impacts on a range of outcomes. An evaluation of a 12-week pilot group weight management programme (n = 11) that incorporated cognitive-behavioural therapy (CBT), mindfulness, Acceptance and Commitment Therapy (ACT) and CFT was conducted within a primary care mental health service [29]. Improvements in weight-related self-efficacy (the ability to resist or control eating) and dietary choices were found, although these were not maintained at 6-month follow-up. Qualitative analysis showed that the group was well-received by participants and lead to improved well-being in the short-term. Participants emphasized the value of the group format of the intervention. Similarly, Nafisi et al. (2022) also found improvements in weight-related self-efficacy in their quasi-experimental study comparing CFT with Rational Emotive Behaviour Therapy (REBT) and a control condition [30]. Participants (n = 45) were women accessing therapy clinics for

dietary support regarding overweight. Both CFT and REBT lead to increases in self-efficacy as well as decreases in self-criticism.

Another pilot study explored the acceptability and feasibility of CFT as a 2-day intensive group programme for women living with overweight and obesity, recruited from community settings (n = 15), and found significant improvements in self-compassion, internalised weight stigma, psychological distress, life satisfaction, loneliness, body shame, body dissatisfaction and eating self-efficacy [31]. In addition, a smaller pilot study (n = 5) found that a 12-session CFT group lead to decreased body weight shame and increased self-compassion, and once again highlighted the importance of the group aspect of the intervention via qualitative feedback from participants [32].

A randomised controlled trial (RCT) conducted by Carter et al. (2023) compared CFT with a wait-list control condition in adults (n = 55) with BMIs of over 30 who experienced body shame, recruited via community settings [33]. They found a significant positive impact of the CFT intervention on body weight shame (both internal and external), self-compassion, fears of compassion, self-criticism and external shame. This is the only RCT that has examined the effectiveness of CFT on body weight shame to date. A large-scale non-randomised study (n = 974) added a digital CFT intervention to a pre-existing commercial weight management programme [34]. The addition of the CFT component lead to reduced binge-eating symptoms and body shame, and also improved psychological adjustment and self-evaluation, as well as lowered drop-out rates.

Palmeira et al. (2017) explored the relationship between internalised weight stigma and binge-eating behaviours in women living with overweight and obesity [35]. They interviewed 125 participants, 43.2% of whom met DSM-V criteria for binge-eating disorder, and noted that toxic self-criticism and decreased ability to self-reassure were important variables to consider within therapy. They suggested that the development of self-compassion, using a compassionate-based approach such as CFT, would be one potential way of addressing these issues. The relationship between obesity and over-eating is complex and we cannot assume that someone living with overweight has a higher calorie intake than someone living at a lower weight. However, binge-eating and emotional over-eating are commonly seen within specialist weight management services and sometimes require onwards referral to specialist eating disorder teams.

CFT for eating disorders has been more widely studied and therapeutic approaches developed, e.g. CFT-E [36]. People presenting with eating disorders have been found to experience high levels of self-criticism, self-directed hostility, and shame [37] and therefore CFT can offer targeted support for these difficulties. The foci for working with different eating disorder presentations may differ depending on the types of symptoms (such as restricting, over-exercising, purging, laxative misuse, binge-eating) but many of the key concepts may be applied trans-diagnostically. For example, the 'three circles' model can be helpful as part of psycho-education when helping people to find alternative ways of accessing feelings of safeness, value and comfort. This model looks at the way that individuals attempt to regulate their emotional state by activating cognitive-physiological systems related to 'threat', 'drive' or 'soothing'. These systems are associated with different neurotransmitter and hormonal patternings as well as affective states. The 'three circles' may also helpfully address the impact of diet culture on the drive system due to its target-oriented nature, whereby people seek relief from distress by moving towards goals. Exploration of early shame memories, attachment styles, social rank self-judgements and related rejection sensitivity may also be helpful as these variables have been round to be associated with severity of eating psychopathology [38-40].

A recent RCT [41] comparing CBT with CFT in a transdiagnostic group of patients with eating disorders in receipt of intensive inpatient treatment (n = 130), found that while both interventions were beneficial, CFT was superior for treating eating pathology in those with a trauma history. The authors suggest that the emphasis on self-compassion may mitigate feelings of shame and self-criticism which can be associated with childhood trauma. With regard to other factors that may influence intervention targets, the presence of weight/shape overevaluation has been found to increase the severity of psychopathology in binge-eating disorder [42] so it may be possible to improve outcomes further by including this as a focus in therapeutic work.

CFT can be used as a stand-alone treatment or CFT techniques may be incorporated into standard treatment programmes, in order to enhance outcomes and minimise factors associated with relapse [43]. Kelly & Carter [44] found that CFT may also be delivered as a self-help intervention, noting that participants low in 'fear of compassion' benefitted more greatly than those with high 'fear of compassion' in their pilot RCT (n = 41) comparing treatments for binge-eating disorder (CFT, behavioural intervention and wait-list control). Related to this, Goss and Kelly [43] discussed how CFT, when offered pre-therapy, can develop compassionate motivations for recovery and therefore enhance how people make use of standard treatments. Consideration of social mentalities can be a useful way of addressing the high degree of social comparison and striving to avoid inferiority commonly seen in this clinical population.

1.3 Surgical Management of Weight

There are some people for whom surgical management of weight is an option following specialist assessment of their medical, dietetic and psychological status, and often an extended work-up process too. There may be many points along this journey that individuals might experience self-conscious, threat-focused emotions. Prior to surgery, there is sometimes a sense of having taken the 'easy route' to weight loss by opting for bariatric surgery [45] and this can be reinforced by others. People can feel as though they have 'failed' at managing their weight by requiring a major elective surgical intervention.

During the assessment and work-up process, patients might join online support groups on social media and start to make comparisons with others regarding their progress. Although being part of a collective can stimulate cooperative and prosocial feelings, there is also the chance that it can simultaneously trigger competitive social mentalities. This can lead to people experiencing shame, guilt, self-criticism and envy. In addition, not all of the information shared via these platforms may be accurate [46]. Managing expectations can be a helpful part of the support offered by the bariatric team.

Following surgery, for many people there is a period of rapid weight loss which is often accompanied by feelings of relief, exhilaration and satisfaction. However, there may be considerable variation in the pattern of weight loss post-bariatric surgery [47]. Those who demonstrate an atypical trajectory, such as slower or uneven weight loss, or experience loose skin post-surgery are at risk of feeling disappointment which can develop into self-blame. Judgements from others regarding the individual's changing appearance and new eating behaviours can make social eating challenging and perpetuate a preoccupation with food, weight, shape and size [45]. Some patients are surprised to find that their self-esteem and/or impulse control has not improved as much as anticipated and may need input regarding deep-seated low confidence and ongoing behavioural

management of weight. In addition, a highly distressing and dreaded occurrence for patients following surgery is weight regain, which may be related to the return or onset of disordered eating behaviours for some. In cases where significant weight regain has occurred, patients can feel both internal and external shame, in that they not only feel bad about themselves but may also fear that bariatric team members will be disappointed in this outcome.

1.4 Weaving CFT into Service Models

Given that CFT has been investigated at varying time points in treatment and within different services that people living with obesity may be referred to, it is interesting to explore how the model could be applied to a single weight management clinical pathway. Even prior to first contact with clinicians, the correspondence sent out to people could be written in an explicitly de-shaming way that takes the complexity of obesity into account. The importance of self-compassion could be emphasised and a description of the service's values and philosophical approach to treatment could be outlined, for example within patient leaflets. Consideration regarding the naming of services is also important. Clinicians may wish to discuss how explicit the focus on weight loss and/or maintenance will be when interacting with clients, e.g. how regularly people will be weighed and who by.

Staff joining the team could be introduced to key concepts from the CFT model, such as compassionate attributes, myths regarding compassion and the three flows of compassion in order to develop a shared language and understanding between team members. These ideas could also be presented to clients, along with a general overview of the service, while waiting for their initial assessment. The research findings indicating that CFT can positively influence the way that people engage with later interventions suggests that sharing these ideas early on in the pathway may lead to improved outcomes, both in terms of weight management and well-being.

As part of the assessment process, particularly when reviewing mental health status and history, team members may wish to explore self-care, self-criticism and motivations for weight management. Staff may also want to explore language matching with their clients, so that they use words that fit with their experience, without reinforcing any internalised weight stigma. Case formulation and identification of different types of social mentalities, as well as potential fears, blocks and resistances could be identified at this stage. This could support later group or individual work which may include balanced education regarding the science of weight, the three circles model and compassionate imagery work. Running alongside these interventions, staff may wish to create reflective practice groups using themes from CFT to support their practice and perhaps their own wellbeing too. Location of appointments and the availability of bariatric equipment (e.g. chairs in waiting areas and clinical rooms) needs to be thought about carefully in terms of patient mobility levels and possible exposure to shaming experiences.

Given that around two thirds of adults in the UK are estimated to be overweight or living with obesity [48], the scalability of CFT interventions needs to be seriously considered. Existing services could possibly review and update correspondence and patient information leaflets without requiring extra personnel. In addition, reflecting on the language used when naming services and within routine assessments and reflective practice or staff training sessions may also only require that one or more existing team members could become CFT champions following training in the model, such as a nominated psychologist within a specialist weight management team. However, in

terms of developing interventions for use with patients, a degree of creativity will be necessary in order to keep costs down. This is likely to involve the use of digital platforms, including the development of video materials and webinar series, which could be added to current clinical pathways.

2. Conclusions

In summary, CFT is a therapeutic model that can be used flexibly within a variety of settings and with different aspects of weight management work. Given the numerous time points at which people may feel intense shame about their weight, shape and size within an environment that stigmatises life at higher weights, it seems that creating a compassionate culture around the issue as early as possible would be helpful. This would include the need to address the unhelpful idea that shaming people who have bigger bodies may help them to maintain a healthy weight [5]. From first contact with services, whether that is via letters or leaflets or posters, it would be beneficial to include balanced information about obesity, social norms and sustainable approaches to weight management.

Beyond the therapy model itself, compassionate approaches towards weight management may include offering weight-neutral interventions, which focus on mindful eating, intuitive eating, eating for nourishment, body acceptance and joyful movement more than weight loss as such. Education of healthcare staff from primary care onwards about the nature of obesity and the disadvantages of diagnostic over-shadowing may help to reduce the self-consciousness and hopelessness that people may feel on contact with professionals. Creation of 'compassionate accountability' spaces that encourage individuals or collectives to set their intentions, maintain motivation and engage in self-correction as opposed to self-criticism could offer an alternative to traditional diet club settings. The self-isolation that may arise as a natural response to shame can perpetuate distress and mental health difficulties which then interfere with an individual's ability to engage in weight management. Therefore the CFT model and related techniques have a valuable role to play in nurturing the connections needed to support meaningful change.

Acknowledgments

Thanks to Denise Ratcliffe and Claire Parkes for reviewing earlier drafts of this article. Thanks also to the North Bristol NHS Trust Library and Knowledge Service for supporting me with my literature searches and with accessing journal articles.

Author Contributions

The author did all the research work of this study.

Competing Interests

The author has declared that no competing interests exist.

References

1. Gilbert P. Compassion focused therapy: An evolution-informed, biopsychosocial approach to psychotherapy: History and challenge. In: Compassion focused therapy: Clinical practice and applications. London, UK: Routledge; 2022. pp. 24-89.
2. Gilbert P. Compassion as a social mentality: An evolutionary approach. In: Compassion focused therapy: Clinical practice and applications. London, UK: Routledge; 2017. pp. 31-68.
3. Gilbert P. The origins and nature of compassion focused therapy. Br J Clin Psychol. 2014; 53: 6-41.
4. Gilbert P. The evolved functions of caring connections as a basis for compassion. In: Compassion focused therapy: Clinical practice and applications. London, UK: Routledge; 2022. pp. 90-121.
5. Flint SW, Brown A, Batterham R. Joint statement: Response to the times article "fat shaming is the only way to beat obesity crisis" [Internet]. London, UK: World Obesity Federation; 2022. Available from: https://www.worldobesity.org/resources/resource-library/joint-statement-response-to-the-times-article-fat-shaming-is-the-only-way-to-beat-obesity-crisis.
6. Pinto-Gouveia J, Ferreira C, Duarte C. Thinness in the pursuit for social safeness: An integrative model of social rank mentality to explain eating psychopathology. Clin Psychol Psychother. 2014; 21: 154-165.
7. Elkin S. 5:2 is just the latest: Britain's diet industry is worth £2 billion, so why do we buy into it? [Internet]. London, UK: Independent; 2013. Available from: https://www.independent.co.uk/voices/comment/5-2-is-just-the-latest-britain-s-diet-industry-is-worth-ps2-billion-so-why-do-we-buy-into-it-8737918.html.
8. Müller MJ, Geisler C, Heymsfield SB, Bosy-Westphal A. Recent advances in understanding body weight homeostasis in humans. F1000Research. 2018; 7: 1025.
9. Government Office for Science and Department of Health and Social Care. Tackling obesities: Future choices [Internet]. London, UK: GOV.UK; 2007. Available from: https://www.gov.uk/government/collections/tackling-obesities-future-choices.
10. Mahmoud AM. An overview of epigenetics in obesity: The role of lifestyle and therapeutic interventions. Int J Mol Sci. 2022; 23: 1341.
11. Aoun A, Darwish F, Hamod N. The influence of the gut microbiome on obesity in adults and the role of probiotics, prebiotics, and synbiotics for weight loss. Prev Nutr Food Sci. 2020; 25: 113-123.
12. Flint SW. Time to end weight stigma in healthcare. EClinicalMedicine. 2021; 34: 100810.
13. Gearhardt AN, Hebebrand J. The concept of "food addiction" helps inform the understanding of overeating and obesity: Debate consensus. Am J Clin Nutr. 2021; 113: 274-276.
14. National Institute for Health and Care Excellence (NICE). Weight management: Lifestyle services for overweight or obese adults [Internet]. London, UK: National Institute for Health and Care Excellence (NICE); 2014. Available from: https://www.nice.org.uk/guidance/PH53.
15. Duarte C, Matos M, Stubbs RJ, Gale C, Morris L, Gouveia JP, et al. The impact of shame, self-criticism and social rank on eating behaviours in overweight and obese women participating in a weight management programme. PloS One. 2017; 12: e0167571.
16. Rothblum ED. Slim chance for permanent weight loss. Arch Sci Psychol. 2018; 6: 63-69.
17. Ahern AL, Boyland EJ, Jebb SA, Cohn SR. Participants' explanatory model of being overweight and their experiences of 2 weight loss interventions. Ann Fam Med. 2013; 11: 251-257.

18. Goss K. The compassionate mind approach to beating overeating. London, UK: Constable & Robinson; 2011.
19. Qazi HI, Keval H. At war with their bodies or at war with their minds? A glimpse into the lives and minds of female yo-yo dieters-the curtain has lifted in UK? J Int Womens Stud. 2013; 14: 311-332.
20. National Institute for Health and Care Excellence (NICE). Obesity: Identification, assessment and management [Internet]. London, UK: National Institute for Health and Care Excellence (NICE); 2014. Available from: https://www.nice.org.uk/guidance/cg189.
21. World Obesity Federation. Our policy priorities [Internet]. London, UK: World Obesity Federation; 2023. Available from: https://www.worldobesity.org/what-we-do/our-policy-priorities.
22. Marshall RD, Latner JD, Masuda A. Internalized weight bias and disordered eating: The mediating role of body image avoidance and drive for thinness. Front Psychol. 2020; 10: 2999.
23. Carter JC, Bojman K, Kelly AC. Compassion-focused therapy in severe obesity. New York, NY: Cambridge University Press; 2018.
24. Gilbert P, Mascaro J. Compassion: Fears, blocks, and resistances: An evolutionary investigation. In: The Oxford Handbook of Compassion Science. Oxford, UK: Oxford University Press; 2017.
25. Mendes CB, Ferreira C. A social rank approach to disordered eating: Exploring relationships between shame, fears of compassion, striving, and body shame. Psychol Psychother. 2020; 93: 490-502.
26. Gilbert P. Explorations into the nature and function of compassion. Curr Opin Psychol. 2019: 28: 108-114.
27. Gilbert P, Catarino F, Duarte C, Matos M, Kolts R, Stubbs J, et al. The development of compassionate engagement and action scales for self and others. J Compassionate Health Care. 2017; 4: 1-24.
28. Kirby JN, Day J, Sagar V. The 'flow' of compassion: a meta-analysis of the fears of compassion scales and psychological functioning. Clin Psychol Rev. 2019; 70: 26-39.
29. McGuire S, Stephens A, Griffith E. "It's changed my life!" Evaluation and improvement of a pilot tier 2 weight management course: Balance. Ment Health Rev J. 2021; 26: 71-86.
30. Sadr Nafisi P, Eftekhar Saadi Z, Heidari A. Comparison of the effectiveness of compassion-focused and rational-emotional behavior therapy on weight self-efficacy and self-criticism. Preventive Couns. 2022; 3: 54-66.
31. Forbes YN, Moffitt RL, Van Bokkel M, Donovan CL. Unburdening the weight of stigma: Findings from a compassion-focused group program for women with overweight and obesity. J Cogn Psychother. 2020; 34: 336-357.
32. Carter A, Gilbert P, Kirby JN. Compassion-focused therapy for body weight shame: A mixed methods pilot trial. Clin Psychol Psychother. 2021; 28: 93-108. doi: 10.1002/cpp.2488.
33. Carter A, Steindl SR, Parker S, Gilbert P, Kirby JN. Compassion-focused therapy to reduce body weight shame for individuals with obesity: A randomized controlled trial. Behav Ther. 2023; 54: 747-764.
34. Duarte C, Gilbert P, Stalker C, Catarino F, Basran J, Scott S, et al. Effect of adding a compassion-focused intervention on emotion, eating and weight outcomes in a commercial weight management programme. J Health Psychol. 2021; 26: 1700-1715.

35. Palmeira L, Pinto-Gouveia J, Cunha M, Carvalho S. Finding the link between internalized weight-stigma and binge eating behaviors in Portuguese adult women with overweight and obesity: The mediator role of self-criticism and self-reassurance. Eat Behav. 2017; 26: 50-54.
36. Goss K, Allan S. The development and application of compassion-focused therapy for eating disorders (CFT-E). Br J Clin Psychol. 2014; 53: 62-77.
37. Steindl SR, Buchanan K, Goss K, Allan S. Compassion focused therapy for eating disorders: A qualitative review and recommendations for further applications. Clin Psychol. 2017; 21: 62-73.
38. Matos M, Ferreira C, Duarte C, Pinto-Gouveia J. Eating disorders: When social rank perceptions are shaped by early shame experiences. Psychol Psychother. 2015; 88: 38-53.
39. Calissano C, Thompson A, Treasure J, Cardi V, Ward T. A systematic review of social rank perception and contribution to eating disorder psychopathology in individuals with eating disorders. Mental Health Sci. 2024; 2: 27-49.
40. De Paoli T, Fuller-Tyszkiewicz M, Halliwell E, Puccio F, Krug I. Social rank and rejection sensitivity as mediators of the relationship between insecure attachment and disordered eating. Eur Eat Disord Rev. 2017; 25: 469-478.
41. Vrabel KR, Waller G, Goss K, Wampold B, Kopland M, Hoffart A. Cognitive behavioral therapy versus compassion focused therapy for adult patients with eating disorders with and without childhood trauma: A randomized controlled trial in an intensive treatment setting. Behav Res Ther. 2024; 174: 104480.
42. Messer M, Linardon J. Trait-level differences in constructs that underpin the contextual behaviour therapies between binge-eating disorder with and without overvaluation of weight and shape. J Contextual Behav Sci. 2021; 22: 1-6.
43. Goss K, Kelly A. The roles of shame, self-criticism, and compassion focused therapy in eating disorders and disordered eating. In: Compassion focused therapy: Clinical practice and applications. London, UK: Routledge; 2022. pp. 519-533.
44. Kelly AC, Carter JC. Self-compassion training for binge eating disorder: A pilot randomized controlled trial. Psychol Psychother. 2015; 88: 285-303.
45. Ratcliffe D. Living with bariatric surgery. London, UK: Routledge; 2018.
46. Koball AM, Jester DJ, Domoff SE, Kallies KJ, Grothe KB, Kothari SN. Examination of bariatric surgery Facebook support groups: A content analysis. Surg Obes Relat Dis. 2017; 13: 1369-1375.
47. Courcoulas AP, Christian NJ, Belle SH, Berk PD, Flum DR, Garcia L, et al. Weight change and health outcomes at 3 years after bariatric surgery among individuals with severe obesity. JAMA. 2013; 310: 2416-2425.
48. Office for Health Improvement and Disparities. Obesity profile: Short statistical commentary May 2023 [Internet]. London, UK: GOV.UK; 2023. Available from: https://www.gov.uk/government/statistics/obesity-profile-update-may-2023/obesity-profile-short-statistical-commentary-may-2023.