UNIT NO. 3

PSYCHOLOGICAL ASPECTS OF OBESITY & BODY IMAGE

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ABSTRACT

The causes of Obesity are multifactorial, involving genetics, environment and lifestyle (diet and activity). Adding behavioural and psychological techniques is a useful combined approach to obesity treatment. It can produce better results in weight loss and maintenance. We need to: assess the readiness for change for better results, exclude psychiatric and eating disorders which can cause weight gain or affect weight-loss attempts as well as adopt behavioural approaches e.g. non-judgement, problem-solving and self-monitoring.

INTRODUCTION

The causes of Obesity are multifactorial, involving genetics, environment and lifestyle (diet and activity). Responsively, the management of Obesity is multi-disciplinary, addressing the multi-form influences on increased body weight. Other units in this course address diet and physical activity/exercise, with pharmacotherapy and surgery as useful adjunctive treatment. Adding behavioural and psychological techniques is a useful combined approach to obesity treatment. It can produce better results in weight-loss and maintenance.

The components of the psychological/behavioural aspects of obesity management are briefly discussed in this paper.

READINESS FOR WEIGHT LOSS

Successful weight reduction requires investment of effort time and sometimes expenses. These can feel deterrent if the patient is not ready for change. Hence obesity treatment is beset by high drop-outs and failure rates.

Assessment of readiness can help determine if the timing is right for the patient and the level of intervention necessary.

Factors determining the Readiness for Change

Internal	External
o Personal reasons and motivations weight-loss	o Support from family and for friends (watch out for saboteurs!)
o Understanding of the risks of obesity and benefits of weight-loss	o Practical considerations Time Finance Facilities available
o Attitudes towards dieting and exercise o Previous attempts (successful or otherwise) at weight-loss	o Other potential barriers

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BODY IMAGE

Medically defined success at weight loss is a loss of 5-10% of original weight. This translates into reduced medical morbidity and 20% reduction in mortality.

However, even with these successes, many patients are not able to realistically reduce down to normal BMI ranges, let alone supermodel sizes. This can lead to discouragement and self-disparagement.

Societal pressures are exerted on obese individuals. They are often subjected to ridicule from society and discrimination in jobs. Sadly, some doctors may unthinkingly make insensitive remarks to them about their weight. Many experience loss of self-esteem, resulting in demotivation and psychiatric disorders.

As a family doctor, help your patients focus on what really matters; improved health and fitness and lowered medical risks, rather than aesthetic slimming and smaller clothing sizes. You can also help them to accept their above-average body size and even celebrate their natural shapes. Encourage them to see the difference between medical obesity and "social obesity". That way, they will continue to be motivated to work on maintaining their weight or even reducing further, keep up their fitness efforts and healthy eating, resulting in better psychological well-being.

As a human being yourself, examine your own attitudes and beliefs about obese people. Any misconception or prejudice may show through subconsciously in your interactions with patients. It helps to subscribe to the disease model of obesity; that is a chronic illness much like Diabetes or Hypertension. This will help you to convey a non-judgemental, empathic bedside manner.

PSYCHIATRIC AND EATING DISORDERS

Psychiatric, eating disorders and alcohol and some substance abuse can cause weight gain and affect weight- loss attempts.

The majority of obese people have normal psychological functioning and enjoy general psychological well-being. Exceptions are : As many as 37% of obese women suffer from Depression; 20% of obese men and women suffer from Binge-Eating Disorder (B.E.D.), 3-4 times the general population.

Another example of an Eating Disorder is Bulimia Nervosa (B.N.). Obese patients should be screened for pre-existing psychiatric disorders and treated. Patients with underlying B.E.D. or B.N., or a history of Anorexia Nervosa, or concurrent alcohol or substance abuse need to be referred for special treatment.

BEHAVIOURAL APPROACH

The behavioural approach towards the management of obese patients is founded on certain basic principles of Behavioural

Therapy. Behaviour Therapy is itself based on learning theory principles; i.e. much of our behaviour is learned and therefore can be "un-learned" and modified. While it is not within the purview of this course to teach behavioural therapy, adopting the behavioural approach is a useful adjunct to diet and exercise.

Underlying principles of the behavioural approach are:
- It is not interactive, not didactic
- It is non-judgmental, forgiving yet encouraging: *Let us not blame our patients!*
- It is problem-solving
- It is realistic and specific.

Practical applications are:
- Make the most of the consultations
- Build up a partnership with your patient: "*We are a team*". Make your patient an active partner in his/her weight loss journey, owning responsibility for his/her actions and achievements. As the medical partner, you can shed information, provide the right perspective and give valuable support. Together, devise an action plan to lose weight.
- As his/her doctor, express your concerns about the effect that obesity has on your patient and his/her health risks associated with obesity.
- Set achievable yet challenging goals
  eg. incremental steps of 0.5-1.0 kg loss each visit
  Ask your patient what HIS/HER goals are and get them to set the steps themselves that they are confident with (while providing guidance).
  Give specific, practical advice. Instead of exhorting them to "exercise more!", suggest dropping off at a further bus-stop and walking the extra distance home.
- Schedule maintenance consultations
  These help in maintaining weight-loss and preventing "relapses". Go over whatever contributed to "slip-ups" and figure out together how to circumvent them in the future.

Consider useful psychological tools to help patients modify their behaviour and maintain their progress eg.
- Self-monitoring
  eg. Dietary diary, exercise record, weight, Blood glucose levels, blood pressure, lipid levels (make sure you at least glance at their diaries!)

  Monitoring is a very useful tool which allows the patient see patterns of behaviour, keep track of their progress (or lack of) and express his/her personal insights. Self-monitoring contributes to higher percentage change in BMI.
- Self-rewards at each incremental step (otherwise known as "positive reinforcements").
  These rewards should be tangible and practical eg. a new music CD, a spa treat - *Let it not be Food!*
- Stimulus control
  Basically this means doing things to avoid temptation. Examples are identifying high-risk situations (such as buffet dinners) or triggers (such as watching cooking shows on TV) and inventing coping strategies (such as ordering food a la carte, changing channels).
- Stress management
  This is especially useful for patients who do comfort eating or eat to relieve stress.
- Support groups
  (for obese or eating-disordered patients)
  eg. "BodyTalk" at Alexandra Hospital
  Overeaters Anonymous
- Websites
  eg. www.oa.org

Examples of Self-Monitoring Diaries

DIETARY	ACTIVITY
o Types of food	o Daily activity
o Portion sizes	o Feelings towards exercise
o Time, place, circumstances	o Feelings during exercise
o Thoughts and emotions(advanced)	

PSYCHOLOGICAL EVALUATION OF THE OBESE PATIENT

A handy, brief psychological assessment is as follows:
- "Has my patient sought weight-loss on his or her own initiative before?"
- "What has spurred my patient to seek help for weight loss now?"
- "Does my patient understand what is required of treatment and believe that he/she can fulfil it?"
- "How much weight does my patient expect to lose?"
  "What other benefits does my patient expect from weight-loss?"
- "What is my patient's stress level?"
  "What is my patient's mood like?"
- "Does my patient have an eating disorder, in addition to obesity?"

RECOMMENDED READING/REFERENCES

MOH Clinical Practice Guidelines on Obesity April 2004
NIH/NHBLI The Practical Guide.
Identification, Evaluation and Treatment of Overweight and Obesity in Adults October 2000.

LEARNING POINTS

- **Combining behavioural approach with diet and exercise produces better results in weight loss and maintenance**
- **Assess the readiness for change for better results**
- **Exclude psychiatric and eating disorders which can cause weight gain or affect weight-loss attempts**
- **Adopt behavioural approaches eg. nonjudgement, problem-solving, self-monitoring**