RACGP | Specific Interests

The role of psychology of obesity management webinar

Frequently asked questions

Answered by Dr Cal Paterson and Dr Georgia Rigas

Sometimes it seems that there are not a huge number of solutions especially as patients often want a quick fix. The drugs are expensive and/or not suitable and the patient seems to have a resistance to activity even if it is brought up. I like consults about weight but often find the changes don't persist. What to do? "Success" is patient-specific and should be something measurable and attainable-which takes us to the all-important issue of appropriate goal setting. The emphasis should always be a sustainable gain in health (which can be measured) rather than weight loss per se.

In any change process, be it weight loss, quitting smoking, etc., relapse is the norm. Given that obesity is a chronic progressive condition, periods of relapse and remission are expected and part of the disease process.

Psychological research in the area of patient-driven change shows that, on average, a person will succeed in achieving a lasting and meaningful change in their behaviour on their sixth attempt. So expectations must be realistic, and relapse or short-lived gains should be understood, and couched with patient, in the constructive terms that they rightly belong. If the patient realises, that they are normal and relapse itself is not an indicator that the patient's attempts are "not working" or that they have "failed", nor that they will not work over time - in fact they are proof that work is being done and the most likely outcome is success - as long as they continue their attempts over time.

Is prevention better than cure for obesity and how do you prevent rather than wait till the disease and then treat? In principle, primary prevention is always better than cure, but in practice it is difficult to do this other than on a public-health level. People who have overweight may not necessarily understand that obesity prevention messages are targeted at them. This is where public health measures are most useful (secondary prevention). Obesity treatment messages need to be crafted differently as the goal is to prevent the complications associated with obesity (tertiary prevention) which is costly-not only to the individual, but also to society. We need both an upstream and downstream approach in prevention strategies, and the recent Australian Senate Enquiry into Obesity (which will report at the end of November 2018) will hopefully include evidence based impactful preventative strategies.

However, we can't ignore the 2 in 3 Australian adults and 1 in 4 school-aged children who currently have overweight or obesity-they need care. Nor can we ignore the fact that if a young person has overweight or obesity prior to puberty, they have a 70% chance of having obesity as an adult, and the comorbidities and health complications associated with this eg. T2DM, NASH etc, which we are increasingly seeing clinically at a much younger age.

I would perhaps say that early intervention with a given individual is better than cure, but even then it is important to ascertain the patient's attitude regarding not only their weight but their health behaviours overall. Early intervention is better than cure, and assessment (of aetiology of weight gain) is arguably a more effective use of time with a patient than moving too quickly to an intervention. This is also supported by the “stool” analogy-see attached.

Any good books resources about shame for obesity? Depending on the patient - "Hunger" by Roxane Gay is very powerful and personal. I note that after many years of resistance, she recently underwent bariatric surgery as well - after she wrote the book about having overweight (note the use of patient-first language).

Is obesity considered a chronic condition so we can involve allied health Services under GPMP? Yes satisfies criteria for chronic condition. – See page 18 of slides

I suspect the question is a legacy of the fact that close to 8 years ago, obesity was listed as an exclusion. This no longer is the case; there is no list of inclusion or exclusion criteria.

Any special tips for how to broach the subject with kids and their parents? This indeed needs to be handled with a sensitive and non-judgemental manner, as you don’t want the young person to feel “awkward” nor the parents potentially upset /offended as it they were to be blamed or their parenting skills being attacked.

Don’t start with the weight when initiating discussion - start with how they are feeling more generally. We all know how obesity affects people at a subjective level; harder to move, play sport, social stigma-ask about bullying (because of their body habitus/ their excess sweating/ any urinary incontinence/ other reasons), concerns about longer term health, etc. Ask them about that, rather than the weight directly.

For example: "So do you play sport? - if yes, then ask more about how they find it. If no, ask about how they spend their free time. Often there will be issues in there that troubles the patient, and this can then form an in-road to a discussion about how to address the issue. Ideally you want the moment you mention weight to come in the form of a question such as "would you like some ideas about how to improve that particular health issue eg sore knees, excess sweating/chaffing…” (with the view that weight management will be one of many suit of therapeutic interventions that you will offer that young person) rather than a statement such as "we need to tackle the weight issue."

The literature shows that a “whole of family” approach needs to be embraced when delaying with children and young adolescents. Whilst a few specialist child and adolescent obesity/ metabolic health services exist scattered throughout Australia, there is often a bit of a wait to get onto such public hospital programme-and inclusion criteria will vary.

In the interim, GPs can work with the family via services such as “Go 4 Fun” in NSW which I would recommend. The outcomes are clinically relevant and the service is excellent at communicating back to GPs about what the patients and their families are taught/discussed,

so that all HCPs are on the same page ie are providing the same consistent health message. We have done a number of webinars about this excellent service within the last 12 months, which you should be able to refer to. I believe other states have similar programmes eg PEACH in Queensland etc

Please advise on how to engage a teenager positively to motivate weight loss. With teenagers as well as adults the key is that there is a constructive working relationship with you and the patient. Any advice or other sort of support you might give them will only be as effective as the relationship allows. So the most worthwhile efforts would be to find a way to engage, rather than find the right sort of advice to give, at least initially.

I need help to motivate overweight teenagers with depression prevent proceeding to obesity, especially as they are less active and less concerned about heathy diet This is a common issue, and highlights a fundamental issue in the area of obesity management: what do we target? For example, do we target symptoms directly (eg via appetite suppression), indirectly (eg via education about healthy eating or referral to exercise physiologist) or (my [Cal's]) preference) recognise that weight gain is only one symptom of a systemic issue in the patient wherein they do not have a high regard overall for their own wellbeing?

Typically a patient with depression and obesity is engaging in a range of behaviours that undermine their health and wellbeing, eg. Sedentary lifestyle, poor diet, but also social isolation, poor sleep hygiene, or even unhealthy interpersonal relationships. It may be most effective to target one's intervention at this overall level, by talking to the patient about how they value or do not value their own selves and what might be behind this. This would then allow the patent to nominate their own preferred area of intervention - they might prefer to work on improving their sleep before tackling the more daunting task of dropping weight, for example.

What resources are available for adolescents? I sometimes recommend social media for teens; there is a website called 'reddit' that most teenagers will have heard of, and there is a section on reddit called "lose it" which is a large, accessible and generally well-informed forum where advice can be sought and shared, as well as useful discussion threads where people talk about what worked for them and what didn't.

Here is a link: **https://www.reddit.com/r/loseit/**

A significant proportion of my patients with obesity are in a lower socio-economic group. It is clear that for many of them seeing a psychologist would be of benefit but despite a MHP they cannot afford the gap payments. Do you have any suggestions about resources that can be accessed for free? eg similar to Mood gym or other online/apps. Online resources are excellent, and free. I've recommended a website above called 'reddit lose it' as a starting point.

What about someone who has "overweight" but not "obesity"? Would you say they qualify for Chronic Disease Management Plan? Whilst they might not qualify for a CDM plan, they still need to be managed / treated, as the majority will continue on the weight gain trajectory they find themselves on.

How to overcome lack of motivation in patients? Most of them don't have time to make an effort to lose weight. Instead want treatment for all negative effects including depression due to obesity. Perhaps lack of motivation is the main issue? Engaging with the patient, in order to understand the causes of their lack of motivation; are they depressed? What lifestyle factors might be contributing to this? Is it work, family, social, historical? Understanding this with the patient will help both of you decide the best place to start in tackling their problems. Obesity management will be something that you and the patient "chip away" at slowly and progressively, hence the importance of the therapeutic relationship between the HCP and the patient. Care needs to be taken to differentiate between nihilism (based on prior lack of success, stigma and self-blame) and a lack of motivation.

I have a few women patients in their 30s & 40s who are very concerned only about the adipose tissue around their waist and the 5kg that they cannot shift despite doing lots of physical activities and maintaining healthy diets. Any thoughts/solutions for this? I have noticed a trend especially in affluent areas where women in their 30s 40s and 50s will present with concerns about this and seek surgical intervention eg. abdominoplasty, and other indirect procedures such as those to remediate incontinence postpartum. This highlights the need to focus on health, function, fitness, quality of life....not kg on scale.

This also highlights the importance of explaining to patients the benefits of physical activity on their body composition, strength/balance, cardio metabolic fitness, mental wellbeing etc.

Body composition analysis may help to determine if it is visceral fat indeed which we know is the pathological location for adipose to collect vs subcutaneous or peripheral localisation of fat.

There is a normalisation of high BMI in society in many places. Overweight patients often state that they feel "normal" and resent the implication that they are unhealthy. Or, "I'm overweight, but I'm not unhealthy"

I am aware that in some cultural ethnic groups being above a healthy weight is *perceived* as a sign of good health (ie lack of illness ie no HIV/TB etc), ability to procreate and/or prosperity etc. Being cognizant and respectful of this "old way" of thinking perhaps in their country of origin, and explaining that now that they have immigrated here-eating different food, living in a different environment, different physical activity levels, we now have to adopt the "new way of thinking"; the emphasis being on gain in health. Using themes from the old way of thinking eg ability to procreate and that actually higher BMI actually has the opposite effect…may be one way of hooking them in to a discussion in health gain (rather than weight loss per se).

I totally understand, especially if their peers/ family members or relatives are of a similar body habitus, it can make it difficult. This can be difficult to argue with and is a good segway to the fact that BMI alone doesn't tell us how "sick" a person is. I (Georgia) prefer to use the Edmonton Obesity Staging system to gauge how "sick" a person is and it's a good visual aid so that patients with obesity can see how their health may deteriorate over time (physical function, emotional wellbeing, medical) & possibly view these as a traffic light system or

when to “come back”. Let’s not forget that people who have “healthy” blood tests may be suffering from asymptomatic osteoarthritis or sleep apnoea.

The only realistic treatment goal here might be to aim for the patient to stay engaged with you, so that when they do start to experience problems with their health due to obesity eg arthralgia, diabetes or pre-diabetes etc, the therapeutic relationship is there, ready for you to assist. Explain it is a chronic progressive disease and you want to help prevent problems from emerging and becoming symptomatic.