The role of psychology in obesity management

Presenters:
Dr Cal Paterson FACPA Clinical Psychologist
Dr Georgia Rigas FRACGP, SCOPE Certified Obesity Doctor

The Royal Australian College of General Practitioners

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Presenters

Dr Georgia Rigas is a Fellow of the RACGP and also the Senior Bariatric Medical Practitioner at Australia's first accredited Bariatric Centre of Excellence at St George Private Hospital, Sydney.

Dr Rigas is recognised as a "SCOPE-certified Obesity Doctor" by the World Obesity Federation and serves on a number of medical advisory committees-both nationally and internationally.

Dr Cal Paterson FACPA is a Clinical and Supervising Psychologist who has been working in the field of behaviour change since 1997.

Dr Paterson started the BodyChanges clinic in Sydney in 2011 as a Psychology service for patients undergoing surgical and non-surgical bariatric medical procedures.

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Learning outcomes

- Implement recall systems for serial assessment of the mental wellbeing of patients with obesity.
- Apply open and positive communication strategies to help reduce stigma often experienced by patients with obesity
- Engage patients in self-efficacy & self-management of their excess weight.
- Describe different strategies to help shift the consultation away from a "weight centric" model to a "health centric" model.
- Explain to patients how much, or rather how little, weight loss is needed to experience improvements in one's health.

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A picture of overweight and obesity in Australia
Publication | Release Date: 24 Nov 2017 | Author: AIHW | Media release
Seven in 10
Australian men have overweight or obesity
One in two
Women have overweight or obesity
One in four
Children have overweight or obesity
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Australian Indigenous HealthReviews
From the Australian Indigenous HealthInfoNet
Summary of overweight and obesity among Indigenous peoples
Jane Burns and Neil Thomson
Burns J, Thomson N (2006) *Summary of overweight and obesity among Indigenous peoples*
Indigenous Australians and those living outside *Major cities* or who are in lower socioeconomic groups are more like to have overweight or obesity
AIHW2014-15
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Background

- Weight gain ←→ Mental illness
- Correlation =/= causation
- Eating disorder =/= Weight disorder
- Identify and target the primary issue, differentiate from secondary issues.

General Practice Activity in Australia 2015-2016: Bettering the Evaluation and Care of Health (BEACH)

Table 7.3 (continued): Problems managed by ICPC-2 chapter and frequent individual problems within chapter

Less than 1% of consultations centre around obesity

Problem managed	Number	Per cent total problems[a] (n = 150,279)	Rate per 100 encounters (n = 97,398)	95% LCL	95% UCL	Per cent of encounters[b] (95% CI) (n = 97,398)
Endocrine and metabolic	**13,151**	**8.8**	**13.5**	**12.9**	**14.1**	**12.3 (11.7–12.8)**
Diabetes (non-gestational)*	3,896	2.6	4.0	3.7	4.3	—
Lipid disorder	2,956	2.0	3.0	2.8	3.3	—
Vitamin/nutritional deficiency	1,419	0.9	1.5	1.3	1.6	—
Hypothyroidism/myxoedema	909	0.6	0.9	0.8	1.0	—
Obesity (BMI > 30)	736	0.5	0.8	0.6	0.9	

Helena Britt et al. Family Medicine Research Centre Sydney School of Public Health, The University of Sydney

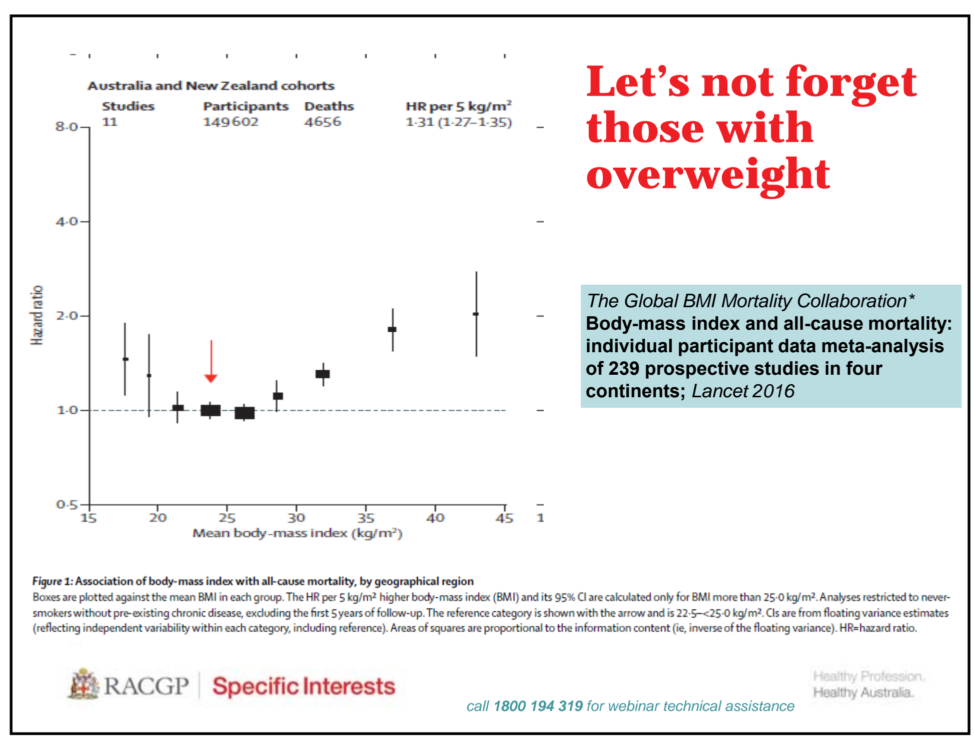
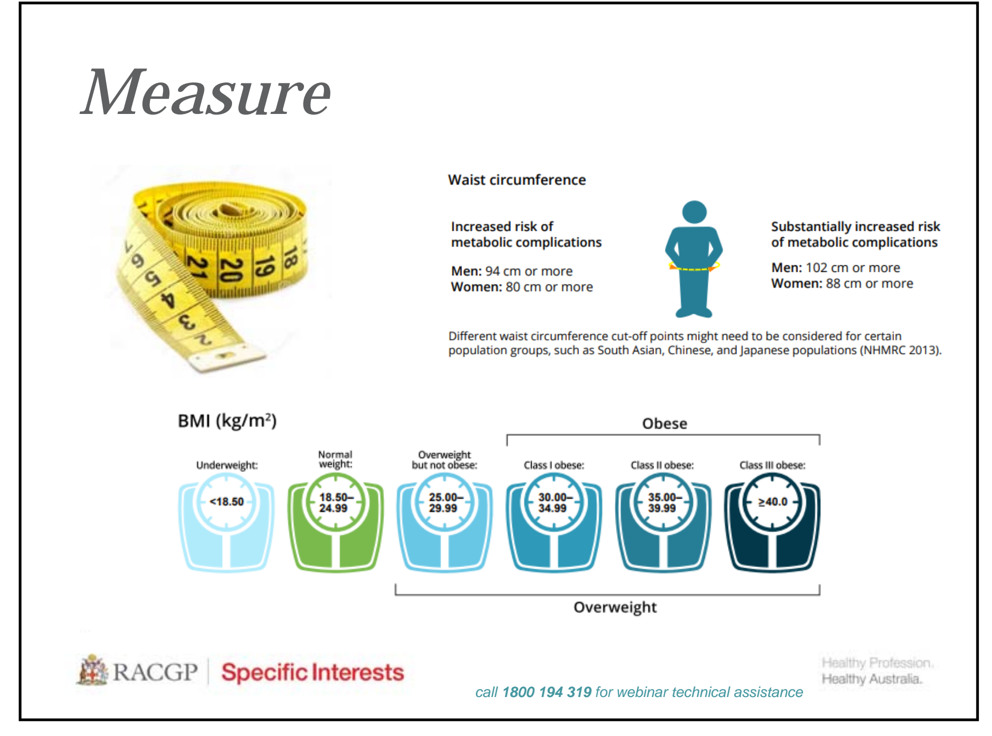


Figure 1: Association of body-mass index with all-cause mortality, by geographical region
Boxes are plotted against the mean BMI in each group. The HR per 5 kg/m² higher body-mass index (BMI) and its 95% CI are calculated only for BMI more than 25·0 kg/m². Analyses restricted to never-smokers without pre-existing chronic disease, excluding the first 5 years of follow-up. The reference category is shown with the arrow and is 22·5–<25·0 kg/m². CIs are from floating variance estimates (reflecting independent variability within each category, including reference). Areas of squares are proportional to the information content (ie, inverse of the floating variance). HR=hazard ratio.



- 22.2% had BMI documented
- 4.3% had WC documented

What’s the big deal?

- MEASURE! IDENTIFY! TREAT!
- We need to do more

Turner LR et al. Obesity management in general practice: does current practice match guideline recommendations? Med J Aust 2015;202(7):370-2.

Identify

Measure waist circumference and calculate BMI:

— every 2 years in all patients (screening)

— annually for adults:

- with DM, CVD, stroke, gout, liver dx OR
- from high risk groups (eg Aboriginal, Torres Strait, Pacific Islands)

— every 6 months for those already overweight or obese

So why should GPs talk about weight with their patients?

- Many patients want and expect weight loss guidance from Health Care Professionals. (1)
- Having the conversation and formally diagnosing and documenting overweight or obesity **strongly predicts**

treatment plan in place → subsequent weight loss. (2)

(1) Rose SA. Physician weight loss advice and patient weight loss behavior change: A literature review and meta-analysis of survey data. *International journal of obesity (2005).* 2013;37(1):118; 118-128; 128.
(2) Bardia A, Holtan SG, Slezak JM, Thompson WG. Diagnosis of obesity by primary care physicians and impact on obesity management. *Mayo Clin Proc.* 2007;82(8):927-932.

Communication strategies to develop trusting therapeutic relationship between GP & patient

5 C's - ingredients for the relationship 'cake':

- Curiosity (about the patient)
- Compassion (towards the patient)
- Continuity (between consults)
- Confidence (consistency, certainty and trustworthiness)
- Creativity (A sign of a strong relationship. New ideas, outcomes being generated)

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Attribution of the clinician vs that of the patient

Clinician:
- How unhealthy is the patient?
- Why are they unhealthy?
- How might this differ from the patient's attributions?

Patient:
- Am I unhealthy?
- Why am I unhealthy?

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Formal Assessment

- Mental health screens are valid, reliable, cheap, quick, patient self-administrable, and informative.
- The K-10 is not an assessment tool
- DASS-21
- OQ-45
- BDI
- Responses will be of use at the time of assessment and into the future; not just for you but for the patient as well.

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Assess readiness to talk

Some patients will mention weight - this is an opening

Some patients won't mention it; how to broach it with them?

"it's a long term problem with a long-term solution."

"I know weight is hard to talk about, maybe it also seems like a hard problem to solve…"

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Brief Case example

1. Steve, 45

- Works as a tradesman, alcohol a key factor in central adiposity
- Complains of headaches, wife says he snores
- BMI 39
- At consult at wife's urging

2. Dorianne, 21, Hairdresser

- Presenting for dysmenorrhea
- BMI 34
- Spontaneously mentions weight but talks about 'thick body pride'

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Patient Engagement

Patient Engagement Survey: How to Hardwire Engagement into Care Delivery Processes

Framing

- Where shame is a factor, it's very important not to reinforce shame by tiptoeing around the issue or going softly
- A direct, compassionate and empathic approach. "I don't want to tiptoe around this, Susan; I am wondering what you think about your weight and if it's been put in the 'too-hard basket."
- Empathy with the struggle with maintaining health.
- Move quickly from acknowledgement of problems, to realistic solutions
- Discussions about weight should be framed around other health issues

Aims of chronic disease management

- **Improve patient health outcomes:**
    1. Improve quality of life
    2. Improve function
    3. Reduce end-organ damage
    4. Reduce morbidity and mortality
- **Engage the patient as playing a central role**

The aim is not just weight loss!

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Stages of Readiness

- Also known as the 'Transtheoretical model' (Prochaska & Diclemente, 1977)
- 5 stages; important marker of amenability to treatment, and for 'pitching' level of intervention to match the patient's stage.
- pre-contemplation - contemplation - preparation - action - maintenance - (termination)
- At each stage a different approach required. treatment involves moving patients from current stage to next stage.

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5 Stages: assessment and approach

- Be curious with **Precontemplative** patient**s**
- Be confident and constructive with **Contemplative patients**
- Set goals with Patients at a **preparation** stage
- Maintain continuity with Patients in **action** stage
- Be confident with **maintenance** stage patients

Use "people-first" language

Image courtesy of:
http://www.imagebank.worldobesity.org

Problematic	Preferred
"Obese people"	"People with obesity"
"Those that suffer from obesity"	"Those who are affected by obesity"
"The woman was obese"	"The woman was affected by obesity"
"There are many obese and overweight people"	"There are many people affected by obesity"
"Weight problem," "fat," "severely obese,"	"Weight" or "Excess weight"
"People who are severely or morbidly obese"	"People with a BMI in the obese range" or "People in obese class I,II or III"
"Obesity is a lifestyle issue"	"Obesity is a complex and multifactorial disease/ chronic condition"
"Diet and exercise are crucial to weight loss"	"Healthy eating and physical activity play an important role in weight loss"

Rethink Obesity*: A media guide on how to report on obesity* .
Obesity Australia, August 2015

Commonly cited barrier is lack of time

- Productive interactions can be relatively short.
- Initial discussions will set the stage for ongoing conversation
- Strategic use of a team-based approach.

N. Forgione, et al Advances in Therapy, January 2018
Managing obesity in primary care: breaking down the barriers

Goalsetting: how to get the patient moving

- Specific
- Measurable
- Achievable!
- Rewarding
- Time-limited

Patient's Dream Weight ....

....Clinically Achievable Weight

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Realistic % weight loss

- Work with pts collaboratively to develop weight & health-related goals.
- Goals should be reassessed and adjusted as needed

- 5-10% TWL= 10% x 100 = 5-10kg (achievable with meds)
- 15-20% TWL = 15% TWL = 15-20kg (achievable with endoscopic Rx)
- 20-25% TWL= 25% x 100= 20-25kg (achievable with LABG & LSG)
- 30% TWL= 30% x 100 = 30kg (achievable with GBP)

Adapted from Dixon, Le Roux et al Lancet 2012

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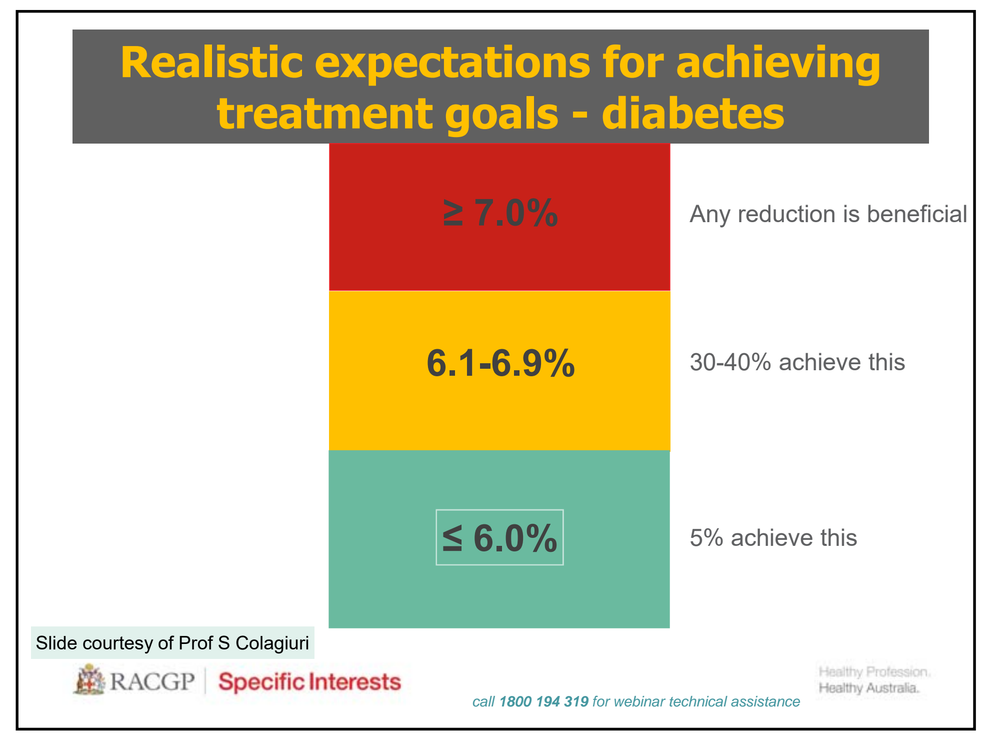
Realistic expectations for achieving treatment goals - diabetes
≥ 7.0%
Any reduction is beneficial
6.1-6.9%
30-40% achieve this
≤ 6.0%
5% achieve this
Slide courtesy of Prof S Colagiuri
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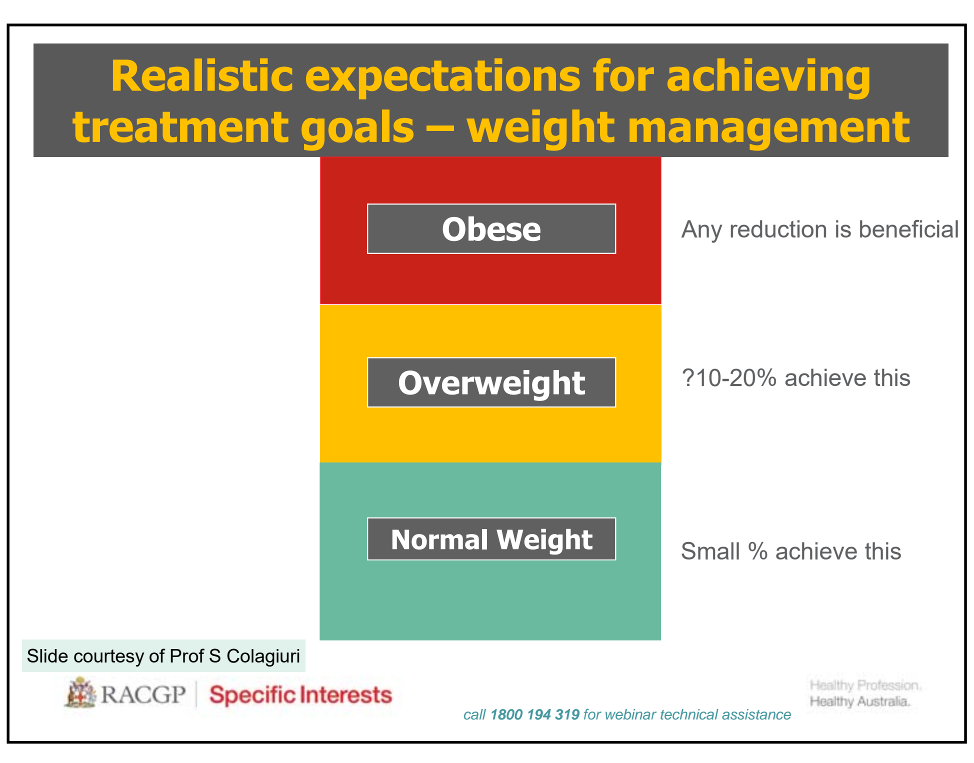
Realistic expectations for achieving treatment goals – weight management
Obese
Any reduction is beneficial
Overweight
?10-20% achieve this
Normal Weight
Small % achieve this
Slide courtesy of Prof S Colagiuri
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5–10% weight loss is clinically meaningful
Weight loss required for therapeutic benefit (%)
0
-5
-10
-15
-20
Obesity complication
Diabetes (Prevention)
Hypertension
Dyslipidaemia
Hyperglycaemia (elevated HbA1c)
Non-alcoholic fatty liver disease
Sleep apnoea
Osteoarthritis
Stress incontinence
Gastroesophageal reflux disease
Polycystic ovary syndrome
Health-related quality of life
Maximum benefit at 10%
Blood pressure still decreasing at >15%
Triglycerides still decreasing at >15%
HbA1C still decreasing at >15%
Improves steatosis, inflammation, and mild fibrosis
Improves symptoms and joint stress mechanics
5–10% in women; 10% in men
>10% optimal; lowers androgens, improves ovulation, and increases insulin sensitivity
Continues to improve with weight-loss
RACGP
Cefalu WT et al. Diabetes care 2015;38(8):1567-82. Wright F et al. J Health Psychol. 2013;18:574-86.
Used with permission from Novo Nordisk Pty Ltd. Australia August 2016
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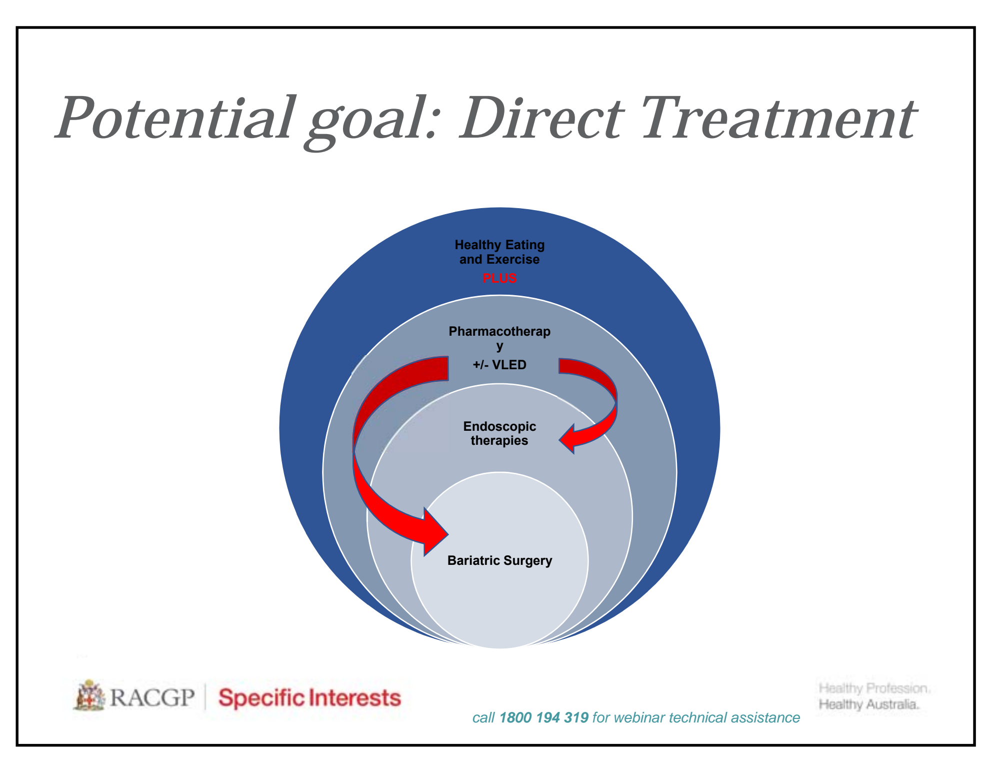
Potential goal: Direct Treatment
Healthy Eating and Exercise
PLUS
Pharmacotherap y
+/- VLED
Endoscopic therapies
Bariatric Surgery
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Road blocks & Action Plans

- Acknowledging the possibility of setbacks during the initial goal setting stage

  AND

- developing strategies to address them will help patients move past these when they happen.

Potential goal: Self monitoring

American obesity action coalition

Eligibility

A person who has a chronic or terminal medical condition (with or without multidisciplinary care needs) can have a GP Management Plan (GPMP) service.

A person with a chronic or terminal medical condition **and** complex care needs, requiring care from a multidisciplinary team, can have a GPMP and Team Care Arrangements (TCAs).

A chronic medical condition is one that has been (or is likely to be) present for six months or longer, for example, asthma, cancer, cardiovascular disease, diabetes, musculoskeletal conditions and stroke. There is no list of eligible conditions. However, these items are designed for patients who require a structured approach to their care and to enable GPs to plan and coordinate the care of patients with complex conditions requiring ongoing care from a multidisciplinary team.

Potential goal: attend a support group

Research shows a positive association between the use of support groups and weight loss, with the strongest correlation in women. If a patient already has a well-defined, supportive group of friends or family members, encouraging the patient to rely on a support system could help him or her to lose weight.

Participants assigned to an internet-based weight maintenance program sustained comparable weight loss over 18 months compared with individuals who continued to meet face-to-face. Therefore, the internet appears to be a viable medium for promoting long-term weight maintenance.

(1)Wing, R. R., & Jeffery, R. W. (1999). Benefits of recruiting participants with friends and increasing social support for weight loss and maintenance. *Journal of Consulting and Clinical Psychology, 67*(1), 132-138.

(2) Jean Harvey-Berino et al (2012) Effect of Internet Support on the Long-Term Maintenance of Weight Loss https://doi.org/10.1038/oby.2004.40

Connecting to community services
healthykids for professionals
Weight management resources for health professionals
get healthy
Information & Coaching Service
Go4Fun
Healthy • Active • Happy • Kids
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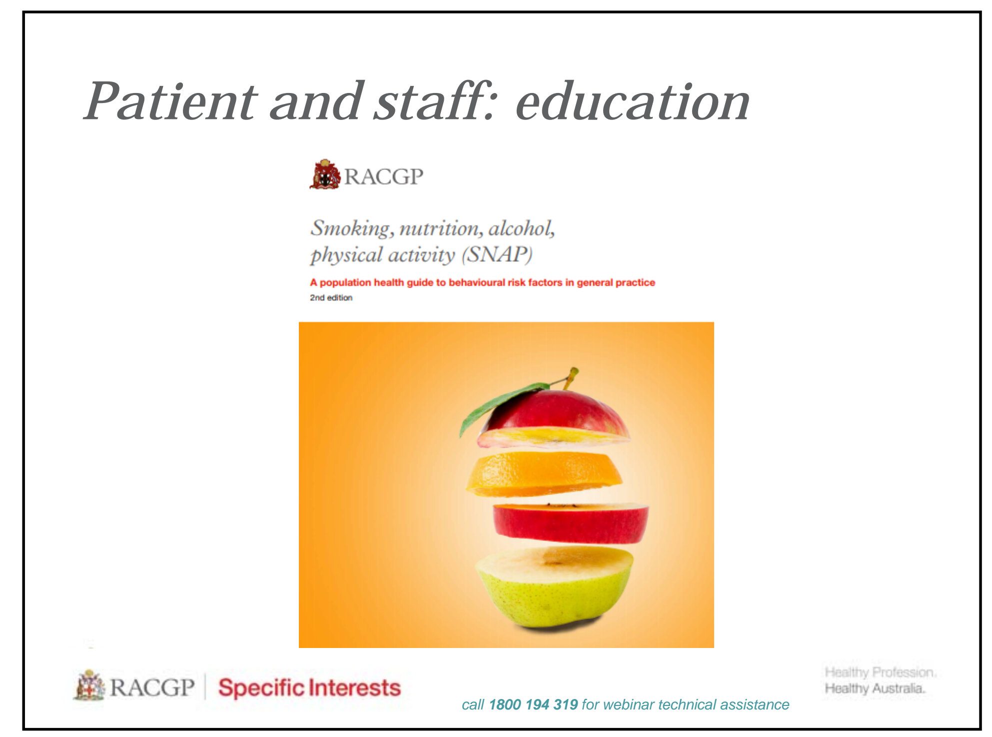
Patient and staff: education
RACGP
Smoking, nutrition, alcohol, physical activity (SNAP)
A population health guide to behavioural risk factors in general practice
2nd edition
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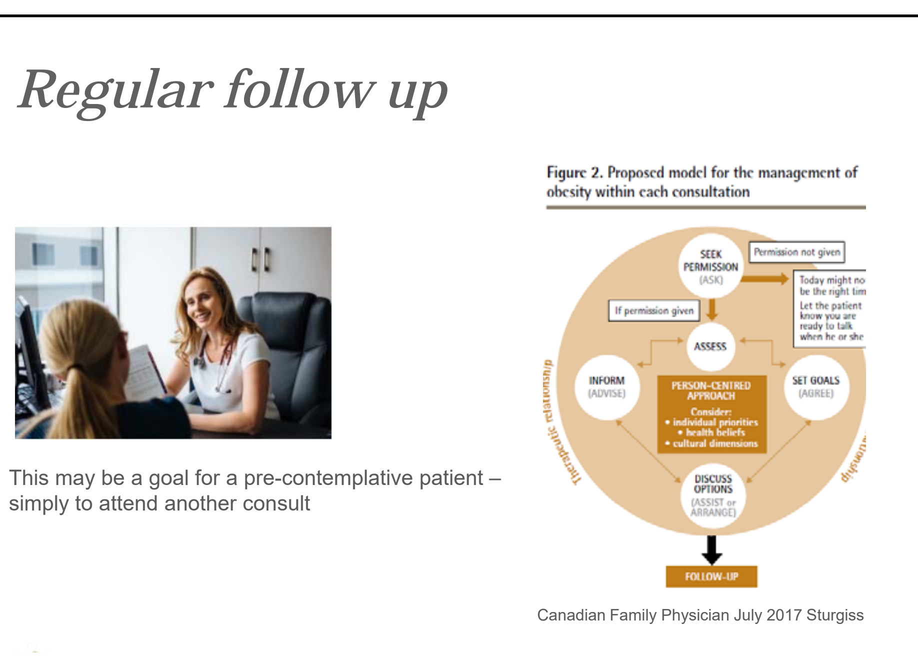
Regular follow up
This may be a goal for a pre-contemplative patient – simply to attend another consult
Figure 2. Proposed model for the management of obesity within each consultation
SEEK PERMISSION (ASK)
Permission not given
Let the patient
know you are
ready to talk
If permission given
ASSESS
INFORM (ADVISE)
PERSON-CENTRED APPROACH
Consider:
• individual priorities
• health beliefs
• cultural dimensions
SET GOALS (AGREE)
DISCUSS OPTIONS (ASSIST or ARRANGE)
Therapeutic relationship
FOLLOW-UP
Canadian Family Physician July 2017 Sturgiss
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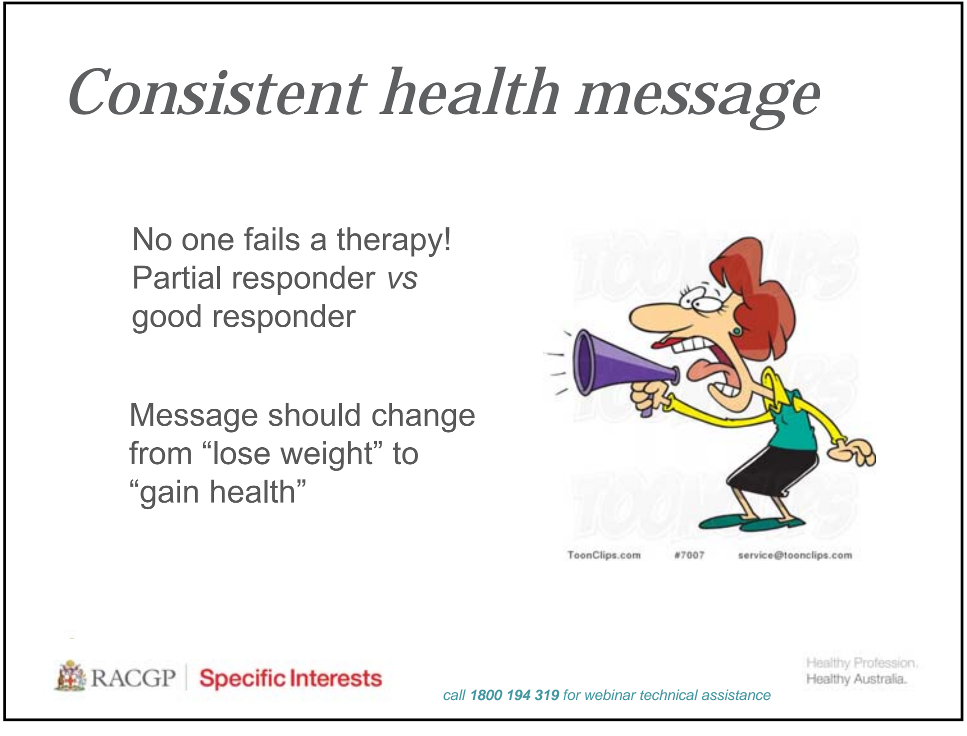
Consistent health message
No one fails a therapy!
Partial responder vs good responder
Message should change from “lose weight” to “gain health”
ToonClips.com #7007 service@toonclips.com
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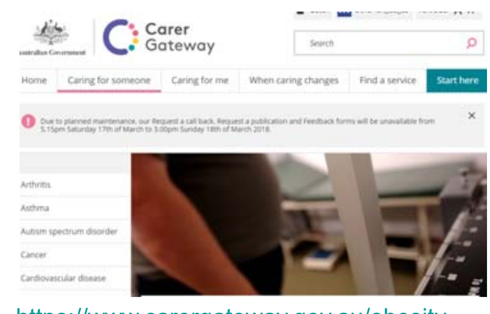
Carer's support is often overlooked

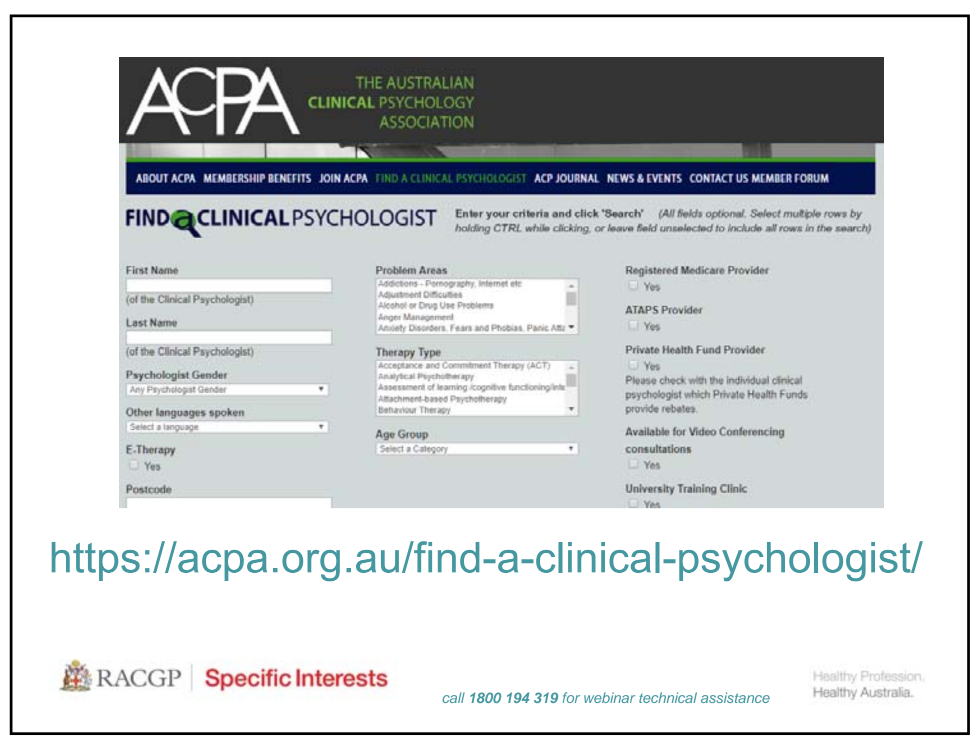


https://www.carergateway.gov.au/obesity

Show compassion by dispelling myths

- Many common myths undermine the successful management of obesity. One example is the prevailing idea that obesity is simply caused by overeating and inactivity or lack of willpower.
- Obesity is not a choice, or a failing of will power. Obesity is a result of factors that have been outside the individual's control. These might include sociocultural, behavioural, psychological, and biological factors.

"I understand your condition and I am here to help"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FIND a CLINICAL PSYCHOLOGIST
Enter your criteria and click 'Search' (All fields optional. Select multiple rows by holding CTRL while clicking, or leave field unselected to include all rows in the search)
First Name
(of the Clinical Psychologist)
Last Name
(of the Clinical Psychologist)
Psychologist Gender
Other languages spoken
E-Therapy
Postcode
Problem Areas
Therapy Type
Age Group
Registered Medicare Provider
ATAPS Provider
Private Health Fund Provider
Please check with the individual clinical psychologist which Private Health Funds provide rebates.
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University Training Clinic
https://acpa.org.au/find-a-clinical-psychologist/
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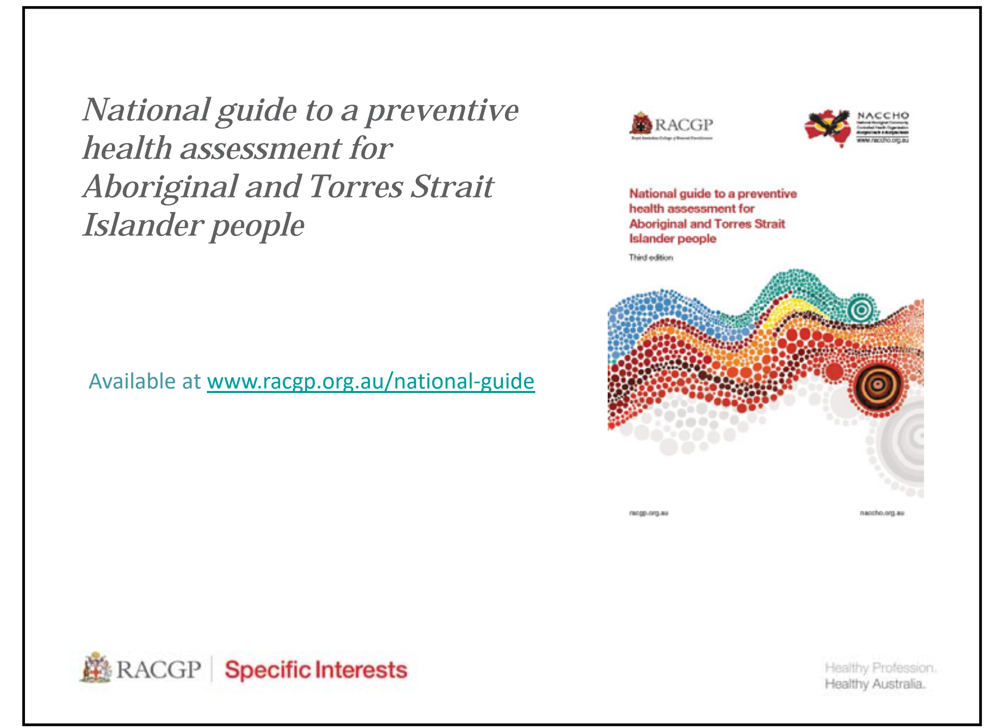
National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people
Available at www.racgp.org.au/national-guide
RACGP
NACCHO
National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people
Third edition
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Obesity management for GPs webinar series

17 May 2018 – Why is losing weight so difficult?

31 May 2018 – Bariatric Endoscopic Procedures & Metabolic Surgery

14 June 2018 – Nutritional needs of patients with obesity

21 June 2018 – Management of pregnant women with obesity

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