

Obesity: All in the mind?

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Article points

1. The failure of diet and lifestyle interventions suggests that information and motivation alone are insufficient to cause weight loss in many obese people.
2. Values and emotions are an often overlooked piece of the weight loss puzzle, and they can form the bridge between knowledge and behaviour.
3. The EatingBlueprint is a novel, online, video-based tool that equips people with the skills and tools to reduce their emotional and automatic eating behaviours.

Key words

- Emotions
- Obesity
- Psychological techniques
- Weight loss

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The medical model of weight loss and maintenance often treats overweight and obesity as a logical, rational process that requires only knowledge, education and motivation for success. In this article, the often overlooked role of emotions in weight management is discussed. A new psychological self-help tool, which equips people with the emotional tools and skills required as a foundation to implement weight loss advice, is described, and the role of the clinical psychologist in weight loss initiatives is discussed.

Whilst current health education is focused on the “eat less and move more” message (Haslam, 2010), we know that for every person who can implement this advice there are many who struggle. This leads to a sense of failure and hopelessness for both the obese individual and the healthcare professional (Hörnsten et al, 2008).

Traditional medical and dietary advice treats weight loss as if it is a logical, rational process. There is an assumption that education alone leads to behaviour change. However, education does not always lead to the desired change, as the prevalence of overweight and obesity in the NHS workforce demonstrates (Press Association, 2014). Health messages concerning alcohol intake, food choices, exercise and smoking behaviours are clear, yet how often do clinicians take their own advice? Readers are invited to acknowledge that they too may be the “patient” when it comes to being able to implement lifestyle change.

What is the missing link? Our patients often know what they need to do to care for their health, but something “gets in the way” when they leave us. Is it motivation? Motivation is a hugely complex phenomenon, yet the term is used as if it is something that can simply be summoned

up at will. However, when considering weight change, the term motivation can be a red herring. Our patients *are* motivated; they are motivated to do the things that are important to them. If you consider your own life, you (generally!) do not have to “motivate” yourself to get dressed in the morning, clean your teeth or kiss your child goodbye. You probably do not use the term “motivation” in relation to these tasks of daily living. Why? Because these activities are in line with your identity, self-esteem and values. You value your children feeling loved as they go to school, so you organise yourself to wave them off in the morning. You value having fresh breath, so you make time to brush your teeth in the morning. Likewise, our patients are motivated to do exactly the right thing for themselves, given the following two aspects:

- Knowledge and information.
- Emotions and values.

Traditional medical and health education models are excellent at catering to the first of these, but conversations about the latter are absent from our healthcare settings. This is where psychology plays a part, and it is perhaps the missing link in

our understanding of people with obesity.

Psychology is all about understanding our identities, self-esteem, values and emotions. These are the bridge between knowledge and behaviour, and they are the key to motivation (Leventhal, 2003). They guide our decision making, including decisions about our health and what to eat. Food in particular is intimately connected with emotions, and the association starts in infancy, when hunger and distress are soothed by the caregiver's milk (Carnell et al, 2012). Psychological models address emotions; however, access to a registered practitioner psychologist for people with obesity, although recommended by NICE (2014a) and an integral part of Tier 3 weight management services, is extremely limited within current service provision.

A novel psychological self-help tool: The EatingBlueprint

Cognitive behavioural therapy (CBT) is the treatment of choice for "atypical" eating behaviour such as binge eating disorder (NICE, 2004); however, some of the techniques and jargon of CBT are not user-friendly for the people we work with or non-psychologists. The EatingBlueprint is a new tool that attempts to address this. It is an everyday approach to techniques drawn from numerous psychological models that address the human capacity to change (e.g. solution-focussed, compassionate, mindfulness-based, dialectical and attachment-based approaches). It is an online, video-based tool designed to develop the emotional and mindset skills that are required as the foundations to implement weight loss advice. The author is prompted by the McKinsey Global Institute's economic analysis of obesity (Dobbs et al, 2014), which urges clinicians towards a "bias for action" in implementing new initiatives and programmes to tackle obesity, especially where risks are low.

The tools used in the EatingBlueprint are grounded in the theories they are drawn from, and audit data demonstrate an average weight loss of 5 kg over 12 weeks in people who complete the programme ($n=162$ to date). Work is underway to establish a robust evidence base. The eight areas of the blueprint are provided below.

1. Forgiveness

The blueprint begins by normalising the idea that it is difficult to lose and maintain a healthy weight. We are fighting a biological, psychological and social world that is set up to promote weight gain, and the person is not "wrong" or "bad" for being overweight. This step is designed to provide relief from shame and stigma.

2. Focus

This area aims to encourage noticing and overcoming "mindless" eating. Whilst it is usual to eat mindlessly for non-hunger reasons occasionally (Waller and Osman, 1998), people need strategies to help themselves interrupt frequent mindless eating. We encourage them to do this using a simple question: "WHY am I eating?" or, simply, the acronym "WHY?" This stands for:

- **Wait**

Remembering to wait is challenging so, in the short term, participants are invited to use a reminder (e.g. a charity band) on their dominant hand/wrist. This is just a very short-term strategy, until the automatic nature of eating becomes interrupted.

- **Hungry?**

Inviting participants to ask themselves, "Am I really hungry? How physically hungry am I, on a scale of 0–10? If I'm not hungry, what AM I hungry for?" (e.g. for a break, as a reward, as a distraction, to cheer myself up or to bond with someone).

- **Yes**

The final stage is to say "yes" to food or whatever the person is truly hungry for. If the person is physically hungry, say "yes" to food and eat. If the person is not truly hungry and still eats, that's ok too. Change takes time and the simple act of pausing brings awareness to what was an unconscious process.

The power in this area is to help people figure out what they are truly "hungry" for and ask themselves whether they can meet their hunger with something other than food. The areas of the blueprint that follow are designed to help increase the flexibility to choose between a range of responses to food.

Page points

1. Emotions are a key part of decision making, including eating behaviours, and they are closely connected with food.
2. The EatingBlueprint employs psychological techniques to address the emotional components of overeating and is divided into eight domains.
3. The first domain involves recognising the difficulties involved in losing and maintaining a healthy weight.
4. The second domain involves interrupting mindless and emotional eating by assessing whether the feelings of hunger are genuine or if they are masking another need.

Page points

1. The third and fourth domains of the EatingBlueprint involve finding alternatives to food as a source of pleasure or comfort.
2. The fifth domain addresses the spoken and unspoken rules and beliefs about food that may be counterproductive in the modern environment.
3. The final three domains involve recognising that weight loss is a long-term, collaborative process that requires planning ahead for the inevitable pitfalls and mistakes that will be encountered.
4. It can be argued that all people who struggle with their weight should receive input from a clinical psychologist; however, access to psychological services for obese people has often been limited.
5. Online services such as the EatingBlueprint may provide a solution to this poor availability.

3. Fun

Eating is pleasurable and entertaining, and it can become “a friend.” People may need help to look for ways to increase their non-food sources of pleasure and entertainment when they feel the urge to eat for non-hunger reasons, particularly in environments where food is a ready and available source of pleasure and distraction.

4. Feelings

It is common to use food to “stuff down” emotions that are not easy to express. It is a skill to be able to express emotions authentically to both ourselves and others, and we often need strategies to express emotions rather than dull them with food. The EatingBlueprint provides a template for identifying and expressing feelings in ways other than through food.

5. Fables

These are the family stories and rules about food, spoken and unspoken. Phrases like “eat your vegetables before having dessert” and post-rationing narratives such as “don’t waste food” and “finish your plate” have value, but we need to question the modern-day utility of these fables, and create more helpful narratives that serve us.

6. Foresight

To continue to maintain a healthy weight, people need to learn from previous life experiences and manage their thinking styles relating to food. This step encourages people to plan ahead and learn from the “predictability of life” (e.g. Christmas and meals out) and to learn how to experiment with trying out new behaviours. It also invites them to challenge the “good/bad” paradigms of diets (e.g. “I’ve eaten something ‘bad,’ I’ll give up trying for today and start again tomorrow”) using CBT techniques.

7. Framework

Weight loss is not a solo journey. The impact of family influence, the obesogenic environment and social events are all crucial. People need to develop assertiveness skills to be able to say no to the “feeders” in their lives, and to spot the signs of sabotage, often by well-meaning but threatened loved ones. The blueprint provides these skills.

8. Future

Weight loss is a skill, yet we don’t treat it as one. Like learning to drive a car, it is a process that requires coaching and facilitation, and “mistakes” and “slip-ups” are an integral part of the journey that need to be welcomed. The blueprint teaches people how to “update the default” and stay solution-focussed on their weight loss journey.

The role of the psychologist

Obesity is currently treated as a medical or educational problem, not an emotional, psychological or skills-development one. Clinical psychologists are generally limited to using structured CBT, in a one-to-one or small-group format, so these ideas are not particularly available for the multidisciplinary team to utilise.

Do all obese people need a clinical psychologist? Controversially, some would argue that, for many people who have received education and are still struggling, yes they do (British Psychological Society, 2011). There is a substantial body of evidence showing that many people who routinely use food for emotional regulation have a history of psychological issues (Felitti, 2003; Bidgood and Buckroyd, 2005). The prevalence of trauma, childhood abuse, sexual abuse, low self-esteem and depression is high among people who are obese and those presenting for bariatric surgery (Gustafson et al, 2006).

Despite this, access to psychological services for obese people has been, in the main, limited to screening for psychiatric disorders in preparation for bariatric surgery (NICE, 2014b). Tier 3 weight management services provide much more scope for psychological intervention, and online tools of this nature may provide a useful and cost-effective support to interventions in these contexts.

Many clinicians report a sense of hopelessness that surrounds the obesity issue (Brotons et al, 2003). This hopelessness may exist because we need to shift our focus. The “what” and “how much” of eating is of key importance, but to be able to intervene at this level we need to first shift the focus onto the “why” of our eating behaviour – and to be creative in taking a macro- and micro-level approach to the obesity challenge. There are reasons for optimism if we learn lessons from the changes we have seen in the area of smoking

cessation. In the last decades, widespread change in tobacco use has occurred, but it required the coordination of government legislation, industry responsibility and effective public health campaigns. The same integrated approach will be required for the obesity challenge (Dobbs et al, 2014).

Conclusion

In our food-abundant environment, for many people, weight management is not simply an educational endeavour; it is a skill. Achieving and maintaining a healthy weight requires the skills of emotional regulation, the ability to tolerate distress and the assertiveness to say no. In other words, it takes a highly developed person. We need to widen the scope of interventions for obesity to include these skills of emotional regulation. We need to empower people with skills and strategies to make choices other than eating so that the person, not the food, is in control. ■

Online Resources

The online, video-based EatingBlueprint self-help programme is available at: www.PsychBody.com

The programme is currently available for individuals on a sliding payment scale, dependent on income. Ask your patient to quote the code "NHS2" when enquiring on the website.

If you would like to discuss commissioning the online programme for your service or accessing "The Blueprint to Weight Loss" training workshop to equip you to use the blueprint skills in your time-limited consultations, or if you would like to partner with us in establishing an evidence base, please contact the author at: hello@psychbody.com

Recommended self-help books

- Beck J (2008) *The Beck Diet Solution*. Robinson, London
- Gauntlett-Gilbert J, Grice C (2005) *Overcoming Weight Problems*. Robinson, London
- Roth G (2004) *Breaking Free From Emotional Eating*. Plume, New York, NY, USA
- Roth G (2006) *When You Eat at the Refrigerator, Pull Up A Chair*. Hyperion, New York, NY, USA

Bidgood J, Buckroyd J (2005) An exploration of obese adults' experience of attempting to lose weight and to maintain a reduced weight. *Counselling and Psychotherapy Research* 5: 221–9

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Dobbs R, Sawers C, Thompson F et al (2014) *Overcoming Obesity: An Initial Economic Analysis*. McKinsey Global Institute, London. Available at: <http://bit.ly/1qZsyVG> (accessed 16.01.15)

Felitti VJ (2003) *The Origins of Addiction: Evidence from the Adverse Childhood Experiences Study*. Available at: <http://bit.ly/1juxdzn> (accessed 23.03.15)

Gustafson TB, Gibbons LM, Sarwer DB et al (2006) History of sexual abuse among bariatric surgery candidates. *Surg Obes Relat Dis* 2: 369–74

Haslam D (2010) Obesity and diabetes: the links and common approaches. *Prim Care Diabetes* 4: 105–12

Hörnsten A, Lundman B, Almqvist A, Sandström H (2008) Nurses' experiences of conflicting encounters in diabetes care. *European Diabetes Nursing* 5: 64–9.

Leventhal H, Brissette I, Leventhal EA (2003) The common-sense model of self-regulation of health and illness. In: Cameron LD, Leventhal H (eds). *The Self-Regulation of Health and Illness Behaviour*. Routledge, London, 42–65.

NICE (2004) *Eating Disorders: Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa and Related Eating Disorders* (CG9). NICE, London. Available at: www.nice.org.uk/guidance/cg9 (accessed 23.03.15)

NICE (2014a) *Managing Overweight and Obesity in Adults – Lifestyle Weight Management Services* (PH53). NICE, London. Available at: <http://www.nice.org.uk/guidance/ph53> (accessed 23.03.15)

NICE (2014b) *Obesity: Identification, Assessment and Management of Overweight and Obesity in Children, Young People and Adults* (CG189). NICE, London. Available at: <http://www.nice.org.uk/guidance/cg189> (accessed 23.03.15)

Press Association (2014) *Overweight nursing and medical staff should slim, says NHS chief*. NursingTimes.net, London. Available at: <http://bit.ly/XjmwHa> (accessed 23.03.15)

Waller G, Osman S (1998) Emotional eating and eating psychopathology among non-eating-disordered women. *Int J Eat Disord* 23: 419–24

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