The psychologist's role in effective weight management

Obesity is a serious long-term health problem that affects millions of people worldwide and has wide-reaching co-morbidites such as type 2 diabetes. Management of obesity broadly involves reduction in calorie intake and increase in physical activity. However, a major aspect of weight management involves understanding and managing thoughts, perceptions and behaviours that can interfere with weight loss.

If behaviour alone is the underlying issue causing obesity, healthcare professionals (HCPs) trained in cognitive behavioural therapy (CBT) could be employed to help with weight management. However, obesity has a complex aetiology, and can include a range of underlying psychological or psychiatric disorders. The spectrum of psychology and psychiatric illnesses related to obesity is unfathomable, and there are no clear criteria for assessing or classifying the varied psychological and mental health disorders prevalent in obese individuals.

Mental health issues are common in people with obesity and type 2 diabetes, and there are bi-directional associations between mental health problems and obesity (National Obesity Observatory, 2011). One study revealed that obese people have a 55% increased risk of developing depression over time, and people with depression had a 58% increased risk of becoming obese (Luppino et al, 2010). Type 2 diabetes is also an established risk factor for mental health problems such as depression (Hassan et al, 2014), and depression in type 2 diabetes is associated with poorer self-care (Sumlin et al, 2014). It is, therefore, important to ascertain if there are mental health problems in an individual with diabesity before referral to a weight management service. Any mental health problems should be addressed before a weight management programme is commenced.

Designing a tier 3 weight management service with a limited budget is an onerous task. I asked the most experienced bariatric physicians for their opinions on providing a psychology service within a weight management programme, and found there was no consensus from the experts and everyone was right in their own remit. I ended with more questions than answers, and have summarised their responses below to kindle the interest of HCPs involved in weight management.

What is the role of a psychologist in a weight management service?

Psychologists are experts in helping people make behavioural and lifestyle changes that assist with weight management. After a thorough assessment, psychologists help to change behaviours and beliefs that often sabotage weight loss efforts. They help in building new coping skills and making appropriate changes to achieve weight and non-weight-related goals. Some centres have psychologists who have been specifically commissioned to help people with obesity, diabetes and eating disorders.

In centres where psychologists are commissioned to manage people with eating disorders, their input is to establish whether there is any underlying eating disorder such as binge-eating syndrome or night-eating syndrome and to identify any other barriers to weight loss. These can include emotional, habit or comfort eating due to an unhappy work or personal life or other life stresses. Psychologists can manage this with appropriate behaviour change techniques, such as CBT or neurolinguistic programming.

Do we need a qualified clinical psychologist?

The best practice must be to seek assistance from qualified rather than unqualified practitioners. Unfortunately there are no studies comparing the effectiveness of clinical psychologists to other healthcare professionals in weight management. Calculating cost-effectiveness is quite complicated and just because a HCP who costs less than a clinical psychologist is employed, does not mean that this is a more cost-effective approach.

What is the minimum psychology input required for tier 3 weight management services?

This depends on the funding, weight management service specification and complexity of the individuals referred to the service.

The Clinical Commissioning Policy for

Chinnadorai Rajeswaran

Consultant Physician in Diabetes and Endocrinology, Mid Yorkshire NHS Trust, and Chair, National Diabesity Forum

"Cognitive behavioural therapy should not be used by itself for the sole goal of weight loss, but rather it should be used to support lifestyle changes including weight loss and weight maintenance."

Complex and Specialised Obesity Surgery (NHS Commissioning Board, 2013) recommends how a psychological element should be included in tier 3 services: it should include the "evaluation of psychological factors relevant to obesity, eating behaviour, physical activity and patient engagement". This document also states that a psychologist should be included in the multidisciplinary team (MDT) to treat obesity and defines their role as "[providing] assessments and targeted interventions e.g. Cognitive Behavioural Therapy and also post operative support".

CBT should not be used by itself for the sole goal of weight loss, but rather it should be used to support lifestyle changes including weight loss and weight maintenance. A HCP trained in CBT should be able to address issues of body image, self image, confidence, excessive alcohol consumption, comfort eating and self-esteem. CBT works by changing a person's "false perceptions" and this hopefully will result in a change in the person's thoughts and feelings, and ultimately lead to change in behaviour.

Does it have to be a clinical psychologist?

Psychologist input within a weight management service is not intended to treat underlying psychological issues like sexual abuse or depression. This should be identified by their own doctor prior to referral to a weight management service and referred to the local psychology department or mental health team.

CBT, motivational interviewing and goal setting could be delivered by non-psychologists who have had training in these modalities of intervention. In some centres, they are delivered by dietitians, obesity nurse specialists, healthcare assistants and talking therapists. Some experts I spoke to argued that non-psychologists would be a cheaper option given the financial constraints and lack of evidence on the effectiveness of a clinical psychologist in weight management.

However, a clinical psychologist should be part of the MDT, and people who do not benefit from psychological intervention from a non-psychologist should be referred to a clinical psychologist.

As a part of weight management service, is the role of a clinical psychologist to provide assessment or intervention or both?

This again will be determined by the specification agreed with the commissioners of the weight management service and the availability of other psychology-related services within the area.

Who decides what percentage of patients need to be seen by a psychologist or equivalent?

There are no evidence-based guidelines for screening individuals with diabesity to assess suitability for referral to a clinical psychologist. Some centres use local criteria agreed with their clinical psychologists, and members of the MDT triage potential candidates for formal psychology referral. It is clear there is no standardisation of psychological care input within the weight management service in the UK.

How should we help individuals who need behavioural and psychological support in a cost-effective tier 3 weight management service?

In view of the sheer numbers of people requiring support, its cost, the deficit of trained psychologists and the complexity of the problem, we should adapt the three-tiered approach for supporting behavioural and psychological services within any weight management service. This will depend on the specification agreed with the local commissioners.

- Step 1: Behavioural approaches could be delivered in groups and some individuals referred to local services like Improving Access to Psychological Therapies (IAPT), stress management courses and community psychiatry nurses.
- Step 2: Individuals with diabesity who have psychological issues related to their eating and weight such as anxiety, depression, body image issues or low self-esteem should be referred to a HCP trained in CBT or a talking therapist.
- Step 3: Individuals with diabesity identified in Step 2 as needing additional support should be referred for brief psychological assessment to determine what would be beneficial. Thereafter they should be referred to a clinical psychologist for intervention, or an eating disorder service if this is not available within the weight management service. ■

Acknowledgements

Chinnadorai Rajeswaran would like to sincerely thank all the members of the Association of Physicians Specialising in Obesity (APSO UK).

Hasan SS et al (2014) *Community Ment Health J* 21 Jun [Epub ahead of print]
Luppino FS et al (2010) *Arch Gen Psychiatry* **67**: 220–9
National Obesity Observatory (2011) *Obesity and Mental Health*. NOO, Oxford
NHS Commissioning Board (2013) *Clinical Commissioning Policy: Complex and Specialised Obesity Surgery*. NHS Commissioning Board, London
Sumlin LL et al (2014) *Diabetes Educ* 17 Jun [Epub ahead of print]