Motivating people to lose weight: self-help and treatment

Pam Dyson

Introduction

The majority of people with diabetes are aware that they would benefit from weight loss, knowing that it leads to improved glycaemic control, reduces the risk of heart disease and improves quality of life. And the solution would appear to be simple – merely eat less and do more! This article looks at the reasons why people with diabetes find it so difficult to lose weight, and suggests that addressing the patient's agenda to facilitate self-help may be more effective than prescriptive advice given in helping patients to lose weight. This approach has benefits for health professionals as well as patients. A case study is presented here to illustrate the technique.

The perils of obesity have been well publicised recently – from a White Paper (House of Commons Health Committee, 2004) to medical reviews (Ostman et al, 2004) and articles in the popular press. All of these publications provide evidence for the existence of an obesity epidemic in the UK, with nearly a quarter of the population obese (defined as body mass index [BMI] >30) and two-thirds of the population overweight or obese (BMI >25).

There is incontrovertible evidence for a causal relationship between obesity and type 2 diabetes (International Obesity Task Force, 2003), cardiovascular disease (Ostman et al, 2004), and some cancers (Bergstrom et al, 2001). Weight gain is associated with increased risk of developing diabetes (Costacou and Mayer-Davis, 2003) and there is evidence that weight loss is effective in the treatment of type 2 diabetes (Aucott et al, 2004).

Figure 1. Muriel at diagnosis of type 2 diabetes in 1990 (weight 137kg).

Weight loss and diabetes

It has been shown that people with diabetes find it more difficult to lose weight than people who do not have diabetes (Wing et al, 1987), and this may well be related to medication and risk of hypoglycaemia. Sulphonlyurea therapy is associated with a mean weight gain of 3kg and insulin therapy with a mean weight gain of 6kg (UKPDS Study Group, 1998).

Case study

Muriel was diagnosed with type 2 diabetes in 1990 at 45 years of age. Her weight was 137 kg (BMI 50) at diagnosis (Figure 1) and she was given weight loss advice. She found it extremely difficult to lose weight, and as her blood glucose levels continued to rise she was prescribed metformin and then gliclazide. Eventually her HbA_{1c} reached 11%, she began to feel very tired and thirsty and then agreed to start insulin therapy.

Gap between knowledge and behaviour

Most people with diabetes recognise that weight loss is an important factor in controlling diabetes, and therefore have the

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1 Most people with diabetes recognise that weight loss is an important factor in controlling diabetes.

2 Weight loss efforts often fail due to perceived non-compliance, and application of traditional and acute healthcare models, which are not appropriate.

3 To be successful, the patient's agenda must be addressed through establishing rapport, setting the agenda, assessing readiness, importance and confidence, activating change, maintaining change and preventing relapse.

4 Patients are able to take control of the decision-making process if their agenda is addressed and professionals are left feeling less frustrated.

KEY WORDS

- Obesity
- Diabetes
- Weight loss
- Diets
- Self-help

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1 Knowledge is not related to behaviour change.

2 Whether or not the management of diabetes and body weight is successful depends largely on the lifestyle decisions made by the individual.

3 Non-compliance is often caused by a mismatch between the expectation of the patient and health professional.

4 Effective consultations focus on establishing rapport; setting the agenda; assessing readiness; importance an confidence, activating change; maintaining change and preventing relapse.

Figure 2. Muriel in 2001, after 11 years of trying a variety of diets (weight 150 kg).

necessary knowledge. However, knowledge is not related to behaviour change: for example, the knowledge that large amounts of chocolate will raise blood glucose levels is often not sufficient to induce behaviour change in an individual who enjoys chocolate.

Why do people with diabetes find weight loss so challenging?

Whether or not the management of diabetes and body weight is successful depends largely on the lifestyle decisions made by the individual with diabetes – the health professional can only offer advice (Rollnick et al, 1999). There are three main reasons why traditional healthcare models fail people with diabetes:

- application of the acute medical model
- traditional view of lifestyle interventions
- non-compliance.

Application of the acute medical model

Medicine is traditionally based on the acute medical model, where the patient reports a set of symptoms, the health professional diagnoses and treats the disorder, and, as a result, the patient recovers or feels better.

This model is best illustrated by conditions where the treatment is some form of surgery, e.g. limb fracture, or appendicitis. However, it is limited in its application to chronic disease management and weight loss, where the patient will never recover and the emphasis is on self-management. The focus needs to shift from what the health professional does for patients, to what patients are able to do for themselves.

Traditional view of lifestyle interventions

Traditionally, health professionals are trained to accept responsibility for solving their patient's problems if they feel the patient cannot solve these alone. They also feel more effective and that they are doing their job well if they can come up with solutions to their patients' healthcare problems, and feel a degree of frustration if they are unable to offer a solution.

This feeling is underpinned by the accepted norm that there is a 'right' way to lose weight and all that is necessary is to communicate this knowledge to the patient. Health professionals are trained to give their solutions to their patients' problems and not to allow the patient to provide their own solution.

Case study (cont'd)

Muriel was constantly re-referred for weight loss advice and tried everything that was recommended – at diagnosis a prescriptive 1200 calorie diet, then general healthy eating choosing low-fat, low-sugar foods. She then joined Weight-Watchers, and in desperation tried the Atkins diet and Slim-Fast. Each time, she would lose some weight, get bored with the diet and then gain more weight. By 2001, she weighed 150 kg (BMI 55) (Figure 2) and was taking metformin and 60 units of Mixtard 30 twice daily.

Non-compliance

This may be called non-compliance, non-adherence or non-concordance, but it usually involves blaming the patient for being unable to make the desired changes to bring about weight loss. Non-compliance is often caused by a mismatch between the expectation of the patient and that of the health professional, and addressing the patient's agenda can minimise this and improve outcomes.

Addressing the patient's agenda

Effective consultations comprise five components (Rollnick et al, 1999):

1. Establishing rapport
2. Setting the agenda
3. Assessing readiness, importance and confidence
4. Activating change
5. Maintaining change and preventing relapse.

1. Establishing rapport

Welcome your patient by name, maintain eye contact during a consultation, and try to ensure that you are not interrupted by telephone calls or other health professionals during a consultation.

2. Setting the agenda

The common assumption is that the patient is going to want to talk about weight loss now, as this is their appointment time. The subject, in this case weight loss, is

addressed by the health professional despite the fact that there may be other (more important) issues on a patient's mind. The use of open-ended questions can help to set the patient's agenda. Examples of such questions include:

'What would you like to talk about today?'

'We could talk about weight loss, reducing your food intake or increasing your physical activity – what do you think?'

'Are you interested in discussing weight reduction or do you have more important concerns today?'

There are three possible outcomes of agenda setting:

- patient is not interested in addressing weight loss
- patient is ambivalent about weight loss
- patient is willing to engage in discussion.

If it is obvious that if there is no interest, the discussion can end there. Forging ahead with a discussion on weight loss with a reluctant patient will only create resistance and decrease the likelihood of any change in behaviour. In practice this rarely happens, as patients feel engaged and in control from the start. Should patients not wish to talk about weight loss, there is always an opportunity for them to return in the future when they may feel ready.

The majority of patients are ambivalent about losing weight and it is useful to address this with a balance sheet. A typical balance sheet is shown in *Figure 3*. Balance sheets can be general or specific, e.g. reducing total fat intake (general) or reducing cheese intake (specific). Balance sheets can act as a motivational tool, and patients often feel that they can make informed decisions about weight loss and begin to talk about specific changes they may make to reduce their weight.

3. Assessing readiness, importance and confidence

For patients who are willing to engage in discussion, it is necessary to determine whether they want to address knowledge or behaviour. To pinpoint this, it is necessary to establish readiness, importance and confidence (Rollnick et al, 1999). This is often done using questions that include a linear scale, such as:

'How ready do you feel about changing your food intake and/or physical activity right now?'

'On a scale of one to 10, where one is not ready and 10 is very ready, can you give me a number that indicates how ready you are?'

Similar questions can be asked about importance and confidence.

The advantage of this form of questioning is that it is patient led. If a patient gives a low number, this indicates that he/she does not feel ready or confident, or that it is important to lose weight, and this should be acknowledged and a follow-up question asked, for example:

'You gave me the number two; this suggests that you don't feel ready to change right now. What would need to change to move you up to seven or eight?'

It is fundamental to establish the difference between importance and confidence. For example, most people with diabetes know that it is important to lose weight, but often feel that they lack

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1 Use of open-ended questions can help to set the patient's agenda.

2 The three possible outcomes of agenda setting are: patient is not interested in addressing weight loss; patient is ambivalent about weight loss; patient is willing to engage in discussion.

3 Readiness and importance of change can be assessed using questions on a linear scale (e.g. 'On a scale of one to 10...'). Confidence can be addressed using similar follow-up questions.

The change I am thinking about making is:		
	Pros (good things about doing this)	**Cons (bad things about doing this)**
Short-term		
Long-term		

Figure 3. A typical balance sheet.

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1 Focus needs to be on how the patient can make the required behaviour change rather that on what behaviour change is.

2 Emphasis on activating change and agreeing targets needs to shift to personal choice and control - the person with diabetes is best placed to make the decision about which approach would suit him/her best.

3 There are a number of weight management strategies that are used including the healthy diet, calorie-controlled diets, slimming clubs, meal replacements, low-carbohydrate diets, very low calorie diets and fad diets. Not all strategies provide adequate nutritional intake and some should only be used under medical supervision.

confidence in making the specific behaviour change. The discussion therefore needs to focus on how the patient can make the required behaviour change rather than on what behaviour change is required.

Case study (cont'd)

Muriel knew the importance of weight loss and felt ready to change, but had little confidence in her ability to produce meaningful weight loss. Using a balance sheet showed her that she could benefit from weight loss in both the short term (buying nicer clothes, feeling in control of her food) and the long term (moving about more easily, reducing risk of diabetes complications), and that the benefits far outweighed the disadvantages.

4. Activating change and agreeing targets

Once the challenges and specific behaviours that need to be addressed have been identified, the next step is activating change. For this to happen, the focus needs to shift to personal choice and control. The emphasis should be on avoiding giving advice (unless actively sought by the patient), using passive or reflective listening, and encouraging individuals to develop their own solutions (Rollnick et al, 1993).

Part of activating change is deciding the most effective way for the person with diabetes to lose weight. There is a strong belief that the only way to lose weight is to adopt a 'healthy diet', i.e. one that is low in fat and sugar, with plenty of fruit and vegetables. Although this is a healthy way to lose weight, there is no definitive strategy for success (Nutrition Sub-committee of the Diabetes Care Advisory Committee of Diabetes UK, 2003), and the person with diabetes is best placed to make the decision about which approach would suit him/her best.

- ***The healthy diet:*** Adopting a low-fat, low-sugar diet with plenty of fruit and vegetables can aid weight loss. Often, this approach has to be combined with a reduction in the total amount of food eaten to promote weight loss.
- ***Calorie-controlled diets:*** These diets are prescriptive and involve the use of diet sheets; they commonly restrict calorie intake to 1200, 1500, 1800 or 2000 calories per day. They are usually unsuccessful if used in isolation, but can be very effective when used as part of a lifestyle programme.
- ***Slimming clubs:*** Some people find the support and motivation offered by slimming clubs very helpful. The majority of large, commercially run organisations offer dietary advice that is compatible with the requirements of diabetes.
- ***Meal replacements:*** These specially formulated foods, drinks or snack bars, e.g. Slim-Fast, can be bought and used to replace meals and snacks. They have been shown to be effective in producing weight loss.
- ***Low-carbohydrate diets:*** Examples include the Atkins diet. There is evidence that these diets are effective in the short term, but there is no evidence for long-term use. There have not been any long-term studies – they may well be effective or had side-effects long term, but we just do not know! Very low carbohydrate diets may induce hypoglycaemia in people on insulin or sulphonylurea therapy.
- ***Very low calorie diets:*** These rely upon liquid meal replacements and produce rapid weight loss, but long-term results are no better than those of other methods. The European Association for the Study of Diabetes (2000) recommends the use of these diets only under close supervision in specialist centres.
- ***Fad diets:*** Examples include the cabbage soup diet and grapefruit diet. These diets produce quick results as a result of significant food restriction. They are not nutritionally balanced and are unsuitable for long-term use.

Case study (cont'd)

Muriel decided that, from past experience, the most successful diet for her had been the use of a 1200 calorie diet sheet and she wanted to adopt this strategy again. She had a large appetite and knew that a diet that allowed her to eat large amounts of green vegetables and salad would help satisfy her appetite.

5. Maintaining change and preventing relapse

Relapses are part of the cycle of change, and often result from boredom or unanticipated problems. It is useful to identify high-risk situations and encourage active problem solving. There are six elements to active problem solving:

- pinpointing the problem
- generating potential solutions
- evaluating solutions
- agreeing the best strategy
- planning and implementing
- reviewing results.

Case study (cont'd)

*Muriel identified that she was coping during the day, but when she sat down to watch television in the evening, she found it very difficult to resist the urge to snack. Potential solutions included stopping watching television, locking the kitchen door, putting a lock on the fridge and cupboards or finding an alternative activity. She decided that the last suggestion would work for her, so she took up knitting while watching television in the evening. After three years of this approach, she had lost nearly 50kg and now weighs 102kg (BMI 37) (*Figure 4*), she had been able to reduce her insulin to 8 units once a day, and her HbA_{1c} had dropped to 7.5%. She also reported feeling much better and was able to buy clothes off the peg.*

Conclusion

Techniques other than prescriptive advice giving can be effective when addressing weight loss in people with diabetes. The benefits of addressing the patient's agenda extend to both the patient and the health professional. For the patient, the benefits include taking control of the decision-making process and the obvious benefits of weight loss, i.e. improved glycaemic control and improved quality of life. For health professionals, the benefit comes from a reduction in the frustration they usually feel when patients fail to act on their well-meaning advice, and the long-term advantage of caring for patients who increasingly become active rather than passive in managing their diabetes and weight. ■

Figure 4. Muriel after three years of choosing to adopt a 1200 calorie diet. She has lost nearly 50kg and now weights 102kg. Her glycaemic control had improved and the effect on her quality of life has been dramatic, as can be seen in these images.

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