The obesity epidemic: Are emotions the "elephant in the room"?

Jen Nash

This article explores the psychology of weight loss and in particular the role of values and emotions as a bridge between knowledge and behaviour. Details are provided of a new online video-based tool designed to provide emotional and mindset support to enable people to better implement weight loss advice. In addition, a selection of practical "conversations starters" are presented that non-psychology clinicians can use within their time-limited consultations.

We are in the midst of a dual obesity and type 2 diabetes epidemic (Abdullah et al, 2010). Current health education messages are focused on "eat less and move more" (Haslam, 2010), yet we know that for every person who can implement this advice there are many who struggle. This can lead to a sense of failure and increased hopelessness, for both the person and the health professional (Hornsten 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 desired change – the evidence for this exists within our NHS employee workforce (Press Association, 2014). Health messages concerning alcohol intake, food choices, exercise and smoking behaviours are clear, yet how often do we as clinicians take our own advice? An invitation to readers is to consider that they too may be the "patient" when it comes to being able to implement lifestyle change.

So what is the missing link? The people we see 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 and is a term that gets used as if it is something we can simply summon up at will. However, when we are considering weight change, the term motivation can be a "red herring".

The people we see *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 and clean your teeth. You probably do not use the term "motivation" in relation to these tasks of life. Why? Because these activities are in line with your identity, self-esteem and values (you value having fresh breath, so your organise yourself to make time to brush your teeth in the morning). Similarly, the people we see *are* motivated to do exactly the right thing for them, given two aspects of themselves:

1 Knowledge and information.
2 Emotions and values.

Traditional medical and health education models are excellent at the first of these, but conversations about the latter are generally absent from our healthcare settings. This is where psychology plays a part, and it is arguably the missing link in our understanding of people with obesity.

Psychology is all about understanding our identities, our self-esteem, our values and emotions. These form the bridge between knowledge and behaviour, and the key to motivation (Leventhal et al, 2003). They guide our decision-making on things relating to our health and on what to eat. Food, in particular, is intimately connected with emotions – from infancy when hunger and distress is soothed by the caregiver's milk

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Article points

1. Understanding why people who wish to lose weight are often unsuccessful can come down to more than simply establishing if they are motivated or not.
2. There is a significant, but often overlooked, role of emotions in weight loss – as a bridge between education and desired behaviour.
3. Even within the setting of a time-limited consultation, by using open questioning it may be possible for non-psychologist clinicians to start meaningful dialogue on psychological aspects of weight loss.

Key words

- Emotions
- Obesity
- Psychological approaches
- Weight loss

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Page points

1. Cognitive behavioural therapy (CBT) is the treatment of choice for "atypical" eating behaviour such as binge eating disorder.
2. Some of the techniques and "jargon" of CBT are not user-friendly for patients or clinicians. The EatingBlueprint is one attempt to address this.
3. The EatingBlueprint is an online video-based tool designed to provide the foundational mindset to support the implementation of weight loss advice.

(Carnell et al, 2012). Psychological models address emotions, but access to a clinical psychologist for people with obesity, while recommended (NICE, 2014), 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 one attempt to address this. Its aim is to take an everyday approach to the techniques drawn from a variety of psychological models that address the human capacity to change (e.g. cognitive, solution-focussed, compassionate, mindfulness, dialectical and attachment 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. A brief description of the eight areas of the EatingBlueprint is provided in *Box 1*.

The author is prompted by McKinsey's global 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 within the EatingBlueprint are grounded within the theories they are drawn from, and work is underway to establish an evidence base for the programme. For further details, see *Box 2*.

Advice for the time-limited clinician

If you would like to move beyond the "eat less, move more" approach within your time-limited consultations (in line with the NHS's Making Every Contact Count initiative [e.g. East Midlands Health Trainer Hub, 2012]), some suggested "conversations starters" are presented below for you to adapt to your own style and language. Tone of voice can be as important as what you say – using a soft, friendly tone and making eye-contact is helpful.

If you only have 15 seconds…

Begin with the approach below:

> "May we talk about your weight for a moment? Don't worry, I'm not here to give you a lecture."

Pause for a moment to allow them to say "no" if they would rather not. Then, if proceeding, continue with:

> "We know that weight loss isn't as simple as "eat less, move more" – life can be difficult, and eating can be a way of coping with feelings, stress and boredom, for all of us. Are you aware you ever eat in this way?"

If the person says "no", just respond "okay" and carry on with your consultation as usual. The person may genuinely not identify with using food in this way or perhaps does not want to talk about it. If this is the case, you have still provided an intervention, by sowing a seed that the conversation is available if the person would like to have it at another point.

If the person says "yes" but you do not have any more time to talk about it, you could respond with: "It's really common. I can point you in the direction of some self-help information, if you would like?" (see *Boxes 2* and *3*).

If you have 30 seconds…

Following on from the above, if the person indicates a "yes" response, and seems open to talking, continue with:

> "Is this something you'd like to think about? We may not have time to explore this much today, but many people I see tell me they eat more when they are feeling down or at a loose end, or are alone, or stressed, or nervous… This is very normal. Do you ever eat in these ways?"

Pause and wait for the answer. Then, if you do not have any more time to talk about it, you can point the individual towards some self-help resources as above.

Box 1. The EatingBlueprint psychological self-help tool.

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. While it is usual to eat mindlessly for non-hunger reasons occasionally (Waller and Osman, 1998), the people we see 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, "WHY?"

WHY is an acronym that stands for:

- **Wait**
  Remembering to wait is challenging – so, in the short term, the person is invited to use a reminder on the dominant hand or wrist (e.g. wearing a charity band). This is just a short-term strategy until the automatic nature of eating becomes interrupted.
- **Hungry?**
  This invites the person 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, for a distraction, to cheer myself up or to bond with someone).
- **Yes**
  This relates to saying "Yes" to the food, or whatever the person is truly hungry for. If the person is physically hungry, this involves saying "Yes" to food and eat. If the person is not truly hungry and still eats, that's okay too. Change takes time and the act of simply pausing brings an 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 by 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.

3. Fun
Eating is pleasurable and entertaining and it can become "a friend". The person may need help to look for ways to increase non-food sources of pleasure and entertainment when there is an urge to eat for non-hunger reasons, particularly in our food-abundant environments.

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 sayings such as "don't waste food" and "finish your plate" have value, but we need to question the modern day utility of these ideas and create more helpful narratives that serve us.

6. Foresight
To continue to maintain a healthy weight people need to know themselves, learn from previous life experiences and manage their thinking styles relating to food. This step encourages the person to plan ahead and learn from the "predictability of life" (e.g. Christmas and meals out) and think about how to experiment with new behaviours. It also invites the person to challenge the "good/bad" paradigm of diets using cognitive behavioural therapy techniques.

7. Framework
Weight loss isn't a solo journey. The impact of family influence, the "obesogenic environment" and handling social events are all crucial. The person needs 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 aims to provide these skills.

8. Future
Weight loss is a skill, yet we don't treat it as being in this paradigm. 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 how to "update the default" and stay solution-focused on the weight loss journey.

If you have 1 minute…

Begin in the same way as above and if the person seems open to talking continue with the following:

"Can I invite you to try something a bit different with me? Perhaps we could think about the times you tend to eat when you're not hungry and think about what else you may

Box 2. Self-help books recommended by the author.

- 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
- Gauntlett-Gilbert J, Grice C (2005) *Overcoming Weight Problems*. Robinson, London
- Beck J (2008) *The Beck Diet Solution*. Robinson, London

Box 3. Accessing the EatingBlueprint psychological self-help tool.

The EatingBlueprint online video-based 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 "NHS" when enquiring via the website.

If you would like to discuss commissioning the 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 would like to partner with us as an evidence base is being established, please contact the author at: hello@psychbody.com

be able to do instead of eating? Sometimes only food will hit the spot, in which case don't beat yourself up if you eat. But often just having a few ideas in mind of different things you can experiment with doing when you're feeling this way can be useful. It's likely there are some times when your brain is telling you to eat, but you can choose whether or not to listen, and try and do something else instead."

If you have 2 minutes…

Following on from above, if the person seems open to talking continue with:

"Would it be useful if we thought of some ideas together now? We could come up with a few, and you could give one or more of them a go next time you're feeling the urge to eat when you're not really hungry. Perhaps you can try it out, and see how you get on? Remember, it won't 'work' every time – that's okay. It's just helpful to see that just because your brain is giving you the instruction to eat, you don't always have to follow it if you're not really hungry. It will likely get easier with practice, like most things."

Possible ideas to suggest for alternative responses to an eating urge (tailored to the age, gender and your knowledge of the person) include: stroke your pet, go online, have a lie-down, text or call a friend, paint your nails, read, do a Sudoku puzzle, mend something, write a letter, organise a drawer or wardrobe or make a shopping list.

If you have 3 minutes…

If the person seems engaged with the conversation above, continue with:

"Can I invite you to write these ideas down or make a note of them in your phone?"

Pause here and wait for a "yes" response. Some people may be uncomfortable with this for literacy and other reasons. If agreed, proceed with:

"You could put the list in your kitchen, so you'll be reminded, or if you don't want others at home to know, you could try something like moving an object in your kitchen counter to a slightly different location to remind you that you're trying something different."

Write the ideas down for the person if that is preferred (you could refer to it as a "prescription" in a light-hearted tone if you think the person might like that style). Then, continue with:

"Remember, don't worry if it doesn't work, just trying it out is useful. We can talk about how you found it next time we meet if you'd like, or I can point you in the direction of a self-help resource?"

The future

None of this advice is "rocket science", yet why aren't we doing it? It may be because we're in a medical paradigm that treats obesity as a medical or educational problem, not an emotional, psychological or skills-development one.

Do all obese people need a clinical psychologist? Controversially, I would argue that for many who have received education and are still struggling, the answer is perhaps yes. There is a substantial body of evidence that demonstrates many who routinely use food for emotional regulation have a history of psychological issues (Felitti, 2003; Bidgood and Buckroyd, 2005). The incidence 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 is limited to screening for psychiatric disorders in preparation for bariatric surgery (NICE, 2014).

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 the level of "what" and "how much" 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 recent decades, widespread change in tobacco use has occurred, but it required the co-ordination 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)

Concluding thoughts

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

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Carnell S, Kim Y, Pryor K (2012) Fat brains, greedy genes, and parent power: a biobehavioural risk model of child and adult obesity. *Int Rev Psychiatry* **24**: 189–99

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Press Association (2014) *Overweight nursing and medical staff should slim, says NHS chief*. Available at: http://bit.ly/XjmwHa (accessed 16.01.15)

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