original article

The power of language and emotion in specialist obesity services: A scientist-practitioner perspective

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My interest in this area began early in my career, where I investigated perceptions of binge eating. I was interested in the number of calories that needed to be consumed to be deemed as 'binging' and the speed at which food was eaten. The DSM-IV guidelines at the time (American Psychiatric Association, 1994) on this classification were vague and my research found that perception of binge eating differed significantly depending on gender and whether one was consciously trying to control their weight (for weight loss and weight loss maintenance). This led to the desire to understand the phenomenon of 'yoyo' dieting and weight loss maintenance, inspired by the work of Keys et al. (1950) on semi-starvation associated eating behaviours and the link between dietary restraint and binge eating. It seemed, the more a person 'diets' or cognitively restrains their eating… the more they binge eat. It is argued that there is a chicken and egg relationship here, questioning which comes first; however, Key's work, and that of Herman & Mack (1975) and Polivy and Herman (1985) researching the Restraint Theory, would argue that dietary restriction precedes binge eating behaviour.

In 2005 I attended a public health conference, discussing the role health psychology can play in weight loss and the treatment of obesity. It highlighted the detrimental influence the focus on dieting can have to weight loss maintenance, and its link with binge eating episodes. I was approached by an exercise physiologist from the Specialist Obesity Services at the Luton and Dunstable hospital who wanted to know more about health psychology as they were unfamiliar with the discipline. We arranged to meet, with the practice manager and lead surgeon/ endocrinologist for the service a week later. The service predominantly delivers tier 4 bariatric surgery (gastric bypass, sleeve and band) to those with a BMI of 40 and above (35 with a co-morbidity), as well as medical clinics supporting those with diabetes and sleep apnoea. After our meeting, these practitioners were impressed with what health psychology could offer to the field of weight loss and weight loss maintenance, most notably in the area of evoking intrinsic motivation and behaviour change. They were keen to adapt their multidisciplinary team to include a health psychologist, expanding the role from what was once solely a role for a clinical psychologist (as they so often are in this type of service).

I was recruited as a Health Psychologist to Specialist Obesity Services a few months later and my role was to assist patients to adhere to their treatment protocol for weight loss and to support their weight loss maintenance. Treatment began routinely with a low calorie liquid diet for the first 4 weeks, which consisted of milk and vitamins and a physical activity plan. This was followed by support to ensure the maintenance of an energy balance through diet and physical activity, and for those who had surgery, adherence to vitamin supplements. Through the multidisciplinary team I would work closely with the specialist nurse, dietician and exercise physiologist, to assist the client to lose 5% of their body weight prior to a collaborative referral to the surgeon and follow-up work post-surgery.

My consultations drew from a tool kit that I had

developed through my health psychology training and additional courses in the areas of motivational interviewing (MI: Miller & Rollnick, 2002), cognitive behavioural therapy, health coaching and mindfulness. I would select relevant Behaviour Change Techniques (BCTs: that can now be found helpfully in a taxonomy developed by Michie et al., 2013) to use based on the client's needs such as goal setting, decisional balance (pros and cons), problem solving, creating cognitive dissonance (incompatible beliefs: discrepancy between current behaviour and goal), emotional regulation (reducing negative emotion, enhancing positive emotion), action planning, self-monitoring, and positive reinforcement (reward). I would always follow a similar format for my clinics, using motivational interviewing skills and techniques such as open-ended questions and reflective listening following the 'typical day' method; and health coaching approaches such as the 'GROW' model (goal, reality, options, will/ way forward; Whitmore, 2002), integrating the BCTs within the consultation. Drawing from health psychology helped me to support my client to action advice given to them from the rest of the multidisciplinary team, while also addressing cognitive barriers and facilitators to behaviour change.

Adapting dietary intake and increasing physical activity, while also reducing sedentary behaviour, were the target behaviours of change. A typical example of what my clients would experience during a multidisciplinary team clinic is as follows:

The client would first be checked in by the clerk and would take a seat in the waiting room (this is where much of the social-support would happen!). They would first see the specialist nurse, who would give feedback to the patient on their blood results, highlighting that their diabetes or cholesterol is not being managed correctly and that they need to change their dietary intake. The nurse would ask about their medication and would often use the 'righting reflex' (where the health practitioner tries to 'right' or fix the client's problems for them) by telling the patient how important it is to take their medication as prescribed and the risks if they do not (this is not MI congruent and can lead to resistance). The patient would then see the dietician who would tell them that they need to eat less calories. Initially, the dietician would calculate how many pints of milk they needed to drink on their 4 week low calorie liquid diet. They would then provide them with a meal planner and tell them what they should and shouldn't eat going forward. The exercise physiologist would then check the patient's fitness levels, and inform them that they need to move more, and sit less, providing them with a pedometer to log their daily steps. Their surgeon would have already told them that if they do not do all of the above, they will be dead within a year. This is an extreme example, but I have witnessed such clinics, and been the final appointment in such multidisciplinary teams on a weekly basis for hundreds if not thousands of patients, with many sitting in front of me saying; "I know all of this… but…" The challenge was how to support their behaviour change best.

Throughout this multidisciplinary team clinic example, first notice that I use the term 'patient'. My clinic did not like me to use to term client as they were under medical care, so immediately they were medicalised. During this example, they are given a number of BCTs to 'support' behaviour change. Using the coding from the BCT taxonomy version 1 (Michie et al., 2013), they were 'provided with information on health consequences', 'provided with bio-feedback', given goals using 'goal setting for both behaviour and outcome', given 'actions plans', asked to 'monitor their behaviour' and so on. However, it was all in a prescribed manner. Although helpful in terms of focusing on behaviour change, the way in which these techniques are communicated may influence their efficacy. Let's take a 15 minute exercise physiologist consultation using goal setting and

action planning to support weight loss maintenance as an example. This could go one of two ways. The amount of exercise (goal setting) and ways in which this could be obtained (action planning) could be prescribed by the practitioner. Or the practitioner could ask the client what their goal is in relation to achieving increased physical activity levels (goal setting) and how they could see themselves achieving this (action planning). In my experience, and research using theories such as Self-Determination Theory (Deci & Ryan, 1985) would support this, the latter approach that encourages a more autonomous way of thinking, is more efficacious. The way in which any type of behaviour change technique is delivered would follow a similar premise, it should be self-generated rather than prescriptive, and for this, practitioners need effective communication skills.

We know that there is an increased link between improved quality of communication and positive health outcomes (Miller & Rollnick, 2002; Rubak et al, 2005), acknowledging the importance of understanding clients' concerns to help reduce distress and support behaviour change, and ensuring that it is 'client-centred'. Therefore, the linguistics of a behaviour change consultation are key to its application and effectiveness (Chater, 2015; Jubraj et al., 2015). So the way in which we communicate to support weight loss and weight loss maintenance is essential to get right.

But I think one missing piece of the puzzle to support weight loss maintenance is affect and the concept of emotional eating. There is a high co-morbidity of negative affect (anxiety, depression, loneliness, boredom) in those with eating difficulties and weight concerns. During my clinics, I would spend time listening to the client's story, their weight-related journey. I would feel saddened by what I heard, the things that had impacted on their eating and exercise patterns. The majority of my clients experienced regular low mood, perhaps not clinical depression, but a battery of 'bad days'. They would often describe eating for comfort. Some told me of traumatic life events; child abuse, domestic violence and bereavement of close loved ones. All understandable events that would need an element of comfort. Others would describe their embarrassment over their inability to cook. One young man had lost his mother in his late teens, she used to cook for him and after her death he felt he had no alternative but to eat take away food and ready meals. Agoraphobia was high in some. A middle aged gentleman described the fear he had of leaving his house, caused by a tirade of abuse about his weight by a local gang of youths. The delivery drivers of his local pizza and Chinese takeaways had become his only friends. One lady told me of her guilt every time she put food in her mouth, developed from a lifetime of dieting. She dreamed of being able to eat a pudding in a restaurant and just enjoy it, stopping when she was full. But her 'all or nothing' thinking prevented her from ever enjoying food, so she would eat past fullness and feel shame thereafter. A young girl told me of her struggle to deal with the anger and frustration she felt over her dad's alcoholism. She would beg him to stop drinking and barter with him; if he stopped drinking alcohol she would stop overeating. But every time in her eyes he 'let her down', she would go and binge eat until she felt physically sick, consuming thousands of calories in one sitting.

After I had listened to their stories, I would use cognitive dissonance to let them explore what their lives would be like if, when they walked out of my consultation room, they made no change. I would visually draw this as a path out of the consultation room door, and they would describe all the limitations in their life. One vividly recalled a time when they visited a friend's house for dinner and their toilet seat broke under their weight. They feared they would never socialise again. Another told me of relatives that had moved to Australia, and the likelihood that they would never see them again if they did not lose some weight as they would not be able to fit in the aeroplane seat. In

all of these future scenarios, my clients looked sad.

I then would ask them to describe to me what their life would be like if they did lose weight and maintain their weight loss… what would this pathway look like, and I would draw another, going in the opposite direction. All of a sudden their expression changed, they smiled and told me of all the positive things they could achieve, how amazing it would feel and how improved their life would be. One lady shared her dream to be able to ride a horse across a sunset beach, something she didn't feel she could do at her current weight. Another told me of all the fun he would have with his grandchildren, playing football in the garden and taking them to a theme park… again something he currently couldn't do because of his size. All of my clients, during this phase of our session, showed me signs of happiness.

So I started to research the power of positive psychology. Our research found that feelings of happiness are linked to higher levels of self-efficacy and a lower BMI (Cook & Chater, 2010). Self-efficacy is an important construct for weight loss maintenance (Latner et al., 2013), so this was an exciting finding. Based on my experience in clinical practice, I started to trial some small scale interventions that aimed to enhance levels of positive affect through simple pleasures (such as taking a bubble bath), as a way of supporting weight loss (Cook, Gaitán, & Chater, 2010). We used Implementation Intentions (Gollwitzer, 1993; Hagger et al., 2016) to identify triggers to over-eating (such as being bored) and asked participants to replace their anticipated outcome (eating) with something that makes them happy. We found that this not only increased happiness and self-efficacy, but it also reduced anxiety, depression and most importantly BMI (Chater & Cook, 2010).

In conclusion… what is my view on how health psychology can support weight loss and weight loss maintenance? I would have to say that a lot of it comes down to the language we use when communicating with our clients and their emotions. You can tell someone to eat less and move more until you are blue in the face, but invariably, they will put a wall up, as no one likes to be told what to do, and in reality, they know this already. But if we listen to their story, understand their triggers and barriers to over eating and lack of exercise and illuminate their strengths and deep rooted desires, values and fears, we are engaging in more than just effective communication, we are helping them to hear their own inner voice. Thus developing a level of intrinsic motivation that they may have never known they could achieve. And at the heart of this in my mind is emotion, as things can so often seem easier and more achievable when you are feeling positive.

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