

Understanding obesity:

The psychological dimensions of a public health crisis

Obesity is not a 'choice'. People become overweight or obese as a result of a complex combination of biological and psychological factors combined with environmental and social influences. Obesity is not simply down to an individual's lack of willpower.

The people who are most likely to be an unhealthy weight are those who have a high genetic risk of developing obesity¹ and whose lives are also shaped by work, school and social environments that promote overeating and inactivity. People who live in deprived areas often experience many stressors, their neighbourhoods offer few opportunities for physical activity and options for accessing affordable healthy food are limited. Psychological experiences play a big role – up to half of adults attending specialist obesity services may have experienced childhood adversity.²

Psychologists work daily with people living with obesity to understand how these biological, psychological, environmental and social factors interact to cause the behaviours that lead to unhealthy weight. Psychological theories help to explain how and why people's experiences can lead them to become obese and why their best intentions can be overwhelmed. Furthermore, psychologists are focusing on prevention by working with people at risk of becoming an unhealthy weight in the future. This work seeks to understand barriers to healthy eating and physical activity, provide alternative ways to deal with low mood or stress and look at how public health approaches can help.

To be most effective, the best psychological evidence must be included at all levels in the government's and society's collective response to obesity; from understanding attitudes and tackling stigma, to tried and tested theoretical approaches to behaviour change, to best practice in designing specialist services that include appropriate psychological support.

Stigma

Unfortunately, many people still believe that obesity is due to lack of willpower and is therefore a negative personal characteristic with equally negative stereotypes. This leads to blaming the individual rather than addressing the underlying causes.³

Shame doesn't help people to make sustainable changes to their lives. In fact, weight stigma perpetuates a cycle of shame and weight gain. It can prevent people from attending local weight management services that do exist, or even leaving their home for fear of abuse, so it is less likely they will get the support they need.⁴



Around two-thirds of adults in the UK are overweight or obese⁵, so all health care professionals will work with people who are overweight or living with obesity. Unfortunately, many health care professionals demonstrate biases that support weight stigma.⁶ Implicit or explicit prejudice against people who are an unhealthy weight affects the way services are designed and can be seen in the language used in public awareness campaigns. People who are severely obese, with a BMI of over 50, face further stigma as many services are unable to accommodate their needs in terms of appropriate equipment, for example furniture that cannot support their weight.

There are concrete steps that can be taken to encourage the cultural change that is needed to reduce weight stigma. This includes encouraging those who frame the debate to think differently and providing health care professionals with the right training, guidance and equipment.⁷

Behaviour change

Behaviour is central to the prevention, development and treatment of obesity. Promoting healthy weight requires an approach that looks to change behaviours and that recognises behaviours are influenced by biological, psychological and social factors.

Interventions that seek to change behaviour can be aimed at individuals, groups or the entire population. These interventions should consider the different influences on behaviour within each target population – for example how capable and motivated they are to manage their weight and the opportunities they have to do so.⁸

Interventions aimed at changing the behaviour of the whole population, such as regulation, legislation or marketing, require a scientific understanding of the mechanisms of action and risk factors that contribute to the development of obesity. Policy and practice is already informed by nutritional and biological knowledge, and by awareness of social issues, but it needs to become better informed by psychological knowledge including stigma and techniques of behaviour change.

There is an urgent need for government to step up its efforts to tackle obesity and to mount a truly cross-departmental response to this public health crisis. At the heart of this must be an understanding of the underlying mechanisms that cause obesity. Frameworks based on the latest psychological theory are available for policy makers designing interventions and these approaches have been highlighted in Public Health England's *'Improving People's Health'* strategy.⁹ Alongside this is a need to ensure that professionals working in this area are equipped with appropriate skills to support behaviour change.¹⁰

Evidence-based services

Interventions for individuals or groups must also be based on an understanding of the interplay between biological, psychological and social factors that lead to obesity. National guidelines, such as those developed by NICE and SIGN already recommend that all weight management interventions include a psychological component.^{11,12} Furthermore, NHS England's *'Five Year Forward View'* recommends more psychological input and integration in obesity services. The challenge is to ensure that these guidelines are followed, that recommendations are fully implemented and that specialist obesity services are strengthened to provide holistic care.

Many people who are overweight will be encouraged to join community-based weight management groups so it is important that their approach is based on the latest evidence and delivered by people with the appropriate skills to support behaviour change.

When lower-intensity interventions have proven unsuccessful, psychological input is needed alongside medication or surgery. Psychologists can help people to establish the behaviour of taking their medication as prescribed.¹³ Every person who undergoes bariatric surgery, including those who go

private, should receive a psychological assessment and psychological support both before and after the procedure. This is to help them understand the psychological factors that contributed to their unhealthy weight as well as how to sustain behaviours relevant for weight loss in the future. In reality this support is patchy and inconsistent and some people face delays and lengthy waits for follow-up appointments.

Psychologists in weight management services play an additional role in assessing and addressing mental health difficulties, particularly in severe and complex cases. It is important to have a strong connection between weight management and mental health services so that referrals between the two are seamless and that staff in both services are aware of how mental health and obesity are connected. However in practice this element of the psychologist's role is often not acknowledged and therefore insufficient time is allocated for this work to be carried out effectively.

Recommendations

1. Journalists, policy makers, service providers and anyone who produces media about weight management should use language and imagery that does not stigmatise, for example using World Obesity's online image bank.
2. Public health research funders should incentivise research that seeks to answer questions around what language to use and how best to frame messaging about healthy weight, nutrition and physical activity to avoid stigma and promote healthy behaviours.
3. Public health campaigns targeting weight management could be more effective by avoiding framing obesity as a simple 'choice' and using psychological evidence and expertise to design campaigns.
4. Evidence-based training, aimed at health care professionals and people working in the fitness and nutrition industries, which covers the impact of weight stigma and outlines best practice would improve clinical practice and service delivery. This should be provided by health education bodies as part of undergraduate training as well as being offered by professional bodies as part of continuing professional development (CPD) and vocational training.
5. All health professionals delivering weight management initiatives should have regular supervision sessions with a practitioner psychologist to increase their awareness of how mental health conditions and psychological factors can contribute to obesity and the success of treatment. This supervision would also help professionals to understand and address their own unconscious biases within their practice, language and behaviour.
6. Building on Public Health England's *'Improving People's Health'* strategy, the government should explicitly adopt a psychological framework using evidence from behavioural and social sciences and proven behaviour change frameworks to organise a cross-departmental response. All new government statements, policy papers and strategies aimed at promoting healthy weight must demonstrate an understanding of the causes of obesity from a perspective that is informed by psychological evidence as well as consideration of the biological and social/environmental factors.
7. The NICE and SIGN guidelines for the prevention and treatment of obesity should be updated with the input of psychologists with expertise in behaviour change and weight management. Clearer examples should be included on the application of behavioural science and how evidence-based services can be implemented most effectively in different settings. Clinical guidelines should incorporate evidence on the role that psychological factors can play in obesity, for example addressing past trauma, unhelpful attitudes and behaviours towards food and physical activity and dealing with stigma.

8. For weight management interventions to work most effectively, they need to be implemented properly and be able to cater for everyone who is an unhealthy weight, including those with a BMI over 50. Service providers, such as local authorities or CCGs, must ensure they commission evidence based interventions and that they are fully implemented, fully resourced and are designed and delivered by people with appropriate psychological knowledge, skills and training.
9. There are still gaps in the evidence base. The National Institute of Health Research and other research funders should incentivise research that will answer questions about how to improve the development, implementation, uptake and variety of weight management interventions; using a suitable evaluation framework. This should include specific research to understand how to tackle the stigma that prevents people from using services and projects to develop the evidence base around emerging psychological approaches.
10. Weight management services are best delivered by multidisciplinary teams (MDTs) that include psychologists who can support and train other team members to provide psychologically informed practice. All members of these MDTs should have an appropriate level of training in the underlying principles of how to change behaviour using psychological approaches.¹⁴ Health education bodies should invest in ensuring both psychological awareness for MDTs and more psychologists to support them.

References

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