Psychological considerations for the holistic management of obesity

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Psychological presence in multidisciplinary obesity teams has been highlighted as an important component of such teams. Although mentioned in guidelines and recommendations, there is little information regarding the extent to which this is present currently in weight management services, and in what form. Here, we discuss important ways in which psychological aspects of obesity can impact a person living with obesity and how psychology can be incorporated to provide holistic support in weight management services. Recommendations are also made to create clearer guidelines to provide a more robust reference for the inclusion of psychology in multidisciplinary teams.

**KEYWORDS:** obesity, psychology, multidisciplinary

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**Introduction**

There is a bidirectional relationship between psychological factors and obesity, which is reflected in guidelines pertaining to the prevention, assessment and treatment of obesity.

There is a four-tiered pathway structure for the management of obesity in the UK. Tier 1 typically includes population-wide health promotion and Tier 2 includes lifestyle interventions. Tier 3 includes specialist weight management services and Tier 4 services provide a bariatric surgical pathway. Guidelines highlight the need for psychological support to be available for individuals living with obesity, with psychologists being embedded as part of multidisciplinary teams (MDTs) in Tier 3 weight management services, as well as part of surgical assessments and postoperative support for bariatric surgery in Tier 4 services.

Despite the prominence of recommendations of psychological input, its provision appears to vary among services; however, data for this variance are lacking. Psychology is not seen as a frontline intervention in some services and psychological input is limited. Therefore, psychological provision has had to adapt in its approach to meeting the needs of individuals within the context of system resources and narratives, as well as trying to influence the system and narratives to advocate psychologically informed care. Psychology can be seen in services as only for those experiencing difficulty engaging with current intervention approaches or for those with mental health conditions, as opposed to providing support to all who live with obesity and giving them the opportunity to explore the psychological factors impacting their eating behaviour as part of their standard care. Normalising psychology by having it as part of standard care could also aid communication of the role of psychology and reduce the stigma around discussing psychological aspects of diet and lifestyle.

The following psychological themes might underpin the current processes of weight maintenance and eating behaviours in an individual living with obesity. If we examine the psychological determinants and themes affecting those coming into services, holding these considerations in mind could create a care pathway that more effectively meets the needs of that individual.

**Weight stigma, body image and self-esteem**

Weight bias and discrimination from others and the self can lead to social isolation, low self-esteem and other negative psychological consequences. Persons living with obesity have consistently expressed their experiences of being subjected to discrimination in multiple life settings, as illustrated in the report published by the All Parliamentary Group on Obesity in 2018, who found that 88% of persons living with obesity reported experiencing stigma, criticism or abuse as a direct result of their obesity. It has been argued that weight stigma can have adverse effects on someone’s health as well as driving weight gain.

Persons living with obesity can struggle with negative body image and low self-esteem resulting from societal stigmatisation of larger bodies, which can influence personal standards of how they should appear. This is unique to the obvious physical changes and fluctuations that can be observed in this condition. There might also be shame or embarrassment about an individual’s weight or weight management leading to societal withdrawal or anxiety in social situations. Body image dissatisfaction with some or all features of the body presents as being directly related to a person’s excess weight. The experience(s) of unsuccessful weight loss, or weight regain, or perceptually marginal changes can damage one’s self-esteem, and it might feel difficult to focus on any strengths or successes that a person might have.

The appearance of loose skin and stretch marks, body image shame, as well as disordered eating, are some of the negative consequences associated with bariatric surgery. Snowden-Carr illuminates further that someone might have a good self-esteem in general but struggle in terms of...
weight-related beliefs about themselves and their body image. The societal heralded consequence that eating too much leads to undesired obesity highlights the lack of understanding that can exacerbate the impact of stigma and this must be challenged to support our clients best.

**Mental health**

Comprehensive reviews have suggested a 20–60% incidence of psychiatric illness in obese cohorts. Using an umbrella review approach, Robinson et al found strong evidence to suggest that heavier weight is associated with mental health. Mediating factors that have been proposed for mental health difficulties as a risk factor in the development of obesity include unhealthy lifestyles, use of maladaptive emotional regulation strategies, such as emotionally driven eating, avoidance of activity, prescription of psychotropic medication and reduced support. This relationship between mental health and obesity is likely to be bidirectional, with development of chronic medical conditions, medication, low self-esteem, dieting and weight cycling, stigma, and hormonal and functional impairment having been proposed as potential mediating factors between obesity and the increased risk of challenges with mental health. Some notable mental health conditions found to be prominent for individuals living with obesity are outlined below.

**Depression**

A link has been suggested by previous research between depression and excess body weight. Persons living with obesity had a 55% increased risk of depression and those with depression had a 58% risk of becoming obese. The prevalence of symptoms of depression in bariatric candidates is around 45%. Weight-related stigma and discrimination, as discussed above, could account for increased rates of depression in persons living with obesity. There also appears to be a stronger risk of depression in women than in men, which might be a manifestation of increased societal pressure on women to be thin. Depression has been linked to predict protective or damaging behaviour that impacts a person’s long-term health, such as smoking or sedentary behaviour. Negative affect is also associated with overeating, as well as with stigma and obesity, illustrating the previously established indirect and direct two-way relationship of obesity with mental health.

**Anxiety**

Social anxiety challenges 9% of persons living with obesity who are candidates for bariatric surgery, and those with extreme obesity report greater levels of anxiety in social situations. This might be because of a societal pressure of thinness as an indicator for beauty, and may influence subsequent eating behaviours, and consequently impact weight loss/gain. This bidirectional relationship of obesity and mental health can mean that the impact of living with obesity, such as social isolation, negative self-image and discrimination, as identified above, can also contribute to the development and maintenance of mental health issues.

**Stress**

Sinha and Jastebuff highlight the association between the physiological processes of stress, appetite and energy regulation.

**Disordered eating**

There are many types of eating difficulty that might be experienced by someone living with obesity, which can make it difficult to manage weight. As mentioned above, food can become a coping mechanism to deal with stress, negative emotions and the many psychological issues described above. Of candidates for bariatric surgery, 5–15% present with binge-eating disorder (BED), characterised by excessive and uncontrollable food consumption in a brief period of time. Hunger is often reported as absent and the event can be followed by feelings of disgust. In their review, Aldao et al showed that food was powerfully used to cope with (by avoiding or suppressing) unbearable thoughts and emotions. This association can become habitual and automatic.

**Social support**

The impact of social support is varied, with a more ‘encouraging’ approach likely to improve self-efficacy by supporting healthy eating habits within a person’s lifestyle and affirming one’s personal capacity to make changes. This is in contrast to more ‘critically’ perceived support, which can be overly directive, more likely to be rejected and defended against by individuals as a consequence. This can lead to shame and secret eating to either cope or rebel.

**Comorbid health concerns**

A diagnosis of obesity often coincides with other health issues. For example, a diagnosis of diabetes is seven times more likely in persons living with obesity, which provides implications for the simultaneous coping pressures of having two chronic health conditions. Diabetes has an established bidirectional relationship with mental health conditions, such as depression, which can create issues with self-care and, consequently, further health deterioration. The effects of more than one health condition and their individual relationships with mental health can have a further compounding effect on a person’s mental and physical health and their management.

**Accessing weight management services**

Living with obesity, one can encounter many complex and challenging experiences that can impact various aspects of an individual’s psychosocial wellbeing and functioning. The emotional experiences highlighted above can impact treatment as well as the journey of treatment itself. Although persons living with obesity are likely to be motivated by the prospect of improved health and wellbeing, concerns of discrimination experienced from professionals and concerns about physical appearance, body image and shame of not having been able to achieve weight-related goals can have a role in whether someone accesses and engages in treatment. Low levels of access to service, speaking comfortability with their GP about obesity or being treated with dignity and respect by healthcare professionals once support was accessed have all been found to be barriers to accessing and persisting with support. Psychologically informed practices would help to identify and contain some of these hidden issues, which
might not be readily addressed when a person living with obesity accesses healthcare for their weight management and health needs.

**The need to understand individual experiences**

Understanding qualitative dimensions has recently been given attention and, in turn, experiences around motivations and lived experience have been explored to enable a conversation around how we address the needs of the individual. Research has provided deeper insights into the complex existential experiences of persons living with obesity.\(^{36,37}\) Ueland et al found that interventions that are not individualised can subject the individual to feelings of objectification and alienation, which impedes their health progress.\(^{38}\)

Ogden et al sought to disentangle and understand the complex experiences of persons living with obesity using focus groups and interviews.\(^{19}\) They suggest six potential dichotomies, each with a spectrum between two extremes where people might fall. Both positive and negative experiences can be found within each dichotomy, indicating the conflict and oscillating experiences plaguing this population, which can be both helpful and destructive in their lived experience. Negative experiences are associated with behavioural arrest, diminished self-efficacy, poor psychological adjustment, behavioural stasis and weight retention/gain. Positive experiences were related to feeling more informed, with empowered and adaptive behaviour coupled with greater efficacy, psychological flexibility and resilience. Consistent with other qualitative studies that aim to understand the struggles and complexity of persons living with obesity,\(^{49,50}\) they have suggested direct implications on facilitation or hindrance to accessing or engaging in services, and encourage a unique reconceptualisation of processes with an aim for healthcare professionals to support the provision of a respectful and compassionate response.

A qualitative study from Norway looked at the perceptions and experiences of persons living with obesity,\(^{42}\) and highlighted a need to provide a multidisciplinary and holistic (and, therefore, authentic) approach in the UK. This would acknowledge the multidimensional factors found to be affecting persons living with obesity\(^{43,44}\) which could further reduce stigmatisation, rather than focusing on a reductionist approach that might apply body mass index (BMI) as the prominent indicator of weight-related health. Representing the full spectrum of complexity would align with the notion of ‘patient-centred care’.\(^{55}\) Focusing on interrelated elements of individual experience might help us to achieve a more comprehensive and effective approach using obesity care. Snowden-Carr reflected on the crucial role of psychological factors in considering the maintenance of weight gain. She stated that ‘prescriptive interventions’ can lead to the reiteration of lapse and relapse cycles, reduced self-efficacy and increased shame.\(^{13}\) These aspects must be considered during assessment.

Clear criteria for psychological assessment and intervention for psychological challenges prevalent in persons living with obesity is limited; thus, guidelines in this regard would be vital in setting up and considering the construction of an effective and holistic service. Physicians have argued for the case of incorporating qualified psychologists into weight management services as potentially being a more cost-effective venture by establishing underlying psychological issues, such as disordered eating.\(^{46}\)

Intervention can take the form of both direct clinical consultation with individuals and indirect consultation with MDTs. Indirect consultation can support the formulation of psychological factors contributing to an individual’s diet and lifestyle behaviours and engagement with interventions. Collaborative working can support development of a holistic formulation and treatment plan to support each discipline in working effectively with individuals to achieve their goals. For example, Table 1 presents an example of a formulation that might present itself in a weight management service. As can be seen, there might be several factors that perpetuate one another and, for each discipline to work effectively with the individual, an understanding of the holistic formulation is beneficial. A holistic intervention plan can then be formed. In the example in Table 1, this could include interventions such as medication management, dietary intervention, support from an exercise practitioner to build self-efficacy in engaging in physical activity, and psychological support exploring self-esteem.

Direct psychological intervention might focus on supporting individuals to reflect on factors influencing their eating behaviour. This could include exploring key narratives regarding food in their formative years, identifying functions that food might have served in their life and identifying current perpetuating cycles between cognition, feelings, diet and lifestyle behaviour. It has been noted that psychological

<table>
<thead>
<tr>
<th>Table 1. Case example of a patient with type 2 diabetes mellitus(^a)</th>
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<tbody>
<tr>
<td><strong>Predisposing factors</strong></td>
</tr>
<tr>
<td>• Processed diet growing up</td>
</tr>
<tr>
<td>• Highly critical environment</td>
</tr>
<tr>
<td>• Lack of exposure to being soothed by others</td>
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<tr>
<td><strong>Precipitating factors</strong></td>
</tr>
<tr>
<td>• Diabetes medication exacerbating weight management challenges</td>
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<tr>
<td><strong>Perpetuating factors</strong></td>
</tr>
<tr>
<td><strong>Thoughts</strong></td>
</tr>
<tr>
<td>• I am worthless</td>
</tr>
<tr>
<td>• I can’t cope with being fat</td>
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<tr>
<td>• Thoughts relating to perceiving recommendations of others as critical</td>
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<tr>
<td>• Thoughts relating to strict dietary restraint rules - I must/should</td>
</tr>
<tr>
<td><strong>Feelings</strong></td>
</tr>
<tr>
<td>• Low mood</td>
</tr>
<tr>
<td><strong>Behaviours</strong></td>
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<tr>
<td>• Try to implement strict dietary restraint rules that are unsustainable</td>
</tr>
<tr>
<td>• Emotionally driven eating</td>
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<tr>
<td>• Challenges sharing experiences with healthcare professionals</td>
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<tr>
<td>• Non-adherence to medication</td>
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<td>• Non-engagement in exercise activities</td>
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<td><strong>Physical sensations</strong></td>
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<tr>
<td>• Fatigue</td>
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<tr>
<td><strong>Environmental factors</strong></td>
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<tr>
<td>• Obesogenic environment</td>
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<td>• Social stigma</td>
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\(^a\)Case presentation of a person living with obesity with poor adherence to medication, negative cognitions of weight gain, high glycaemic index diet, low self-esteem, with a history of receiving high criticism, and emotionally driven eating in an obesogenic environment.
therapy should focus on supporting lifestyle change rather than the sole attention being applied to weight loss. Reframing the message away from weight loss and toward self-care could enable persons living with obesity to more conscientiously and consistently engage in beneficial health behaviours. Therefore, social support embedded into interventions, including understanding of how to increase motivation and self-care, has been suggested to be less likely to inadvertently sabotage the client’s journey. Psychological intervention can support an individual to explore their readiness to change, using approaches such as motivational interviewing. It might also help an individual to explore the gap between positive attitudes toward behavioural change and having the knowledge about what behaviours to change, and the implementation of such behaviours. Psychological therapy can support an individual to explore the effectiveness of their responses to the internal experiences and identify alternate responses. For example, cognitive behaviour therapy (CBT) supports individuals to challenge negative perceptions to facilitate change in their thoughts and feelings, and subsequently lead to changes in unhelpful behaviours. A CBT-trained professional would be able to work with issues concerning body image, self-esteem, anxiety and emotionally driven eating, among others. Learning more helpful ways of coping with stress and acknowledging this interplay could help to create an understanding of how best to tackle weight-loss challenges associated with stress eating.

Other third wave CBT approaches that have been found to be beneficial in supporting those living with obesity include Acceptance and Commitment Therapy (ACT). This model aims to build an individual’s awareness of internal experiences, such as thoughts, feelings and physical sensations, as well as external cues, that are associated with taking actions that move them away from acting consistently with their goals and associated values regarding diet and lifestyle. Avoidance of challenging internal experiences can result in individuals taking actions that are inconsistent with their goals and associated values for diet and lifestyle change, for example eating an item non-conducive to weight management in response to a craving. ACT supports an individual to explore an alternate response of willingness to accept challenging internal experience to commit to living life in line with their values. Psychological factors have been found to be predictive of surgical outcomes of bariatric surgery and, therefore, psychological therapy focused on the areas above could support the effectiveness of both Tier 3 and Tier 4 weight management services.

In conclusion, although the potential role of psychology is widely recognised in guidelines for supporting individuals living with obesity, its provision is varied and it might not be viewed as a first-line intervention. Psychological support alongside other disciplines could provide the opportunity for more holistic formulations and cohesive intervention plans, supporting each discipline to work effectively to provide person-centred care for individuals living with obesity. Further research into current psychological provision across weight management services could be beneficial to draw upon the experiences of different teams, which might enable a benchmark as well as guiding principles to be developed regarding the level and nature of psychological input in weight management services. This can then be integrated to fit local population demographics and demands. It is understood that a national audit is underway into provision that can hopefully facilitate and enable such psychological guidance.

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Summary

Key practice implications from the review

- Psychological aspects of living with obesity are vast and complex, and with far-reaching consequences.
- Psychological intervention and MDT input have been acknowledged to be an important part in the care of a person living with obesity. Holistic formulations can aid each discipline in weight management services to support one another to work more effectively.
- There appears to be limited guidance on standard care or suggestions for a psychological pathway within an obesity team, particularly in terms of psychological provision being available for all who wish to explore psychological factors influencing diet and lifestyle behaviour.
- It is imperative to have a clearer understanding of what services currently exist and provide benefit to persons living with obesity.
- Further investigation and evaluation into psychological input and effectiveness are required to identify how best to use psychological skills and tools within this population, and within an MDT setting.
- Following investigation, clearer guidelines would facilitate services to have robust recommendations, which are empirically supported.

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References
