EXPERIENCES IN PRACTICE

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Alison has been an NHS Dietitian for over 20 years. Her primary interest is working with overweight patients with psychological and behavioural eating problems and who are struggling with traditional care.

The practical integration of dietetics and cognitive behavioural therapy in weight management

I have been a dietitian for over 20 years and in that time, I have seen many changes in practice. One of the biggest has been the move away from a medical model of care, to using increasingly advanced counselling and motivational skills.

I was fortunate enough to study for a year with Sheffield Hallam University on a foundation level 6 Cognitive Behavioural Therapy (CBT) course. The basis of CBT is looking at the interaction between thoughts, feelings, physical symptoms and behaviours, already an integral part of the dietetic role. Once I had completed this course, a job became available as a CBT Weight Management Dietitian for the new Sheffield Weigh Ahead service, which was a tier 3 weight management service. As this was a new service, there were opportunities to create novel ways of working. Supervision was available with the team psychologist to support the development of my CBT work.

We agreed early on which patients would come to me and which to psychology, although there was overlap and transfer between us. My client group was primarily made up of those with a history of eating disorders or disordered eating, complex food behaviours and beliefs, emotional connections and emotionally driven behaviours around food and weight, needing dietary support alongside behavioural and emotional work. Although my patients were often suffering with depression and anxiety, I did not see patients for whom this was the primary issue with weight and eating, or who had other significant psychological or psychiatric disorders, such as personality disorders and psychosis.

What quickly became clear was the complexity of this patient group, many of whom had not received any support that gave consideration to their psychological needs and the origins of their eating behaviours before. As a team, we developed a multidisciplinary assessment which included Gad-7[1], PHQ-9[2] and Rosenberg self-esteem scale[3] alongside dietary assessment, physical activity assessment and social information. In addition to this, my initial assessment would include a basic formulation of the presenting problem, discussion about the wants and needs of the individual patient, confidentiality and boundary setting. I was able to see patients for 45-minute sessions weekly, for up to 10 weeks.

A high proportion of patients had suffered loss, grief, or had been victims of crime or abuse. Supervision and a strong multidisciplinary team were essential in maintaining our own health and perspective in this role.

One of my first cases in this new role was a sharp indicator of things to come. A patient whose obesity began with all their male relatives being murdered in the home. As a result, this patient, as a child, was fed by the mums, aunties and grandparents of the deceased relatives, as a treat and comfort. This had never been disclosed before, so previous healthcare professionals had gone down the route of eat less, exercise more and 'why are you not complying'? This had served to increase the sense of guilt and failure of this otherwise very successful professional and unsurprisingly led to little success with weight control.

There were some common themes and, over time, I developed a way of

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working that seemed to fit this group of patients. Where is the evidence base? Well, there is a vast amount of evidence for CBT as a therapy, working with change and specifically to obesity and eating disorders; the key text that I began with was 'The Cognitive Behavioural Treatment of Obesity'.[4]

Integral to this approach is building rapport. Obvious, I know, but this is a patient group with an often skewed view of health professionals, including dietitians. They bring with them a range of sometimes terrible experiences of how others have treated them because of their obesity. My experience at this point is of patients presenting with very closed body language (arms crossed is common), fear, tears and, in one memorable case, a 'witness'!

I learnt early on that time to draw out and listen to the patient's own story of their weight and eating difficulties was a key part of truly understanding not only what was happening, but what had been tried before and how distressing this was for the patient as an individual. Active listening, gentle encouragement and non-judgemental verbal and non-verbal language were key. I never cease to be amazed by just how much people will confide in an initial appointment, to a complete stranger, if given the opportunity. A poker face was essential; this patient group are highly attuned to negative verbal and non-verbal cues in professionals. While listening, I would make notes, often in a simplified five areas template.[5] A small cohort may be too scared at this point to tell their story, or even make any eye contact. If this is the case, I revert back to gentle open questioning.

I ask patients to complete a journal, starting with their own goals and aspirations: weight, lifestyle or otherwise. I find it helpful to add thoughts and feelings, triggers or purges as appropriate to each individual. A common style I will use, especially with binge eating, compulsive eating or secretive eating, is to ask patients to record only what they feel is excess eating, so not ordinary planned meals, snacks or drinks; but binges, extra snacks and nibbles, extra portions and so on. This approach has proved very helpful in identifying those who feel that they binge, but in fact do not and in quantifying the amount and types of binge episodes. It is not unusual for patients to return for follow-up, having spotted trends in their own diaries and started to make changes after seeing the 'extra' eating clearly for the first time.

Using the diary and assessment, I discuss and agree next steps with each patient individually. The types of changes we work on have common themes. Emotional eating, binge eating, habitual overeating, eating to please others, secret eating, eating as self-harm or, commonly, a combination. We usually agree a number of areas for change and then begin with those that the patient feels will be the easiest to manage. This can take some negotiation, as often patients will want to start with the most difficult problem first, or indeed change everything at once. Some have no idea where to start, as the prospect is simply too overwhelming. Often the starting point is uncomplicated habits such as a biscuit with a cup of tea or chocolate out of the machine at work. We aim to build a sense of hope and self-efficacy at this stage.

Dietitians will be familiar with many of the treatment methods used. The use of distraction and alternative food choices, which can be just as valid with this group as any others, some further methods used include thought stopping, harm reduction, mindful eating, urge surfing, self-soothing and Helicopter view/perspective. The resource website www.getselfhelp.co.uk is invaluable in this work.[5]

Case Study

A typical case was that of a 54-year-old lady who had gained weight through three pregnancies, tried Slimming World and Weight Watchers in the past, losing 1-2 stones and then regaining. At initial assessment she had a BMI of 41.77kg/m2, Rosenberg score 12, fruit and vegetable intake two/day and zero physical activity.

This lady described a history of repeated bullying in her life from neglect in childhood through to domestic abuse in a previous relationship. We identified during assessment that this had led to low self-esteem and depression and

this had impacted on her weight through a pattern of emotional eating and occasional binges. Previous attendance at commercial groups had increased her guilt and further reduced her self-esteem, as she felt unable to disclose her secretive emotional eating behaviour.

Dietary assessment showed that she had started to reduce her portions, takeaways and eating out. She ate regular meals with low fat and low sugar choices. During binges and emotional eating she would eat large amounts of cake, biscuits and chocolate. She was knowledgeable about healthy eating and weight loss.

Goals of treatment were agreed as improved understanding of the triggers for emotional eating and links with self-esteem, increased physical activity and weight maintenance.

We began with psycho education about managing emotional eating, breathing techniques for anxiety and normalising responses to stress and distress. She completed an eating and emotions diary which we used to explore the triggers for emotional eating. We worked together to devise individualised strategies for difficult situations. Physical activity was encouraged and reviewed. At times during treatment, she was bothered by negative thoughts about herself and feeling 'pressure' to lose weight. We explored thinking about health in broader terms, moving the focus from weight alone, including positive self-esteem and mood. This approach led to increases in physical activity and reduction in emotional eating responses.

This lady gained a much greater understanding of her use of food to manage emotions. She was able to reflect and felt much calmer and less critical of herself during difficult family stresses and was subsequently less likely to turn to food binges. Weight loss was modest, -1.5kg; however, she had significant increase in self-esteem, fruit and vegetable intake and physical activity. Rosenberg 25 (+13), fruit and vegetables 5 (+3), physical activity 200 minutes per week (+200).

This lady was initially apprehensive about how we could help her, having focused on diet alone in the past. She was able to share her feelings about her low self-esteem and be open about her real problems with food. The sessions allowed us to get to the origins of her weight gain and the difficulties that she had in addressing them, rather than straightforward education which she neither needed nor wanted. Increased confidence in herself then led to her being able to initiate physical activity and manage some very difficult times at home.

It is crucial that we identify those patients for whom there are more complex underlying causes for the maintenance of their obesity. In this way, we have the potential to be able to create longer-term change. This case illustrated the benefits of not neglecting the wider definitions of health, in this case, as in many; overall physical and mental health was improved in advance of weight loss.

Integral to this approach is looking holistically at all the aspect that affect a person's choices around food and this often requires discussion and referral on, for example, for relationship counselling, stress management, mental health services, exercise on referral, alcohol and drugs services.

I am clear that this is a lifelong process of managing overeating, much like any other chronic health condition. Ideally, ongoing support would be available as with other chronic syndromes. My experience is that most people are not 'cured', but that they can move the difficulties with food to a less prominent position in their lives.

One of the key points I learnt from my experiences, was the value of having the CBT skills alongside extensive dietetic experience. This combination meant that I could adjust dietary treatments, at times moving away from standard practice, to allow a reduction in anxiety, guilt and failure by the patient. This gave me an advantage over our psychologists in managing treatment plans, especially for patients with conditions such as diabetes. An example would be negotiating an increase in oral hypoglycaemic agents with a patient's GP to control their diabetes whilst they work on the psychological elements of their eating. Focusing away from low sugar, managed carbohydrate for a binge eater with diabetes, whilst they establish a regular eating pattern and physical activity. This approach does require a great deal of communication with other professionals, as, often, patients who I would be working with would leave enthused and feeling more in control, only for that empowerment to be crushed by a well-meaning professional reverting to standardised advice.

The underlying philosophy of my work remains that: given the right approach, most people are honest about their eating difficulties: any progress in any area of health, is valuable.