Obesity: Evaluation, treatment, & how to talk about it with patients

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Agenda
- Background
- Evaluation
- Treatment
- Talking about weight with your patients

Background

Prevalence (2020)
- Body mass index of ≥ 30
- US adult obesity rate: 42.4%
  - First time national rate exceeded 40%
  - Lowest rate of obesity: Colorado, 23.6%
- US child (ages 2-19) obesity rate: 19.3%
  - Increasing with time, exhibiting earlier onset

Trust for America’s Health, 2020
**Causes**

- Complex health issue with interacting, multifactorial causes
- Obesogenic environment
- Hereditary
- Socioeconomic and sociocultural
- Individual behaviors (physical activity, diet, medication use)

**Demographic trends**

- **Protective factors**
  - Higher income (vs lower)
  - More education (vs less)
  - Living in suburban & metro areas (vs rural)

- **Risk factors**
  - Poverty
  - Discrimination
  - Black 49.6%, Hispanic 44.8%, white 42.2%, Asian 17.4%
  - Food insecurity
  - Increased during COVID-19 crisis

**Consequences**

- Associated with:
  - Poorer mental health, reduced quality of life
  - Leading causes of death: T2DM, heart disease, stroke, some types of cancer
  - More serious consequences of COVID infection, including hospitalization and death

**Recommendations to address**

- National organizations recommend physicians screen for obesity & provide intensive behavioral counseling
- However, obesity is not well managed in current health systems
  - Lack of training of healthcare workforce
  - Baseless assumptions of people with obesity
  - Lack of experience working in multidisciplinary teams
  - Lack of training in behavior change strategies

*Hruby & Hu, 2015; Trust for America’s Health, 2020*
Role of primary care

• Small portion of adults with obesity ask a healthcare professional about weight loss
  • Of these, most consult their PCP
• Primary care: main point of contact for most people seeking health services
• Numerous articles have detailed strategies to manage obesity in primary care

Evaluation

• 5As model for weight management counseling in primary care:
  • Assess
  • Advise
  • Agree
  • Assist
  • Arrange

Assess

• Screening for obesity, comorbidities, patient’s willingness to make health behavior changes
• Using appropriate language without indication of stigma & shame
  • Patients prefer providers refer to their weight or BMI
  • Caution against the “personal responsibility” notion
**Assess**

- BMI & waist circumference (visceral adiposity)
- Obesity-related complications
- History: diet, exercise, sleep, mental health, medications
- Characteristics & comorbidities associated with poor weight loss
  - Binge eating, sleep disorders, depression, chronic pain
  - Weight loss outcomes differ by race/ethnicity

*Fitzpatrick et al., 2016; Forgione et al., 2018*

**Assess**

- Readiness to change
  - Barriers: more pressing health or mental health issues, lacking self-efficacy, financial or psychosocial problems
  - If not ready: plan to address barriers, invite patient to inform you when ready, build on patient’s confidence
  - If ready: praise efforts, what methods have been successful, ask how you can help, acknowledge their value of health

*Fitzpatrick et al., 2016*

**Advise**

- Counseling patient about:
  - Health risks of current weight
  - May influence patient’s motivation
  - Health benefits of modest weight loss
  - Individualized diet plans & gradual change → long-term adherence

*Fitzpatrick et al., 2016*

**Agree (on goals)**

- Goal setting: key health behavior change strategy
  - SMART: Specific, Measurable, Attainable, Relevant, Time-based
  - Unrealistic goals can lead to failure & disappointment

- Collaborative approach
  - Initial weight loss goal of 5-10% of weight
  - Self-monitoring, mobile applications

*Fitzpatrick et al., 2016*
Assist

- Problem solving: identifying barriers in achieving goals & developing plan with clear strategies to overcome
- ADAPT: Attitude (normalizing), Define problem, Alternative solutions, Predict consequences, Try out solution
- Some patients may require more intensive counseling
  - Consider referrals: behavioral psychologist, dietician, commercial programs

Arrange

- Increase accountability through regular (e.g., monthly) follow-up
  - Assess patient’s progress towards goals
  - Review self-monitoring records
  - Problem-solve barriers

Treatment

- Important to treat obesity as a **chronic, relapsing, multifactorial disease**
  - Nutrition, physical activity, emotion/behavior, medication
- Primary care counseling alone has limited ability to achieve clinically meaningful weight loss
- More benefit is seen with:
  - Added pharmacotherapy
  - Intensive counseling from dietitian or nurse + meal replacement therapy

Fitzpatrick et al., 2016

Bronner, 2009; Tsai & Wadden, 2009
Nutrition
• Language matters
• Nutrition planning should be individualized
  • No one diet that is better than the rest
  • Depends on patient’s motivation, resources, finances, personal preference
• Recommend 25% less calories
  • Not by restriction, but by improving calorie choices
• Focus on mindfulness of eating, including self-monitoring
• Viewing nutrition as a lifestyle change

Physical activity
• Language matters
• Physical activity planning should be individualized
• Remember: SMART goals
• Get your patients moving – any movement helps
  • Get creative with ideas
• Self-monitoring can be helpful

Emotion/Behavior
• Anxiety & depression are prevalent
  • Can impact eating behavior & adherence (decreased motivation)
• Screen for eating disorders
• Discuss alcohol & substance use
• Assess sleep
• Discuss eating habits
  • Dining out, distracted eating, stress eating, meal planning

Medication
• Anti-obesity medications (& surgery) change the physiology of body regulation & offer best chance for long-term weight loss
  • Cannot replace diet, exercise, & lifestyle modification
  • May help to feel less hungry or full sooner, or make it harder for the body to absorb fat from foods
• Numerous US FDA-approved medications currently available
**Medication**

1. Identify medications possibly contributing to weight gain & change patient’s regimen
2. Identify if patient meets FDA-approved anti-obesity medication indications
3. Trial medication
   - If no improvement after 3-4 months, consider different medication or increase dose
4. Medication as adjunct treatment

**Medication**

<table>
<thead>
<tr>
<th>Medication</th>
<th>How it works</th>
<th>Weight loss at 1 year</th>
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| Orlistat         | Works in gut to reduce amount of fat the body absorbs from food consumed | -5.5 lb with 60 mg  
|                  |                                                            | -7.5 lb with 120 mg   |
| Liraglutide      | Mimics a hormone (glucagon-like peptide-1) that targets areas of brain that regulate appetite & food intake | -13.5 lb             |
| Qsymia (phentermine & topiramate) | May lead to feeling less hungry or feeling full sooner | -14.5 lb with 7.5/46 mg  
|                  |                                                            | -19.5 lb with 15/92 mg |
| Contrave (bupropion & naltrexone) | May lead to feeling less hungry or feeling full sooner | -13.5 lb             |

*Be aware of contraindications & adverse effects of different medications*

**Bariatric surgery (referral)**

- Promotes weight loss by restricting amount of food the stomach can hold, causing malabsorption of nutrients, or by a combination of both restriction & malabsorption
- Does not replace diet, exercise, & lifestyle modification!

**Talking about weight with your patients**
Weight bias & stigma

- Both healthcare professionals & patients with obesity endorse weight bias attitudes & beliefs about obesity
- Patients with obesity perceive biased treatment in healthcare, & this impacts how they access healthcare services
- Avoid making assumptions or judgments about patients’ health & behaviors based on their weight

Campbell-Scherer et al., 2020

Weight bias & stigma

- Weight bias can be:
  - Subtle & overt
  - Verbal, physical, relational, cyber
  - Can lead to rejection, prejudice, & discrimination
  - Individuals affected may be:
    - Reluctant to seek medical care
    - Likely to delay important preventative healthcare services
    - Cancel medical appointments

Bronner, 2016

Weight bias & stigma

- Be aware of the following **misperceptions** of individuals with obesity:
  - Non-adherent
  - Dishonest
  - Lazy
  - Lacking in self-control
  - Unintelligent

Bronner, 2016; Puhl & Brownell, 2006

Obesity terminology

- **People-first language**: recognizes the potential dangers of labeling individuals by their disease
  - Say “patient with obesity” instead of “obese patient”
- Use **preferred/encouraged terms** & avoid discouraged terms

<table>
<thead>
<tr>
<th>Encouraged</th>
<th>Discouraged</th>
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<tbody>
<tr>
<td>Weight</td>
<td>Morbidly obese</td>
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<tr>
<td>Unhealthy weight</td>
<td>Obese</td>
</tr>
<tr>
<td>Overweight</td>
<td>Fat</td>
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<tr>
<td>Body mass index</td>
<td></td>
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<tr>
<td>Affected by obesity</td>
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Bronner, 2016; Puhl et al., 2013
### Considerations for clinic environment

- Ensure clinic furniture & equipment is appropriately sized for individuals with obesity
  - Chairs, toilets, doorways
  - Scales, gowns, blood pressure cuffs
- Ensure scales are in private areas
- Ensure staff are educated about obesity & weight bias

### Other weight bias reduction strategies

- Assess your own weight bias attitudes & beliefs
- Be mindful of patient’s previous weight bias experiences & internalized weight bias
- Recognize & acknowledge multiple determinants of weight
- Separate weight from health — explore all causes of presenting problems
- Highlight importance of behavioral goals vs weight loss goals

### References