Aims for today

1. What is Cognitive Behavioural Therapy?
2. Why CBT in weight management?
3. Specific CBT strategies for Preparation; Action; Maintenance; Relapse
4. Conclusions

What is CBT?

- A psychological approach that emphasises the role of thoughts in how we feel and what we do
- Supports people to change
- Collaborative effort
- Has a framework to follow, is educational, and sets goals
- Evidence base across range of emotional & behavioural problems
Behavioural Model

Problem behaviours are the result of past and present learning processes

- Alter environmental cues: Classical conditioning (Pavlov)
- Alter reinforcers (positive/negative): Operant conditioning (Thorndike)

Behavioural → CBT Model

- Social learning: observation of others’ behaviour & self-efficacy (Bandura)

Cognitive Model

- Beck 1970’s/80’s
- Early experiences can influence our thinking
Cognitive Behavioural Model

Why CBT in weight management?
- SIGN Guidelines (2010) Individual or group based psychological interventions should be included in weight management programmes. CBT techniques specifically mentioned.
- NICE (2006) Interventions should be multi-component and include behaviour change.
- European Obesity Management Task Force (2004) Multiple treatment approaches should be used. CBT approaches mentioned specifically. CBT approaches can and should be delivered by other professionals, with training.
- BPS Report (2011) Obesity in the UK: BT and CBT interventions need to be tailored to the complexity of the client.

CBT in GCWMS
- 1:1 DEG
- Psychology talks
- Weight loss groups
Aim of CBT in WM groups

Combine with dietary therapy to achieve a negative energy balance for weight loss;
- Alter eating habits to reduce calorie consumed
- Use up more energy (activity)
- Support people to develop self-help skills to help them control their weight

Components of CBT Approaches for Obesity

- Self Monitoring
- Problem Solving
- Contingency Management
- RP & Maintenance
- Cognitive Restructuring
- Social Support
- Stress Management
- Stimulus Control

Strategies to Prepare for Change

“What do I need to change?”
Self Monitoring

<table>
<thead>
<tr>
<th>Time</th>
<th>Food</th>
<th>Hunger 1-10</th>
<th>Situation</th>
<th>Calories Portions</th>
<th>Mood Feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 am</td>
<td>2 slices wholemeal bread, margarine, Orange juice</td>
<td>6</td>
<td>Before work, in front of TV</td>
<td>2 starch 1 fat 1 fruit</td>
<td>Feel pleased; positive start to the day</td>
</tr>
<tr>
<td>10.30</td>
<td>Tea, Banana</td>
<td>5</td>
<td>Break at work</td>
<td>1 fruit</td>
<td>Normally crisps, trying to swap for healthy snack, pleased I managed the craving</td>
</tr>
</tbody>
</table>

Self-Monitoring Consistency and Weight Loss

Weight change (lb) at 18 wk of behavior therapy

Self-Monitoring Index Quartiles

P = 0.01 for weight change among quartiles

Specific Change Strategies for Later Stages

“How will I change?”
Useful CBT Strategies for Preparation and Action

- **Goal Setting**
- Developing a Change Plan for each goal

To initiate the plan and take control;

- **Stimulus Control**
  - Changing Environmental Triggers
  - Controlling Internal Triggers

“SMART” Exercise Goals

- Specific
- Measurable
- Achievable
- Relevant
- Time-specific
Stimulus Control

- Unplanned eating is triggered by either INTERNAL or EXTERNAL events
- Internal - emotions such as boredom, anger, sadness, tiredness or feelings of hunger/thirst

GCWMS-Training
Stimulus Control

- External – situations we are in such as shopping, at home alone, seeing adverts etc.

Stimulus Control – Coping with INTERNAL/EXTERNAL Triggers

- Make changes Internal & External environment to reduce exposure to triggers.

- Start with:
  1. **Self-monitor** using a diary to identify the context of eating i.e. setting, situation, thoughts, feelings
  2. Use this information for ‘Functional Analysis’ to increase self-awareness of problems e.g. ‘behaviour chains’
Breaking the Habit Chain

Stimulus Control – Making changes to EXTERNAL Triggers
- Designed to limit exposure to problem situations and foods. Advice is given on;
  - Storing food
  - Preparing food
  - Consuming food
- Rewarding positive eating behaviours
- Learned Self-control
Stimulus Control – Coping with INTERNAL Triggers

- **Cravings and Urges**
  - Psychological desire to eat rather than physical hunger. Need to learn to distinguish the two.
  - Let them pass:
    - Distraction techniques
      - Activity based
      - Cognitive based

  - **In our head**
    - Specific foods
    - Agitated
    - Trigger?
    - Have you eaten?
    - Go away

  - **In our stomach**
    - Eat anything
    - Gnawing
    - Shaky/Light headed
    - Is it time to eat?
    - Gets worse

- **Cognitive Restructuring**
  - **Challenging Negative thinking**
    - Clients with weight problems often express a number of negative thoughts about their weight, their difficulties controlling it and chances of achieving change.
  - Negative thoughts have certain characteristics:
    - Automatic
    - Distorted
    - Unhelpful
    - Plausible
    - Involuntary
Are our thoughts always true?

How would you think about the following situation?

“You come along to your first group meeting. You sit down and say hello to the person sitting next to you. They look at you and don’t say hello back.”

Thoughts, Feelings, and Behaviour

- You might think that this person is very rude because they ignored you.
- You might think they ignored you because they don’t like you.
- You might think they are very shy.

**Not all of these thoughts are TRUE. The way you think about this situation will affect the way you feel and behave.**

Cognitive Restructuring—Thinking Errors

- Modifying negative thinking & unhelpful beliefs
- All or nothing
- Mind reading
- Fortune-telling
- Catastrophising
- Emotional reasoning
Emily…

“I have always been unhappy with my weight and appearance. My dad used to call me “chubby” and I was larger than the other girls at school.

Looking back at pictures of myself I don’t think I was that big. I used to tell myself I was really fat and ugly. I especially hated my thighs, hips, and bottom. I would stare at them for hours at a time, pinching, folding, and pulling the fat and skin backwards.

I am now a lot bigger and I hate my body more than ever! I’m disgusting! My thighs are so fat and wobbly. The cellulite on my body is criminal! I deserve to be in jail because I am so fat and unattractive.

My body image has gotten so bad that I rarely go out. When I do go out, I often think people are staring at me and making comments about my weight. I spend hours deciding on what to wear and sometimes get so frustrated that I decide to stay at home and eat instead.”

Challenge Unhelpful Thoughts

- The first step is to identify unhelpful thoughts and write them down.

- The second step is to challenge those thoughts:
  - What would you say to a friend?
  - What is the evidence that the thought is true/false?

- Over time we should be able to retrain our thoughts and become more realistic in our thinking.

What then?………..Useful CBT Methods for Maintenance and Relapse

- Relapse Prevention
  - Managing lapses and relapses

- Weight Maintenance Skills
  - Clients need to be taught how to stop weight cycling problems
What is Relapse Prevention?

- Psycho-educational approach to ‘habit change’
- Is more relapse management rather than prevention as it is concerned with the PROCESS of change rather than absolute success
- Teaches principles of self-management or self-control
- A method of learning from mistakes as well as successes

What is Relapse?

- Most common outcome of interventions to change behaviour. Slips occur in High Risk Situations
- Lapses and Relapses are not the same thing
  - Lapse = a one-off slip
  - Relapse = sequence of lapses
  - Collapse = complete return to old eating patterns

*It is the largely psychological factors (thinking processes and mood) following a lapse that decide whether relapsing is more likely

Thinking Traps = 'Apparently Irrelevant Decisions' & 'Rule Violation Effect'

High Risk Situations

A HRS is any situation or condition that poses a threat to the client's sense of control (self-efficacy). Broad general categories associated with high rates of relapse:

- **Internal causes**
  - negative emotional states
  - positive emotional states
- **Social Causes**
  - interpersonal conflict
  - Social pressure
John…

“Every time I visit my mother she always buys in loads of cakes and biscuits for me coming. I keep telling her that I'm trying to lose weight and that I don't want those foods anymore. She always says that I'm fine the way I am and don't need to lose weight.

Most of the time I end up eating the cakes and biscuits because she always seems really offended and put out when I say no, but the other day I got really mad and shouted at her. She got very upset and started to cry. It doesn't matter what I do, I can't get the message across that I don't want to eat like that anymore.”

Relapse Prevention Strategies

- Increasing self-awareness i.e. self-monitoring (identify habit pattern, possible triggers, high risks, consequences etc.)
- Skills training and behavioural procedures (anxiety management / assertiveness training)
- Cognitive strategies (cognitive restructuring)
- Lifestyle interventions (lifestyle balance, substitute indulgences, stimulus control)

Weight Maintenance Plan

Reasons for not wanting to regain weight:

The good habits I will continue:

Danger areas and risky situations:

Things I can do to help in risky situations:

Who will support me:

What I will do if my weight increases by 5lbs:
Conclusions

- Useful to teach clients **HOW** to make the changes required to their diet not just tell them **WHAT** they should do.
- Client ‘readiness’ to change behaviour is crucial.
- Increasing clients awareness of the external and internal cues for problem-eating & teaching skills to manage these situations is helpful.
- There should be an emphasis on weight maintenance.

References

Adapted from Wadden and Foster, Med Clin North Am 2000;84:441.

* http://www.motivationalinterview.org/