Chapter 6
Creating a Framework for Effective Conversations

6.1 Introduction

Effective conversations about obesity and weight are the gateway to effective treatment and improved health. Despite the barriers, it is possible to structure a conversation in a manner in which the topic can be introduced in a respectful, time-efficient manner. This chapter will provide you with a framework, as well as specific techniques that can be used. It will provide guidance on how to select patients who will be receptive to your inquiries, how to broach the topic, how to structure the initial conversation so that it can take place in 5 min or less, and how to set the stage for further conversation.

6.2 Build a Partnership

A collaborative, respectful clinician-patient relationship is the scaffolding from which effective conversations take place. Regardless of a clinician's knowledge about obesity, productive conversations occur when clinicians focus on building a trusting partnership that informs and empowers. From the beginning, conscious effort must be made to counter the effects of the bias, stigmatization, and discrimination that patients have experienced in healthcare. This is accomplished through attunement to language and behaviors that may indicate prior negative experiences, and by providing a collaborative, respectful experience that is free of judgement. Through words and behaviors, you can send the message: *It's you and me against the disease*.

The attitude that you bring to the conversation is more important than the specifics of what you say. Attempting new behaviors feels awkward at first but with time and experience, skills improve. We often learn as much from our missteps as we do from our successes. Your sincere dedication to getting it right is felt by your patients.

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When they know you are on their side and you make a communication error, they are likely to forgive you, stay connected, and move on. When you recognize that you have made an error or have been insensitive, set things right by apologizing and expressing your desire to maintain a positive relationship.

When patients experience genuine curiosity and compassion from their clinicians, they feel seen and accepted. With time they will internalize those qualities, resulting in a more curious mindset and the cultivation of greater self-compassion. Both are needed to establish and maintain the health behaviors that are required to successfully manage obesity. This type of interaction is in stark contrast to the all-too-common experience in which patients internalize weight bias from their healthcare providers.

6.3 Seek the Patient's Perspective

One of the most powerful strategies for building a clinician-patient partnership is for clinicians to inquire about their patients' perspective about their weight, health, and motivation. The process of inquiring about the patient's perspective with interest and sincerity is a therapeutic intervention in itself. Not only does it provide clinicians with valuable information that will guide the conversation and treatment plan, patients internalize the process and gain an improved ability for self-inquiry that allows them to get in touch with their own wisdom and answers. Your inquiries should take place in the beginning phases of a conversation about weight and be continued throughout the discussion. If you are providing obesity management care to your patient, the inquiry process is an invaluable clinical tool that should be continued throughout treatment. If you are seeing the patient for another reason while they are receiving obesity care from another clinician, your inquiries about their treatment experiences provide them with valuable support and further solidify their commitment. If your patient has dropped out of obesity care, your interest and empathy may rekindle your patient's commitment to health. In such a situation, the tools of inquiry and understanding may be just what your patient needs to reengage.

Regardless of the reason they are seeking healthcare, patients with obesity frequently receive unsolicited advice to lose weight without any inquiry as to their current or past efforts. They are rarely asked for their perspective about their weight, health, motivation, previous attempts, or if they are currently engaged in weight reduction. These experiences leave patients feeling judged and unseen, particularly in cases in which patients are actively losing weight or have lost weight in the past and are successfully maintaining their weight loss. Not only do these experiences erode the clinician-patient relationship, they may sever it completely, and contribute to people with obesity choosing to delay or avoid healthcare altogether [1]. The following scenario provides an example of this all-too-common experience.

A patient is seeing an orthopedic provider for a knee issue that is causing pain. The patient sees an obesity specialist regularly and has lost 60 pounds in the past 15 months. The patient has been riding an exercise bike for 15–30 min a day for the past 9 months and knee pain arose recently during one of those sessions. The patient has been unable to ride since that time due to the pain and has come for an evaluation by the orthopedic provider. The orthopedic provider has taken a history on the knee problem and without inquiring about the patient's weight history or physical activity history, the clinician says, "Your knee would hurt less if you lost some weight."

This clinician demonstrated bias and did not make any attempt to seek the patient's perspective or build the clinician-patient relationship. As a result, the experience felt stigmatizing and invalidating to a patient who is actively managing obesity and is regularly engaging in physical activity.

Research shows that there are discrepancies between clinicians' and patients' perceptions as to patients' motivation to manage their weight. Clinicians have an explicit belief that patients aren't motivated to lose weight [2–5], whereas patients report much higher levels of motivation [6]. These discrepancies occur because clinicians don't inquire about their patients' motivation and instead make biased assumptions, highlighting the need for clinicians to seek their patients' perspective.

Many patients have made numerous attempts to lose weight and maintain the loss and have insights about what has worked and what hasn't. They are often aware of their strengths and the places where they have encountered challenges. Inquiries about their previous attempts—what worked, what didn't, and their perspective on the factors that contributed to the outcome of those events—provide clinicians with valuable information about how to formulate a treatment plan. These inquiries also provide an opportunity for clinicians to educate their patients about the challenges of weight management and the chronic nature of obesity. All too often patients internalize the idea that they haven't tried hard enough despite all the effort they have expended. They believe that past difficulties with weight loss, maintaining consistent health behaviors, or regaining weight while consistently maintaining their health behaviors are evidence that they have done something wrong. When clinicians recognize this belief, they can remind patients that their struggles with their weight aren't as much about their efforts as they are about the physiological and environmental challenges they face. This helps patients release some of their shame and internalized bias, further strengthening the therapeutic alliance. It reinforces the concept of: *It's you and me against the disease.*

6.4 Select Appropriate Patients

As you consider opening discussions about weight with your patients, you may feel overwhelmed by the sheer number of patients who would benefit from the discussion. Because it's impossible to open the conversation with everyone, especially in the beginning, it's best to start with a few patients and build momentum. This gives you the space to practice your skills and refine your approach before expanding your reach. It is best to choose patients who you feel are most likely to be receptive, which will likely be patients with whom you already have a positive, trusting relationship.

It is advisable broach the topic during an appointment in which adequate time has been scheduled. An ideal situation is during the yearly wellness visit, when the focus is on reviewing the health history, reviewing existing health problems, addressing patient concerns, and determining which health issues could become a concern in the future so that they can be addressed before they become problematic. Other opportunities include diabetes follow-up visits and other follow-up visits that have been scheduled to manage the complications of obesity.

6.5 Guiding Concepts for Conversation

During any conversation about weight, clinicians should be guided by three concepts—focus on health, focus on the long-game, and use appropriate language.

6.5.1 Focus on Health

When initiating conversations about weight and obesity, the focus should be on health, rather than weight or appearance. Conversations—and treatment—are more effective when they are health-centric, rather than weight-centric. This requires clinicians to shift their mindset from discussing weight to supporting health. Health-centric conversations improve the chance that patients will engage in health behaviors that prevent, improve or resolve obesity-related complications, improve quality of life, and lead to successful long-term health and weight management. Patients report that when their clinicians initiate discussions with an imperative to lose weight without any mention of their health it feels like a judgement, rather than a concern about their health. As a result, patients delay care out of fear that they will receive unsolicited advice to lose weight from their clinicians [7].

Helping patients make the connection between their current concerns, symptoms, and function and their lifestyle choices, increases their motivation and focus. This strategy puts an emphasis on the here and now, rather than the elusive future. Most patients care about their health but struggle to connect today's choices to

future health. Clinicians are often far more aware of potential obesity complications than their patients are. It is more difficult to connect today's choices with health outcomes in 5–10 or even 20 years, than to connect them to how it will feel to live life tomorrow.

6.5.2 Focus on the Long Game

Given the chronic nature of obesity, it is best to focus on the long game. Obesity will not be resolved in one appointment. Because it will require a series of conversations over the course of months to years, it is best to conduct each encounter in a manner that will lead to future conversations. In the case that you may only have one conversation with a particular patient, it is advisable to consider the conversations that patient may have with other clinicians in the future and focus on making it a positive experience. Successful obesity management requires all members of the healthcare team—even those who do not know or practice with the other members of the team—to accomplish what is possible and set the stage for future conversations. A positive, respectful experience makes it far more likely that patients will be receptive to discussing their weight with healthcare providers in the future. There will be times when patients are not receptive to your efforts. If that is the case, it is best to honor their wishes, end the conversation, and inform them that the door is always open for future conversations. This honors their autonomy and demonstrates respect for their wishes. It is appropriate and advisable to bring up the topic again at future encounters, when they may be more receptive. Future receptivity is based on the experience they have had with you in the past, reinforcing the importance of maintaining a positive clinician-patient partnership.

6.5.3 Use Appropriate Language

Language is a powerful tool. That's why the type of language we use when discussing weight and obesity with patients matters. Given the bias and stigma that many with obesity have experienced, particularly in healthcare, clinicians must use language that makes patients feel welcome and respected and avoid language that is stigmatizing and dehumanizing. The primary goal of any conversation is to build a collaborative, respectful clinician-patient relationship, for this will increase the likelihood that patients will continue to seek healthcare. As discussed in Chap. 2, when patients experience bias and stigma, they are far less likely to return for follow-up care and worse health outcomes are seen.

An important guiding principle is to approach patients with obesity with the same respect, compassion, and clinical mindset that you use when approaching patients with any other health condition, whether it is chronic—diabetes, hypertension, autoimmune disorders—or acute, such as infections or injuries. This mindset

will keep you focused on the fact that obesity is a chronic condition and that patients need you to treat them as you would any other patient with a serious health issue. Keeping this in mind informs you about the importance of using language that is therapeutic and empowering, not stigmatizing. Non-stigmatizing language increases motivation to change behavior, particularly when the focus is on specific health behaviors as opposed to weight.

6.5.4 People-First Language

People-first language (PFL) for obesity promotes patient-centered care and should always be used when speaking to or about patients with obesity. PFL puts the person before the disease and is used by clinicians when referring to other chronic health and mental health conditions such as diabetes, depression, and autism. It is also used when referencing or speaking to people with disabilities or those who are experiencing poverty or homelessness. PFL for obesity is supported by several national and international professional associations in the U.S., Canada, and Europe, and the list is growing (Obesity Action Coalition, n.d.; Obesity Canada, n.d.). These organizations understand the importance of avoiding biased language and stand as examples of what organizations can do to support non-stigmatizing language.

PFL for obesity refrains from using labels such as *obese* and *morbidly obese* and instead favors terms such as *the person with obesity* and *the individual affected by obesity*. These are phrases that show respect and put the person before the disease. Table 6.1 provides the preferred terms and those that should be avoided.

While PFL has been adopted and promoted by major obesity organizations and has been emphasized in obesity education programs, many healthcare professionals find it difficult to consistently use it, even when they have been educated on its importance in reducing stigma and improving the patient encounter [8]. It is not uncommon to hear clinicians use the term *obese* in the medical literature, professional presentations, and clinical conversations. Even when professional organizations set the clear standard that all obesity education must use PFL and speakers agree to use it, there are still instances in which these speakers are not fully compliant. It is clear that more work needs to be done to not only increase awareness about PFL for obesity, but to increase its consistent use.

Table 6.1 Appropriate language

Preferred terms	Terms to avoid
Person/individual with obesity	Fat
Person/individual living with obesity	Obese
Increased BMI	Morbidly obese
Eating plan/eating habits	Heavy
Physical activity	Large size
	Diet
	Exercise

If you hear other clinicians or staff use terms such as *obese*, *morbidly obese*, or other derogatory terms, it is important to provide a respectful reminder of the need to use PFL at all times. This in-the-moment education will help shift the thinking and behavior of the members of the healthcare team. It is not uncommon to hear patients refer to themselves or others as *obese* or *morbidly obese*. If this happens during a clinician-patient discussion, take the opportunity to educate your patient about PFL and encourage its adoption. This new perspective will help your patients see themselves in a new light, one in which they put themselves before their disease and can begin to release their internalized bias and shame.

6.5.5 Patient Preference

Asking patients about their language preferences conveys respect and provides clinicians with the specific terms each patient is comfortable with. Direct questions such as, “As we talk about your weight, which types of words and language would be most comfortable for you?” are effective. Some patients will state their preferences, whereas others may not have considered the impact of language and need guidance and time to determine their preferences. The word obesity has different connotations to different people. Given the stigma surrounding obesity, the word itself may be uncomfortable for patients to speak and hear. If a patient is unsure about preferences, questions that provide education and contain options may help the patient sort it out. One example is: “Obesity is a clinical word, but some patients are uncomfortable with it and prefer terms such as excess weight, unhealthy weight, extra weight. Do you have a preference?” This approach normalizes the patients’ discomfort, invites them to give it further thought, and establishes a collaborative partnership between clinician and patient.

In clinical literature and discussions, the phrases “obesity is a disease” and “the disease of obesity” are often used with the goal of framing obesity as a health condition rather than a lifestyle choice. While these phrases are much needed in professional discussions, they may be uncomfortable for patients if used during clinician-patient discussions. Some patients feel relief when they hear “obesity is a disease” or are told they have a disease, as they have longed to have it identified as a health issue rather than a personal failing or lifestyle choice, whereas others are uncomfortable with the reference that they have a “disease.” A sensitive approach is to refer to obesity as a *chronic health condition* and avoid using the word *disease* in clinician-patient discussions. If desired, you can wait until the discussion has progressed and then ask about preference, by asking the following: “When I discuss obesity with other clinicians, I refer to it as a disease to educate and reinforce that it is a health issue, not a personal choice. Some patients are uncomfortable with hearing the word disease in reference to their weight, while others feel relief. Some feel both. What is your preference?” This question not only invites your patients to explore their thoughts and feelings and better understand their own experience, it empowers them to speak their own truth. It communicates to patients that you are

knowledgeable about obesity and that you are leading and advocating for them. Furthermore, it sends the message that you are on the patient's side, which is much needed given the weight bias that patients have experienced in healthcare.

All of these concepts—the value of building a partnership, seeking the patient's perspective, selecting appropriate patients, and the need to use respectful, non-biased language while keeping the conversation focused on health in a manner that will benefit the patient in the long-term—provide a framework from which conversation can begin. Two evidence-based theoretical frameworks, Motivational Interviewing (MI) and the 5As of obesity counseling, provide further guidance on how to conduct conversations that incorporate these concepts.

6.6 Motivational Interviewing

Motivational Interviewing (MI) is an evidence-based counseling approach that is used by clinicians when discussing health conditions for which behavior change is needed for successful management [9]. When compared to traditional advice giving, MI has been shown to be superior in the treatment of a broad range of physiologic and psychologic conditions and has been effective in improving health behaviors that have led to smoking cessation, cholesterol reduction, blood pressure reduction, improvements in eating and physical activity, and reductions in alcohol use [10]. Because obesity outcomes rely more on patient behaviors than clinician recommendations, an approach that effectively contributes to behavior change is needed. MI has been shown to be effective when counseling patients on weight and obesity, as it leads to changed behavior [11, 12].

This empathic person-centered style of therapeutic communication emerged as the psychologist William Miller became more attuned to the elements of his counseling that evoked change. In a particularly poignant moment, while demonstrating his structured behavioral approach for treating problem drinking to psychologists in Norway, he recognized that it wasn't the techniques he employed that were beneficial, but rather the empathy he conveyed and the way in which it strengthened motivation and reduced resistance [13]. After returning home he constructed a model and created clinical guidelines for MI, which were first published in 1983. Since that time, MI has been increasingly utilized by clinicians in the treatment of addiction and in the management of health conditions, particularly those that are chronic in nature, as it elicits behavior change that improves health outcomes and improves clinician-patient relationships [9].

MI is a clinical style that integrates person-centered empathy with behavioral therapy techniques, with a focus on developing and strengthening a collaborative clinician-patient relationship and eliciting patients' motivation to make behavior changes that promote health [9]. Given the predominance of advice-giving that clinicians have traditionally engaged in when discussing weight and obesity with patients and the negative impact it has had on those patients' health, a clinical conversation style that builds the therapeutic alliance and leads to improved health behaviors is much needed.

MI is derived from social-cognitive theory that applies the processes of attribution, cognitive dissonance, and self-efficacy [14]. It focuses on creating a clinician-patient relationship from which MI can be utilized to bring about behavior change that improves health. The relationship is founded on the concepts of collaboration, evocation, and autonomy [15], which are needed to build a trusting relationship that focuses on the patient's goals, rather than the clinician's goals. This relational approach conceptualizes motivation as something that is derived from the interpersonal process, rather than a personality trait of the patient [14]. The resultant change is attributed to the synergy of the relationship. Cognitive dissonance is created through contrasting the current behavior with its negative consequences. Through the application of empathic processes, utilization of the social psychological principles of motivation, and the provision of objective feedback, the dissonance is channeled towards behavior change that promotes self-efficacy [14]. The objective of MI is not to solve the problem, but to assist patients in believing that change is possible. MI shifts clinician thinking from one of advice giving to skillful reflective listening.

MI identifies, explores, and resolves patients' ambivalence about changing behavior. Ambivalence—feeling two seemingly opposite ways about making a change—is a natural part of the behavior change process. The clinician's role is to attune to the patient's ambivalence and explore it in a manner that makes it more explicit and understandable to both parties. This is accomplished by evoking patients' verbalized motivations for change, known as "change talk", as well as their resistance to making that change, which is called "sustain talk." Once it has been voiced by the patient, the clinician amplifies and reflects the change talk, which further strengthens it. It is powerful and change-promoting when patients hear themselves argue for change, which is a guiding principle of MI. When the "sustain talk" argument has been identified and verbalized, the clinician conveys empathy for that position, rather than pushing or arguing against it, as confrontation has been shown to be counterproductive [15]. When resistance has been voiced, the spirit of MI guides clinicians towards the expression of compassion and understanding, and the avoidance of confrontation. When clinician responses are consistent with the spirit of MI, patient change talk significantly increases and sustain talk decreases. As the patient voices desire, ability, reasons, and need for change, and sufficient motivation is apparent, the clinician intervenes in a manner that strengthens the patient's commitment and converts motivation into specific goals and plans [13]. This is the fertile soil from which change takes place.

6.7 The "Spirit" of Motivational Interviewing

MI is intended to help clinicians create a style of conversation, rather than provide them with techniques. Clinicians are most effective when they incorporate the spirit of MI into their approach and focus on their "way of being", as opposed to following a step-by-step formula of techniques. One of the tenets of MI is to build rapport

in the initial stages of the clinician-patient relationship and to maintain the rapport as the relationship progresses [16]. The "spirit" of MI is comprised of three key elements: collaboration, evocation, and autonomy [9].

6.7.1 Collaboration

A collaborative clinician-patient relationship is foundational to the success of MI. Such a relationship relies on the creation of a partnership that is grounded in the perspectives and experiences of the patient, rather than positioning the clinician as the expert [9]. Because it is not a hierarchical relationship, decisions are made collaboratively. And because the clinician is not positioned as the expert, it prevents the patient from being a passive participant while the clinician directs the patient's behavior. It also reduces confrontation, which is likely to elicit defensiveness and resistance from the patient [9].

6.7.2 Evocation

The spirit of MI seeks to evoke the patient's motivation and resources for change and connect them to the patient's personal goals, values, aspirations, and dreams [9]. It requires clinicians to refrain from imposing their opinions or attempting to convince patients to change and to instead draw out the patient's motivators and skills for change. Unless the motivation comes from the patient, it will not result in lasting change.

6.7.3 Autonomy

The power for true change resides in the patient. When practicing the spirit of MI, clinicians accept the decisions patients make and detach themselves from the outcomes, while maintaining a caring presence [9]. Paradoxically, this stance is one that is more likely to facilitate behavior change. When clinicians communicate respect for their patients' autonomy, they increase the chance that patients will exercise that autonomy for their own benefit. Honoring patients' autonomy strengthens their ability to harness their power to make choices that promote health.

Incorporating these three elements into clinical conversation is in stark contrast to the traditional view that the clinician is the expert, and the patient is the passive recipient. Yet given the evidence that communicating from a position of expert by advising patients to lose weight contributes to patients disengaging from not only the clinician-patient relationship, but from seeking healthcare altogether, a new

approach is needed [1]. The elements of collaboration, evocation, and autonomy provide a more effective approach.

6.8 The Principles of Motivational Interviewing

In *Motivational Interviewing in Health Care: Helping Patients Change Behavior*, Rollnick et al. [9] provide the four guiding principles of MI, which are: (1) resist the righting reflex, (2) understand your patient's motivation, (3) listen to your patient, (4) empower your patient. These four principles—resist, understand, listen, empower—can be expressed in the acronym RULE [9].

6.8.1 Resist the Righting Reflex

Individuals typically enter healthcare professions to heal and lead people towards better health. These inclinations contribute to a "righting reflex" in which they automatically or reflexively step in to correct their patients' course when they see that they are headed down an unhealthy path [9]. When this occurs, it can have a paradoxical effect on their patients' motivation by evoking resistance and strengthening their argument against change. Therefore, it is incumbent upon clinicians to recognize and resist this tendency to step in and course correct. When the conversation becomes one in which the clinician is attempting to persuade the patient to change and is arguing with the patient about the best course, the righting reflex is at play. When the clinician is employing the spirit of MI, it is the patient who will voice the case for change, not the clinician [9].

6.8.2 Understand Your Patient's Motivation

Without an understanding of what is important to their patients, clinicians will not be able to strengthen their patients' change talk [9]. Because motivation is discovered and strengthened through interpersonal processes, inquiry about patients' concerns, values, and motivations not only provides clinicians with valuable information, it is a therapeutic intervention in its own right. Although such an inquiry may sound like a time-consuming endeavor, it may actually be one that saves time. Asking patients what they want to change and how they might make that change can be accomplished in a far shorter amount of time than trying to convince patients to change and then attempting to force a strategy. When motivation comes from the patient, it is more likely that the patient will make the changes necessary to improve health.

6.8.3 *Listen to Your Patient*

Listening is a necessary component of any type of effective conversation. The collaborative approach of MI recognizes that patients are the experts on themselves and that most of their answers reside within them [9]. The clinician's role is to ask evocative questions and listen with empathic interest for those answers. It's a sign of engagement when the patient is talking more than the clinician. When clinicians listen well and their patients feels heard, the relationship is strengthened. Quality listening is about more than hearing the words that are spoken, it is about hearing the messages and feelings that lie beneath those words. When clinicians listen for deeper meaning and themes, they are in a position to reflect on their impressions and share them with their patients, increasing both parties' understanding of the patients' truth—their motivations, their insights about what is needed, and their commitment to making the necessary changes. This type of listening relieves the clinician from having to provide all the answers, prevents resistance, and ultimately saves time. A good rule of thumb is for clinicians to listen more than they talk.

6.8.4 *Empower Your Patient*

The principle of empowerment is vital to helping patients take an active interest in their health, as the best outcomes are seen when patients are actively engaged in their own care [9]. The clinicians' role is to facilitate their patients' ability to locate and amplify their motivation, and then guide them in translating it into meaningful, consistent action. While clinicians are often clear on *why* change is needed, it is the patients who knows best about *how* it can be accomplished. Clinicians empower their patients when they invite them to tap into their own strengths and resources and support them in applying those strengths and resources towards the betterment of their own health. Providing hope that change is possible and conveying faith that patients have the capacity to make the needed changes are empowering actions. When clinicians acknowledge and celebrate their patients' autonomy, their patients feel empowered.

6.9 Bringing MI Principles to Life

The four guiding principles—resist the righting reflex, understand your patient's motivation, listen to your patient, empower your patient—paint a picture of two people interacting in a manner that looks and feels like dancing, not wrestling [9]. In order to create interactions that evoke images of two partners gliding across the dance floor, clinicians need a set of strategic actions, as well as specific skills, known as micro-counseling techniques.

6.10 Strategic Actions

There are four strategic actions that you can take to assist your patients in locating their motivation and putting it into action. Those actions are: (1) express empathy, (2) support self-efficacy, (3) roll with resistance, (4) develop discrepancy. These actions are ones that ensure your interactions with your patients will be aligned with the spirit and principles of MI.

6.10.1 Express Empathy

Empathy is the ability to enter into and understand the thoughts, experiences, and feelings of another person—to see the world through their eyes. Empathy is not the same as agreement, it is the ability to step into the experience of another person in order to understand it better. When you express empathy for your patients' thoughts and feelings, they will feel heard and understood and are likely to share themselves in deeper, more honest ways. Comments such as, "I understand how frustrated you feel," and "Your perspective makes sense," are expressions of empathy.

6.10.2 Support Self-Efficacy

Self-efficacy is a belief that one has the strength and capacity to successfully change. Without it, change is impossible. Most patients have likely made numerous attempts to change a problematic behavior or implement a new health behavior and not been successful, leaving them discouraged and questioning their ability to make the necessary changes. That is why it is vital that clinicians communicate their belief that their patients are capable of making the changes they desire. One strategy is to identify and highlight the skills and strengths that your patients already possess. Linking their ability to change and be effective in other areas of their health and life, provides them with the hope that they can access those strengths to make the change that lies in front of them. Examples of comments that support self-efficacy are: "You consistently take your blood pressure medications, I know you will be able to add this new medication to your routine," and "When you face a challenge at work, you stay with it until it is resolved. I know you will be able to apply that strength to this new health challenge."

6.10.3 Roll with Resistance

Resistance arises from a patient's ambivalence about change or when there is a conflict between the perspective of the patient and that of the clinician. It may also arise any time the patient feels an impingement on, or loss of, autonomy. If this

occurs, it is strategic to roll with it rather than confront it. Because the goal is to dance, not wrestle, clinicians must de-escalate the situation in order to preserve the relationship and release patients from feeling the need to defend their position. If you do not roll with it, your patients are likely to strengthen their arguments not to change. When you invite your patients to define the problem and what can be done to solve it, rather than impose your perspectives, the likelihood of resistance arising is significantly reduced. In the event that you encounter a patient's resistance, you can de-escalate it with statements such as, "I sense that you feel that I have not fully heard your perspective. Please share your position again."

6.10.4 Develop Discrepancy

By identifying and leveraging the discrepancy between patients' goals and current actions, you can strengthen patients' motivation to change. Helping patients to see how their current behaviors are in conflict with their goals, values, and dreams has the power to increase their motivation and move them closer to making changes that are aligned with those goals, values, and dreams. Developing discrepancy is more of a process than a one-time action, as it takes time for patients to fully recognize that their behaviors may be moving them away from their goals, rather than towards them. While this is an important strategic action, clinicians need to ensure that it does not interfere with the principles of MI. When skillfully done, it will not induce resistance. An example of a reflection that illuminates discrepancy while maintaining the therapeutic relationship is: "You have expressed your desire to increase your stamina, yet you are struggling to walk regularly. What do you think is needed to make the change you desire?"

6.11 Micro Counseling Techniques

When utilizing MI, clinicians can employ micro-counseling techniques that will elicit the necessary information and motivation that is needed in an effective patient encounter. These techniques—open-ended questions, affirmations, reflections, and summaries—create the acronym OARS. Not only does OARS provide clinicians with specific behaviors, it summarizes the concepts of MI.

6.11.1 Open-Ended Questions

Open-ended questions require more than a yes or no response. They invite deeper thinking that leads to forward momentum. When patients elaborate on both their reasons for and the possibility of change, they become more attuned to what is

motivating them to take action. Exploring one's own thought processes and behaviors can provide clarity about what is important and what is needed next. Open-ended questions facilitate patient engagement in the treatment. An example of an open-ended questions is: "What would it take to regularly get more sleep?"

6.11.2 Affirmations

Affirmations are statements that recognize and reinforce patients' strengths and how they can be utilized to facilitate positive change. They provide patients with the opportunity to see themselves in a more favorable manner and recognize that change is possible. This is particularly important if prior attempts have been unsuccessful. In order to be effective, affirmations need to be both relevant and genuine. Affirmations support self-efficacy. "You handled that challenge with courage. You stayed with it even when it was difficult."

6.11.3 Reflections

Reflective listening expresses empathy, making it crucial to effective MI. Effective reflections capture the essence of what the clinician has observed in the patient's body language, tone, and choice of words, and integrates them with the clinician's intuition and perceptions. This is a more challenging skill to master as it requires you to be attuned to the underlying thoughts and feelings that the patient may not be aware of. Reflections help patients clarify their reasons for and against change and illuminate the discrepancies in their thinking. Reflection may be as simple as repeating patients' words back to them or re-stating them in a manner that captures the deeper message you heard. An example of the latter scenario is: "You care deeply about preventing future health problems."

6.11.4 Summaries

Summarizing statements typically take place at the end of an appointment but may be utilized for transitions during the appointment. If a patient veers off topic, summarizing statements can be used to redirect the patient back to the topic at hand. Summaries call attention to the important elements of the discussion but may also highlight both sides of the patient's ambivalence or develop discrepancy. When the topics discussed have elicited strong emotions, summarizing statements provide the patient with a framework from which to think about what has been discussed and felt, and provide emotional closure before the patient reenters the outside world. A summary serves to shift attention from past challenges to the opportunities that lie

ahead. It establishes metrics and outlines the next step. Summaries ensure that the clinician and the patient are both on the same page. An example of a summarizing statement that redirects the patient back to the topic being discussed is: "You came in today with the goal of discussing your eating plan, but we have spent the last five minutes discussing your co-worker. Let's shift back to your eating plan." An example of a summarizing statement at the end of an appointment is: "Today you made a commitment to menu plan and grocery shop every Saturday in order to stay on your eating plan."

6.12 The 5As

The 5As model provides an effective framework for counseling patients and has been used universally to teach clinicians how to encourage behavior change in their patients [17]. It was first developed by the U.S. Department of Health and Human Services as a framework for smoking cessation [17] and was informed by the transtheoretical model of behavior change by Prochaska and DiClemente [18]. The model is used in Australia for smoking, alcohol, and physical activity counseling [19] and in Canada and other countries for obesity counseling [20]. The original 5As model was modified by the Canadian Obesity Network, now known as Obesity Canada, for the purpose of obesity counseling and is rooted in behavior change theory—self management, support, readiness, assessment, behavior modification, and self-efficacy enhancement [20]. It has been shown to be an effective framework from which to counsel patients about their weight [11, 21].

The 5As model has five elements—ask, assess, advise, agree, assist—that work well with the MI approach to conversation. While MI provides guidance on the style of conversation, the 5As model provides structure by identifying the phases and tasks that are required to move the conversation from inquiry to action. MI principles and techniques are incorporated into the conversation that takes place within the structure of the 5As. As with MI, the 5As model is patient-centered and emphasizes the importance of a collaborative clinician-patient relationship. It also supports the guiding concepts of focusing on health, focusing on the long-game, and using appropriate language.

The 5As model provides a time-efficient structure that can be used in busy practice settings, including primary care, specialty care, and other practice settings. This section will utilize the 5As structure to initiate sensitive conversations, move the patients who are ready into making a commitment to begin treatment, and provide the necessary support. For those who are not ready, guidance will be given on how to increase the likelihood that they will return for treatment in the future. While the 5As model identifies five distinctive phases, in real-life conversations these phases flow and blend. The delineation of each phase provides you with a more in-depth understanding of each phase and emphasizes its role in the overall approach.

The model can be adapted to fit into short appointments or expanded if more time is available. Unless the appointment was scheduled for the purpose of discussing obesity treatment, it is likely that the initial conversation will take place during an appointment that was scheduled for other reasons, making it more important that it be done efficiently and effectively. There may only be enough time to complete the first two As, ask and assess. When this is the case, obesity-specific follow-up will need to be scheduled to complete the conversation, whether it is with you or with a clinician to whom you are referring the patient. Although studies show that the 5As are effective in primary care only when clinicians include every phase in a single conversation [22], this is difficult to achieve in most practice settings due to time limitations and patient readiness factors, making it necessary to move beyond the perspective that everything needs to be discussed in one appointment [17].

6.12.1 Ask

In this stage of the conversation, the focus is on asking questions and minimizing statements. Some questions will be open-ended while others may only generate one-word answers. Both types are important, as they provide clinicians with information that will determine how to direct the conversation.

6.12.1.1 Ask Permission

When initiating discussions about weight, the first question should be one that asks patients for their permission to discuss weight. This approach differs from the initiation of discussions about other health issues, which do not typically involve asking for permission. Because weight is a sensitive topic and because many patients have received unsolicited advice to lose weight from clinicians in the past, asking permission sets the tone for a patient-centered discussion that honors patients' autonomy. The act of asking permission demonstrates a level of respect that many with obesity have not experienced in healthcare settings.

Examples of initial questions are:

- Do I have your permission to discuss your weight?
- Would it be alright if we discuss your weight?
- May I talk to you about your weight?
- Would you be open to a conversation about your weight?

If the patient agrees, the conversation should proceed. If not, it is best to respect the patient's wishes. It is advisable to acknowledge that respect with a statement such as, "I respect your wishes. If you are open to a discussion in the future, please let me know. I want you to know that the door is always open."

6.12.1.2 Ask About Readiness

Once permission has been obtained, the next questions should explore readiness.

Examples of questions that explore readiness are:

- Do you have any concerns about your weight?
- Do you have any concerns about how your weight affects your health?
- Do you have any concerns about your weight and your quality of life?
- Do you feel ready to work on your weight?
- How important is it to you to work on your weight?
- Would you be willing to discuss strategies to manage your weight?
- Are you open to discussing strategies to manage your weight?
- Would it be okay if I helped you manage your weight?
- Are you interested in discussing weight management strategies with me?

Although statements should be minimized, it can be beneficial for clinicians to share that they have knowledge about weight management and obesity, and/or treatment resources prior to asking questions about readiness. Such statements communicate that the clinician understands the complexities of weight issues and is someone patients can trust to provide accurate information and treatment resources, as opposed to the simplistic solutions that many have received in the past. Based on prior experiences, patients may be unwilling to continue the discussion, even if they are ready and willing to address their weight. Again, it is advisable to respect their wishes.

Examples of statements that are followed by questions that explore readiness are:

- I understand the complexities of weight. Would you be willing to discuss strategies with me?
- I can help you with your weight. Are you interested in discussing strategies with me?
- I've completed additional education on weight issues. Would you be willing to discuss strategies with me?
- I am sensitive to the challenges of weight management. Would you be willing to discuss strategies with me?

Readiness to Change

Patient responses provide information about their readiness to change. Readiness will run the spectrum from no interest to fully ready to commit to change. Prochaska's Stages of Change model identifies the five stages of change—precontemplation, contemplation, preparation, action, maintenance—which can assist you in identifying your patients' readiness to change [18]. Figure 6.1 provides further detail about the stages.

Patients in the precontemplation stage are not ready and may not be interested in further discussion. However, some may be interested and will accept your offer. The

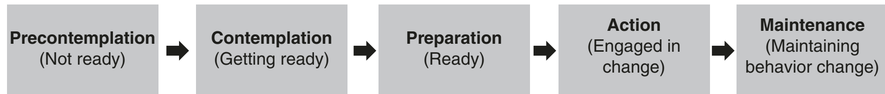

Fig. 6.1 Transtheoretical model of change (Adapted from: Prochaska JO, DiClemente CC. Stages and processes of self-change of smoking: toward an integrative model of change. J Consult Clin Psychol. 1983;51(3):390–5)

tone of the conversation and the information they receive may move them from precontemplation to contemplation. Those in the contemplation stage have an awareness that their weight is an issue and are considering taking action. Some may be ready to move into action, while others may not be there yet. If the patient isn't interested in pursuing it at this time, that should be respected.

However, it is important to invite patients to revisit the topic at a later date and provide information that will help move them to the next stage, such as brochures, links to websites that provide accurate information about obesity and evidence-based treatment options, as well as your contact information in the case that they desire further resources and support.

- I hear that you are not interested at this time. We can discuss this again when you feel ready. I have treatment options and resources when that time comes. Do you have any questions before we end this topic?
- I don't have the sense that this is something you are ready to embark on at this time. Is that correct?
- Weight management is challenging and it's important to be ready. We can revisit this at a later date. Perhaps you will feel differently as time passes or your circumstances change. Feel free to contact me when you are ready. Do you have any questions before we end this topic?
- I can see that you have other priorities at this time. You are welcome to contact me when your circumstances change. Do you have any questions before we end this topic?

Asking patients if they have any further questions provides them with the opportunity to clarify anything that is confusing and seek further information. It also provides them with a chance to evaluate your trustworthiness and commitment to a respectful clinician-patient relationship, which, based on prior experiences, they may be skeptical of.

When a patient chooses not to further the conversation or pursue treatment at the time the topic is broached, it is not a failure. An important health issue has been raised, which will not only help the patient make a deeper connection between weight and health, it will set the stage for further conversation. Having their wishes respected strengthens the therapeutic relationship.

Patients in the preparation stage are ready for change. Once you have obtained their permission to discuss weight, you can move into the next stage—assess.

6.12.2 Assess

The information gleaned from asking about interest and readiness leads naturally to the next stage—assess—which involves assessing health status. The assessment includes BMI, obesity stage, and identification of weight related risk factors and complications. BMI and obesity-related risk factors and complications may already be available in the medical record and may have been what prompted the clinician to initiate the conversation in the first place. If this information is not available, it can be assessed at this point if time permits.

The diagnosis and assessment should be recorded in the patient record. Even when obesity has been diagnosed, it is not always recorded in the record. One study looked at nearly 6200 health records in a primary care teaching practice and only 21.1% of patients with overweight or obesity had the diagnosis recorded in the chart [23].

6.12.3 Advise

In this phase of the discussion, clinicians provide education about the chronic, relapsing nature of obesity, the health benefits of a modest weight loss of 5–10%, the need for a long-term treatment strategy, and available treatment options. This education should include a personalized assessment of the patient's health status and how treatment can reduce risk and improve health. Before offering treatment recommendations, it is best to determine if the patient is interested in pursuing treatment by asking questions such as:

- Now that you have more information about what is involved, are you interested in discussing treatment options?
- Based on your understanding, would you like to discuss treatment options?
- Are you interested in pursuing treatment?
- Would you like me to recommend treatment options?

The answers to these questions will indicate whether or not the patient is ready to take action or would prefer to contemplate treatment or defer it to a later date. If the patient chooses not to pursue treatment, treatment information and resources should be provided, as well as an invitation to return when the patient is ready or if any questions arise in the interim. If the patient is agreeable, follow-up should be scheduled in 3–6 months so that the discussion can be revisited. Knowing that there will be further discussion increases the likelihood that the topic will remain active in the patient's mind.

When patients choose to pursue treatment, the conversation moves into the next phase: agree.

6.12.4 Agree

In this phase the clinician and patient agree that treatment is advisable, and realistic treatment goals are agreed upon. Treatment goals should be formulated collaboratively, rather than being imposed on the patient by the clinician. Patients are the ones who will be doing the hard work of behavior change and treatment plan implementation, so it is necessary for treatment goals to reflect their priorities and preferences. Many patients have unrealistic expectations about weight loss, so it is important to agree on an initial 5–10% loss and emphasize the physical and mental health benefits of a modest loss. Because weight regulation is complex and influenced by many factors, some of which are out of the patient's control, the conversation should focus on behavioral changes, rather than specific weight goals. Research shows that patients become discouraged if they don't meet their goals, reinforcing the importance of focusing primarily on behavior changes [20].

If this is the initial weight discussion between you and the patient and there is little time remaining in the appointment, further discussion will need to be deferred to a follow-up appointment. If a follow-up appointment is not possible, the patient should be given referral sources with an agreement about the need to pursue treatment and the benefits of doing so.

6.12.5 Assist

Once there is agreement about the treatment goals and the benefits of pursuing treatment, the clinician assists the patient in identifying facilitators such as motivating factors, support systems and other resources as well as any social, medical, emotional, and economic barriers. Discussion about available treatment options and resources should occur, with the clinician assisting the patient in arranging follow-up. If you will be managing the obesity treatment, a plan will be made for obesity-specific appointments during which a more thorough evaluation will be conducted, and a treatment plan will be formulated and implemented. If the patient will be referred, then a clear plan for the next step should be given. Chapter 8 provides guidance on treatment options and resources.

6.13 Summary

Conversations about weight and obesity are most effective when the focus is on the patient's health. This is accomplished by building a respectful, collaborative clinician-patient partnership in which the patient's perspective is elicited and

valued. Using appropriate, non-stigmatizing language, particularly PFL, is vital to ensuring that the conversation feels respectful to the patient. MI provides a framework for building this relationship and evokes the patient's own motivation. The 5As model provides the structure from which to move the conversation from initiation of the topic to the initiation of treatment and beyond. Discussions about obesity are not a one-time event; each conversation should set the stage for the next one.

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