

Motivation and Obesity Care

Sanjay Kalra^{1,2}, Komal Chawla³, Nitin Kapoor^{4,5}

Abstract

Motivation is essential to maintain achieved targets in the long-term management of chronic diseases like obesity. Moreover, the role of motivation becomes even more important when the physiological set point tries to act against the achieved targets. In this brief communication the authors propose a rubric that should assist health care professionals in enhancing the quality of their communication skills, improving the delivery of obesity management, and optimizing therapeutic outcomes by helping their patients with obesity to manage their motivation drive.

Keywords: Motivation, Obesity setpoint, weight maintenance, Intensive behavioural therapy.

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Introduction

The word motivation means the reason to initiate, maintain and/or terminate any behaviour or activity. From an obesity care perspective, motivation implies the reason to seek, accept, initiate, continue and persist with obesity management.¹

While some people living with obesity are self-motivated, and actively participate in their weight management, others need support. This support can be in terms of counselling, therapeutic education, pharmacological and invasive interventions. At other times, all that is required is simple motivation. Motivation, therefore, becomes an integral requirement at every level of intervention and care, whether preventive or curative, diagnostic or therapeutic, lifestyle-, drug- or procedure-related. Motivation, need not always come from a health care professional but at times can even come from another person living with obesity, a concept called Baro-Buddy.²

Motivation is a hygiene factor that must be addressed in order to achieve optimal outcome. As obesity is a chronic

¹Department of Endocrinology, Bharti Hospital, Karnal, India; ²University Center for Research & Development, Chandigarh University, Mohali, India

³Department of Psychology, British University of Bahrain, Bahrain.

⁴Dept. of Endocrinology, Diabetes and Metabolism, Christian Medical College, Vellore (TN) -632004, India, ⁵Baker Heart and Diabetes Institute, Melbourne, Victoria, Australia.

Correspondence: Sanjay Kalra. e-mail: brideknl@gmail.com

ORCID ID: 0000-0003-1308-121X

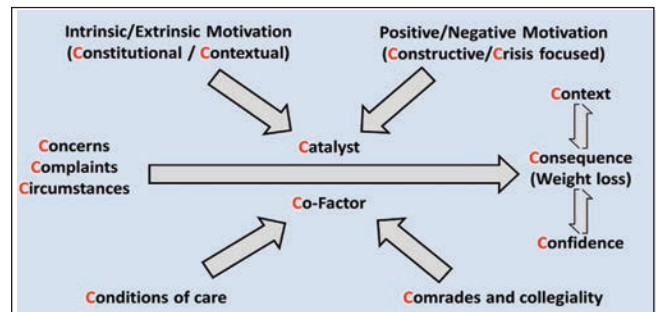


Figure: The Clear and Crisp Obesity Motivation Construct.

disease, long-term motivational strategies are necessary. These must have in-built mechanisms to ensure fluidity and dynamism, so as to respond to changes in biophysical and psychosocial circumstances. In this opinion piece, the authors utilize various theories and constructs to craft a unified model for motivation. This rubric should assist health care professionals in enhancing the quality of their communication skills, improving the delivery of obesity management, and optimizing therapeutic outcomes. (Figure)

Binary Model: Failure Versus Achievement/Positive Versus Negative Rewards

Perhaps the simplest model of motivation is a binary one, with two opposing motivators: a fear of failure, and a need for achievement. There will be some individuals who will be motivated to lose weight so as to avoid, or reduce the severity of, metabolic, cardiovascular or musculoskeletal disease. Examples may include an episode of myocardial infarction in the family or a close friend. Yet others may be motivated by a need for achievement of better health. The overweight athlete or singer, for example, may be motivated to lose weight so as to improve her running speed on the track, or strengthen her singing tone on stage.³

While the above illustrations use biophysical or 'medical' catalysts, the impetus for obesity treatment may stem from psychosocial reasons. "Fear of failure" may occur if one wishes to propose to a loved one who enjoys a lower body mass index. Need for achievement will kick in if one is induced to fit into a shirt that is one size too small.

Another way of looking at this binary model is in terms of rewards or incentives. Motivational rewards can be positive

(the promise of better health) or negative (the threat of increased medical expenses). This thought process is congruent with the two-sided view of fear of failure vs need for achievement.

Understanding the needs of the particular individual, in this binary manner, is the first step towards crafting an individualized motivation plan. It must be noted that there is a wide spectrum between the two ends of the rainbow, and each person's place on this spectrum is fluid.⁴

Pyramidal Model: Maslowian Needs

A more complex framework is based upon Maslow's hierarchy of needs. Conventionally, this pyramid is used to classify human needs as basic needs (love and belonging) and "higher" needs (self-esteem, followed by self-actualization). A similar process operates in obesity care as well. Some persons may have basic expectations from their obesity care provider (improved functionality, flexibility, freedom), while others may aim for greater social acceptance and acknowledgement (a "slim" body). Yet others may choose weight loss as a means to ensure better medical health and increase longevity. An even "higher" motivational calling may be to serve as a model for others.

The binary model and maslowian pyramid help assess the current level of motivation, and allow efficient exploration of cues for motivation. They also offer a means of benchmarking, which can be used to monitor changes in future.⁵

2x2 Model: Intrinsic and Extrinsic Control and Cues

Another motivation theory distinguishes between intrinsic and extrinsic motivations. Some persons have an intrinsic locus of control, and are motivated by a need to ensure autonomy and self-competence. Such people will accept lifestyle restrictions, but may not be willing to adhere to pharmacological treatment. Others live with an extrinsic locus of control, and are more reliant on external sources of authority—such as a physician, for decision making. Various people prefer external regulation ("You must take orlistat), interjected regulation ("You should get surgery done") identified regulation ("You need to exercise; you can reduce your sugar intake"), or integrated regulation ("You know that you have to begin semaglutide, and I am confident you will do so"). Understanding each individual's locus of control allows us to choose the right vocabulary to maximize efficacy and efficiency.

Just like the locus of control, cues for motivation can be internal or external. Internal cues come from "within", and may be objective or subjective. Objective cues are number-based and may range from an unwanted change in shirt size, an undesirable body mass index or unhealthy fat

percentage, to a report of dyslipidaemia or raised liver enzymes. Such objective cues, therefore, are usually linked to a fear of failure. Internal cues may be subjective as well. The person may report relative reduction in the ease of buttoning her blouse or tying his shoe laces, and identify weight loss as a means of accomplishing better health.

External cues come from the outside environment, both physical and social. An inability to fit into a chair, a disdainful look from a co-passenger or a sarcastic comment from a co-worker: all these are external cues which prompt weight loss. Some cues may be mixed: development of an obesity-related complication in a close friend is an external cue, but converting it into a motivation for weight loss makes it an internal cue.

Two Layered Models: Promotors and Enablers

Herzberg's two factor theory can be extrapolated to motivation for obesity care. This theory demarcates motivating factors, which if present, lead to satisfaction, from hygiene factors, which if absent, lead to dissatisfaction. While motivating factors of various types (positive/negative, internal/external extrinsic/intrinsic objective/subjective) promote a particular behaviour or action, absence of hygiene factors (e.g., a supportive ecosystem at home, at work or in the health care ecosystem) prevents these motivators from exerting their due influence. Thus, motivation for obesity can be viewed as a two-layered rubric, which requires presence of both hygiene factors and active reasons for change. We propose other two-layered models for use in obesity praxis: passive and proactive motivators, ecosystemic/environmental and internal/individual, and constitutional and catalytic motivators. While there may be subtle difference in semantics, all these models are based upon the two-factor theory of Herzberg.⁶

From Akrasia to Enkrateia

Another way of viewing motivation is through the Greek terms akrasia (weakness of the will) and enkrateia (power over self; self-control). One may classify reasons as two: motivating reasons and normative reasons. While normative reasons are rational considerations that should guide our decision (e.g.; smoking is bad for health, therefore I will not smoke), motivating reasons are those which we use in an attempt to justify our actions (as in blaming peer pressure for substance abuse). Ideally, there should be no discordance between motivational and normative reasoning. Such a situation will lead to optimal acceptance of, and adherence to, obesity therapy. Usually, however, akrasia (weakness of the will) prevents this from happening.⁷

One therefore needs to find a catalyst, a motivating factor,

which can shift the individual from akrasia towards enkrateia. Such a process is termed as enkratic rationality. This includes awareness of the consequences of obesity, benefits of weight loss, alternative options to achieve it, and realistic expectations from therapy.

COM-B and MOC-B

The COM-B model (capability, opportunity and motivation, leading to appropriate behaviour) seems more appropriate for obesity when viewed as MOC-B (motivation, followed by opportunity, and then by capacity building, facilitates behaviour change).⁸ While the various aspects of motivation have been discussed above, equal focus is needed on opportunity and capability. Building an obese-friendly health care system, and using obesity friendly language are means of ensuring adequate opportunity. Capability can be bolstered by creating a peer support system (Baro buddies, Adiposity Anonymous) and training health care professionals in obesity management.

We paraphrase the MOC-B model to craft a unified model of motivation for obesity care that can serve both persons living with obesity, and their care providers. The consolidated concept of motivation starts with the concerns and complaints of the individual, assessed as part of the overall circumstances of the person. A catalyst for motivation must be found. This catalyst may be single or multiple, and may be static or dynamic, but needs to be reinforced by co-factors. These cofactors are the 'hygiene factors': a supportive health care system (conditions of care) and supportive comrades, who exhibit collegiality.

Successful identification of a motivating factor, whether intrinsic or extrinsic, positive or negative, objective or subjective, depends upon an accurate assessment of the person's circumstances, complaints and concerns. The same complaint, e.g., osteoarthritis of the knee, may serve as a motivation factor in one person (*I will lose weight to help my joints*) and as a confounding factor in another (*I cannot exercise because I have bad knees*).

Putting together the right catalyst and cofactor ensures that a chemical reaction proceeds in the right direction. Similarly, the right motivation helps achieve the desired consequence (weight loss) in obesity management. It must be mentioned that the individual's self-confidence, and confidence in the treating physician, is of paramount importance. Also, success should be viewed in the

individual context: each person has a unique barophenotype, and therapeutic targets should be planned accordingly. Just as many chemical reactions are reversible, so is weight loss. Weight maintenance requires continuous, and concerted motivation by the treating team. The concept of motivational fluidity, should be understood, along with therapeutic fluidity, as a means of tackling the metabolic set point, as well as refractory or resistant obesity.⁹

Summary

The composite framework that we share offers a comprehensive, yet clear, coverage of motivation and its role in obesity management. It strengthens all obesity care professionals by equipping them with skills to choose appropriate person-centric motivational strategies, and ensure not only acceptance of therapy, but adherence as well. It integrates motivation within existing clinical evaluation protocols, and also calls for provision of effective efficient obesity care services, staffed by qualified, trained and sensitized professionals. Motivation is dynamic, and we hope that this discussion motivates our readers to practice, and perfect, pragmatic and practical models of motivation in their obesity care clinics.

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