🔦 Spotlight On… Dr Daniela Alves

Meet **Dr Daniela Alves** – a Consultant/Principal Clinical Psychologist working across bariatric and complex obesity services, with valuable experience in developing and shaping psychological pathways within multidisciplinary care.

Daniela brings a wealth of clinical expertise, leadership, and thoughtful insight into service design – and we're delighted to feature her in this issue's *Spotlight On…* Q&A, where she shares reflections on building bariatric services and the evolving role of psychology within obesity care.

Can you tell us a bit about your background and current roles?

I currently work as a Consultant Clinical Psychologist in the Complex Obesity Service at East Suffolk and North Essex NHS Foundation Trust (ESNEFT) based at Colchester Hospital, and as a Principal Clinical Psychologist in the Bariatric Service at the Homerton Hospital. I also collaborate with the Cleveland Clinic London and Roczen, where I provide specialist assessments in bariatric/obesity care, alongside consultation and training. Prior to these roles, I worked in the Obesity Service at Guy's and St Thomas and in the Bariatric Service at Imperial College Healthcare NHS Trust (St Mary's Hospital).

I completed a PhD in Clinical Psychology at the University of Minho in Portugal, in 2013. My early work focused on Prolonged Grief and Depression, particularly processes of clinical change and ambivalence in grief psychotherapy. I moved to the UK in 2014 while completing a postdoctoral research project on the effectiveness of online grief therapy. This was an incredibly interesting project, already showing how therapeutic work delivered in a virtual environment can be helpful for people experiencing significant suffering and struggling to adjust to major life changes.

My transition from research/academia into the NHS happened in 2016/17, and since then my clinical work has focused on weight management, obesity, and bariatric surgery. I have now worked in obesity care in the UK for 9 years and have had the opportunity to be part of several specialist obesity and bariatric multidisciplinary teams.

What has been the biggest challenge in setting up your new bariatric service?

One of the biggest challenges - but also one of the most rewarding parts of the work - has been developing a shared understanding of the role of Psychology within bariatric and obesity services across multidisciplinary teams. Historically, psychological input has often been concentrated around preoperative assessments and framed mainly in terms of risk screening or *suitability* for treatment. While risk and safety are clearly important, this can narrow Psychology's role and unintentionally position it as a *gatekeeping* function.

A central part of the work, alongside the wider MDT, has therefore been developing a more integrative and formulation-led framework that supports multidisciplinary decision-making across the whole pathway. This has meant moving away from a model focused primarily on exclusion criteria or *discharge*, towards a more inclusive and nuanced approach that prioritises tailored levels of psychological support at different stages of care.

Overall, this has been a joint effort with MDT colleagues to develop a shared language around readiness, vulnerability, risk and safety, and the different levels of support patients may need across their treatment journey.

What have been your key priorities when designing the pathway?

My key priority in designing the pathway has been to create a more inclusive model that takes into account clinical complexity, readiness for treatment, and the level of psychological support a patient may need at different stages of care. This framework supports MDT decision-making by moving beyond binary *proceed or delay* judgements and instead considering how psychological input can be used proportionately before and after treatment. In practice, this means helping the MDT and the patient to think more clearly about underlying emotional and psychological factors that may be impacting eating behaviours and emotional regulation. These may include experiences of adversity or trauma, as well as neurodivergence and the need for reasonable adjustments, so that care can be better tailored to support readiness, adjustment, and longer-term outcomes.

Another key priority has been to strengthen post-treatment Psychology pathways, recognising that adjustment after bariatric surgery is often complex and non-linear. Many patients benefit from psychological support at different points in their journey, rather than only in the preparation stage.

How do you see the role of psychology evolving with the growth of anti-obesity medications?

The growth of anti-obesity medications is increasing the need for psychologically informed care across obesity services. Empirical evidence shows that these treatments can have a significant effect on appetite, food reward, and eating behaviours, but clinical experience and emerging discussion in the field also suggest that, for many patients, some of the complex underlying drivers of eating may still need attention alongside treatment. For some, this creates new opportunities for change; for others, it can bring a more complex process of adjustment, particularly where eating has been closely linked to coping, emotional regulation, or longstanding patterns of distress. In this context, Psychology has an important role not only in supporting patients directly, but also in helping to create the reflective clinical space within MDTs to think carefully about complexity, adjustment, expectations, and longer-term support.

What do you think is currently the biggest issue facing bariatric psychology services nationally?

I think one of the biggest issues in bariatric psychology services nationally is not only variation in resourcing, but also variation in how Psychology is positioned within services. Where Psychology is used mainly for preoperative assessments, risk identification, or decisions about *suitability*, the role can become narrowed in a way that underuses the broader clinical skills Practitioner Psychologists bring to obesity care. Although robust and proportionate assessment - including a clear formulation of the risk-safety balance -, remains an important part of the role, psychological practice should extend beyond this to include intervention, evidence-based treatment, training, consultation, and support for psychologically informed MDT practice. In my view, one of the national priorities is therefore to strengthen MDT culture so that vulnerability, complexity, and readiness are understood more confidently across the team, and Psychology is used more purposefully where specialist input is most helpful - before, during and after treatment, when needs are identified. Protecting time for this broader contribution makes services more robust and also helps make bariatric psychology posts more sustainable and attractive, by enabling Practitioner Psychologists to use the full range of their skills rather than being confined to a narrow assessment role.

What advice would you give to someone trying to develop a new bariatric psychology post or service?

My main advice would be to design the post or service as an integrated part of the MDT from the outset, rather than as a stand-alone assessment role. Psychology is most effective when it contributes not only through direct clinical work, but also through formulation, consultation, training, and service development across the whole pathway.

Training in evidence-based therapeutic approaches such as Compassion-Focused Therapy and Acceptance and Commitment Therapy is valuable, but it is equally important to develop a broader biopsychosocial understanding of obesity that extends beyond psychological models alone and includes the biological and medical aspects of the disease. This supports more coherent clinical thinking about the range of interacting factors that impact patients' health, engagement, and understanding of their health needs. The impact of weight stigma in healthcare, its contribution to internalised weight stigma, and the role of language in patients experience are also important considerations. Regular supervision, CPD, and engagement with national professional networks are also important in supporting this work.

What's helps you stay grounded during demanding periods?

Spending time with my family and friends, and getting outdoors whenever I can. I live by the canal in London, and being near the water helps me slow down and notice the quieter things around me. Professionally, regular supervision has played a big part in helping me do this work. I have been very fortunate to have supervision with Dr Denise Ratcliffe (Consultant Clinical Psychologist and lead in Obesity/Bariatric care) for the past 3 years, and her support has been invaluable. Through her generosity, depth of experience, and the thoughtful way she works, I have learned so much about how to practise in a way that is reflective, exciting, and *full of possibilities*.

Do you have a favourite place to escape to when you need a reset?

I'm from a small place in Portugal called Melgaço, and I try to go back every few months to spend time with my parents and wider family. I also spend time in Porto, where I see family and close friends. That time with family and friends, alongside being near the sea, is very important to me. Travelling with my daughter has also become one of my favourite ways to enjoy life outside work. We love exploring new places together, and she has become a good companion in many of our adventures. We've just booked a trip to Sicily in May, which we're both really looking forward to.