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Psychological perspectives in obesity

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ABSTRACT

Obesity has become a leading public health concern. Over 1 billion people are now overweight or obese, and the prevalence of these conditions is rising rapidly. Psychological aspects of obesity are so important, psychological assessments and interventions have become an integral part of a multidisciplinary approach to treating obesity. Multiple environmental, genetic, neuro-endocrinological, and psychosocial factors contribute to the development of obesity. Though there are many different, and even controversial, frameworks for obesity, most researchers acknowledge that it can lead to serious medical and psychological morbidity.

Introduction

Obesity is a condition of excess body fat. It has been variously defined. Using body mass index (BMI = weight (kg) / height (m)2) as a measure of adiposity, in most countries obesity is defined as a BMI more than 30, and overweight as a BMI of 25 to 30. However, measures of obesity and overweight do vary according to country and ethnic group.[1] The prevalence of obesity continues to increase in Western countries where approximately half of the population is currently overweight.[2] Obesity is as much a psychological as a physical problem. Psychological issues can not only foreshadow the development of obesity, but they can also follow ongoing struggles to control weight.

Psychological Aspects of Obesity

There has been considerable effort to find personality variables associated with obesity, however there is no evidence that

obese people differ psychologically from non-obese people. There is no difference between obese and non-obese people in the following characteristics: degree of depression,[3] the incidence of psychopathology,[4] social adjustment,[5] 'traits' of masculinity-femininity, locus of control, assertiveness and self-consciousness and personality type.[6] However, obese people in general do not find their state desirable. For example, in a sample of formerly obese people who had undergone gastric surgery, Rand and MacGregor found that all of the 47 participants who were interviewed would rather be deaf, dyslexic, diabetic, or suffer bad heart disease or acne than return to being morbidly overweight.[7] Forty-two percent preferred blindness to obesity, and 43 participants would rather have a leg amputated. This dislike of obesity felt by sufferers may reflect stigmatisation by others in the population. Diverse groups hold negative stereotypes of obese people. Boys between six and ten years old rate silhouettes of obese boys as someone who would fight, cheat, get teased and lie, and who was lazy, sloppy, naughty, mean, ugly, dirty and stupid.[8] Studies of adult attitudes similarly demonstrate negative attitudes. Adult hospital outpatients rate silhouettes of an overweight child as less likeable than a child with a deformed leg, with a missing hand, with a facial deformity, or who was confined to a wheelchair.[9] Similarly, doctors and medical students hold negative views of people who are obese. Medical students rate overweight women as less likeable, more emotional, and less likely to benefit from treatment. Doctors rate overweight patients as weak-willed, ugly and awkward.[10] Job prospects are also affected. Larkin and Pines showed that overweight candidates were less likely to be hired, even though equally competent on job-related tests.[11] Given these negative attitudes, it is surprising that obese people are not more likely to be depressed or to have psychopathology. Because studies comparing obese and non obese persons have generally failed to find differences in global aspects of psychological functioning, the resulting conclusion has been that obesity is not a risk factor for psychological problems. This is at odds with clinical impression, reports from overweight people, and a consistent literature showing strong cultural bias and negative attitudes toward obese people.[4] It is clear that obesity confers negative consequences on both the physical and psychosocial aspects of quality of life, especially among the severely obese. Therefore the lack of evidence supporting the existence of psychological morbidity in obese people is likely to be a reflection of the limitations of studies performed to date rather than an accurate reflection of the psychological well-being of individuals who are obese. Also, studies which demonstrate that the effects of weight loss appear to be psychologically favourable with improved self-esteem, social functioning and sense of wellness support the notion that excess weight is associated with higher levels of psychological morbidity than normal weight.[12]

Psychological Sequelae of Obesity

Society views obesity very negatively and tends to believe that people who are obese are "weak-willed" and "unmotivated".[13] Obese individuals are often aware of these negative views, and internalize them, putting themselves at risk for disorders of mood, anxiety, and substance abuse. They perceive interpersonal and work-related discrimination,[14] often suffer from low self-esteem as a result, and feel uncomfortable with their bodies (i.e. body image dissatisfaction).[15] Obese individuals have typically made multiple attempts to lose weight,

with little or no success. Their failed attempts result in discouragement, frustration, hopelessness, and learned helplessness about the prospect of losing weight in the future on their own. For this reason, many turn to bariatric surgery as a last resort. Not surprisingly, significant weight loss confers psychological as well as medical benefits, with improved mood, self-esteem, motivation, and relationships.

Psychological and *Behavioral* Treatments for Obesity

Behavioral and/or cognitive therapy can be used as part of a program of lifestyle modification with diet and exercise for individuals who do not meet criteria for or do not want bariatric surgery. Classical and operant conditioning are the two traditional behavioral therapy models, usually used in weekly sessions lasting 1-1.5 hours over a six-month period. Participants generally have lost an average of 10% of their initial weight.[16]

In *classical conditioning*, eating behaviors are associated with other activities. The behaviors become conditioned to occur together, as when a person eats nachos while watching the evening news. If these two behaviors are paired repeatedly, they become so strongly associated with one another that turning on the news alone triggers a craving for nachos. Behavioral intervention involves identifying and extinguishing the inappropriate psychological or environmental triggers and cues.

Operant conditioning uses reinforcement and consequences. A person who uses food as a reward or to temporarily attenuate stress will associate food with a more pleasurable state, which makes it more likely to to become a repeated behavior. Although behavior therapy results in lifestyle changes and weight loss in the short-term, there is no strong evidence of its long-term effectiveness. More recently cognitive therapy and cognitive behavioral therapy (CBT) have become an important aspect of the treatment of obesity. Cognitions influence both feelings and behaviors, and they cannot be ignored when treating obesity. CBT is utilized in the treatment of obesity as a way to help individuals change their negative eating behaviors and incorporate healthy lifestyle changes.[17] These CBT interventions are self-monitoring techniques (e.g. food and exercise journals), stress management, stimulus control (e.g. eating only at the kitchen table), social support, problem solving, and cognitive restructuring (e.g. helping patients have more realistic weight loss goals, avoidance and challenging of self defeating beliefs).[18]

Psychological Interventions

Avariety of individual and group psychological therapies have been used in weight loss treatments. These are briefly outlined below. Behavioural and cognitive behavioral therapies are the most commonly used psychological therapies for weight loss. Attitude and relationship techniques are also often utilized in designing comprehensive psychological interventions for individualized weight loss programs. Psychotherapy is less commonly used.[19] Behaviour therapy and cognitive behaviour therapy appear to be the psychological treatments of choice inasmuch as they have been demonstrated to facilitate better maintenance of weight loss than other therapies. Behavioural treatments appear to work primarily by enhancing dietary restraint by providing adaptive dietary strategies and by discouraging maladaptive dietary practices, and by increasing motivation to be more physically active. Therapy aims to provide the individual with coping skills to handle various cues to overeat and to manage lapses in diet and physical activity when they occur. Treatment also provides motivation essential to maintain adherence to a healthier lifestyle once the initial enthusiasm for the program has waned.[20] Therapeutic techniques derived from behavioural psychology include stimulus control, goal setting, and self-monitoring. They have been used for some time as adjuncts to the treatment of weight problems. When cognitive techniques are added to behaviour therapy they appear to improve program success and reduce weight regain.[17] These strategies are aimed at identifying and modifying aversive thinking patterns and mood states to facilitate weight loss.[21] Interest in using cognitive behaviour therapy to achieve more modest and sustainable weight loss and improved psychological well-being is increasing. Psychodynamic therapies (therapies based on the idea that problems stem from hidden inner conflicts, e.g. psychoanalysis), humanistic therapies (therapies that focus on helping clients to find meaning in their lives and live in ways consistent with their own values and traits, e.g. person-centred therapy) and group therapies have also been trialled in obesity management with mixed success.[22] Group treatments for obesity combine therapy and education. They are widely used in commercial programmes and in self-help programs. Group treatments do not generally promote deep exploration of psychological issues. Instead they utilize social support, problem solving, and imparting information and encouragement to facilitate weight loss.[23] There has been limited research into group processes and testing whether group interventions are more or less effective than individual treatment.[23] There are a limited number of systematic reviews examining the effectiveness of psychological interventions for overweight or obesity. Four systematic review examining the effectiveness of behavioural therapy have demonstrated that behavioural therapy techniques, in combination with otherweight loss approaches (diet and / or exercise) improve weight loss. Systematic reviews of other forms of psychological interventions are lacking.[24]

Conclusions

Psychological issues play significant roles in both the development and consequences of obesity. A multidisciplinary approach to the treatment of obesity that addresses psychological, social, environmental, and biological factors is critical to ensure comprehensive care, as well as best practices and outcomes. The importance of addressing the psychological aspects of the treatment of obesity has become more explicit over the last two decades. Not only is the role of a psychologist important for behavioral treatment of obesity and pre-surgical psychological assessment, but also following surgery to help them adjust to the post-operative lifestyle and subsequent emotional, behavioral, and social changes that often occur. The achievement of substantial weight loss from surgical or non-surgical approaches is significantly related to one's ability to make permanent changes in one's lifestyle that involves not only adherence to more appropriate nutritional intake and exercise, but also improved management of stress and emotional states with decreased reliance on eating.

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