

LETTERS

Dear Editors and Readers,

I thank the editors for this opportunity to respond to Vincent Felitti, MD's comments on our article: ***Effects of 12- and 24-Week Multimodal Interventions on Physical Activity, Nutritional Behaviors, and Body Mass Index and its Psychological Predictors in Severely Obese Adolescents at Risk for Diabetes***,¹ for which I was the primary author. Although I wholeheartedly agree with Dr Felitti that providing basic education, alone, has not made even a dent in the obesity problem, I also have concerns with several of his statements made in his Letter to the Editor, which appeared in the Fall 2010 issue. Some issues may have their basis in my being a behavioral scientist (focused on health behavior change) within the emerging field of health psychology. For example, his concern that we, "and with many others," lack focus on "Why these children became obese ..." seems to be indicative of a common criticism of behaviorists who, admittedly, are more concerned with obtaining sustained behavioral changes than dwelling on possible underlying psychological factors. Many within our discipline believe that, in our quest for large-scale changes in health behaviors (within an epidemic of obesity and sedentarism), it is an inefficient use of our resources to seek out nuanced personal psychosocial factors that may *or may not* lead us to effecting changes. Rather, we seek to uncover meaningful patterns in psychological variables that may be used to reliably advance desired behavioral changes, with an eye on disseminating evidence-based treatments based on those findings to the many, rather than a few. In the real world, such interventions may best be delivered through referrals to trusted community organizations (eg, YMCAs), considering the reality of time restrictions that physicians are under.

Dr Felitti also stated that we "avoid exploration" of constructs such as "self-concept, general self, and overall mood," but just the opposite is true. This article is just one of dozens of peer-reviewed reports that I have authored in which we used established behavioral models (here, social cognitive theory as developed by Albert Bandura) to derive treatments that focus on predictors of sustained improvements.^{2,6} Other researchers skillfully continue this quest

through similar scientific means. For example, behavioral theory (specifically, self-efficacy theory) suggests that individuals feel an improved sense of accomplishment, self-concept, and self-efficacy when they perceive that they can make meaningful progress while applying themselves to a task they see as worthwhile. This leads to sustained health behavior changes. Thus, treatments following self-efficacy theory may incorporate systems where long-term goals are broken down to short-term goals. As a reasonable plan of action is facilitated and adhered to, and incremental progress is documented, feelings of self-efficacy emerge. Unfortunately, left on their own, people typically set lofty goals, get disappointed by slow progress, and relapse to their original behaviors. Although it is true that we have little knowledge of "Why" one person complies while most do not, we have been able to systematically empower the skills needed for sustained change—and *that's quite worthwhile*. Another example of this is when we teach self-regulatory skills such as positive self-talk, cognitive restructuring, and thought stopping. Although we do not know *why* negative self-statements emerge and undermine progress, we feel that a primary focus should be to teach how to realign self-talk when it becomes unproductive. In the treatment referred to in our article, a computer program was used to help in the large scale dissemination of these and other behavioral methods.

I hope that this letter serves to clarify our perspective in designing the research and interpreting its findings. It is true that although the behavioral methods used succeeded in increasing the severely obese adolescents' physical activity levels (just as theory predicted), the nutrition education portion failed to obtain much change. As mentioned in the Discussion section, we are preparing to better apply behavioral theory to the nutritional portion of the treatment in the future. In fact, through studies such as the one focused on here, we recently found that, when administered properly, A) exercise-induced mood change is associated with reduced emotional eating, B) self-regulation skills learned in an exercise context "generalize" to self-management for controlled eating, and C) self-efficacy derived from persistence with

an exercise program carry over to confidence in sustaining improved eating. It stands to reason that our future weight management efforts build upon these findings. Such is the nature of applied research.

I hope that, ultimately, behavioral science will gain the trust of the medical community so that, as a team, we may contribute to the large-scale prevention and treatment of physical inactivity and overeating behaviors. To be of best service to society, we must efficiently use our resources, effectively incorporate the most current knowledge base of our fields, and accept the responsibility to facilitate meaningful health behavior changes. ♦

James J Annesi, PhD, FAAHB
Director of Wellness Advancement
YMCA of Metropolitan Atlanta, GA



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Dear Editor,

I am writing in support of the article in the Spring 2010 issue¹ by Felitti et al summarizing their work over the last 25 years running the Kaiser Positive Choice Weight

Loss program, which

details the struggles and successes of treating obesity using supplemented absolute fasting in conjunction with weekly group therapy.

For the last five years, I have been naively prescribing my obese patients a formula that goes something like this: to lose weight, calculate your basal metabolic rate, add on an activity factor and then eat 500 calories less than that each day. Using this formula, they would lose one pound a week and in time, they would shed the weight. In theory this is true.

My paradigm was recently broken when I read Dr Felitti's recent article. Out of curiosity, I drove down to their San Diego clinic and visited the group. I met with Dr Felitti, Dr Ray, and Kathy Jakstis who lead the clinic and also sat in on a prospective member orientation and a group that had been meeting for more than 12 weeks.

The following findings particularly struck me: As Dr Felitti points out, obesity is not a disease. It is a sign, similar to tachycardia or jaundice.

Then what is the cause? Well, rarely are people born obese. This was shown in Dr Felitti's interview of 2000 obese patients with only one individual having been born obese. The only aspects of obesity that are genetic are a person's distribution of fat (ie, do they hold excess weight in their abdomen, buttocks, thighs) and the maximal weight the human frame can hold (approximately 1100 lbs for men and 850 lbs for women). In addition, rarely do people gain weight in a linear fashion. It usually occurs in an abrupt fashion following a specific event in life.

If that is the case, then in obese patients, we have to ask two fundamental questions—

what caused them to gain weight and what keeps the weight on.

To answer the first question, obese patients appear to be using the psychoactive benefits of food to heal past traumas. Thus, food is the "solution" and obesity is the result of too much of that "solution." However, there are other ways to respond to past traumas. We as humans exert free will and thus the stimulus-response equation is different in all of us—some negative (nicotine, gambling, alcohol, high-risk sexual behavior, overeating), some positive (medications when appropriate, meditation, counseling). This explains why not all patients who have experienced traumatic events respond by becoming obese. Only those who choose to medicate themselves with food would travel this route. Easy access to food is also a necessity, explaining why those who suffer severe trauma cannot always use food to medicate these wounds if the food simply does not exist (ie, concentration camp victims, prisoners).

To answer the second question, obese patients appear to maintain the weight gain because it is beneficial to them socially, physically, and sexually. Sexually, because it wards off the unwanted attention of others; physically, because it provides a means of intimidation and power, and socially, because people tend to expect less from you.

When comparing the obese population to the lifelong slender population, the obese have more than double the rates of family discord, ie loss of a parent in childhood, at least one alcoholic parent, the suicide of a family member, current marital dysfunction, personal history of divorce.²

This program appears to be successful although longer-term follow-up data are clearly needed. At present, at 18 months, half of the participants keep off more than 60% of the weight lost. Standard weight loss programs report weight loss of 5% to 10% of initial weight at 12 months.³ Patients who have undergone bariatric surgery lose an average of 25% of their initial weight at 12 months and this weight loss appears to hold at greater than 48 months⁴ although tracking these patients is difficult.

Medically supervised absolute supplemented fasting is safe, effective, and surprisingly well tolerated by patients. But that is not in dispute—if you take in fewer calories than you expend, you will lose weight. Maintaining the weight lost is the difficult part. Many methods exist and have been studied.⁵ Dr Felitti's approach of accompanying weight loss with ongoing counseling to reveal the underlying psychological need to use the psychoactive benefits of food to medicate oneself, and to address the benefits of keeping that weight on appears to be an effective strategy, at least within 18 months.

Finally, the immediate change in my practice is that I now ask my obese patients "at what point in your life did you become obese" and "what life event happened during this time."

The above observations have changed my understanding and approach to obese patients. I am in favor of the above approach and hope that as obesity becomes one of Kaiser Permanente's top clinical goals, this program will achieve widespread adoption throughout the Kaiser Permanente system and beyond. ❖

Amal L Puswella, MD
Lakewood Medical Center
Anaheim, CA

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