Obesity treatment: The high cost of false hope

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Abstract Although millions seek treatments for obesity, the benefits of treatment have been overstated. For most people, treatment is not effective; the majority of the obese struggle in vain to lose weight and blame themselves for relapses. Repeated experiences of failure add to the psychologic burden caused by the social stigma and the presumption of psychopathologic conditions attached to obesity. Many therapists may be contributing to this psychologic damage by giving their patients false hope for success and by failing to recognize that seeking treatment for obesity may be triggered by psychologic problems that are not addressed in obesity treatment. *J Am Diet Assoc. 1991; 91:1248-1251.*

The purported benefits of weight loss are so well known that to question them is to defy almost unshakable beliefs. An especially telling sign of the value placed on weight loss is the continuing willingness of professionals to provide, and consumers to participate in, programs known to have only a small chance of success. Even if one's chances of losing and keeping off weight are better than one's chances of winning the lottery, the motivation is much the same: winning, though known to be unlikely, promises transformation. It is because so few people win the lottery that we continue, in the absence of contradictory information, to imagine that sudden wealth brings happiness. And indeed, the paucity of people who have successfully lost and kept off clinically significant amounts of weight prevents us from knowing with any real certainty what the actual benefits are. We do not know, for example, whether a person who has reduced his or her weight is heir to the health benefits associated with being naturally thin or whether that person can expect improved long-term psychologic functioning.

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Of the available medically sanctioned treatments, only surgical techniques have resulted in large samples of people who have sustained major weight losses. Although there are reports indicating psychologic, social, and physical improvements with surgery (1), not all studies reach such positive conclusions. Some long-term follow-up studies describe serious and negative consequences (2,3). In any event, surgery patients are not particularly representative of the obesity population seeking treatment. It is likely that their initial high levels of obesity and their willingness to undergo procedures that carry great risk set them apart. Ravitch and Brolin (4) note that most of their patients were unwilling to consider reversal of the surgical technique even when it was discussed in terms of saving their lives.

Another substantial population of successful weight losers is the population with eating disorders. These people are usually not thought of as successful dieters because for them the cost of thinness is the development of a clinical eating disorder. Major weight loss is obvious in the case of anorexia nervosa; however, it is also common in bulimia nervosa. Bulimic patients with a normal body weight may have been at a much higher weight and lost almost as much weight as those with anorexia nervosa (5). Eating disorders involve two major strategies to achieve and sustain weight loss: the suppression of food intake and the use of compensatory techniques to offset the effects of eating, most commonly self-induced vomiting. Although successful as weight loss strategies, these disorders have well-known emotional and physical costs.

The following findings suggest that obese individuals who lose large amounts of weight experience many of the same psychologic and physical consequences found in people who have starved at or below normal weight: high rates of binge eating (6), lowered caloric maintenance requirements (7), and adverse psychologic effects such as depression, impaired concentration, and preoccupation with food and weight (8). The improvements in self-esteem, depression, and general psychologic functioning that are observed tend to be short-lived; they return to initial levels when the weight is regained (9). Many studies also suggest that individuals who have had a major weight loss may not, in fact, enjoy an improved health status (10).

In short, it seems quite possible that the actual benefits of weight loss have been overstated and that the few

individuals who experience treatment success may be consigned to a lifetime battle against biological mechanisms that operate to return them to their natural, or set-point, weight (11). Increasing knowledge about these biological mechanisms and rapidly growing evidence that they are genetically controlled make understandable both why so many diets fail (12) and why those that succeed require extraordinary behavioral alterations and may have distressing emotional sequelae.

All of these issues have been considered in detail elsewhere (13-15). This article, however, examines the experience of the typical patient in a weight loss program who loses some weight, though rarely enough to achieve the goal of "normality," and who subsequently regains it. In this article we address some of the issues that affect the unsuccessful dieters who form the majority of those treated. Because few data exist on the topic, our examination will, of necessity, be speculative, but we hope that it stimulates future research.

Adverse effects of treatment

Movement toward inevitable failure

Although most patients in therapy experience growing success as treatment progresses, overweight patients experience growing failure. In the first week or two they may show a rapid weight loss due to dehydration. Filled with hope, they may for a while adhere rigorously to the prescribed diet and, before their metabolic rate has dropped to its lowest level, lose weight at a gratifying rate. On very-low-calorie diets, the loss may be substantial, but rarely is it likely to approach the hoped-for goal.

Then the early success begins to unravel. Compliance with a rigid diet begins to take an unmanageable toll; despite the patient's best efforts, there are inevitable lapses. Extreme hunger may trigger binges. With the passage of time, less weight is lost on the same intake. As therapy draws to a close, most patients are reaching a peak of discomfort and a valley of reward. Shaky and worried, they end their treatment with well wishes based on little more than hope. In the following months and years, they will almost certainly see their success eroded little by little until they are as bad off, or worse, than when they began.

Goodrick et al (16) found that patients in very-low-calorie diet programs greatly overestimate the overall success rate of the program. They believe the therapy to be effective and blame themselves for failure. Usually no one is able to help such patients manage the impact of failure. Too ashamed to return to their therapists, patients struggle alone with their sense of worthlessness and hopelessness. They may start treatment in a new setting but only after they have shored up their strength. Treatment providers are usually spared even a glimpse of the later misery of their program's "graduates." On the occasions when they hear a new patient describe the pain of past failures, they are apt to insist that this time it will be different. Almost always, it is the same.

The inability to attain thinness, to garner social approval, to be regarded as attractive, and to be accepted as normal is a serious loss, but it is one for which obese people are never allowed to grieve. Because the loss is repeatedly denied, it is never worked through, and it may fill a lifetime with despair.

Social stigma in the therapeutic relationship

Whatever else may or may not be accomplished in therapy, the therapeutic relationship can provide a patient with a sense of being valued, respected, and understood. Unfortunately, the obese patient is apt to find the therapeutic encounter to be one that diminishes rather than enhances a sense of personal worth. Obesity is greatly stigmatized in our culture, and health professionals, regrettably, are no exception in their endorsement of prevailing views.

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Maddox et al (17) found that physicians regarded overweight patients as weak willed, ugly, and awkward. In a study of health care professionals, Maimon et al (18) found that 84% considered the obese to be self-indulgent, 88% assumed they ate to compensate for other problems, and 70% assumed they were emotionally disturbed. In agreement with nearly all other studies, a study by Goodman et al (19) found that health professionals felt more negatively toward obese children than toward children with a variety of other handicaps (19). Most discouraging of all, Harris and Smith (20) reported that negativity toward the obese is not lessened by sophisticated knowledge about the causes of obesity.

Whatever negative attitudes health professionals bring to the therapeutic encounter are undoubtedly intensified as the professionals' failure in achieving allegedly attainable therapeutic goals leads them to question their own competency. Obese patients can become symbols of inadequacy. Moreover, the fundamental activities of therapy—helping patients eat less, exercise more, identify emotional determinants of eating, and make environmental changes that augment control over eating—inevitably tend, as a result of cognitive dissonance, to strengthen the beliefs that obese people eat more, exercise less, are more emotionally immature or unstable, and are less disciplined than others. Because dietary therapies are based on an inacccurate model of the pathogenesis of obesity, they simply do not work very well. Both patient and therapist are victims of misinformation. Unfortunately, both are likely to find in the patient a suitable target for the anger that arises out of repeated experiences of helplessness.

Such helplessness has led those who treat obesity to some extraordinary therapeutic stances. Patients have been subjected to startling authoritarianism, exposed to shaming procedures, and infantilized by childlike rewards and punishments. Patients' attempts to describe the difficulties they are encountering have often been discredited as evidence of their inability to face the truth about themselves. The literature abounds with statements that exemplify these attitudes, some of which have been cited elsewhere (21).

However, to single out particular individuals is to miss the point that these problems are nearly universal—built into the treatment process at its very foundation. Probably everyone who has ever written about obesity has at some time displayed prejudice, condescension, or hostility. We have often observed that when obese patients sense that it is safe to express their real feelings, they say they have felt deeply humiliated in therapeutic relationships.

It is now widely agreed that obesity treatment is, in general, ineffective; moreover, it may be argued that in many cases obesity treatment is destructive

False assumption of a psychopathologic condition

Perhaps the most pervasive harmful consequence of treatment stems from exposure to the unjustified insistence that overweight is an outward manifestation of underlying emotional disturbance. Even though obesity may reflect or coexist with primary psychologic disturbance in some individuals, controlled studies fail to find the obese to be more emotionally disturbed than the nonobese (22,23). Nevertheless, the view that obesity is a manifestation of emotional disturbance persists in the face of no obvious signs other than the obesity itself.

Extraordinary examples of this prejudice can be found in empirical studies. Gottesfeld (24, p 182) found that obese subjects were more satisfied with their personality than "neurotic" patients and concluded therefore that the obese "tend to deny that there is anything wrong with their personalities [with a] facade of satisfaction." Similarly, Simon (25) asserted that the relative absence of measured depression in a group of obese military personnel indicated that obesity was a reflection of masked depression. These types of tautological formulations are still common in clinical practice.

Many obese individuals are poised to accept psychologic interpretations for their condition or even to provide their own psychogenic explanation; they, like others, assume that they could not have become obese unless they possessed some fundamental character deficit. Many obese individuals experience psychologic and behavioral symptoms such as binge eating and depression, which are the *result* of attempts to lose weight, but they interpret these symptoms as further evidence of underlying disturbance (26).

Often such self-diminishing beliefs are adhered to with surprising tenacity; to give them up would be to relinquish dieting which, in turn, would imply that there was no hope of conquering obesity and that the condition must indeed be accepted. In reality, most obese individuals do not have inordinate psychologic disturbances. Therapists must be able to differentiate primary psychopathologic conditions from the consequences of dieting, as well as from the effects of living in a society that holds the obese in contempt for their condition.

Negation of experience

To the extent that the assumptions of treatment provided do not correspond to the realities of patients' experience, the patients, not the assumptions, are usually judged to be wrong. As indicated earlier, simply by virtue of their size, obese patients are usually persuaded to believe that their eating is not a response to "real" hunger, but is rather a response to an emotional state or to the confusion of one biologic drive with another. In fact, there is little in the scientific literature to warrant such a blanket assertion, but the therapists' interpretations have great credibility for the patient. Obesity treatment then becomes a process in which patients learn to ignore their own sensations and to replace knowledge of their inner experience with external interpretations that reflect current theories.

In addition, in many instances patients' reports of food intake are believed only if they concur with the therapist's preconceptions. It is almost universally assumed that people get and stay overweight by overeating and that they cannot fail to lose weight by a reduction in intake. Thus, the actual experience of obese people who eat the same or less than others, or whose slowing of metabolic rate has produced a cessation of weight loss, is often discounted. Patients are encouraged to distrust their own memories and observations in favor of what others tell them must be the truth. As succinctly expressed by Aldebaran (27), "The failure of reducing diets is fat people's collective experience and therapy tells us to ignore it." We do not know how encouragement to ignore and disclaim such vital experience generalizes to other areas. It is reasonable to speculate, however, that obesity treatment, as currently constituted and especially when often repeated, may gradually erode confidence and self-trust.

Masking of other important issues

An individual's decision to seek treatment for a psychologic problem at a particular point in time is generally agreed to be of significance. In some instances, an extraordinary precipitating event is readily apparent. More often, the problem for which an individual seeks help is a relatively chronic one, and the timing of the request carries crucial information. Some argue that this is the most important question the therapist must explore with the patient because it involves understanding a personal threshold of distress beyond which life feels unmanageable or intolerable.

Such an exploration is rarely undertaken with patients who seek obesity treatment. Often they are seen in specialized treatment centers and their mere arrival is considered evidence of appropriate self-screening. To the extent that obesity is defined as a medical problem, such questions may seem less pressing. The benefits of weight loss are so universally prized that it may seem absurd to ask why a patient is seeking treatment at this or any time. Nevertheless, examination of a patient's reasons for obtaining medical treatment would likely uncover important but usually unrecognized issues.

An untoward consequence of treating obesity may, then, be a missed opportunity to discover, articulate, and address other important issues. The distress signal embedded in the search for professional help may be disregarded, and the patient may be encouraged to take actions that are essentially irrelevant to his or her real problems. Obese

patients are often encouraged to believe that weight loss is an appropriate way to combat depression, save a failing marriage, or increase the chance of career success. The irrationality of hopes pinned on weight loss is so striking that dieting might almost be likened to superstitious behavior.

Many women respond to difficult life transitions with a wish to lose weight. This response is undoubtedly, in part, a legacy of the many centuries during which one of the few ways women could control their lives was by controlling their appearance. Passing from childhood into adolescence, leaving home, marrying, starting a new job, having a baby, experiencing marital difficulties, adjusting to children leaving home, and growing old—all these life situations may become unexamined reasons to diet. In other instances, concerns over weight mask even more serious problems.

McReynolds' review (23) found that obese people undergoing medical or psychiatric treatment showed evidence of psychologic disturbance, whereas those in the general population showed comparable or better mental functioning than the nonobese. This suggests that the search for treatment often signals psychologic distress. Rarely does dieting solve the problem it is intended to address. It may well exacerbate the problem by draining away emotional and physical resources and, in the event of failure, by increasing a sense of ineffectiveness and inferiority.

Implications

All of us have our patients' best interests at heart when we try, again and again, to infuse them with enthusiasm as they try to achieve the much sought-after goal of slenderness. However, we have learned in the past few decades, as we have applied increasing sophistication and dedication to the problem, that despite our best efforts we are rarely successful, except in the most transitory and illusory sense.

It is now widely agreed that obesity treatment is, in general, ineffective. It may be argued, moreover, that it is more than ineffective: in many instances it is destructive. It may provide patients with failure experiences, expose them to professionals who hold them in low regard, cause them to see themselves as deviant and flawed, confuse their perceptions of hunger and satiety, and divert their attention away from other problems. Such negative consequences obviously do not occur all of the time or to all people; but they need to be given more serious consideration than they have in the past if we are to do no harm.

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