

Why diets fail: Obesity and mental health

Simplistic approaches to the treatment of obesity focusing on restrictive diets or increased exercise power the lucrative weight-loss industry and provide endless hours of reality television, but provide clinicians with no useful models to help those who struggle with serious obesity. While research has shown almost every popular diet to assist in weight loss, there is no diet that seems to help more than a small fraction of participants beyond a couple of years. Further, most gain back the weight they lost. It seems that no matter how well a diet works early on, long-term adherence to popular diets tends to be dismal.

Research is helping us understand why we should consider a more thoughtful and empathic approach to obesity. As we grow up, our normal weight is adjusted upward and food intake is hormonally regulated to ensure that it is sufficient to support growth. If we gain excessive weight, what our body considers our normal weight continues to increase.¹ After intentional weight loss, potent neuroendocrine physiology defends our previous maximum weight and our food intake eventually increases until we regain most or all of the weight lost. This physiological pressure to regain lost weight is persistent and likely permanent. Bariatric surgery impacts the hormones regulating this set point. Anti-obesity pharmaceuticals also target these systems, with less impressive outcomes. Although these interventions have their place, to treat obesity successfully, we need

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to consider addressing modifiable contributors to weight gain, and assist patients with barriers to successful lifestyle modification.

The complex and inseparable relationship between obesity and mental health is one reason why a simple diet or exercise plan has no lasting value. Childhood trauma, neglect, abuse, food insecurity, and posttraumatic stress disorder often precede lifelong, severe obesity, and pose challenges to treatment.^{2,3} Attention deficit hyperactivity disorder (ADHD) is strongly associated with obesity, especially in adults, and coaching those with ADHD to maintain lifestyle modifications is difficult.⁴ Depression is a common comorbidity in obesity, and is strongly associated with hyperphagia, anxiety, severe fatigue, and chronic pain, all of which are barriers to effective treatment.⁵ Obesity is associated with a high risk of obstructive sleep apnea, which is strongly associated with depression, severe sleepiness, fatigue, cognitive impairment, and increased appetite promoting hormones.⁶ Disorderly eating patterns and comorbid eating disorders (especially binge eating disorder) are common, especially with severe obesity. Simply prescribing a restricted diet or strategies such as fasting may exacerbate disorderly eating patterns.⁷ Perhaps the most common problem seen in obesity treatment are patients struggling with chronic stress and anxiety who develop habitual emotional eating behaviors to cope.⁸ Prescribing dietary changes without assisting these patients in stress management and treating their anxiety is of little long-term value.

Patients with obesity experience judgment, bigotry, and discrimination in all facets of society, including health care settings.⁹ Motivating

positive change in patients with low self-esteem and a history of repeated failures to maintain weight loss is best achieved by establishing an accepting, nonjudgmental milieu, and helping them reframe their efforts to change as a lifelong journey rather than a race to achieve a weight-loss goal. By helping patients set realistic behavioral goals and assisting them to identify and address the root causes of their obesity, physicians can empower them to make lifestyle changes that are enjoyable, sustainable, and effective.

—Michael R. Lyon, MD, ABOM

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Waiting 18 months between pregnancies reduced the risk to 0.5%. For younger women, researchers found an 8.5% risk of spontaneous preterm birth for pregnancies spaced at 6 months. For younger women who waited 18 months between pregnancies the risk dropped to 3.7%. Among older women, the risk of spontaneous preterm labor was about 6% at the 6-month interval, compared to 3.4% at the 18-month interval. Although the causes of poor pregnancy outcomes at short intervals among older and younger women were not examined in this study, the findings suggest different risk profiles for each age group.

The authors reflect that whether the elevated risks are due to the body not having time to recover if women conceive soon after delivering or to factors associated with unplanned pregnancies, such as inadequate prenatal care, the recommendation might be the same: improve access to postpartum contraception or abstain from unprotected sexual intercourse with a male partner following a birth.

The study was coauthored by Laura Schummers, SD, Jennifer A. Hutchison, PhD, Sonia Hernandez-Diaz, DrPH, Paige L. Williams, PhD, Michele R Hacker, SD, Tyler J. VanderWeele, PhD, and Wendy V. Norman, MD. It is available at <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2708196>.

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Midwifery linked to lower odds of birth complications for low-income women

Research from UBC and the University of Saskatchewan adds to the evidence in support of midwives as a safe option for prenatal care, especially for women who have low socioeconomic status.

The study, “Reduced prevalence of small-for-gestational-age and preterm birth for women of low socioeconomic position: A population-based cohort study comparing antenatal midwifery and physician models of care,” published in the *British Medical Journal Open*, found that low-income pregnant women who receive care from a midwife compared to a physician are less likely to go into early labor, to have a baby with a low birth weight, or to have a small-for-gestational age birth.

Midwives, general practitioners, and obstetricians each offer a different style of prenatal care that matches different women’s preferences and needs. Midwives tend to spend more time with their patients with a focus on the overall physical, emotional, and psychological well-being of mothers and their newborns, which benefits women who are more vulnerable.

For the study, researchers followed 57 872 women in BC who carried a single baby, had low- to moderate-risk pregnancies, and received medical insurance premium assistance sometime between 2005 and 2012. They used maternity, medical billing, and demographic data to investigate the odds of small-for-gestational age birth, preterm birth, and low birth weight for low-income women receiving care from a midwife, GP, or OB.

After controlling for differences such as age, previous pregnancies, where they lived, and pre-existing medical conditions, researchers found that low-income women who received prenatal care from a midwife had 29% lower odds of a small-for-gestational age birth compared to women who

received care from a GP, and a 41% reduction compared to those who received care from an OB.

Authors of the study suggest the findings could help develop policies that make the service more accessible to low-income women, who might not be as aware of this option.

The study was coauthored by Patricia Janssen, Saraswathi Vedam, and Maureen Mayhew at the University of British Columbia, and Deborah Mpofo and Ulrich Teucher at the University of Saskatchewan. It is available at <https://bmjopen.bmj.com/content/8/10/e022220>.

Mitochondrial disease resource

MitoCanada is a patient advocacy organization, established in 2010, focusing on awareness, support, and funding research, and the only Canadian mitochondrial disease charity. The organization seeks to increase public awareness of mitochondrial disease and dysfunction; be an information resource and support for individuals, families, and caregivers, and the clinical communities that serve them; and advance research into the diagnosis, care, treatment, and cure for mitochondrial disease. Visit their website for patient advocacy and support information: <http://mitocanada.org>.

Hiring an MOA? Free resource for the medical community

Whether it is finding temporary help or adding team members to an expanding office, the challenge to find qualified medical office assistant candidates is the same for most medical clinics, especially in an unfocused recruitment space. As a physician’s spouse, over the past 10 years I have been tasked with hiring MOAs, and I have noticed that the recruitment process is fragmented. We scatter advertisements across various websites—craigslist, Indeed.com,

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