WHAT ARE OUR PSYCHOTHERAPEUTIC OPTIONS?

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Over the past two decades, behavioral treatment programs have become increasingly more effective in producing initial weight loss. The best programs now yield average weight losses of approximately 10 kg at the end of treatment (usually 20-24 weeks). However, long-term results are still modest, averaging about 5 kg (Wadden, & VanItallie, 1992). Therefore, the key problem facing us today is how to improve long-term results.

Several approaches deserve our consideration. First, it seems necessary that longer treatments be developed, and a chronic disease approach to obesity be adopted. It may well be that obese patients need to remain in therapy forever. Evidence supporting the concept of longer treatment interventions comes from a study by Perri, et al (Perri, McAdoo, Spevak, & Newlin, 1984). These investigators found that subjects treated with a standard 20 week behavioral program with no subsequent treatment contact lost weight initially, but maintained a loss of only 3.6 kg at 12 month follow-up. In contrast, subjects given the same initial treatment, but seen biweekly throughout the 12 months of follow-up, maintained weight losses of 8.4 - 13.5 kg. A recent study that we conducted with Type 2 diabetic patients also used a chronic disease model. In this study, where subjects attended treatment every week for 52 weeks, the mean weight loss at the end of the 52 week program was 10.2 kg.

However, one of the major problems in developing such long-term interventions is burn-out. Most patients are unwilling to attend treatments weekly for a year, and attendance in such programs decreases markedly over time. Thus, we need to carefully consider what can be taught in a chronic disease approach to obesity and how we can maintain interest and attendance over time. Using different treatment approaches at different phases of treatment may be helpful, such as starting the program with a focus on diet and adding exercise strategies at 6 months. Techniques to increase group cohesiveness may also be useful.

Moreover, lengthening treatments may be only one component of a more general issue—the need to develop more intensive approaches to behavior change. To date, behavioral treatments have been primarily educational in nature; participants are instructed in techniques for modifying the cues and reinforcers that control eating and exercise behavior, but the burden of implementing these procedures and modifying the home environment is left entirely to the
patient. Better results might be obtained by more directly modifying the antecedents and reinforcers in the patients' environment for them. A recent study, using more direct manipulations of the antecedent cues for eating, by actually providing subjects with the foods they should eat, showed positive effects of this approach (Jeffery, Wing, Thorson, Burton, Raether, Harvey, & Mullen, in press). In contrast, a stronger incentive approach, based on paying people to lose weight, had no effect. Further research using stronger approaches to modifying the environment are clearly needed.

Other more intensive approaches to behavior change may also be warranted. The positive results obtained by Ornish (Ornish, Bron, Scherwitz, Billings, Armstrong, Ports, McLanahan, Kirkeide, Brand, & Gould, 1990) with a very low fat diet and meetings held twice a week are of interest. These results suggest that setting stricter goals (i.e. <10% of calories from fat vs 20-30% as is customary in behavioral programs) may actually be helpful to patients. Similarly, Bjorvell and Rossner (Bjorvell, & osser, 1992) obtained positive results with a treatment program that involved weekly meetings for 4 years. This program started with a 6 week in-hospital program, which included instruction in behavior modification, a low calorie diet (600 kcal/day) and aerobic exercise. Patients were able to return to the hospital for 2 week phases of inpatient therapy as needed over the 4 years. In subsequent studies, it would be interesting to determine whether it is possible to replicate the success of this program and to identify the active ingredients in the intervention. There are several aspects of the treatment that could be related to its success, including the long-term, ongoing contact, the self-initiated return to strict dieting, and the use of periods of in-hospital intervention.

Another option that has received only limited attention is the use of combination therapies. Combining pharmacotherapy and behavioral treatment produced significant long-term weight loss in both a study by Weintraub, where the drugs phentermine and fenfluramine were used in combination with behavior therapy (Weintraub, 1992), and in a study by Marcus et al. (Marcus, Wing, Ewing, Kern, McDermott, & Gooding, 1990), which combined fluoxetine with behavior modification.

The strategies discussed thus far all maintain the current focus on changing diet and exercise behaviors. Another option is to broaden our target and to realize that obese patients may have problems in other psychosocial domains that affect their eating. Targeting these other areas may be more helpful than targeting the eating per se. For example, an individual may be having marital problems, and stressful interactions with the spouse may trigger eating. Perhaps better outcomes would be achieved by intervening on the marital problems, and reducing the source of stress, rather than merely trying to teach patients not to eat in response to the stress. This approach would clearly require more individualized therapy, as the associated psychosocial issues would differ across patients.

We should also consider the range of reinforcers currently available to the subject. For some overweight individuals, food may be one of the few reinforcers in their life. It is unrealistic to expect these individuals to give up food without some type of substitute reinforcer. Stuart emphasized this in his early, successful treatment of obesity (Stuart, 1967). A key part of his treatment was to help subjects cultivate other activities that were reinforcing to them, such as birdwatching or caring for African violets. The development of alternative reinforcers is also a key component of Azrin's community reinforcement approach to the treatment of alcoholism (Hunt, & azrin, 1973).

As we consider broadening the therapeutic targets, we should also consider utilizing other psychotherapeutic approaches in addition to behavior therapy and cognitive behavior therapy. For example, interpersonal therapy has been shown to be effective in the treatment of bulimia nervosa, in one recent study, results with interpersonal therapy were comparable to those achieved with cognitive behavior therapy at long-term follow-up (Fairburn, Jones, Peveler, Hope, & O'Connor, 1993). This is of interest since interpersonal therapy focuses on interpersonal relations and does not specifically address issues related to eating, weight or shape, which are considered central to bulimia nervosa.