Conservative treatments for obesity 1,2

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Characteristics of conservative treatments

There is a growing consensus as to the characteristics of conservative treatments for obesity. We will begin by describing these characteristics without attempting a precise definition. Conservative treatments can be characterized in a negative sense as treatments other than surgery or adjunctive instruments such as gastric balloons, very-low-calorie diets, or pharmacotherapy. They can be characterized in a positive sense by the rate of weight loss that they produce: ~1% of total body weight per week.

Kilograms of weight lost per week is a more conventional measure rate of weight loss but one with two disadvantages. First, it fails to take into account the different weight-loss requirements of patients of differing initial body weights. Heavier persons can, and probably should, lose more weight than lighter persons. Second, the use of weight loss per week as a measure makes it difficult to compare the weight losses of persons with widely varying initial weights. Using instead the measure of percentage of body weight lost has the advantage of permitting such comparisons, which are of value in the assessment of programs that treat different patient populations.

The use of a percentage of total body weight lost as a measure of the rate of weight loss is simple and readily understandable. Thus, the weight loss of a modestly overweight women of 70 kg would be 0.7 kg/wk while that of a severely obese person of 140 kg would be 1.4 kg/wk.

Conservative treatments for obesity can be characterized also in terms of the caloric deficits that they prescribe. Instead of prescribing a fixed number of calories or a particular caloric deficit, however, conservative treatments are perhaps best characterized in terms of the percentage of the energy required to maintain the body weight of the individual. This value is ~50% of maintenance energy requirements and rarely, if ever, < 40% of these requirements.

Defining caloric intake in terms of baseline values permits the individualization of treatment by adjusting caloric deficit to the needs of particular persons. Thus, someone whose energy requirement to maintain body weight is 2000 kcal/d will be reduced to a caloric intake of 1000 kcal with a deficit of 1000 kcal. A person with a maintenance energy requirement of 4000 kcal will be reduced to a caloric intake of 2000 kcal/d, leaving a deficit of 2000 kcal.

Conservative diets spare lean body mass

One of the virtues of conservative treatment with the above characteristics is that it minimizes the loss of lean body mass. The loss of lean body mass during dieting is a matter of some concern. Webster et al (1) have suggested that the weight lost during even modest caloric restriction comprises ~1 g lean body mass for every 3 g fat. Thus, even the most benign regimens produce nontrivial losses of lean body mass. More stringent caloric restriction produces even greater losses. Subjects receiving very-low-calorie diets remained in negative nitrogen balance for the duration of a 2-mo study (2). Furthermore, there was wide variation in the extent of the negative nitrogen balance and some subjects showed distressingly large deficits. Because there is no a priori method of determining which patients will suffer the largest losses of lean body mass, there is no way of knowing which patients are at highest risk. We do know that the greater the caloric deficit the greater the risk.

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The problem of the loss of lean body mass is of particular concern following weight reduction when patients tend to regain the weight that they had lost. Although it is as easy to replace body fat as it was to break it down, it is much harder to replace protein than to break it down. Keys et al (3) have shown that 58 wk were required to restore the lean body mass that had been lost during 24-wk of semistarvation by young men in the Minnesota study. Furthermore, the continuing pressure to regain the lost protein drives patients to increase their food intake. In the course of this increased food intake, any calories in excess of those required for restoration of lean body mass will be laid down as fat. Unless caloric intake is controlled with the greatest precision, therefore, (and obese persons are not noted for precise control of caloric intake) the drive to replete lost protein stores leads inexorably to repletion of the fat stores that were the reason for dieting in the first place. Thus, any measure that depletes lean body mass can lead inadvertently to restoration of the fat that had been lost during treatment. It is a virtue of conservative treatments that they minimize this problem and limit the pressures to regain the weight lost during treatment.

Status of conservative treatments during the recent past

In 1979 Wing and Jeffrey (4) reviewed 145 papers on the outpatient treatment of obesity that had appeared during the previous 11 yr. The results, illustrated in Figure 1, showed that weight losses produced by different methods, from behavior therapy to anorectic medication, were very similar and very limited. Weight losses averaged no more than 5.4 kg. There were, however, a small number of programs with clinically significant weight losses.

FIG 1. Distribution of weight losses for studies of outpatient therapy for obesity. From Wing and Jeffrey (4).
and they shared a common characteristic. Each of the four programs with weight losses of at least 14.5 kg were of 1 yr in duration. Most of the programs with small weight losses, on the other hand, were of very limited duration. Thus, although the state of the art in 1979 left much to be desired, there was a strong suggestion of how to improve these results: increase the duration of treatment.

Some strengths of behavioral programs

Although most of the behavioral programs reviewed by Wing and Jeffery (4) showed only modest weight losses, there were two important strengths of these programs. First, their attrition rates, rarely in excess of 15%, were far lower than those of traditional weight loss programs. Second, the maintenance of weight lost during treatment was also superior to that of traditional programs. These virtues were exemplified in a program reported by Foreyt et al (5). The program was a large clinical one that enrolled 817 patients (188 men and 629 women) during its first year of operation. Treatment was confined to eight weekly sessions during which patients were treated by registered dieticians in groups of 12–15. Men lost 6.8 kg during treatment and an additional 0.9 kg at a 1-yr follow-up; women lost 4.3 kg during treatment and an additional 1.0 kg at follow-up. The distribution of these weight losses among the patients is shown in Figure 2. Thirty percent of the patients continued to lose weight during the year after treatment, 43% showed no change, and 27% regained some weight.

Behavior therapy was introduced into the treatment of obesity with the assumption that obesity was due to disordered eating behavior that could be remedied by behavioral measures. In accordance with this view, a variety of behavioral treatment strategies were developed and were specified with increasing precision in a series of treatment manuals that brought a highly desirable standardization into

![Graph](http://example.com/graph.png)

**FIG 2.** Weight change following behavioral treatment of obesity from end of treatment to 1-yr follow-up. From Foreyt et al (5).
the treatment of obesity. Furthermore, behavioral researchers introduced far more careful and sophisticated measurement of the treatment process than had heretofore been available. The report by Foreyt et al (5) established the ability of even a modest 8-wk behavioral treatment program to reduce attrition from treatment and to produce reasonable maintenance of weight loss. It served as a kind of minimal program which could be expanded in scope by the addition of a wide variety of different treatment methods.

A developing consensus on conservative treatment

Early behavioral treatment programs placed their emphasis largely on changing food habits and eating behavior. Some of the measures to be described below, such as self-monitoring and stimulus control, went beyond the simple goal of slowing eating and gaining control over eating behavior. But for the most part early behavioral programs were conducted in a setting of ideological purity that was derived from the original assumptions about the central role of disordered eating in the etiology of obesity.

During the period when behavioral programs were developing, traditional programs continued to place their emphasis on diet, nutrition education, and increasing physical activity. The past 5 yr, however, have seen these two camps move closer and closer together. Programs that began as behavioral have increasingly incorporated features of traditional ones while traditional programs have incorporated behavioral measures. Very few purely behavioral or purely nonbehavioral programs exist at the present time and there is a developing consensus that treatment is best advanced by incorporation of measures from both types of programs.

An interesting example of the amalgamation that is currently taking place is the use of behavioral methods to increase physical activity, a goal that had formerly been restricted to nonbehavioral programs. Similarly, efforts to improve nutrition education, which had formerly been the province of nonbehavioral programs, are playing an increasingly important part in programs with a heavy behavioral emphasis. The synthesis of measures developed in these two traditions is well exemplified in the program of conservative treatment described below, which is characteristic of growing numbers of eclectic programs in all parts of the world.

The effectiveness of these conservative programs has been assessed in the course of comparing them with a variety of other, more radical, treatments. Recourse to these more radical treatments arose out of concern with the limitation in the weight losses produced by both traditional and behavioral programs. The comparison has favored conservative treatments over such radical ones as jaw-wiring and very-low-calorie diets. In three well-documented studies, conservative treatments produced weight losses of 10.9, 15.8, and 14.1 kg and these weight losses were reasonably well maintained. These studies, are briefly described below.

Conservative treatment and pharmacotherapy

In 1980 Craighead, Stunkard, and O'Brien (6) undertook a study to determine the relative effectiveness of behavior therapy and pharmacotherapy and to explore the potential of combining the two modalities. There were three major treatment groups and two control groups: 1) conservative therapy (then called behavior therapy) presented in a highly structured group format; 2) pharmacotherapy consisting of fenfluramine (a serotonin-reuptake blocker) in doses of up to 120 mg/d as tolerated, together with supportive group counseling designed to serve as a placebo for the attention that patients receive in the other treatments; 3) combined treatment including conservative treatment as in the first condition and fenfluramine as in the second condition; 4) a doctor's-office control group designed to provide a comparison with traditional office treatment of obesity including the use of fenfluramine; and 5) a waiting-list control group comprised of patients who were assessed, placed on a waiting list, reassessed at 4 and 6 mo, and then provided treatment.

Patients consisted of 108 obese women who were 63% overweight, whose median age was 47 yr, and who were of middle socioeconomic status. They were randomly assigned from stratified blocks (based on percentage overweight) to treatment conditions: 32 patients
to conservative (called behavior) therapy, 25 patients to pharmacotherapy with fenfluramine, 33 patients to combined therapy, 8 patients to the doctor’s-office control group, and 10 patients to the waiting-list control.

For the three major treatment conditions patients met weekly for 6 mo in groups of 8–10 for 1.5 h. Each of two female behavior therapists led at least one group in each of the three major treatment conditions. Physicians were responsible for administration of the fenfluramine.

Figure 3 shows that during treatment patients receiving behavior therapy lost 10.9 kg, significantly less than those who had received medication alone who lost 14.5 kg. The hope that combining treatments might increase their efficacy was not realized: patients in combined treatment lost no more than 15 kg.

One year after the end of treatment the results were strikingly different. Patients who had received conservative treatment maintained their weight losses very well regaining no more than 1.9 kg and remaining 9 kg below their starting weights. The weights of the patients who had received medication alone rebounded sharply (as is usually the case) with a gain of 8 kg. Combined treatment showed the most surprising and the most disappointing results: these patients regained no less than 9.5 kg and ended the year weighing only 4.5 kg less than they had at the start of treatment.

This study indicated that conservative treatment was an effective method of helping obese patients lose moderate amounts of weight and to maintain these weight losses for at least 1 yr. It appeared clearly superior to pharmacotherapy, another major treatment modality for obesity, and even to the combination of pharmacotherapy with conservative treatment.

Conservative treatment and jaw wiring

In 1985 Björvell and Rössner (7) reported on a comparison of conservative treatment with a program of jaw wiring. The conservative-treatment program incorporated the standard elements of such programs but it was initiated

![Graph showing weight changes during 6-mo treatment and 12-mo follow-up.](image-url)
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in a somewhat different manner—with 6 wk of treatment in a day care center during which time patients received a 600 kcal diet. After the day care program patients were treated once per week for an indefinite period of time, which varied for the participants. Patients consisted of 53 women and 15 men in their early 40s in age who averaged 70% overweight.

The results of conservative treatment of these patients were compared with those of two other forms of treatment. One such treatment was jaw wiring, which was administered to 39 men and women. Treatment continued until weight loss ceased at ~6 mo. A second comparison group consisted of 16 men and women selected from among patients who were eligible for the conservative treatment but who did not receive it. Instead their program consisted of a minimum intervention: two interviews of 45 min and written instructions based upon the principles utilized in the conservative program.

This report is notable for the fact that it includes the results of a period of 4 yr. Figure 4 summarizes these results in terms of percentage overweight for men and women combined. In terms of weight loss, women lost 10 kg during the first 6 wk of treatment, which increased to 16.7 kg at 6 mo, fell to 15 kg at 1 yr and 12.3 kg at 2 yr, and then remained stable. These results include 89% of the women who began treatment including those who had dropped out (and whose results were poorer than those of the patients who remained in treatment). Among the smaller number of men both the attrition rate and the weight losses were somewhat higher.

Patients who underwent jaw wiring had significantly greater initial weight losses: 21.1 kg for the women. There was, however, a far higher dropout rate among patients in the jaw-wiring condition and far fewer of them were traced over the 4 yr. Furthermore, even among the limited group that was traced, which presumably performed better than those who dropped out, there was a considerable regain of body weight: 11.1 kg. As a result after 4 yr the net weight loss, even of those women who could be contacted, was only 9.4 kg.

Patients in the minimal-treatment group lost 5.4 kg during the first 6 wk with a further weight loss to 6.8 kg at the end of 1 yr when follow-up was terminated.

The study of Björvell and Rössner (7) complemented the earlier study of Craighead et al (6) in showing that conservative treatment of obesity although producing a smaller initial weight loss than more radical measures resulted in better maintenance of weight loss. Once again over the long term, patients weighed less following conservative treatment than following more radical measures.

FIG 4. Percentage of change in overweight in subjects during and after treatment. Control group, open triangles; conservative treatment, closed triangles; and jaw-fixation group, open circles. From Björvell and Rössner (7).
Conservative treatment and very-low-calorie diets

A third report has confirmed the findings of the two previous studies that conservative treatment of obesity is relatively effective, both short term and long term. In 1986 Wadden and Stunkard (8) reported the result of a controlled trial that compared conservative treatment with both a very-low-calorie diet alone and with the combination of conservative treatment plus very-low-calorie diet. A total of 59 women averaging 93% overweight were stratified by percentage overweight and then randomly assigned to one of the three treatment conditions.

The conservative treatment was conducted in small groups for a period of 6 mo. The very-low-calorie diet was designed to approximate the treatment delivered in standard medical practice. Thus, patients were prescribed a 1200 kcal balanced diet for the first month, a very-low-calorie diet consisting of 1.5 g of protein/kg of ideal body weight for the second and third months, and a refeeding diet of conventional foods for the fourth and final month. In the combined-treatment program, the dietary intervention was the same as that of patients who received only the very-low-calorie diet but the combined-treatment patients also received extensive training in behavior therapy throughout the 6 mo of the program.

Figure 5 shows the results of treatment and at the 1-yr follow-up. Fifty of the 59 patients completed the program and attrition was spread evenly across the three conditions. Mean weight losses at the end of treatment for the conservative-treatment, diet-alone, and combined-treatment conditions were 14.3, 14.1, and 19.3 kg, respectively. Losses for combined-treatment patients were significantly greater than those for patients in the other two conditions, which did not differ from each other.

A major focus of this study was on the maintenance of weight losses. This first controlled trial of a very-low-calorie diet confirmed the pessimistic impression of clinicians who have utilized this method. Thus, in the year following treatment, patients who had received a very-low-calorie diet regained two-thirds of the weight that they had lost (9.5 kg of a 14.1 kg weight loss) resulting in a net weight loss of only 4.6 kg. Not a single patient

FIG 5. Weight changes during treatment and at 12-mo follow-up. From data in Wadden and Stunkard (8).
remained within 2 kg of her end-of-treatment weight while three patients exceeded their pre-treatment weight by ≥ 2 kg.

In contrast to the very-low-calorie diet, conservative treatment proved effective in both the short term and long term. Patients in this condition regained only one half as much weight as had patients who had received very-low-calorie diets alone, despite almost identical weight losses during treatment. At the 1-yr follow-up conservative-treatment patients had regained only one-third of the weight that they had lost during treatment (4.8 kg), yielding a net weight loss of 9.8 kg. Patients in the combined-treatment condition also regained one third of the weight that they had lost during treatment (6.8 kg of their 19.3 kg weight loss) for a net weight loss of 12.5 kg. As a result of these differences in rate of weight regain, there was no longer a statistically significant difference between the net weight losses of patients in the conservative-treatment and combined-treatment conditions. The weight losses in the combined-treatment condition, however, were significantly greater than those of patients on the very-low-calorie diet alone.

Once again conservative treatment performed relatively effectively over both the short term and the long term and significantly better than another more radical treatment.

The issue of cost effectiveness

The usefulness of a treatment program involves not only its effectiveness but also the costs that it incurs. Even an effective treatment will be of only limited usefulness if its costs exceed its benefits. In recent years this issue has been approached by considering both the costs and the effectiveness of a treatment. A cost-effectiveness analysis of the treatment of obesity is facilitated by the availability of easily measured indices: the extent of weight loss and the cost of treatment. The resulting ratio permits a comparison among the three treatments assessed in this study. In this comparison, for the reasons noted above, we utilized the cost to lose 1% body weight, approximately the weight lost during one week of conservative treatment.

Assessment of the three treatment conditions in this study revealed comparable cost-effectiveness ratios for the period of treatment. The cost to lose 1% of body weight was $19.62 for conservative treatment, $28.30 for very-low-calorie diet, and $26.02 for the combined treatment. One year later, however, the differences in the regain of body weight among the three treatments resulted in a vastly different picture. At this time the cost for the conservative- and combined-treatment conditions had risen to $29.52 and $38.94, respectively. Because of the large regain in weight of patients who had received the very-low-calorie diet alone, however, the cost to lose 1% of body weight that was retained for 1 yr had risen to $84.84. These values compare favorably with those of other treatment programs (9) and show that conservative treatment compares favorably with other professionally administered treatment programs for obesity.

Commercial opportunities

The time seems ripe for aggressive commercial exploitation of the opportunities provided by conservative treatment for obesity. Most of the information necessary for appraising the feasibility of a commercial program is already available: a standardized treatment program that can be delivered in large part by nonprofessional personnel, the approximate results to be obtained, and an estimate of the costs. The availability of at least preliminary cost-effectiveness assessments provides a useful management tool for the evaluation of alternative strategies.

The potential financial benefits of treating obesity have not entirely escaped the attention of industry. There is already a thriving network of lay-led weight-reduction programs. The potential of these programs is indicated by the remarkably favorable cost-effectiveness ratio of one of them. The study by Yates (9) developed data which, updated for inflation so as to make it comparable to the data of Wadden and Stunkard (8), revealed a cost of $7.31 to lost 1% body weight. Clearly these programs have the potential of providing treatment that is more economical than traditional medical treatment. Unfortunately, so far they do not.

Figure 6 shows the reason why: people simply do not remain in treatment.
A critical problem in all treatment and one which has plagued treatment for obesity in the past is the high rate of dropout of patients entering these programs. Commercial programs are unusually susceptible to this problem. Although no commercial organization has yet released information on dropouts, recent reports on commercial programs by neutral observers indicate the severity of the problem.

An example is the study by Volkmar et al. (10), who studied 100 women enrolled in a well-known commercial weight-reduction program. No less than 50% dropped out within 6 wk and 70% within 12 wk. The results of this study together with those of other commercial weight-reduction programs are illustrated in Figure 6. Note the similarity in the attrition rates encountered in programs with different procedures and different populations conducted on three continents. Dropout rates of this magnitude make it impossible to assess the effectiveness of these programs and suggest that it is limited at best.

The pressing need for the widespread delivery of effective treatment for obesity suggests a magnificent opportunity for industry. Here is a chance to utilize the latest scientific findings to establish effective programs for the widespread delivery of conservative treatment for obesity. There would appear to be an important place for industries such as the pharmaceutical industry, which have confined their activities to the development of products, to enter the field of service delivery. By bringing to it their tradition of research and development, which has so far been absent from commercial ventures, they could advance the treatment of obesity and their own interests at the same time, doing well by doing good.

A representative program of conservative treatment of obesity

Conservative treatments for obesity involve seven elements: 1) self-monitoring, or keeping records of the behavior to be changed; 2) control of the stimuli that precede eating; 3) development of techniques to control the act of eating; 4) reinforcement of the prescribed behaviors; 5) cognitive restructuring; 6) nutrition education; and 7) increasing physical activity.

1) Self-monitoring

A key element in most conservative treatment programs is a diet diary in which patients keep careful records of the food they eat. Each time that they eat they write down precisely what the eat, how much, at what time of day, where they were, whom they were with, and how they felt. Many patients come to view this record keeping as the single most important part of the treatment program and it vastly increases their awareness of their eating behavior. Despite years of attention to their obesity, when they begin to keep records patients are often surprised at how much they eat and how varied are the circumstances which elicit their eating. There is a surprising degree of unanimity on the value of self-monitoring. The more specific the items monitored, the more effective the results. Just how specific the items may be is indicated by the example of a monitoring sheet illustrated in Figure 7.

2) Control of the stimuli that precede eating

A carefully kept diet diary soon begins to reveal to the patient the large number of circumstances that elicit her eating and overeating. Identification of these circumstances is the first step in controlling them and Table 1 lists a number of representative methods for the control of stimuli that have been found to elicit eating.

3) Development of techniques to control the act of eating

A number of techniques have been found useful in helping patients to decrease the speed of their eating, to become aware of the various components of the eating process, and to gain control over these components. A few representative measures are a) put fork down between mouthfuls, b) chew thoroughly before swallowing, c) prepare foods one portion at a time, d) leave some food on the plate, e) pause in the middle of the meal, and f) do nothing else while eating (ie, read, watch television).

4) Reinforcement of the prescribed behaviors

In addition to the informal and incidental rewards that patients receive from a treatment program, a system of formal rewards facilitates their progress. Separating the reward schedules
FIG 6. Life table of participants in six treatment programs showing dropout rate during first year of membership. All three conditions of the study by Volkmar et al, Y-USA; another American group, X-USA; Weight Watchers, Australia, WW-AUS; Silhouette Slimming Club, UK, Sil-UK; and Weight Watchers, UK, WW-UK. From Volkmar et al (10).

for changes in behavior from those for weight loss is useful; rewards for changing behavior are more prompt and appear to be more effective. In treatment sessions patients are helped to learn how to obtain rewards for their changed behavior by learning to a) solicit help from family and friends, b) help family and friends provide this help in the form of praise and material rewards, c) utilize self-monitoring records as basis for rewards, and d) plan specific rewards for specific behaviors.

5) Nutrition education

Nutrition education plays an important part in conservative treatments for obesity. Despite their preoccupation with food, many obese persons have little solid information about nutrition and they are particularly vulnerable to the fanciful notions that pervade the media.

A discussion of dietary treatment could easily fill a volume but the general principle is simple: any diet that reduces caloric intake
FIG 7. Food diary for first week of a behavioral weight-reduction program. Patients record information on index cards during the day and transfer information to the record each evening. From Stunkard (11).

below caloric expenditure will produce weight loss. In this sense all treatments for obesity are dietary, but diets today have become far more than simply a means of producing a caloric deficit. They have acquired all manner of magical properties in the minds of the lay public. How does one make a rational choice among them?

Perhaps one should not choose. The whole idea of dieting may, for mildly overweight persons, at least, be unwise. Going on a diet implies going off it and resuming old eating habits. For this reason, the most effective diet may not be a diet in the traditional sense at all but rather a gradual change to foods that the patient can continue to eat indefinitely. This means increasing the intake of complex carbohydrates, particularly fruits, vegetables, and cereals, and decreasing the intake of fats. Such a course of action probably gives the best chance of maintaining the weight that is lost and it is an eminently safe one. A diet that
TABLE 1
Stimulus control

A. Shopping
1. Shop for food after eating
2. Shop from a list
3. Avoid ready-to-eat foods
4. Don't carry more cash than you need for shopping

B. Plans
1. Plan to limit food intake
2. Substitute exercise for snacking
3. Eat meals and snacks at scheduled times
4. Don't accept food offered by others

C. Activities
1. Store food out of sight
2. Keep all food out of sight
3. Remove food from inappropriate storage areas in the house
4. Keep serving dishes off the table
5. Use smaller dishes
6. Avoid being the food server
7. Leave the table immediately after eating
8. Don't save leftovers

D. Holidays and parties
1. Drink fewer alcoholic beverages
2. Plan eating habits before parties
3. Eat a low-calorie snack before parties
4. Practice polite ways to decline food
5. Don't get discouraged by an occasional setback

6) Increasing physical activity

An exercise component is incorporated into most current weight-reduction programs. Although increased physical activity contributes only marginally to weight loss, part of the problem is an increase in muscle mass that partly compensates for the decrease in body fat. A better reason for increasing physical activity is the clinical impression that persons who continue an increased level of physical activity maintain weight loss better than those who discontinue it.

Methods of increasing the physical activity of obese persons are still relatively primitive. An attempt is made to help patients monitor their physical activity by the use of records or of mechanical pedometers. Once the level of physical activity is being monitored, behavioral measures are used to increase this level. It is important to begin slowly, so that patients do not repeat their all-too-frequent experience of failure. For this reason, programmed activities and sports are not the first choice. Instead, life-style activities are encouraged: getting off the bus a stop too soon or a stop too late, parking the car some distance from one’s destination, using the stairs instead of the elevators, in short, any means of wasting energy that appeals to the patient. Even modest increases in physical activity have a salutary effect upon patient morale and this may be the single most important benefit of such efforts.

7) Cognitive restructuring

The first step in applying cognitive strategies to weight control is to help persons to become aware of the maladaptive monologues that occupy much of their time and to develop strategies to modify them. The pessimism of most obese persons about their ability to control their weight is frequently exemplified and perhaps even sustained by this type of maladaptive monologue. During treatment patients are helped to discover their most common negative cognitions and then are taught arguments against them. Because negative cognitions tend to be stereotyped and limited in number, the process is not as difficult as it might seem. Furthermore, simply repeating the counterarguments over a period of time may help, even if the person does not completely believe them at the outset. And with repetition often comes a measure of belief. Some examples of negative cognitions with illustrative counterarguments are:

Weight loss. “It’s taking so long to lose weight.” Counterargument: “But I am losing it. And this time I am going to learn how to keep it off.”

Ability to lose weight. “I’ve never done it before. Why should I succeed this time?” Counterargument: “There always has to be a first time. And this time I’ve got a good new program to help me.”

Goals. “I’ve simply got to stop snacking!” Counterargument: “That is an unrealistic goal. Just keep on trying to cut down the number of snacks.”

Food thoughts. “I keep finding myself thinking about how good chocolate tastes.”

consists primarily of sensible eating habits does not require medical monitoring and is particularly well suited to treatment programs that make extensive use of lay personnel.
Counterargument: "Stop that! It's just frustrating you. Think about lying on the beach in the sun" (or whatever activity the patient finds enjoyable).

**Excuses.** "Everyone in my family has a weight problem. It's in my genes." Counterargument: "That just makes it harder, not impossible. If I stick with this program, I will succeed."

**References**