Comparative study of three weight loss programs use different methods of motivation.

Presented at the 5th International Congress on Obesity, held in Jerusalem, Israel, October 1986 by Dr. Maurice Larocque MD.

Over the years it has become generally accepted that the treatment of obesity will always follow a yo-yo course. Treatments based on behavior modification, begun in the 60's and 70's, represent the first attempt to break the syndrome. This approach finds its origins in the work of Pavlov on conditioned response. The principles of the "behavioral" school rest on the following premises: patterns of human behavior are acquired by repetition; they can, therefore, be unlearned or replaced.

In the 70's, we put together a complete group treatment program run by a team that included a psychologist and a dietician. The participants were enthusiastic, but average weight loss was disappointing, and less than 10% of our regular patients were motivated to join the groups.

It became apparent that, if we could "weigh" what was going on in our patient's heads and identify blockages, we could treat the causes of their problems and thereby achieve much more satisfactory results.

To help us do this, we created two computer programs: Bert and Liza. In order to work efficiently in a clinical setting, the programs had to be user friendly, quick (no more than 15 minutes) and easy to interpret.

The first program, Bert, "weighs" the patient's mental attitude. It's a new concept. It analyses data and assigns a value to reflect the patient's behavior with regard t o food: habits, motivation, physical symptoms of stress, emotions and personality. The ideal *Mental Weight*® program results should be the same as the ideal weight, in order to maintain it easily. Patients may take the Bert monthly and monitor their behavior in the same way they use a scale to monitor their weight. Since 1982, 20,000 tests have been done.

In addition, Bert provides the therapist with a wealth of useful information: eating HABITS (physical activity, the use of food as reward, bulimia); MOTIVATION with reference to reaching and maintaining ideal weight; STRESS symptoms; EMOTIONS (perfectionism, dramatization, guilt, assertiveness, signs of depression); PERSONALITY (goals, self-esteem, passivity, aggressiveness). These data are quantified on a scale and may be compared to determine the most significant factors. The variations within each can also be monitored on a monthly basis. Bert, then, allows for a quick evaluation of the problem and of the methods appropriate to its treatment. It also allows the therapist to motivate patients from month to month by showing them that changes are occurring not only in their bodies, but also in their attitudes.

Liza, the other computer questionnaire, serves to identify motivation blockages contributing to the weight problem. It can identify more than twenty possible blockages and place them on a scale according to the probability of their being a factor (sexual blockages, fear of success, fear of failure, guilt, self-punishment, emotional stress, loss of contact with one's body, etc.).

Liza also provides information as to the experiences that lie at the root of a patient's blockages (education, relationship with parents, personal failures, social status, etc.). After some 2,000 patients had benefited from the program, we decided to test its effectiveness. We went back to our charts and chose as subjects of this study all new patients who met the following criteria:

- women between the ages of 20 and 60,
- in good general health,
- at least 40 lb. (18 kg) overweight,
- on the same low calorie diet (600-800 Kcal) completed with protein supplements,

- with at least one follow-up visit,
- under the care of the same doctor.

These women were then split into three groups: Group O:
21 patients who underwent no motivation treatment beyond visits to the doctor.

Group MP:
19 patients who underwent a minimum of our motivation program, i.e. Bert at least once and had read at least one motivational book.

Group BT:
10 patients who had taken part in our group behavior therapy and who fulfilled the other criteria.

Over the 16 week period of the study, the results were as follows:

· Average weight loss:
- Group O: 14.3 lb.
- Group MP: 27.7 lb.
- Group BT: 20.3 lb.

· Drop-out rate within the first month:
- Group O: 42%
- Group MP: 4.7%
- Group BT: 0%

· Average number of weeks on diet:
- Group O: 9 weeks.
- Group MP: 12 weeks.
- Group BT: 15.3 weeks.

· Number of patients who completed the 16 weeks:
- Group O: 23.8%
- Group MP: 52%
- Group BT: 80%

· Average weight loss among those who lasted 16 weeks:
- Group O: 21.2 lb.
- Group MP: 40.1 lb.
- Group BT: 22.5 lb.

The first conclusion one can draw from these results is that those who followed our motivation program lost twice as much weight as those in the other two groups.

Group therapy patients are more determined and less prone to give up in spite of lower initial weight loss.

The results also suggest that if we could combine group therapy and our motivation program, we could expect a higher level of success.

Our experience over the last few years has shown that it is rather difficult to put together homogeneous groups interested in undergoing group therapy. Fewer than 10% of our patients expressed an interest in groups.

Finally, in comparing the results of our program to those of simple consultations with the attending doctor, we note twice the weight loss, 30% more motivation, one tenth the drop-out rate in the first month and more than twice the number of patients who completed the 16 weeks.

I can hear skeptics suggesting that while the results of our motivation program may be encouraging over 16 weeks, it would probably have little effect after two years.

I see the treatment of obesity a little like the treatment of high blood pressure. If one of your patients stops taking his blood pressure medication, and his pressure begins to rise, are you going to tell the patient to forget about the medication, or are you going to say that the control of blood pressure is lifetime commitment that requires the regular use of medication?

In order to help long term patients maintain weight loss and remain motivated, we have provided them with long term motivation tools they can use at home (books, documents, audio and video cassettes).

Motivation is exactly like physical conditioning. A person who wants to stay in shape has to work out regularly at least three times a week. Motivational work-outs consist in repeating positive messages to oneself, reading positive books, listening to and watching positive programs and surrounding oneself with positive people and positive thoughts

Over the years it has become generally accepted that the treatment of obesity will always follow a yo-yo course. Behavior therapy has brought a slight improvement. A motivation program, based on the use of the computer to assess the *Mental Weight*® program, has shown very interesting short-term results. Motivation is the key to maintaining weight loss. Remember that we are not born motivated, we are born crying. Motivation must be acquired and maintained. Encourage your patients to work out on a regular basis, both physically and motivationally.