



Conceptual Articles

Acceptance and Commitment Therapy for weight control: Model, evidence, and future directions



Jason Lillis*, Kathleen E. Kendra

The Miriam Hospital, Brown Medical School, Weight Control and Diabetes Research Center, 196 Richmond Street Providence, RI 02903, USA

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ABSTRACT

Behavioral weight loss programs achieve substantial short-term weight loss; however attrition and poor weight loss maintenance remain significant problems. Recently, Acceptance and Commitment Therapy (ACT) has been used in an attempt to improve long-term outcomes. This conceptual article outlines the standard behavioral and ACT approach to weight control, discusses potential benefits and obstacles to combining approaches, briefly reviews current ACT for weight control outcome research, and highlights significant empirical questions that remain. The current evidence suggests that ACT could be useful as an add-on treatment, or in a combined format, for improving long-term weight loss outcomes. Larger studies with longer follow-up are needed as well as studies that aim to identify how best to combine standard treatments and ACT and also who would benefit most from these approaches.

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1. Introduction

Behavioral weight loss programs, which include diet and exercise recommendations supplemented by basic behavioral therapy skills training, are effective at producing an average weight loss of 8–10% over 6 months (Butryn, Webb, & Wadden, 2011; Wadden, Butryn, & Wilson, 2007). However participants regain about a third of lost weight within the first year, and by 5 years more than half of participants have returned to or exceeded their baseline weight (Butryn et al., 2011; Jeffery et al., 2000; Perri, 1998). Furthermore, despite often rigorous screening methods, clinical trials show attrition rates above 30% (e.g. Honas, Early, Frederickson, & O'Brien, 2003; Teixeira et al., 2004).

Treatment innovation has been lacking. The primary approach to improving effectiveness has been to extend the length of treatment, which seems to only delay weight regain (Middleton, Patidar, & Perri, 2012; Perri, Nezu, Patti, & McCann, 1989). Another approach has been to study successful maintainers and recommend strategies that they use (e.g. Klem, Wing, McGuire, Seagle, & Hill, 1997); however studying successful maintainers has not resulted in improved long-term effectiveness of, or adherence to, behavioral weight loss interventions.

Predictors of attrition include binge eating, psychological distress, body-image dissatisfaction, and poor quality of life (Teixeira et al., 2004). Risk factors for weight regain include psycho-social stressors, disinhibition, emotional or stress eating, depression, and feelings of food-related deprivation (Elfhag & Rossner, 2005; Wing & Phelan, 2005). Broadly speaking, coping with difficult or

unwanted cognitive and emotional experiences seems to play a vital role in predicting long-term weight loss success.

Recent developments in mindfulness and acceptance-based interventions provide a potential avenue for treatment development. Often referred to as third-generation behavioral approaches, mindfulness and acceptance-based interventions seek to change one's relationship to unwanted thoughts, feelings, or bodily sensations, as opposed to trying to change or control them (Hayes, 2004). Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) is one of the most widely used third generation interventions and is empirically supported for a range of psychological and behavioral problems, including anxiety, depression, chronic pain, and smoking cessation, among others (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). Third generation interventions have been growing in popularity and have broad empirical support (e.g. Hayes, Masuda, Bissett, Luoma, & Guerrero, 2004); however weight control interventions have been slow to adopt these newer methods.

In this article we make a case for using ACT in weight control interventions. We compare and contrast the standard behavioral and ACT approaches to weight control, and discuss the relative fit of the two approaches as well as barriers to integration. Finally, we identify research questions that need to be answered in order to better understand if, and to what degree, ACT processes can contribute to better long-term weight control.

2. The standard behavioral approach to weight control

The model for standard behavioral treatment (SBT) for obesity stems from Learning Theory, which suggests that a behavior can be modified by altering the context in which it occurs (i.e. changing the

* Corresponding author. Tel.: +1 401 793 8375.

E-mail address: Jasonlillis22@gmail.com (J. Lillis).

antecedents or consequences of a behavior of interest; Wing, 1998). SBT aims to reduce maladaptive behaviors (e.g. high calorie diet; sedentary behavior) and replace with and reinforce healthy behaviors (e.g. reduced calorie diet; exercise) by teaching a variety of first generation behavior therapy techniques (Butryn et al., 2011; Wing, 1998).

Two major components of SBT are self monitoring and goal setting, which are intended to help the individual adhere to caloric targets, exercise regimens, and regular weighing. Individuals are given eating, exercise, and weight loss goals and taught to monitor progress. Guidelines for generating new goals are also taught.

Another component of SBT is stimulus control, or changing cues in the environment to make healthy behavior more likely to occur. For example, to decrease the potential for an overeating episode, one may choose to limit the portion size that is available (e.g. by buying one cookie at the store versus a large package). In turn, to increase the possibility of exercise, one could keep their workout clothes in their car to ensure they are available immediately after work.

Finally, SBT utilizes cognitive interventions (often referred to as second generation behavioral strategies). These strategies are designed to help the individual identify typical cognitive and emotional triggers for eating and sedentary behavior, learn to challenge their maladaptive thoughts, and modify problematic emotional states in order to engage in behaviors consistent with their weight loss goals. For example, thought stopping is taught to deal with food cravings, and stress reduction methods (e.g. non-food self-soothing) are utilized to combat emotional eating.

The overall philosophy of SBT is best described as “skills based.” Treatment delivery is psychoeducational and topics are often presented as stand-alone modules, usually in group-based settings. Goals are provided to clients. For example, the caloric intake goal and initial weight loss goal (usually 10% of initial body weight) is typically determined by the client’s starting weight. The treatment is narrowly focused on the goal of weight loss, and topics are discussed in the context of how they relate directly to reducing caloric intake or increasing physical activity. The primary target is to build well-trained habits that become part of regular, daily activities. For example, weighing oneself is often likened to brushing teeth—it should be done at the same time in the morning upon waking, so there is no need to remember to do it later.

3. The ACT approach to weight control

ACT comes from the same tradition as SBT, with a shared focus on modifying behavior by changing the context in which it occurs. While both approaches aim to foster engagement in healthier behavior, ACT makes different assumptions about the etiology of behaviors that contribute to obesity, and thus focuses on different mechanisms in treatment.

ACT methods are based on Relational Frame Theory (RFT; Hayes, Barnes-Holmes, & Roche, 2001), a basic science model of language and cognition. RFT research has shown that the natural and normal use of language can have a number of maladaptive consequences. A full treatment of RFT and its relationship to ACT methods is outside the scope of this manuscript; however we will briefly summarize relevant findings here (for full treatments of RFT theory and empirical evidence, see Barnes-Holmes, Hayes, Barnes-Holmes, & Roche, 2001; Dymond & Roche, 2013).

Language makes psychological pain possible in the absence of a painful stimulus. For example, the memory (a verbal construct) of being ridiculed because of your body shape can be just as painful as any instance of ridicule. Psychological pain can also be triggered by virtually anything, because language is an arbitrarily applied ability. Thus stepping on a scale can occasion painful thoughts and

feelings about one’s weight, even though no direct aversive consequences are present in the moment.

Given the natural human tendency to avoid pain, private experiences themselves can become targets of avoidance. For example, someone might avoid going swimming because getting into the swimming pool could occasion anxiety, fear of judgment from others, feeling “disgusting,” and self-criticism. This is referred to as experiential avoidance, or the tendency to try to change, control, or escape from unwanted thoughts, feelings, or bodily sensations when doing so causes harm (Hayes et al., 2004).

Experiential avoidance is a common core process that contributes to a broad range of mental and behavioral health problems (Hayes et al., 2006; Hayes et al., 2004), and preliminary evidence suggests it is relevant to weight control (Forman et al., 2007; Hooper, Sandoz, Ashton, Clarke, & McHugh, 2012; Lillis, Hayes, Bunting, & Masuda, 2009). This makes logical sense, as experientially avoidant moves are often toxic to weight control. Emotional or stress eating tends to function in part to reduce or change negative affect (Macht, 2008). Furthermore if someone is feeling shame after overeating, one way to try to avoid additional shame is to refrain from dieting and recording calories all together, so as not to be reminded of a “diet failure.”

ACT uses acceptance, mindfulness, and values processes to produce psychological flexibility, or the ability to take values-based action in the presence of unwanted thoughts, feelings, and bodily sensations. In the context of weight control, ACT seeks to promote healthy behavioral patterns consistent with stated values, while teaching mindfulness and acceptance skills to increase behavioral commitment to values-based behavior.

4. Differences between ACT and SBT

One of the differences between ACT and SBT is that ACT does not supply a priori goals to treatment. In SBT, the overarching treatment goal is to lose weight or prevent weight gain. In ACT, the overarching treatment goal is effective living, defined as behaving consistent with one’s personal values. The individual in treatment defines the values. From an ACT perspective, values are desired qualities of action, and thus weight loss itself cannot be a value. However healthy living often relates to the ability to engage in desired activities, set a positive example for family members, or live longer to continue to participate in valued relationships, and weight loss can be one pathway to these valued ends. Thus, in ACT, weight loss is situated broadly into values-based living across a variety of domains (e.g. relationships, health, work, and recreation).

Given this, ACT places greater emphasis on internally-based motivation. In SBT, it is acceptable to lose weight in an attempt to stop feeling bad about how you look, or to try to increase your self-confidence, or to avoid potential disease in the future. In ACT, clients would be encouraged to find appetitive, non-avoidant forms of motivation. For example, if an individual wanted more self-confidence, she might be asked what behaviors she would engage in if she was more self-confident (e.g. seek a new job, be intimate with her partner, go dancing). Treatment would be organized around these values-based actions and would focus on getting her to engage in these desired activities now, as opposed to waiting for her body shape to change.

Another difference between ACT and SBT is that, generally speaking, ACT emphasizes the function more than the topography of behavior. For example, if an individual did not exercise in the past week, an SBT approach would utilize direct problem-solving. The interventionist might brainstorm alternative times to exercise (morning vs. night), identify strategies to make working out easier (take your gym clothes to work and change there), or help with

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