

## New Year Diets Explored: The Good, The Bad and The Ugly

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**Happy New Year! And welcome to the next round of diet mania. Dietitian Lyndel Costain delves into the evidence to discover which diets offer hope rather than hype, which if any can be recommended to your patients and practical tips on how to help your patients lose weight safely and keep it off.**

A New Year. A new diet? As part of an annual £10 billion diet industry, we will be encouraged to eat coconut oil, detox, fast on alternate days, count points, syns or calories, calculate GI or GL, use meal replacements, combine certain foods, or banish candida and hypoglycaemia - the current bestseller! Designed to appeal to the 36% of women and 21% of men who report trying to lose weight - and the further 36% who are 'watching their weight' (1) - many come served with the alluring promise of quick, easy and lasting weight loss. But as health care professionals we know that weight loss is anything but and that frequent dieting is linked to reduced weight loss success (2).

### **Weight and health**

Obesity and overweight are a major cause of preventable health problems in the UK. Around two thirds of adults are now overweight, and 1 in 4 are obese (3, 4). Sustainable changes to diet and physical activity are the cornerstone of weight management but in our obesogenic (socially influenced, activity limiting and food-filled) environment these can be difficult (4).

A modest weight loss of 5 to 10% of body weight (around 5-10kg) can significantly improve health status (3, 4). However, weight loss is notoriously difficult to maintain with approximately half of initial weight loss typically regained after 3 years (5). Despite this, a sustained modest weight loss of 4kg over 4 years has been associated with 58% reduction in progression from impaired glucose tolerance to type 2 diabetes (6).

### **What does the evidence say about popular diets?**

***First of all forget the fads that claim to defy thermodynamics.*** There is no magic to weight loss. Any 'diet' promoting weight loss only 'works' because it helps people consume fewer calories than they expend (3, 4). Diets must also be nutritionally safe and help people make sustainable behaviour changes for longer term weight management.

### **Dietary change must be 'do-able'**

Adherence is more important than diet composition. The BBC 'diet trials' study (7) found that clinically useful weight loss can be achieved in adults who are able to follow commercial diets such as slimming groups or meal replacements for 6 months to one year. In two 12-month US studies (8, 9) comparing popular diets including Atkins diet (low carbohydrate), Weight Watchers, Ornish diet (very high carbohydrate) and the Zone diet (moderate carbohydrate), greatest weight losses (and generally improvements in metabolic risk factors) were achieved by participants who followed their assigned diet most carefully (8, 10). Average weight loss ranged from a modest, but clinically useful 2 to 5% of body weight.

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Sacks et al (11) found four diets with different macronutrient compositions all equally successful in promoting and maintaining clinically beneficial weight loss (4kg on average) over a 2 year period. Weight loss success was related to diet adherence and attendance at educational sessions. Behavioural factors rather than macronutrient metabolism were the main influencers to minimising regain and longer term success.

**Low glycaemic index (GI) and load (GL) diets** don't appear more effective for weight loss, weight control or satiety, than other similarly calorie-controlled diets (12, 13, 14). Generally based on sound nutrition principles they give an engaging twist to healthy eating.

**Low carbohydrate diets** (e.g. Atkins diet) suggest equal effectiveness as other dietary approaches over 2 years (7, 9, 15) due to reduced calorie intake and the satiating effect of protein (8, 9, 16). Their restrictiveness can be hard to maintain (8, 11, 16) and over-restricting nutritious and fibre-rich carbohydrate sources whilst promoting high fat intakes is not in line with sustainable and healthy eating recommendations (9, 16, 17). Diets with less carbohydrate restriction can be more acceptable and as effective (11).

**Food combining diets** involve not mixing carbohydrates and proteins at the same meal, and avoiding 'processed foods'. Be cautious of those restricting meat and dairy foods. There is no evidence that this approach aids weight loss over and above calorie restriction (18).

**Meal replacement** approaches are structured and calorie-controlled. They involve replacing two meals (one during maintenance) with nutritionally formulated shakes or bars, eating one balanced meal and planned snacks. Evidence supports their safety and efficacy over a year (7, 19), and up to four years (20).

A calorie-controlled **Mediterranean diet** has also been shown to be effective with favourable effects on metabolic risk factors, especially glycaemic control (15). A 1-year commercial programme (Jenny Craig) based on meal provision and individualised support, facilitated clinically beneficial weight loss (21).

Some studies tried to reflect experiences of people following diets by themselves. However, all participants had some level of health professional contact making it difficult to fully assess their 'real-life' efficacy. Most of the diets also recommend some level of physical activity.

### Do diets do more harm than good?

Concerns that weight cycling (yo-yo dieting) affects metabolic rate or body composition are not supported by evidence (22) although it can knock people's confidence in their ability to lose weight and is associated with less weight loss success (2). Studies don't generally support concerns that dieting induces eating disorders or other psychological dysfunction in overweight and obese adults. If desired, people should not be deterred from aiming for

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modest weight loss and preventing additional weight gain via lifestyle changes (23). Most people slowly gain weight year on year, so just stopping further gain through healthy eating and physical activity is a big achievement and can promote overall health (3).

The British Dietetic Association ([www.bda.uk.com/foodfacts](http://www.bda.uk.com/foodfacts)) provides guidance on how to spot diets which set unachievable goals without teaching the skills and confidence important for sustainable lifestyle changes. Be wary of diets which deny calories count, cut out or limit whole food groups, have no health professional expertise, focus on appearance benefits only or promise rapid, painless weight loss.

### What does NICE say?

NICE (3) offers guidance on different dietary options, when to consider linking with commercial programmes and when to progress on to more intensive treatments to facilitate the implementation of evidence-based care. No single dietary approach suits everyone.

In recognition of limited NHS resources and the role of the wider community in weight management, NICE advises that commercial, community or self-help programmes that meet 'best-practice standards' should be considered as an option for patients (see Table 1). Referring health professionals should also continue to monitor their patients and provide support and care (3).

### Summing up

Quick-fix diets, with unsound theories can undermine people's confidence as well as healthy weight control messages. They can also reinforce a mind set of being 'on a diet' that will do 'it' for them, rather than making realistic and sustained behaviour changes. If a diet, or weight loss pill, sounds to be good to be true – it is!

Studies show that popular dietary approaches which safely help people consume fewer calories than they expend can promote modest weight loss. However, in such studies, most weight tends to be lost in the first 6 months with customary macronutrient intakes reverted to, and some regain, over time. Nonetheless participants may learn enough behaviour changes to maintain a modest (for a few it may be greater) clinically beneficial level of weight loss (7-9, 11, 15).

Research suggests different weight loss approaches suit different people. Interestingly, a cluster of similar behaviours are associated with weight maintenance success (Table 2). Behavioural strategies such as goal setting, problem solving, enlisting support, self-monitoring, relapse prevention and personally developed flexible eating and activity plans appear more influential (8, 24, 25) for long term weight control than a diet's nutrient make-up.

In our current environment, people not devoting some level of daily conscious effort and choices towards managing body weight are likely to be gaining

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weight (26). Helping people to develop the skill of flexible restraint rather than rigid control over eating (and physical activity) - provides a structure to manage weight without the feelings of deprivation and rules which can trigger disinhibition e.g. overeating, loss of control and feelings of failure (2, 24, 27).

## Finally

There is nothing 'quick and easy' about weight management. The array of often confusing diet messages out there can make it tougher. We can provide a great service to our patients by helping them make better sense of popular diets, working in a patient-centred way and reminding them that their worth is not measured by weight loss success.

**Table 1**

### **Best Practice Guidance Commercial & Self-Help Weight Loss Programmes (3)**

- Help people assess their weight and decide on a realistic healthy target weight (usually aim to lose 5–10% of original weight)
- Aim for a maximum weekly weight loss of 0.5–1 kg
- Focus on long-term lifestyle changes rather than a short-term, quick-fix approach
- Be multi-component, addressing diet and activity with a variety of approaches
- Use a balanced, healthy-eating approach
- Recommend regular physical activity (particularly activities that can become part of daily life) and offer practical, safe advice about being more active
- Include some behaviour-change techniques, e.g. keeping a diary, advice on how to cope with 'lapses' and 'high-risk' situations
- Recommend and/or provide ongoing support

**Table 2**

### **Key behaviours of successful weight loss maintainers (23)**

- Eat breakfast
- Eat a lower fat, balanced diet
- Regularly check their weight, keep tabs on food intake
- Stay active e.g. walk for around 1 hour a day and limit TV
- Accept that weight management requires ongoing commitment

## References

1. Wardle J & Johnson F. *IJO* 2002; 26, 1144–1149.
2. Texeira PJ et al. *Int J Behav Nutr Phys Act.* 2004; 1 (1): 12.
3. NICE. Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children. NICE CG no 43. 2006. [www.nice.org.uk/guidance/CG43](http://www.nice.org.uk/guidance/CG43)
4. Healthy Weight, Healthy Lives: A toolkit for developing local strategies. London: National Heart Forum in association with the Faculty of Public Health and the Department of Health; 2008. [www.dh.gov.uk](http://www.dh.gov.uk)
5. Dansinger ML et al. *Ann Int Med.* 2007; 147, 41-50.
6. Diabetes Prevention Program Research Group. *N Engl J Med* 2002; 346: 393-403.
7. Truby H et al. *BMJ* 2006; 332: 1309-1314.

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8. Dansinger ML et al. *JAMA* 2005; 293(1):43-53.
9. Gardener CD et al. *JAMA* 2007; 297: 969-977.
10. Alhassan S et al. *Int J Obes*. 2008; 32(6):985-91.
11. Sacks FM et al. *JAMA* 2009; 360 (9):859-873.
12. Sloth B & Astrup A. *Int J Obes*. 2006; 30 Suppl 3:S47-51.
13. Aston LM, Stokes CS, Jebb SA. *Int J Obes*. 2008 ; 32(1): 160–165.
14. Das SK et al *AJCN* 2008; 85(4):1023-30.
15. Shai I et al. *NEJM* 2008; 359(3): 229-41.
16. Foreyt J et al. *Nutr Rev*. 67(Suppl. 1): S99–S101
17. Astrup A. Dietary management of obesity. *JPEN*. 2008; 32(5):575-7.
18. Golay A et al. *Int J of Obes Rel Met Dis*. 2000; 24 (4):492-6.
19. Heymsfield SB et al. *IJO* 2003; 27: 537-549.
20. Flechtner-Mors M et al. *Obes Res* 2000; 8: 399-402.
21. Rock CL et al. *Obesity* 2007; 15 (4) :939-49.
22. National Task Force on the Prevention and Treatment of Obesity. *JAMA*. 1994; 272 (15): 1196-202.
23. National Task Force on the Prevention and Treatment of Obesity. *Arch Intern Med*. 2000;160 (17):2581-9.
24. National Weight Control Registry research findings. [www.nwcr.ws/Research](http://www.nwcr.ws/Research)
25. Westenhoefer J. *Int J Obes Relat Metab Disord*. 2001; 25 Suppl 1:S85-8.
26. Peters JC et al. *Obes Rev*. 2002, 3: 69–74.
27. Dalle Grave R et al. *JADA*. 2009; 109 (12), 2010-2016.