

Obesity Related Eating Behaviors and Weight Loss Maintenance.

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Abstract

Background: This study examined the differences between maintainers and regainers regarding obesity related eating behaviors. A secondary objective was to develop an eating behavior index predicting the likelihood of successful weight loss maintenance.

Methods: The current cross-sectional evaluation was based on the Cypriot cohort of the MedWeight study (Greece). Eligible participants (maintainers=145; regainers=87) were adult men and women who reported being at least overweight (BMI ≥ 25 kg/m²) and experienced an intentional weight loss of $\geq 10\%$ of their maximum weight, at least 1 year before participation. Among other assessments, obesity-related behaviors were evaluated through a Healthy Eating Behavior Index (HEBI).

Results: Statistically significant differences between the two groups were observed regarding meals per day (P=0.008), frequency of eating home cooked meals (P=0.004) and HEBI total score (P=0.022). Results from logistic regression models indicated that the odds of maintaining weight loss increase at 23% (Model 1: P<0.05, OR 1.230, 1.062-1.424 95% C.I., Model 2: P<0.05, OR 1.233, 1.064-1.428 95% C.I.) and to almost 30% after adjusting for physical activity (Model 3: P<0.05, OR 1.293, 1.077-1.552 95% C.I.) for each point scored in HEBI total score.

Conclusions: Eating more frequently home cooked meals and less eating away from home meals may be beneficially associated with weight loss maintenance. HEBI seems as a useful tool when dealing with patients who have previously lost significant weight.

Background

Weight loss maintenance has become the greatest challenge in the management of obesity. Despite the fact that many people manage to lose weight, the percentage of those who succeed to maintain this loss remains low [1, 2]. There is currently no consensus on the definition of weight loss maintenance in adults. Some studies proposed a definition of intentional weight loss and maintenance for at least 6 months [3], while others proposed a definition of weight loss $\geq 5\%$ of initial loss and maintenance for at least 1 year [4]. Achieving an intentional loss of $\geq 10\%$ of maximum body weight and maintaining it for ≥ 1 year is the most widely used description of successful weight loss maintenance [5, 6], and based on it, $\geq 20\%$ of at least overweight individuals who had previously lost weight manage to maintain a significant amount of weight loss [6–10].

Registries of individuals with successful long term weight loss have been developed worldwide to explore factors leading or related to successful maintenance of weight loss [6, 11–14]. Notably, data within these registries include information on socioeconomic background, medical history of individuals as well as data related to individuals' lifestyle such as sleep, physical activity and dietary patterns. In particular, higher levels of physical activity, regular monitoring of diet and body weight were the most frequently reported factors [4, 15–18]. In relation to the diet, several studies have examined specific nutrients, foods or dietary schemes as potential factors affecting weight loss maintenance; however, none of these

studies has managed to identify a single nutrient, food or even a specific dietary scheme as the most effective [19].

Recent guidelines related to the management of overweight and obesity refer to the importance of incorporating behavioral techniques into various obesity treatment interventions and promote healthy eating related behaviors [20, 21]. Findings from Weight Control Registries support that reducing energy intake by high frequency of self-weighing and regular meal frequency may promote weight loss maintenance [14]. In addition, it is apparent that individuals who maintain their weight report the use of more behavioral techniques [16, 22]. However, evidence supporting the use of specific eating or obesity related behaviors that promote weight loss maintenance of overweight or obese individuals, who have previously lost significant weight, is scarce [14, 16, 22].

The current study aimed to explore differences in eating related behaviors between maintainers and regainers enrolled in the MedWeight control registry in Cyprus. Moreover, another aim was to develop an eating behavior index predicting the likelihood of weight loss maintenance which could be used as a simple target tool by the Health Care Professionals to monitor weight loss maintenance.

Methods

Study population

The present cross-sectional evaluation is based on the Cypriot cohort of the MedWeight study, a registry of weight loss maintainers and regainers [11]. Eligible for participation in the registry were adult men and women aged 18–65 years of Cypriot ethnicity, who reported being at least overweight (Body Mass Index $\geq 25 \text{ kg/m}^2$) and experienced an intentional weight loss of $\geq 10\%$ of their maximum weight, at least 1 year before participation in the study. Each participant was classified as “maintainer” if his/her current weight was $\leq 90\%$ of his/her maximum weight or “regainer” if his/her current weight was $\geq 95\%$ of his/her maximum weight. Participants who had a current weight between 91% and 94% of their maximum weight were excluded so as to avoid overlapping between the two groups.

This study was conducted according to the guidelines laid down in the Declaration of Helsinki and the study protocol was approved by the National Bioethics Committee. The recruitment procedure held for two years (2/2018-2/2020) and it was communicated through press releases, advertisements in tv, radio and social media. All eligible participants signed the consent form prior participation to the study and were then advised to access a website platform (<http://medweight.hua.gr>) to fill in a series of questionnaires. In specific, volunteers were asked to report socio-demographic status such as marital status (single, married/cohabitating, divorced, widowed, then coded for married/cohabitating or not), occupational status (employed or not) and years of education. Eligible volunteers were asked to report physical/personal characteristics such as sex, age, weight, height, BMI, maximum weight, maximum BMI, initial loss, maintenance loss and duration of maintenance.

Assessment of dietary intake

Two telephone 24-h dietary recalls were conducted for each participant in order to assess dietary intake [23]. The recalls were performed by two well-trained dietitians within the period of 10 days for each participant, with weekdays and weekends proportionately represented among participants. Using the multiple-pass method, dietitians asked for all foods and beverages consumed the previous day [24, 25]. Dietitians were blinded regarding the participant's maintenance status. All data were analyzed in terms of total daily energy intake by using the dietary analysis software SNPRO Nutrition Software (Cheapsoft Softwares, 2017).

Assessment of obesity-related behaviors and development of the Healthy Eating Behavior Index (HEBI)

The frequency of obesity-related eating behaviors was also assessed. We selected specific behaviors that have been previously reported to be associated either with weight loss and/or weight loss maintenance [26–33]. In specific, participants were asked about the frequency of eating out, eating with others, eating breakfast (rarely/never, 1–3 times per month, 3–6 times per week, daily, more than twice a day), the number of meals per day (1–3 meals, 4–5 meals or ≥ 6 meals per day), the number of main meals per day (1–3 main meals per day) and eating visible fat or meat skin (almost all, part of or none). Moreover, other questions related to food supplements (yes or no), eating rate (very fast, fast, medium, slow, very slow), food preparation (yes or no), person responsible for food preparation (mostly you or mostly others) and eating home-cooked meals (almost never, sometimes, often, almost always) were also included.

The eating behavior responses were collectively evaluated through the Healthy Eating Behavior Index (HEBI), a simple to understand and easy to use index developed specifically for the current study. This index consisted of 10 variables as listed above; 9 of these variables were related to eating behaviors and 1 variable was related to the frequency of self-weight measurement. In particular, the variables used for the development of the index were: eating out, eating with others and eating breakfast frequency, meals per day, main meals per day, eating rate, time spend on food preparation, responsible for food preparation, eating home cooked meals frequency and self-weighing frequency. The variables were then coded to dichotomous types. Each variable was scored with 0 or 1 (0 indicates less healthy behavior and 1 indicates more healthy behavior). The scoring system allowed the development of more distinct categories for each variable of the final index. As an example, for the eating out frequency, rarely/never and 1–3 times per month were coded to 1 and 3–6 times per week, daily or more than twice a day were coded to 0. The score range is 0–10: the higher the score is the more the individual is engaged to a behavior that it is not expected to promote weight loss maintenance.

Assessment of physical activity

The short version of the International Physical Activity Questionnaire (IPAQ) validated for the Greek population was used to assess physical activity [34]. Participants were asked to report high, intermediate and low intensity activities lasting ≥ 10 min, as well as sedentary activity and time spent during these activities on a weekly basis.

Statistics

Using Q-Q plots we explored normality of distribution of data. Normally distributed values were presented as means and standard deviation (SD), non-normally distributed values as medians and interquartile range (IQR) and data from categorical variables as frequencies (in percentage). We explored differences between maintenance status in participants' characteristics using independent t test or Mann Whitney rank tests, depending on the normality of the data, and chi-square tests for categorical variables. Differences between maintainers and regainers were tested by logistic regression models for categorical variables (results were expressed as odds ratio [95% confidence interval]).

Logistic regression models were performed using maintenance status as a dependent variable and HEBI total score as independent variables: Model 1 was adjusted for age, sex, and marital status (married or not); Model 2 was additionally adjusted for energy intake; Model 3 was additionally adjusted for physical activity (IPAQ total Met-minutes per week). Data analysis was carried out using SPSS Statistics 22.0; a P-value of 0.05 was considered statistically significant.

Results

Table 1 (*placed at the end*) presents the characteristics of all the participants enrolled in the study, based on their weight maintenance status. In particular, 232 men and women enrolled in this study of which 145 were maintainers and 87 regainers. Concerning the total sample, 52.2% were women, 29.7% married and most of them employed (60.2%). Regainers were older than maintainers (37.3 ± 14.4 years vs 33.0 ± 12.2 years, $P < 0.05$) and they also had less years of education (13.3 ± 4.2 years vs 15.1 ± 3.2 years, $P < 0.05$). Moreover, initial weight loss was significantly higher among the maintainers compared to regainers (26.7 ± 16.0 kg vs 15.4 ± 7.6 kg, $P < 0.05$) and maintainers reported maintaining this loss for over 3 years. Although maintainers reported a lower weight and BMI, their max weight, max BMI and initial weight loss was higher than regainers ($P < 0.05$ for all comparisons).

Table 1
PARTICIPANTS' CHARACTERISTICS (N = 232)

	Total (n = 232)	Maintainers (n = 145)	Regainers (n = 87)	P value
Sex (% female)	52.20	51.70	52.90	0.893
Marital status (% married)	29.70	33.10	41.40	0.396
Employment status (% employed)	60.20	69.40	72.90	0.524
Age (years)	34.61 (13.21)	33.00 (12.19)	37.29 (14.43)	0.022
Weight (kg)	82.41 (18.86)	77.61 (17.49)	90.43 (18.43)	0.001
BMI (kg/m ²)	28.67 (5.48)	26.90 (4.86)	31.60 (5.19)	0.001
Max weight (kg)	96.13 (22.10)	98.38 (23.61)	92.38 (18.83)	0.045
Max BMI (kg/m ²)	33.41 (6.13)	34.08 (6.45)	32.29 (5.40)	0.031
Initial loss (kg)	22.46 (14.52)	26.72 (15.96)	15.37 (7.62)	0.001
Weight loss maintained (%)		12.44 (12.66)		
Maintaining years		3.37 (3.14)		
Education years	14.45 (3.69)	15.11 (3.18)	13.31 (4.20)	0.002
Abbreviations: BMI: Body mass index, Statistically significant results are denoted in bold, Values are presented as mean (standard deviation) for quantitative variables and relative frequencies for qualitative variables.				

For the development of HEBI index, a conversion of the range of participants' responses was performed in order to simplify the responses of the final index based on the results of differences between the responses of two groups (Table 2) (*placed at the end*). Results after the development of the HEBI index showed statistically significant differences between the responses of two groups regarding the following obesity related eating behaviors: meals per day (P = 0.008), frequency of eating home cooked meals (P = 0.004) and frequency of eating out (P = 0.058). Although no statistically significant differences were observed regarding the other behaviors, their inclusion in the HEBI index was considered critical to provide a more comprehensive assessment of nutritional behavior, as described in other indexes or scores when assessing diet and other lifestyle factors.

Table 2
HEALTHY EATING BEHAVIOR INDEX (HEBI) SCORING SYSTEM AND FREQUENCIES OF RESPONSES

	Score (0/1)	Maintainers (%)	Regainers (%)	P value
Eating out frequency				
rarely/never	1	60	45.5	0.058
1–3 times per month				
3–6 per week	0	40	54.5	
daily				
more than twice a day				
Eating with others frequency				
rarely/never	0	71.3	62.1	0.203
1–3 times per month				
3–6 per week				
daily	1	28.7	37.9	
more than twice a day				
Eating breakfast frequency				
rarely/never	0	38.3	45.5	0.343
1–3 times per month				
3–6 per week				
daily	1	61.7	54.5	
Meals per day				
1–3 meals	0	74.8	90.9	0.008
4–5 meals				
≥ 6 meals	1	25.2	9.1	
Main meals per day				
1	0	34.8	42.4	0.307
2				
3	1	65.2	57.6	
Eating rate				

	Score (0/1)	Maintainers (%)	Regainers (%)	P value
very fast	0	38.3	47	0.252
fast				
medium	1	61.7	53	
slow				
very slow				
Time spend on food preparation				
≥ 1 hour	1	87.8	83.3	0.399
< 1 hour	0	12.2	16.7	
Responsible for food preparation				
mostly you	1	60.9	60.6	0.972
mostly others	0	39.1	39.4	
Eating home cooked meals frequency				
almost never	0	47.8	69.7	0.004
sometimes				
often				
almost always	1	52.2	30.3	
Weighing frequency				
daily	1	50.4	36.6	0.063
2–6 times per week				
weekly				
1–3 times per month	0	49.6	63.4	
a few times per year or never				
HEBI Max Total Score		5 (3–7)	4 (1–6)	0.022
Values are presented as median (IQR) or relative frequencies. Statistically significant results are denoted in bold.				

In regards to the HEBI total score, statistically significant results were observed between the two groups (P = 0.022). Notably, results from logistic regression models indicated that for every point scored in HEBI total score the odds of maintaining weight loss increase at 23% (Model 1: P < 0.05, Odds ratio 1.230,

1.062–1.424 95% Confidence interval., Model 2: $P < 0.05$, OR 1.233, 1.064–1.428 95% C.I.) and increase to almost 30% after adjusting for physical activity (Model 3: $P < 0.05$, OR 1.293, 1.077–1.552 95% C.I.).

Discussion

The current study aimed to examine the association between eating behaviors and weight loss maintenance among adults who had previously lost weight and maintained it or regained it. The main findings indicate that maintaining weight loss is associated with eating at least 6 meals per day and almost always eating home cooked meals. Hence, the HEBI total score was positively associated with weight loss maintenance, indicating that the HEBI index could be a useful tool for monitoring weight loss maintenance and/or as a guide for relevant nutrition counseling. Health care professionals need more practical tools to address weight management success. It was therefore considered wise to develop an index incorporating obesity related eating behaviours that could potentially affect weight loss maintenance. A more holistic approach which incorporates interactions of eating behaviors, such as the HEBI index, may produce many benefits of clinical research and practice than any other single variable. To our knowledge this is the first study to produce such a healthy eating behaviour index. Previous efforts regarding the development of similar tools were mostly based on foods or nutrients [35–37], and not on behaviors.

In relation to specific behaviors, our results indicated that maintainers reported having more meals per day than regainers. This is in line with the results of a previous study examining self-reported eating frequency of meals and snacks consumed per day in weight loss maintainers, normal weight and overweight individuals. Although there were no differences regarding participants' main meals per day, maintainers and normal weight individuals consumed more snacks than overweight individuals [38]. However, results from the National Weight Control Registry in the USA, highlighted that maintenance of weight loss could also be achieved by eating fewer meals, a behaviour reported mostly by older people [39]. However, findings regarding the effect of meal frequency in weight loss maintenance seem to be conflicting and a possible reason could be the fact that different definitions of "a meal" or "a snack" were used in various studies. For the purposes of the current study, we decided to choose eating ≥ 6 meals daily as the healthy behavior, due to reasons related with the inclusion of comparison groups and distinct definition of meal/snack reported by previous study [38].

Findings of the current study also agree with previous findings in relation to the frequency of home cooked meals per day. In a cross sectional study of 11,936 participants, it was found that eating home cooked meals more frequently is associated with lower adiposity and better diet quality [40]. This could possibly explain the differences found regarding frequency of home cooked meals between the two groups of the current study. However, previous studies indicated that eating home cooked meals could help individuals monitor their food and energy intake and that self-monitoring of food and energy intake was positively related to weight maintenance status [41, 42].

The strength of this study is that, to the best of our knowledge, the population used has not yet been examined related to weight loss maintenance. In addition, the population was consisted of both maintainers and regainers which allowed for direct comparisons of obesity related eating behaviors, as well as young volunteers, whereas in most relevant studies participants were middle-aged [16, 17, 43]. Moreover, the use of two 24-hour recalls as assessment tools allowed a more detailed dietary assessment. This study has also some limitations. In particular, the observational nature of this study indicates associations, but no causation can be drawn. The small number of participants and the fact that they were not equally distributed in the two groups, resulting in a group of maintainers twice the size of the regainers' group, are another limitation. However, it is unlikely that this inequality could have influenced our results as previously reported [44].

Conclusions

Adoption of healthy eating behaviors, such as eating more frequent home cooked meals and less eating away from home meals may influence weight loss maintenance. A Healthy Eating Behavior Index was designed to incorporate specific obesity-related eating behaviors previously shown to influence long term weight loss. The use of HEBI index by the Health Care Professionals could be either an assessment or a target tool to support overweight or obese individuals to maintain their weight after significant weight loss. Further studies are required to validate the use of HEBI index among different populations.

Abbreviations

BMI: Body Mass Index; HEBI: Healthy Eating Behavior Index; IPAQ: International Physical Activity Questionnaire; SD: Standard Deviation; IQR: Interquartile Range; OR: Odds Ratio; CI: Confidence interval

Declarations

Ethics approval and consent to participate

The lead author affirms that this manuscript is an honest, accurate, and transparent account of the study being reported. The reporting of this work is compliant with the requirements of the Transparent Reporting of Evaluation with Nonrandomized Designs (TREND). The National Bioethics Committee (Cyprus) approved the study protocol (EEBK.EP.2016.01.29). All participants provided their informed consent, and all aspects of the study were performed in accordance with the ethical standards set out in the 1964 Declaration of Helsinki.

Consent for publication

Not applicable

Availability of data and materials

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Competing interests

Authors have no conflicts of interest to declare regarding the contents of the manuscript nor has it been submitted for consideration elsewhere.

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Authors' contributions

YK, SC and MY formulated the research concept and design. YK, SC and MY involved in data collection. YK and KY conducted statistical analyses. All authors drafted the manuscript. The final version submitted for publication was read and approved by all authors.

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