Healthy Living News and Research Update

August 14, 2017

The materials provided in this document are intended to inform and support those groups that are implementing the SelectHealth Healthy Living product as part of their employee wellness program.

We welcome your feedback and suggestions.

Best Regards,

Tim

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SelectHealth Healthy Living Program Updates

The Outback Physical Activity Challenge

Prepare for an experience like no other
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With lush rainforests, lofty mountains, and crimson plains,
Australia is full of sights and sounds for adventurers. Teamwork will
be especially important in the Outback, so step up your game!

JOIN THE CHALLENGE, JOIN A TEAM, AND JOIN THE FUN!

To register, log in to your My Health account, click on SelectHealth followed by Healthy Living. On your Checklist, choose Activity Challenges.
**Workplace Wellness**

**Study: Employers focus on health costs, employee well-being**

Aug. 2, 2017, by Katie Kuehner-Hebert

http://www.benefitspro.com/2017/08/02/study-employers-focus-on-health-costs-employee-wel

Employers are integrating emotional, financial, social and career well-being with physical health.

Employers are increasingly focused on addressing the needs of “the whole employee” within their benefits offerings, integrating emotional, financial, social and career well-being with physical health, according to the 2017 Arthur J. Gallagher & Co. Benefits Strategy & Benchmarking Survey.

Gallagher Benefit Services Inc., AJG’s employee benefits consulting and brokerage unit, surveyed 4,226 employers and found that more are taking a holistic approach to their wellness programs, as demonstrated by the increase in programs now covering financial well-being (34 percent), volunteer opportunities (28 percent) and community engagement (27 percent).

And it’s not just about trying to keep workers physically healthy. While reducing health care costs remains the main driver for offering a wellness program (60 percent), employers also cite investing in the organization’s culture (43 percent) and improving employees’ work experience and satisfaction (37 percent) as other top motivators for having such benefits.

“This shift in thinking is one of the reasons we expect 70 percent of organizations will offer wellness programs by 2019,” says William F. Ziebell, president, Gallagher Employee Benefits Consulting and Brokerage. “When employers rebalance their priorities to include benefits like professional development and a workplace culture that promotes employee engagement and total wellbeing, they differentiate themselves in the talent marketplace.”

In tandem with this emerging trend, health insurance brokers must roll out robust, holistic solutions for employers.

Attracting and retaining a competitive workforce is the top operational priority for 58 percent of employers, while attracting (43 percent) and retaining (41 percent) talent rank as the second and third most important priorities for human resource departments.

Controlling benefit costs remains the highest HR priority, at 52 percent, but declined slightly in overall importance compared to 2016. However, boosting workforce engagement and productivity (37 percent) and creating a strong workplace culture (33 percent) increased in importance.

To achieve these increasingly comprehensive goals, employers are striving to achieve 360-degree integration across total compensation strategies and programs, according to the report. “A big-picture perspective makes it possible to more fully address employee well-being and human capital talent needs, while controlling costs and managing risk,” the authors write. “As employers gain a deeper understanding of how these elements work together, they can see more clearly how to align human resource and organizational strategies to drive better business results.”

**Other key survey findings include:**
• Properly administering and managing lost time is a top pursuit for 62 percent of employers, including Family Medical Leave Act compliance, incidental absences, short-term disability, workers’ compensation, and related implications of the Americans with Disabilities Act and the ADA Amendments Act.
• Increases in employee contributions to the cost of premiums (48 percent) and higher cost sharing through plan design changes (48 percent) remain the top two health care cost-control tactics.
• Roughly two-thirds of employers offer long-term disability and short-term disability or salary continuation. Far fewer (44 percent) have developed an absence management strategy for administering leave for both occupational and non-occupational disabilities.
• For communications, most employers shifted toward greater use of external support, including 38 percent overall and 53 percent of large organizations that count on the help of vendors. At the other end of the spectrum, just 3 percent overall and 11 percent of large employers work with consultants that specialize in this discipline.
• Sixteen percent of employers rely on health plan vendors to administer wellness programs and 14 percent enlist the expertise of an outsourced wellness vendor, including 24 percent of large employers.
• For pharmacy benefits, 19 percent of all and 50 percent of large employers use a specialty pharmacy benefit manager.
• There is a trend toward increased self-insurance of medical plans among lower mid-size (42 percent), upper mid-size (68 percent) and large employers (83 percent), up 8 percent to 10 percentage points from 2016.
• One-third or more of employers use quality-focused and value-based tactics to control medical costs, including cost-transparency tools, telemedicine, and health care decision support for employees. Some of the tactics employers expect to adopt by 2019 include cost-transparency tools (24 percent), health care decision support (19 percent), and reference-based pricing for health care services.
• Among the 78 percent of employers that offer a retirement program, only 37 percent take steps to measure employee retirement readiness, while three-quarters of employers evaluate wellness program performance — employee participation is the leading indicator at 58 percent. Few look at financial claims data (21 percent), the impact on lost work time (6 percent) or lost productivity (3 percent).

Now is the time for a health revolution
We need to shift the focus of sick care, to place importance on the key lifestyle factors and personal commitment that are necessary to maintain health

Too many economic incentives are aligned to get us sick and then to treat that illness, with very few focused on keeping individuals healthy. (Photo: Getty)

The aging process is not what it seems.

We’ve been sold a fallacy.

It is generally accepted that as we age, there is a slow deterioration in our health and bodies that is natural and to be expected.
It starts gradually, often unnoticed at first: perhaps with slightly high blood pressure and weight that creeps up bit by bit. We asked those in the industry what products are missing from portfolios today. Here is what they had to say.

One day, you notice the spare tire around your midsection. Prescription medications start popping up in your medicine cabinet, one by one, until finally, the realization of a diagnosis – hypertension, type 2 diabetes, etc. echoes as a new norm.

Hey, it’s just the natural breakdown of health in the aging process, it happens to everyone! Cue the additional meds and health care providers lining up to help.

But this scenario should not be written off as normal.

Admittedly, there are some gradual health changes that accompany aging, but very few of the changes we have come to accept as inevitable are actually normal.

Many have stiffness, lower back pain and some decreased mobility as we age, but we shouldn’t jump to the conclusion that it’s all part of the process.

Perhaps, we are accelerating the loss in strength and bone density because we aren’t moving our bodies enough; maintaining sedentary lifestyles that welcome in the deterioration process.

Poor diets, elevated stress levels and a lack of physical activity contribute to the onset of a slew of problems, such as high cholesterol, heart disease and type 2 diabetes, just to name a few. In fact, statins, which treat cholesterol, are the most prescribed drug in the US.

The writing is on the wall - the vast majority of individuals are experiencing an accelerated and unnecessary breakdown in health that is preventable. And at what cost?

The numbers are staggering. Forbes magazine recently reported poor health costs the U.S. economy more than a half a trillion dollars per year.

And 39 percent of that amount, or $227 billion, is from “lost productivity” from employees missing work due to illness. Of the remaining $576 billion tallied in the report, the cost of wage replacement was $117 billion.

This number represents absence due to illness, as well as both short and long-term disability workers’ compensation. Finally, another $232 billion of poor health costs come from medical treatment and drugs.

In essence, our ‘health care system’ is reactionary sick care, focusing on disease management with little importance placed on disease prevention.

Too many economic incentives are aligned to get us sick and then to treat that illness, with very few focused on keeping individuals healthy. This is the heart of the problem: we wait until we are sick and then we deal with our health.

Our aim isn’t so much about thriving as it is about simply surviving. How did this happen and how can turn the tides?

**Better nutrition**

In 2012, the Journal of the American Medical Association investigated the cause of heart disease, stroke, and type 2 diabetes in the U.S.

Nearly half of the causes were associated with suboptimal dietary factors. This study clearly outlined the top 10 nutritional mistakes we make that are slowly making us sick.
Whether it be not eating enough vegetables and healthy fats to eating excessive amounts of sugar and salt, these choices slowly take grip on our health.

**Being more active**

Exercise guidelines suggest a minimum of 150 minutes of moderate activity per week, and according to the CDC, 80% of American adults don’t adhere to those recommendations.

The effect being active has on reducing obesity, type 2 diabetes, heart disease, and some cancers is indisputable. In addition, being active improves mood and has a notable impact on mental health.

**Listening to our bodies**

The way we view stress and deal with it has also evolved. Originally, stress was designed to invoke a fight or flight reaction, in which we would physically move, but that isn’t the case anymore.

Now, in addition to the usual sources of stress, it also comes from sensory overstimulation, which does not require movement. The physical act of moving is what lowers stress hormones, protecting us from the short-term surge.

Compounding the effects of stress is sleep deprivation. Sleep is necessary to ensure repair and rejuvenation of the body.

We don’t listen to our bodies anymore; heeding when we are tired and allowing ourselves to rest and restore. Instead, when we notice signs of fatigue, we attempt to mask them with caffeine.

**Choosing better health**

An unnecessary and premature breakdown of health is running rampant in the U.S. The effects are verifiable. Health care costs are spiraling out of control. People are focused on disease management instead of prevention.

Our health is determined by our choices. We choose our lifestyle, and the choices and commitments we make to ourselves in turn determine whether we age gracefully, or poorly.

We need to shift the focus of sick care, to place importance on the key lifestyle factors and personal commitment that are necessary to maintain health and reject the falsehood that a breakdown in health is inevitable.

Simply put, our health care system, employers, and insurers can’t afford it, and neither can we. It’s time for a health revolution.

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**Exercise incentives do little to spur gym-going**

**ScienceDaily**

Date: July 31, 2017

Source: Case Western Reserve University


Summary: Even among people who had just joined a gym and expected to visit regularly, getting paid to exercise did little to make their commitment stick, according to a new study.
Even among people who had just joined a gym and expected to visit regularly, getting paid to exercise did little to make their commitment stick, according to a new study from Case Western Reserve University.

The rewards also had no lasting effect: gym visits stabilized after the modest incentives ended.

Despite timing incentives to when people were already more motivated to exercise, the approach proved ineffective in initiating a healthy behavior that continues to elude most Americans: only 21 percent get a recommended amount of weekly exercise, according to the Centers for Disease Control.

"They wanted to exercise regularly, and yet their behavior did not match their intent, even with a reward," said Mariana Carrera, an assistant professor of economics at the Weatherhead School of Management and co-author of the study. "People thought earning the incentive would be easy but were way overoptimistic about how often they'd go."

In the study, new gym members intended to visit three times per week but ended up averaging one weekly visit by the end of the six-week study.

Nearly 95 percent said they expected to visit the gym more than once per week. But by the end of the third month, only about a third had.

**The experiment**

For visiting the gym nine total times during the study (an average of 1.5 times per week), participants were promised one of three modest rewards: a $30 Amazon gift card; a prize item, such as a blender, of equivalent value; or a $60 Amazon gift card. A control group received a $30 Amazon gift card regardless of how often they visited. (The value of incentives was based on what gyms were likely to offer.)

After the first week, 14 percent did not visit the gym again.

Incentivized participants showed a slight increase in gym visits in the sixth week -- their last chance to make enough visits to earn their prize. But overall, those given incentives made only 0.14 more visits per week than those promised no reward at all.

"Focusing on people when they're ready to make a change may be misguided," said Carrera. "Maybe the internal motivation that gets a person to start a gym membership is unrelated to what drives them to earn financial incentives. What's clear was there was no complementarity in lumping these two motivations together."

The group promised the $60 gift card also did not visit the gym more often than those given the $30 gift card or prize.

Researchers thought that selecting the prize item at the outset might create a sense of ownership and prove to be a more powerful motivator, because failing to hit the target visit rate might feel like a loss. However, while the item induced slightly more visits, the difference was insignificant.

Story Source: Materials provided by Case Western Reserve University. Note: Content may be edited for style and length.


America’s Soldiers Are Fatter Than Ever. Here’s The Army’s Plan To Fix That

TASK & PURPOSE
July 28, 2017, by Sarah Sicard

The U.S. Army is bulking up — just not in the way it probably intended.

In October 2016, a Department of Defense study revealed that the Army was the fattest of all the service branches, with 10.5% of soldiers classified as overweight based on body mass index. But less than a year later, the problem appears to have worsened: At the 2017 Medical Symposium on June 24, the Army Surgeon General’s Office presented data indicating that a full 13% of soldiers are now overweight.

Army officials claim to have a solution in the works, and not just in terms of more intensive PT. Called “Holistic Health and Fitness,” the initiative aims to improve soldiers’ physical performances, performance education, and fitness centers, according to an Army press release — and initiative that includes removing unhealthy food from vending machines, offering cleaner meals in chow halls, and adding vegan and vegetarian dishes, similar to the Marine Corps’ switch to healthier chow fare in March.

“Holistic health and fitness is a radical change — radical departure,” Michael McGurk, director of the Research and Analysis Directorate at the Army Center for Initial Military Training, said in the release. “It is going to cost the Army money, time and people. And we’ve got to be willing to give that up to make the changes that we need.”

Tom Higdon, manager for the Healthy Army Communities program that sets dietary standards for the Army, added in the release that the branch may move to provide box breakfasts at fitness centers so soldiers on tight schedules will no longer have to choose between eating and working out.

HAC will also replace the contents of installation vending machines, oases of salt and sugar for soldiers on the run. According to the Army release, 15 to 50% of vending machines “[will] have healthier options, while others will be 100-percent comprised of healthy items.”

The Army has selected eight bases across the globe to test its initiatives: Fort Belvoir, Fort Meade, Fort Riley, Fort Sill, Fort Benning, Fort Huachuca, Redstone Arsenal, Fort Bliss, USAG Italy, and USAG Humphreys.

And while the plan sounds promising, much of the onus will still be on soldiers to choose to eat healthier and work out more. But that may prove challenging for soldiers increasingly stretched thin and facing myriad health issues — including the inability to sleep, tobacco addiction, and chronic disease, all of which impact dietary behaviors, according to a 2015 Army report. You can lead a soldier to kale, but you can’t force him to eat it. And while the Army tries to bulk up its numbers, soldiers will need to slim down.

As much as we hate to say it, maybe there is something soldiers can learn from Marines, traditionally the fittest of the service branches. No, not how to eat crayons... how to cut fat and build muscle — unless the crayon diet is what makes Marines so fit.
Vacation time can boost employee performance

July 31 2017, by Amanda Eisenberg

Employers who want to boost employee performance may want to encourage workers to take a break from working.

New research indicates that high-performing employees take more vacation time, suggesting that a generous — or unlimited — vacation policy benefit has a positive impact on the workplace.

The report from HR technology company Namely analyzed data from more than 125,000 employees and found that high performers take about 19 days of paid time off a year, five more than an average performer under a regular PTO plan.

Still, vacation time is underutilized, the firm said. Nearly 700 million vacation days went unused last year, but 80% of employees said they felt more comfortable taking time off if a manager encouraged them.

Putting PTO in place
Percentage of employers using paid time off plans in lieu of traditional sick and vacation time

Namely said that unlimited vacation policies may be beneficial for employers, adding that it’s a myth that employees with such benefits abuse the policy. For the 1% of companies that offer unlimited vacation days, employees only take about 13 days off, according to Namely’s “HR Mythbusters 2017” report.

“Unlimited vacation time can be a strong benefit that increases employee engagement, productivity, and retention — but only if the policy is actually utilized,” according to the report.

Computer software company Trifacta, for example, encourages its employees to use their paid time off with a recognition program.
“We offer a discretionary PTO policy because we want people to truly take the PTO they need,” says Yvonne Caprini Sorenson, Trifacta’s senior manager of HR. “We have a recognition program called Above + Beyond. Employees can nominate high-performing peers, and the winners receive $1,000 to spend toward travel. It’s a great way to encourage vacation use and to make it clear that Trifacta supports work-life balance.

6 essential aspects of workplace culture

Aug. 10, 2017, by Katie Kuehner-Hebert
http://www.benefitspro.com/2017/08/10/6-essential-aspects-of-workplace-culture

What are the main ingredients to crafting a successful company culture? Photo: iStock

Yet another study is showing that money isn’t the only thing that can make a worker stay — and it’s not even at the top of the list for many employees.

The main ingredients to crafting a successful culture are purpose, opportunity, success, appreciation, wellbeing and leadership, according to “The Six Essential Aspects of Workplace Culture to Focus on Today,” a joint study by the O.C. Tanner Institute, Y2 Analytics and Harvard Business School professor, Ashley Whillan.

“Organizations that marginally improve in each of these six areas see dramatic improvements in recruiting, engagement, tenure, satisfaction, and other business metrics such as revenue growth and expansion,” the study says.

The survey of nearly 10,000 workers shows that most companies could stand to improve their culture. The researchers asked workers to describe their organization’s culture with a single word or short phrase. While positive words such as “friendly,” “happy,” and “great” were among the most frequently used terms, the single most commonly used word that employees used to describe their current organizational culture was “stress.” Meanwhile, the word “average” was among the top five most frequently used words.

Related: Culture makes the difference for employees. Employees say a company’s culture is key to recruiting and retention, but a new survey shows many employers are failing...

On average, respondents rated their current workplace culture a 65 on a 100-point scale. The study also found that 40 percent think their organization only cares about its profits, 42 percent believe their accomplishments go unnoticed, and 35 percent do not trust senior leadership at their organization.

The researchers also asked workers to differentiate between a “good culture” and a “bad culture.” The most common term used to describe “good culture” was the term “pleasant,” while other popular terms were “meaningful,” “peace,”
“strong,” and “collegial.” Meanwhile, the terms used to describe bad culture included “lack,” “poorly,” “negativity,” “unhappy” and “toxic.”

The study also compared employers that do “marginally better” on the six aspects of a successful culture, and found that they are:

- 54 percent more likely to have employees who are promoters on the standard Net Promoter Score scale
- 53 percent more likely to have highly engaged employees
- 29 percent more likely to have innovate employees innovating and creating great work
- 27 percent more likely to have increased in revenue last year
- 22 percent less likely to have experienced layoffs in the last year
- 25 percent more likely to have teams growing in size instead of stagnating or decreasing in the last year.

As a result of the study, O.C. Tanner has created a culture assessment, a service to help companies evaluate how well they are meeting these six fundamental culture aspects.

“Our study and new culture assessment helps companies figure out where their culture is strong, where it could be improved, and what it takes to cultivate their ‘way of being’ as an organization — which is what really draws talented people to want to join, work together, contribute, and be part of a fantastic and vibrant workplace community and culture,” says O.C. Tanner president and chief executive Dave Petersen.

“Leaders who pay attention to these talent magnets are going to attract people who want to be part of something great,” Petersen says. “And culture is where it all comes together.”

SHRM Symposium: Stay Competitive with Benefits or Risk Employee Flight

Aug. 8, 2017, by Stephen Miller, CEB

Does your company offer the benefits that most employees want? If not, you may be wasting money and finding it hard to hire and retain valued employees.

"If you're there for your employees, they'll be there for you," said Shonna Waters, vice president of research at the Society for Human Resource Management (SHRM) at SHRM's Rewarding Work: Spotlight on Benefits Strategy symposium, held Aug. 7 in Cleveland.

Every employer should ask whether the cost of their benefits is money well-spent, she told the nearly 300 attendees.

A point to keep in mind: "Much of the media's coverage of employee benefits is dominated by Silicon Valley—the high-tech industries and the companies that are pushing the edge of benefits," Waters said. "We hear a lot in the news about organizations such as Netflix and Amazon that are offering extremely generous and even 'unlimited' parental leave.
policies, [but] the data actually shows that a minority of U.S. organizations are offering any paid maternity leave and even fewer are offering paid paternity leave."

Employers should keep their focus not necessarily on what the big, cutting-edge companies are doing "but what your peers are doing," she advised, because those are the employers with whom you’re competing for talent.

Waters further cited SHRM’s 2017 Employee Job Satisfaction and Engagement survey report, which showed that the top three benefits employees value are health care, leave and flexible work schedules. However, the report also pointed to large gaps between the percentage of employees who view these benefits as "very important" and the percentage that said they are "very satisfied" with that benefit.

**Importance-Satisfaction Gap**

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<td>Flexibility</td>
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The findings point to the need to help employees better understand the value of their benefits package, as well as the need to evaluate whether the company has the right benefits offerings to begin with, Waters said. That requires understanding employee needs.

While only 4 percent of employers provide student loan repayment as a benefit, many younger employees have said they would prefer that their employers contribute to loan repayment first rather than to their 401(k) account, she pointed out.

Waters advised:

- Get smart about the competition. Review your benefits mix at least annually and use market data for comparison with your competitors' offerings.
- Take an employee-centered approach. Ask employees what benefits they value and whether they know about all their benefits offerings and how to use them, and note variations in how different demographic groups reply. Along with traditional employee surveys, use focus groups, stay interviews and social media polling. Let employees know that their responses will help in designing their benefits package.

People tend to support what they help to create, "so include them in the process," recommended Rosie Ward, CEO and co-founder of Minneapolis-based consultancy Salveo Partners, in another symposium presentation.

**Communication Tips**

Karl Ahlrichs, SHRM-SCP, a consultant at Gregory & Appel in Indianapolis, also spoke to symposium attendees about communications challenges.
"Meet your employees where they are," he advised. Some prefer hearing about benefits by sitting together at meetings, while others want to watch a video presentation.

Optimize materials for viewing on a desktop computer and mobile devices, he said, and "if some want a benefit statement mailed to their home, then mail it to their home."

Create a benefits blog, allow comments and provide answers, he suggested. Create short, simple video reminders by using your smartphone: "Hey, Karl from benefits here. The open enrollment deadline is in five days, so click this link if you'd like to receive benefits next year.

"We're getting better at communication," he noted. "We're starting to figure this out."

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**Health Promoters Should Stop Promoting Health: New Science For Behavioral Sustainability**


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**Please Stop Promoting Health**

The suggestion to stop promoting health might seem heretical in the context of health and even business.

Health promotion is an intersection of medical and business interests. The general aim is to foster healthy lifestyles (eat more fruits and vegetables, move more, get enough sleep) among individuals as a means to promote better health and disease prevention and also improve other desired outcomes, such as reduced stress, increased productivity, and reduced absenteeism.

Yet it has been an expensive assumption that promoting health as the reason for living in healthy ways is effective for engaging patients and employees in taking better care of themselves and fostering long-term behavioral sustainability. In fact, this presumption has no basis in science – it has simply been the convention.

Based on research on behavioral economics and self-determination theory and my own published studies about how to motivate healthy lifestyles, here are four reasons why organizations should stop promoting health:

**1. Health Promoter’s Goals Are Irrelevant to What Is Most Motivating to Individuals: Marketing 101 Revisited**

The logic behind promoting healthy living to people is easy to understand: “If my patients or employees make healthier choices, they will be healthier and use fewer health care dollars, so let’s promote healthy living.” The problem is that logic doesn’t motivate. Emotions do.

Most successful businesses (think Apple) do not develop marketing campaigns that explicitly promote their goals (i.e., profit). Instead, they conduct extensive market research and use their target customers’ needs, wants, and worries as the hooks in their marketing campaigns and social media initiatives.

Successful businesses brand products and services in strategic ways so that customers decide to try them and then continue to buy them. Businesses that are successful don’t want one-time buyers, they want repeat customers.
For the most part, there has not been a repeat customer mentality when it comes to promoting lifestyle changes within organizations, health care, or society. Health promotion programs, services, and marketing tend to feature the desired medical outcomes that health promoters hope for, instead of the wants and worries of their audience. This has been a strategic error that has expensive consequences for health promoters, organizations, and individuals.

In order to prevent and manage illness and achieve other desired outcomes (e.g., less stress, higher productivity), people have to sustain the lifestyle behaviors that they start. Taking a Health Risk Appraisal or participating in a competition won’t achieve sustainable behavior for most. In fact, the majority of people who try to change health-related behaviors do not maintain them – they eventually drop out.

2. Health Is Too Abstract to Be Compelling

University of Michigan research published in fall 2011 showed that there is a gap between what people say they value and what they actually do when it comes to exercising.

Figure 1, below, shows how much study participants said they “valued” their reason or goal for exercising. As can be seen below, participants reported equally valuing exercise as a way to achieve “health-related” goals and “daily quality of life.”

![Figure 1: Value of Exercise Goals](image1.png)

![Figure 2: Exercise Participation by Goal Type](image2.png)

Yet when followed over one year, participants with goals to improve their “daily quality of life” were more motivated and exercised about 20% more over one year compared to those having “health-related” goals. See Figure 2 below showing the average exercise participation by type of goal.

The difference between these two graphs illuminates the important gap between what people say they value and their actual behavior. The key point is that it’s easy to say being healthy is “important” but it’s another matter entirely to make health-related behaviors a must-do priority on a daily basis.

Taking medication offers another example to support the notion that despite being valued, health may not be the optimal frame to promote sustainable behavior. The purpose of taking medication is to improve health and prevent disease, not unlike physical activity. Taking pills, however, while not a simple behavior, does not include the same level of logistics and negotiating time that is necessary for sustaining behaviors like physical activity and healthy eating. Despite this, there are well-documented low adherence rates to prescription medication around the world.
Behavioral economists have taught us that people have a present-focus bias, meaning that we choose things that will reward us now over selecting rewards in the future. In other words, larger distant rewards (“better health”) are not as motivating as smaller rewards that can be immediately experienced. Think increased energy.

3. Health Is Not the Goal

Health isn’t really the goal we all think we want. It is only valuable because it helps us live our daily lives well.

Health is valuable because without it we lack energy. Lack of vitality challenges our happiness, sense of well-being, and ability to fulfill the daily roles and responsibilities that make life meaningful. Health is really just a proxy for the experiences we desire and that make our life worth living.

Research on goal striving and behavioral self-regulation (how we manage and negotiate goals in our busy lives) clearly shows that if people are to continue to strive towards their goals, they need feedback that they are approximating them. Without evidence that they are making progress, people quit.

While there are biomarkers that can show people that they are progressing toward their health and disease prevention goals (i.e., blood pressure), this type of feedback is not compelling enough to motivate the numerous decisions that most people have to make every day that are necessary for sustaining healthy lifestyles.

In contrast, when individuals make decisions to practice self-care behaviors as ways to feel good, increase well-being, and have more energy, they get feedback immediately that they have achieved their goal.

Health promoters need a better hook than “health” if they want to achieve their better health and bottom-line objectives related to successfully promoting sustainable self-care behaviors.

Rebrand Health as Well-Being

Health and self-care behaviors have been, unfortunately, branded as “medicine” and are promoted in clinical, instrumental, and uninspiring ways. Instead of branding “health” or self-care behaviors in the realm of medicine, it would more strategic to rebrand them as direct vehicles that ignite daily success, well-being, and fulfillment – as they truly are.

Many of the behaviors that improve health (getting more sleep, moving more, making better eating choices) also lead to experiences (reduced stress, feeling strong, lifted mood) that help us better succeed in our roles and responsibilities, all of which contribute to happier lives.

We just have to look toward Big Pharma to know that marketing outcomes like “happiness” and “quality time with family” for their behavior of interest (taking their drug) is a smarter strategy. They’ve been doing it for years. Even Oprah understands the value of this idea. She changed the name of her magazine’s column from “Health” to “Feeling Good” in 2010.

A recent article in the Wall Street Journal also reported that having a “focus on quality of life helps medical providers see the big picture – and makes for healthier, happier patients.” This WSJ article talked about helping patients living with a chronic illness and shows that even individuals who have lost their “health” are more motivated by feeling good than improving their health.

Even new research among the elderly, another group that should be hyper focused on their health, showed that “feel good” reasons to exercise motivate more participation than reasons tied to staying healthy.
I must reveal that before 2006, I would have been one of the strongest advocates of “health” being a great reason to sustain self-care behaviors. In fact, I hypothesized that “health” as the primary reason to exercise would be optimal for motivation and participation in a longitudinal study among working individuals. I couldn’t have been more wrong. Individuals who exercised to benefit their health were among the least active and also had non-optimal motivation profiles.15, 16

Sustainable self-care behaviors are made up of a multitude of decisions every day. Research shows that people often don’t do what is in their best interest, and that willpower depletes with use.17, 18 So, to better motivate consistent decisions that favor self-care and “health,” it is helpful for people to notice immediate, experiential rewards,19 ones that can be tied to well-being and enhance the areas of life that are most meaningful. Consider these as better reasons, or “Whys,” for creating sustainable behavior.

4. Motivation Is the Result, Not the Source

Until now, we’ve been taught to think about motivation in terms of “quantity” and how much of it people have – or don’t have. Thinking about motivation in this black-and-white way is not very helpful because it doesn’t address how to change it.

We’ve also been taught to think of motivation as the primary driver of behavior. Yet, research shows that motivation results from the main reason why individuals initiate any behavior change.20, 21 The foundation of motivation is people’s primary reason for initiating that behavior.

Motivation isn’t the cause. It’s actually the result.

How Behavior Actually Works

When people initiate a behavior change out of pressure or for abstract reasons, such as “better health,” this does not bode well for long-term motivation or behavior.22 Consider these types of reasons for behavior change as “The Wrong Whys.” These types of reasons are The Wrong Whys not because they are inherently “wrong,” but rather because they have a hard time trumping the other daily tasks and responsibilities against which they constantly compete.

It is important to note that The Wrong Whys are different for different people, often depending upon their life stage, gender, etc. We still need more research to determine which reasons for adopting behavior are more or less optimal for behavioral sustainability. (My team is currently researching which “Whys” for health-related behaviors are more or less effective by gender and life stage.) You can, however, identify a Wrong Why by how people feel about pursuing it. In general, the Wrong Whys (and the behaviors they are attached to) feel like chores or “shoulds,” and because of that, they tend to result in unstable motivation and less persistent behavioral pursuit.23

Importantly, when people start any behavior with The Wrong Why, it often leads to cyclical rather than sustainable behavior. Because this is the only model people have been taught, most have been stuck repeating the same cycle for 10, 20, or even 30+ years. See the image below for “The Vicious Cycle of Failure.” It starts at 11:00, with The Wrong Why.
Luckily, escaping The Vicious Cycle of Failure is actually quite simple.

We can create high-quality motivation and lasting change by going to the origin: The primary reason for initiating any desired behavior change.7

The Successful Cycle of Motivation

In contrast to The Vicious Cycle of Failure, “The Successful Cycle of Motivation,” depicted below, starts with “The Right Why,” rewards from behavior that can be immediately experienced. These types of Whys often result in good experiences, as well as being personally meaningful. Because of that, the behavior starts to feel like a “gift.” It’s easy to see why high quality and more stable motivation results from starting the behavioral cycle with The Right Why.24,25,26
The Right Whys initiates a cycle that is more likely to successfully result in sustainable behavior, because it reflects the neuroscience of reward. 27

Thus, health promotion efforts based on Right Whys should be more cost-effective than those based on Wrong Whys because they are more likely to lead to higher quality motivation and greater behavioral persistence.

If on-going daily decision making in favor of self-care is the goal, we must reconsider which reasons and purposes for behavior are actually the most motivating and help us both feel and function better in our most cherished daily roles and goals. Willpower is vulnerable to fatigue, but the pursuit of daily well-being offers immediate, fulfilling rewards.

To learn more about the science-based methods that help people desire and sustain behaviors like physical activity, including topics and questions that should be addressed in behavioral design algorithms, messaging, counseling and other types of interventions, read No Sweat: How the Simple Science of Motivation Can Bring You a Lifetime of Fitness (Amacom, 2015).

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Michelle Segar, PhD, MPH, motivation scientist and author of critically acclaimed No Sweat! How the Simple Science of Motivation Can Bring You a Lifetime of Fitness (AMACOM 2015), is Director of the Sport, Health, and Activity Research and Policy Center (SHARP) at the University of Michigan, and inaugural Chair (2014-2017) of the U.S. National Physical Activity Plan’s Communications Committee. No Sweat was chosen as the #1 book in Diet/Exercise in 2015 by the USA Best Book Awards, and when released, it achieved the #1 selling Exercise & Fitness book on Amazon.

Michelle’s 360-degree perspective is informed by more than 23 years of award-winning research, individual fitness and self-care coaching, and consulting, uniquely positioning her to help organizations understand and leverage the emotional drivers and internal rewards of consumers’ decisions that lead to well-being and health.
Laura Putnam, author of Workplace Wellness that Works: *10 Steps to Infuse Well-Being and Vitality into Any Organization*, is the CEO and founder of Motion Infusion, a wellness organization that has worked with public companies, NGOs, universities and public institutions. According to her, the secret sauce to wellness initiatives that offer the best results are ones that are not programs, but are “movements” started organically in the organization by inspiring leaders and employees. Laura shares best practices and case studies of several organizations creating healthy practices and shaping the built environment.

LS: Laura, tell me a little bit about your background and what led you to write Workplace Wellness that Works.

Laura Putnam: I don’t have a background in exercise physiology or nutrition or medicine. Rather, I’m a former dancer, gymnast and educator (I was an urban public high school history teacher), so I come at wellness a little differently from other professionals in the field. The impetus for my book was that I was seeing a lot of workplace wellness programs that were not working. As a country, and increasingly around the world, we are facing a giant tidal wave of health issues – chronic stress, chronic conditions like obesity, and chronic disease – that are all largely preventable. The question is – what are we going to do about it? Workplace wellness is a really good idea if you consider that the workplace is one of three portals where we can take action (if you include school, the workplace and the community). The problem is that we are wasting this opportunity when you consider that 80% of companies have some sort of wellness offering, but over 80% of those employees are opting out. Something is wrong here. That is what this book is about – offering 10 steps on how to roll out wellness programs a little differently.

For starters, I believe that instead of starting yet another workplace wellness program, companies should think about starting a movement. That’s what inspires me – seeing examples of “mini movements” started not by people who have positioned themselves not as experts or program administrators, but as leaders of a movement.

LS: I hear you! Where I live in Washington DC, there is a lot of buzz around political movements – all constructed on the premise that people get excited when a campaign is tied to a wider purpose and mission, not just about the individual candidate. It’s a pretty successful strategy.

LP: Yes, that’s one reason wellness efforts fit nicely into mission-driven organizations. At Eileen Fisher, for example, they have “sustainability ambassadors” (similar to wellness ambassadors you might find in other organizations) combining the efforts to promote well-being with sustainability – connecting individual and corporate wellness to something bigger.

LS: I know that at their headquarters, Eileen Fisher also provides space for the Westchester Buddhist Center, connecting mindfulness (one of their core values) to that of the local community. Their space also supports a wider mission.

LP: Exactly. But focusing on a wider mission is not something an expert is likely to do. This is why I contend that the first step to achieving better results is to shift our mindset from expert to agent of change. I would argue, for example, that Oprah Winfrey has had more impact on our behaviors than any expert out there in the field of health promotion. It’s no wonder that President Obama studied her in devising his 2008 campaign. What we can learn from people like Oprah is that programs and interventions don’t move people; feeling part of something bigger does.
Yvon Chouinard, founder of Patagonia is another great example of an agent of change who has inspired well-being in his company with messages like “Let my people go surfing” or “The work can wait but the weather can’t.” Patagonia doesn’t even have a wellness program – and yet, people are surfing at lunchtime, training for ultra-marathons, holding meetings outdoors, giving back, the list goes on. There is so much well-being woven into the fabric of the organization, there’s no need for a program. That’s where we ultimately need to move towards: a workplace where the culture and the environment embody health and well-being. It’s infused into everything we do.

LS: I’ve noticed that in many organizations, wellness efforts operate in silos. One department might be responsible for engagement and leadership programs, another is looking at developing health programs and yet another is building the workplaces employees occupy. But these groups are not connected – they are not talking to each other and working towards an overall objective, which is to increase the health and human performance of people in the organization.

LP: Yes, there are too many stand-alone, silo-ed wellness programs. It’s no wonder why the people who are leading these efforts are exhausted! The good news is that there are bright spots. I’ve seen and worked with large Fortune 500 companies, non-profits, schools, universities, even government entities who are doing great work. One example is Nintendo. Here, you have a member of the executive team, Flip Morse, who personally embraces wellness. He’s super active and likes to bike to and from work. The Pacific Northwest, as you know, is wet and cold. This means that if you’re biking to work, your clothes are typically wet and cold when you arrive. Then, at the end of the day, you know you are going to have to put those wet and cold clothes back on to commute home – certainly a deterrent for an active commuter! Flip wanted to change this, so he came up with the idea of “ventilated lockers” in the bike cage which he personally designed. It’s a place where active commuters can store their bikes and hang their cycling clothes. So, at the end of the day, you’ve got a nice set of dried out biking clothes waiting for you – and a much more comfortable ride home.

Bike storage at Nintendo headquarters office building

This is so great because 1) it’s a nudge to get people to bike to and from work, and 2) it was built by someone on the executive team. It’s not an executive standing up and saying “Everyone participate in a wellness program,” it’s an executive who is actively engaged. I call this the “I want to see my boss in spandex” phenomenon. I mean, employees don’t want to see their boss talking about it; they want to see him or her actually doing it. Two other members of Nintendo’s executive team are also avid cyclists and triathletes. Nintendo’s ventilated locker system, which spurred an innovation award from the American Heart Association, is part of a larger build-out at their headquarters in Redmond, Washington, that is LEED Gold certified and designed with environmental sustainability as well as human health in mind. The building is filled with natural light, Wii kiosks, “Green Arrow” healthy food options in their on-site cafeteria (subsidized) and a 75,000 square foot green “part walkable” roof.

IDEO is another great organization I’ve studied. One of their traditions is to “redesign” a coworker’s workstation while they’re away on vacation. Apparently one employee went away and when he returned, coworkers had replaced his workstation with a Volkswagen van, fully stocked with a desk, computer, and a phone. The redesigned workspace was a huge hit, and now is a popular meeting spot in the office. As this story demonstrates, IDEO approaches wellness in the same way it approaches work: through play and experimentation.
approach. They have outside experts come in to design and deliver “evidence-based” programs that are, frankly, boring and stale. (And, then they scratch their heads and wonder why no one is participating.) But, at IDEO it’s much more playful. People just try things out, like an employee might teach a “pop up” yoga class or might post an open-ended question on a giant chalkboard.

Companies like Patagonia, Nintendo and IDEO are examples of organizations that are integrating a way of working with a way of approaching wellness to drive a “culture of health” within the organization. Another trend I’m starting to see – and one that I advocate – is the integration between building a culture of health and a “culture of learning.” This makes sense, as the two go hand in hand. I would say that IDEO’s approach to wellness definitely embodies this concept. Here, the focus is less on health outcomes and more on engaging employees in a learning process. In their recent book An Everyone Culture: Becoming a Deliberately Developmental Organization, Harvard researchers Robert Kegan and Lisa Laskow propose the idea that work should be a place where employees get to develop themselves and become better versions of themselves through their work. This is exactly what we need to be doing in empowering employees to adopt healthier behaviors – encouraging them to view well-being as a process, an ongoing series of opportunities to learn and grow.

LS: Your examples are excellent and I’m sure resonate with people working in corporate organizations. But what about hospitals, higher ed institutions, NGOs, government organizations and other places? Do you see other glimmers of hope outside of Fortune 500 companies?

LP: I think there is this perception that everything is happening in Silicon Valley and in these high tech start-up companies. Actually, I would argue the opposite. I travel all across the country and I see a lot of wellness programs. In some ways, other parts of the country are ahead of us out here in Silicon Valley, as there is a dark side to the story. While these companies have lots of wellness perks, such as free food, these are also are a way to keep people at work for long hours, and tech companies admit it. There is evidence to suggest that there is significant amount of stress tech employees feel as a result.

LS: You can see it in their retention rates. I was reading that the average tenure for employees at Apple, Google, Amazon and other tech companies is between 1 and 2 years. That seems a little insane! That’s a tell-tale for me.

LP: In all fairness, a lot of the people who work for these tech companies are gaming the system. They know they will work at one place for a little while and then work at another place for more money or better benefits. There is a war for talent, and those who can take advantage of it, do.

But, let’s take a look at some real bright spots out there:

Oklahoma State University set out to establish itself as “America’s Healthiest Campus®” in 2013. Under the leadership of a designated Chief Wellness Officer, they’ve developed this incredible multi-dimensional well-being program that serves students, staff and faculty across all of its campuses and dispersed extension offices. Would you ever expect that OSU was the first university system to become tobacco-free or the first university to have a Chief Wellness Officer?

And, then one of my favorites is Sioux Empire United Way, in Sioux Falls, South Dakota. Several years ago, Coleen Thompson, the Finance Director decided to give up smoking, get healthy and lose weight, but she didn’t want to do it on her own. She came up with the idea of walking twice a day, every day. She mapped out an outdoor route and an indoor route (this is South Dakota after all – long winters) and each route was one mile in length. Then, she convinced her coworkers to join her on her walks. Now, fast forward to today. Thanks to her persistent (and persuasive) leadership, this organization has been walking together twice a day, everyday, for 11 years running. Best of all, it doesn’t cost any money, there’s no “expert” who’s overseeing it, and the program has endured over time. One person sparked a
movement. After seeing the success of the walking program, the president Jay Powell got inspired to find additional ways to support wellness at work, and began offering sit to stand desks for any employee who wanted one.

Colleen Thompson (leader of the walking meeting movement) at left next to Jay Powell, President, and other employees on one of the Sioux Empire United Way’s daily walks

Schindler Elevator Corporation brought me in to develop a leadership development program that incorporates well-being. We delivered a two-day off-site program for their top-tiered managers. Rather than focusing on health per se, we encouraged the managers to consider questions like “Do I have the energy to lead well?” This one leadership program literally catalyzed a movement that spread to other parts of the organization, including safety and HR.

Schindler Elevator Corporation “Safety Odyssey” workshop for top area safety managers working with Laura Putnam to explore the connection between safety and health

The MD Anderson Cancer Center brings the gym to where people work. They have created mini-fitness facilities called “Be Well” stations throughout the campus. These are great de-stressors. You can go and jump on the elliptical for a few minutes and then return to your work.

The Centers for Disease Control launched a stairwell campaign in the headquarters in Atlanta, Georgia. They use music, upgraded appearance, and motivational signage to nudge employees into using the stairs more often.

Duke Patient Safety Center has been employing resiliency programs, including one called “Name 3 Good Things” which employees do together in groups over a six-week period. These programs have proved to be phenomenally effective in addressing issues related to burnout and stress.

LS: How can learnings from the field of education apply toward promoting health and well-being in the workforce?

LP: My experience as a dancer turned teacher inspired me to start my company Motion Infusion in 2008. As a former dancer, I was really interested in finding new ways to bring movement into the classroom. I wanted to explore how movement might increase engagement and enhance the learning process. So, I started trying out simple things, like just getting students to stand up, go to the wall to write something in response to a question on butcher paper. What I saw was that even these little episodes of movement really increased their engagement. In a more extreme experiment, we conducted a week-long program where we taught students about the progression of movement from swing dance to Lindy Hop to hip hop. Students learned about the history of these dance forms, got to actually practice them, and at the end, delivered a performance. It was incredible. Through these experiences, I discovered how learning can be
transformed just by getting up on your feet. Motion Infusion is based on the premise that when we move, we get healthier, we get happier and we even get smarter. Now of course there is all sorts of research showing how movement positively impacts not only our bodies but our brains.

So, getting back to your question, what I often see is a lot of health experts who are trying to share more and more information about the perfect diet or the perfect way to exercise. But, the truth of the matter is that health promotion is really about getting people to adopt very basic lifestyle practices. By and large, everybody already knows what to do already. You would be hard pressed to find someone who doesn’t know that smoking is bad for them, or that it’s a good idea to eat fruits and vegetables or to move. The real question is, how do we help people to close the “knowing” and “doing” gap? And this is where a background in education can be really helpful.

A first step in applying best practices from education toward health promotion is to recall the Latin root word for “education,” educare, which means “to draw forth that which is already there.” So how do we, as wellness providers and leaders facilitate a learning process – rather than just deliver information and dump data? One way is to put learners in the driver’s seat. We need to spend less time providing information and more time allowing learners to interact together. To do that, we have to think about things like “how to build safety” within a group to encourage participation and engagement. You can’t just start with asking questions to a large group. You have to do things like pair individuals up or discuss in small groups before they can feel safe sharing with a bigger audience.

A second best practice, and one that any teacher knows, is that emotions rule. There is cognitive learning, but also affective learning (the manner in which we deal with things emotionally, such as feelings, values, appreciation, enthusiasms, motivations, and attitudes).

At the end of the day, our work comes down to the question: “How do we create the conditions in which individuals are more likely to motivate themselves?” This brings us to a third best practice from education, which is a deep understanding of motivation. Any teacher can tell you that you can have all of the incentives in the world, but if people are not motivated, they will not sustain change and they will not be authentically engaged. Meanwhile, research shows that the average health incentive is now a whopping $693 per employee – which is almost four times the amount that is directed toward the programs themselves. It’s no wonder that employees are checking the box to collect on their incentive, or in many cases, are actually leaving money on the table!

As a field, we need to do a much better job of tapping into intrinsic motivators. One of the ways we can do this is to design wellness programs that focus on the here and now, i.e. what is front and center for people. For most people, it’s not about disease prevention (that’s a long way off). Instead, it’s more about how they can be the best mom or dad, or how they can be more effective in their job or how they can have more energy every day. Interestingly, research from people like Michelle Segar, a behavioral sustainability scientist and author of No Sweat: How the Simple Science of Motivation Can Bring a Lifetime of Fitness, have found that people who exercise for energy compared with those who exercise for a health outcome like weight loss are more likely to sustain it.

Intrinsic motivation really is about connecting with our deepest human needs, things like the need for mastery, autonomy, purpose, social connections and the like. Fortunately, more and more people are starting to realize that the wellness profession needs to adopt a multi-disciplinary approach to change behaviors and make a difference.

LS: Not to get off on a rant, but as you’re talking, I can’t help think that government officials leading our country would be well served by having more educators as advisors. But I digress. This is really important stuff!

LP: So much of the field of corporate wellness has been historically based in fear. “Do this, or else you will gain weight, and if you gain weight, you are setting yourself up for a lifetime of diabetes and heart disease!” But instilling fear to drive change just doesn’t work. You would think, for example, that having a heart attack would be enough to “scare”
someone into being healthy for the rest of their life, but research shows that after a year, only 10% of post cardiac patients are still putting into practice healthy lifestyle changes. Often their well-meaning cardiac surgeon will tell them after surgery, “Put these healthy practices into place or else you will die!” But people don’t respond to that. The approach that seems to work better is one where the health care providers encourage the patients to “embrace life” and they foster a non-judgmental, learning approach to making change.

LS: Thank you so much for your insights, Laura. Your advice is super practical, researched and insightful! For all of you interested in learning more about Laura, her practice or her book Workplace Wellness that Works, you can find links to everything here: [http://www.motioninfusion.com/](http://www.motioninfusion.com/)

**Workplace wellness: Don't underestimate a spouse's role**


If employees surround ourselves with healthy people, odds are better that we will be healthy.

When it comes to improving the health of a workforce, an employer’s biggest ally might never set foot in the office. Why? Because that ally is the spouse or partner of your employee. These individuals have the power to either suggest going for an after-dinner walk or bike ride or suggest curling up with a bag of chips and a marathon of whatever’s hot on Netflix.

Spouses and domestic partners have a significant impact on whether employees participate in a workplace wellness program and on the health habits they adopt, so it’s important that employers find ways to include them in wellness program offerings.

The underlying idea here isn’t revolutionary. Numerous studies over the years have demonstrated that we are creatures of our environment. If we surround ourselves with healthy people, odds are better that we will be healthy. The opposite is also true.

There are a few possible reasons for this. In a presentation at the 2016 Health Enhancement Research Organization (HERO) Forum, Ashlin Jones, MA, director of research and advanced data science at Sharecare Inc., suggested the correlation could be due to the fact we are likely to marry someone who shares our interests, or the simple fact married couples are around each other so much they take on each other’s traits. Married couples also make decisions together — should we spend that bonus on a new exercise bike or a TV? — that affect each person’s health.

This isn’t just talk. The people we surround ourselves with can have a measurable physiological impact on us. In a separate presentation at the HERO Forum, Andrew Rundle, DrPH, associate professor of epidemiology in Mallman School of Public Health at Columbia University, discussed research that showed connections between partners’ BMI, blood pressure, and both high- and low-density lipoprotein. Meanwhile, a study by Jones found individuals were more likely to develop health risks such as obesity, stress, and reduced life satisfaction if their spouse had the risk, and were less likely to eliminate those risks if the spouse shared them.
Yet another study found that individuals are more likely to make a positive behavior change if their spouse makes the same change. For example:

- 48 percent of men and 50 percent of women quit smoking when their spouse did, compared to 8 percent if their spouse did not quit.
- 67 percent of men and 66 percent of women became more physically active when their spouse did, compared to 26 percent and 24 percent, respectively, when their spouse stayed sedentary.
- 26 percent of men and 36 percent of women lost weight when their partner did, compared to 10 percent and 15 percent when their partner did not lose weight.

Employers can use this dynamic to their advantage to improve employee health and well-being. Data from the HERO Health and Well-being Best Practices Scorecard in Collaboration with Mercer® found that employees are more willing to participate in an employer-sponsored wellness program if their spouse is also involved. According to the report, 28 percent of employees participated in life coaching activities when their spouse did, compared to 14 percent when their spouse was not involved.

That makes a difference, but getting spouses involved can have an even more direct impact on the bottom line. The HERO report also shows that spouses generate about one-third of health care costs in employer-sponsored plans, despite representing just one-fifth of covered members. It makes sense, then, that by improving the health of spouses, employers can potentially reduce their overall health care spend.

Beyond the health-related benefits of having healthier employees, there is evidence people in happy relationships at home spend more time at work, and that job satisfaction goes up when marital satisfaction improves.

There is also a significant opportunity here for savings in the area of mental health care, where the United States spent an estimated $201 billion last year — more than on any other medical condition. This is an area where spousal support can potentially make a big difference. Mental health is an area of growing concern for employers.

A spouse is more than someone who shows up for the occasional office party. They are an employee’s partner in life and in health, and their opinions carry significant weight. Encouraging them to participate in a workplace health and well-being program has the potential to positively impact an employer’s bottom-line health costs, while also improving employee engagement and productivity. That’s good news all around.

5 ways to include spouses or partners in workplace well-being

How can employers encourage involvement in health and well-being activities that will support their employees?

- Formally extend wellness benefits to spouses and families.
- Help couples develop joint strategies for implementing a healthy diet or exercise plan.
- Provide well-being education in formats that employees can easily share with spouses.
- Create information targeted specifically to spouses.
- Provide on-site wellness activities and coaching specifically for spouses.

Study shows wellness program boosted average worker productivity by more than 5%

BECKER'S
HOSPITAL REVIEW
Wellness programs can increase companies' operational productivity, suggests a new study titled "Doing well by making well: The impact of corporate wellness programs on employee productivity."

For the study, researchers from University of California, Riverside, UCLA, and Washington University in St. Louis used health and productivity data from 111 workers in five commercial laundry plants in the Midwest to determine how the corporate wellness program affected worker productivity. The data cover the time period of 2009 to 2012.

Four of the laundry plants participated in the wellness program as the treatment group while the plant that did not participate — because is used different insurance coverage, according to a UC Riverside report — acted as a quasi-control group.

According to UC Riverside, wellness program participants could access a health exam that included blood testing, checking blood pressure and a health survey. The participants subsequently received a report on their health status.

Overall, the study found wellness program participation increased average worker productivity by more than 5 percent — "roughly equivalent to adding one additional day of productive work per month for the average employee," according to UC Riverside. More specifically, researchers said sick and healthy individuals who improved their health through diet and exercise increased productivity by about 10 percent.

"Although the small worker sample limits both estimate precision and our ability to isolate mechanisms behind this increase, we argue that our results are consistent with improved worker motivation and capability," the study authors wrote. "The study suggests that firms can increase operational productivity through socially responsible health policies that improve both workers' wellness and economic value, and provides a template for future large-scale studies of health and productivity."

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**Lifestyle Medicine News**

**Short Answers to Hard Questions About the Opioid Crisis**

**The New York Times**

Aug. 3, 2017, by Josh Katz

This week, President Trump’s commission on combating the opioid crisis, led by Gov. Chris Christie of New Jersey, recommended that the president declare a national emergency.

The problem has become significantly worse recently, so you might feel that you could use a little catching up. Here are 11 things you need to know.

1. **How bad is it?**

   It’s the deadliest drug crisis in American history.

   Drug overdoses are the leading cause of death for Americans under 50, and deaths are rising faster than ever, primarily because of opioids.

   Overdoses killed more people last year than guns or car accidents, and are doing so at a pace faster than the H.I.V. epidemic at its peak. In 2015, roughly 2 percent of deaths — one in 50 — in the United States were drug-related.
The chart includes both deaths from drug poisoning and those caused by drug-related mental disorders. Sources: W.H.O.; Statistics Canada; Ireland Central Statistics Office; National Records of Scotland; National Center for Health Statistics, Centers for Disease Control and Prevention.

Overdoses are merely the most visible and easily counted symptom of the problem. Over two million Americans are estimated to have a problem with opioids. According to the latest survey data, over 97 million people took prescription painkillers in 2015; of these, 12 million did so without being directed by a doctor.

2. **What is an “opioid”?**

Something that acts on opioid receptors in the nervous system.

That’s not really a helpful answer.
The first such drug, and the one from which the opioid receptors get their name, was opium. Opium, a narcotic obtained from a kind of poppy, has been used in human societies for thousands of years. From opium people derived a whole host of other drugs with similar properties: first morphine, then heroin, then prescription painkillers like Vicodin, Percocet and OxyContin. Opium along with all of these derivatives are collectively known as opiates.

Then there are a handful of compounds that act just like opiates but aren’t made from the plant. Opiates along with these synthetic drugs — chiefly methadone and fentanyl — are grouped together into the category of substances called opioids.

Opioid receptors regulate pain and the reward system in the human body. That makes opioids powerful painkillers, but also debilitatingly addictive.

3. So is this crisis about prescription painkillers or heroin?
Both.

The crisis has its roots in the overprescription of opioid painkillers, but since 2011 overdose deaths from prescription opioids have leveled off. Deaths from heroin and fentanyl, on the other hand, are rising fast. In several states where the drug crisis is particularly severe, including Rhode Island, Pennsylvania and Massachusetts, fentanyl is now involved in over half of all overdose fatalities.

While heroin and fentanyl are the primary killers now, experts agree that the epidemic will not stop without halting the flow of prescription opioids that got people hooked in the first place.
4. Show me one way the epidemic has changed.

Sure.

The latest iteration of the opioid epidemic has been especially deadly among adults in their 20s and early 30s.

In 2000, the most common age for drug deaths, including those not involving opioids, was around 40. This was the generation that first grew addicted to prescription opioids in large numbers — white people especially so. Now there’s evidence that the opioid epidemic is dividing into two waves, with a new group of younger drug users growing addicted to, and dying from, heroin or fentanyl rather than prescription pills.

5. Where is the worst of the problem?

The Midwest, Appalachia and New England. For now.

There’s a lot of geographic variation in the rate of drug deaths, with the highest overdose rates clustered in Appalachia, the Rust Belt and New England.
In counties with fewer than 20 drug overdose deaths, the map combines observed totals with modeled estimates. Source: National Center for Health Statistics, Centers for Disease Control and Prevention

Teasing out the reasons for the geographical differences is not easy. In certain places, the ways in which people use drugs could be more dangerous (you’re more likely to die from injecting heroin than you are from smoking it, for example).

But it’s clear that a significant portion of the variation in deaths, if not necessarily in use, is being driven by the appearance of fentanyl in the drug supply. Fentanyl, a highly potent opioid, affects heroin users and pill users both, the latter often falling victim to counterfeit pills that look like prescription painkillers.

So far, the white population has been hardest hit, but this is beginning to change. Several critics have been quick to point out that the country’s response was not nearly as public-health-oriented during the crack cocaine epidemic in the 1980s, which disproportionately affected African-Americans.

**6. Why has this problem gotten so much worse in recent years?**

Decades of opioid overprescription, an influx of cheap heroin and the emergence of fentanyl.

Addiction to opioids goes back centuries, but the current crisis really starts in the 1980s. A handful of highly influential journal articles relaxed long-standing fears among doctors about prescribing opioids for chronic pain. The pharmaceutical industry took note, and in the mid-1990s began aggressively marketing drugs like OxyContin. This aggressive and at times fraudulent marketing, combined with a new focus on patient satisfaction and the elimination of pain, sharply increased the availability of pharmaceutical narcotics.
Pill mills began popping up around the country as communities were flooded with prescription opioids. Over the next decade, a growing number of people grew addicted to the drugs, whether from prescriptions or from taking them recreationally. For many, what started with pills evolved into a heroin addiction.

At the same time, the heroin market was changing. The price plummeted. Newly decentralized drug distribution networks pushed heroin and counterfeit pharmaceuticals into suburban and rural areas where they had never been. Everywhere the suppliers went, they found a ready and willing customer base, primed for addiction by decades of prescription opiate use.

Then in 2014, fentanyl began entering the drug supply in large amounts.

![Drug seizures containing fentanyl](image)

7. What is fentanyl and why is it killing people?

It’s a synthetic opioid 50 times more potent than heroin.

Heroin is derived from opium, a plant. That means its growers need fields and labor to harvest the crop. They are tied to land, weather and time.

Fentanyl is purely synthetic. Think chemistry, not agriculture. It’s commonly used for surgical anesthesia and is prescribed to treat pain, but almost all of the fentanyl on the streets is illicitly manufactured. According to the Drug Enforcement Administration, the majority of illicit fentanyl in the United States is manufactured either in China or in Mexico using precursors bought from China. And at least some portion of it comes to the United States in the mail, ordered from dark web sources like the recently shuttered AlphaBay. But we don’t know how much.

Fentanyl is a fine-grained powder, meaning that it’s easy to mix into other drugs. This is how most people are exposed to illicit fentanyl: It will be mixed into, or made to look like, powdered heroin or it will be used to produce counterfeit prescription pills.
It’s super potent, meaning you’re dealing with very small quantities. That makes it almost impossible to control supply. Though most of the fentanyl in America is thought to originate in China, the fact that it’s synthetic means it’s much harder to know where the drugs are coming from. With heroin, investigators could rely on regionally specific chemical markers to indicate where the drugs had been produced. With drugs synthesized in a lab, it’s harder to tell.

8. **Why would people take fentanyl? It does not sound fun.**
Many aren’t intending to.

From a dealer’s perspective, fentanyl is easier to get and more profitable to sell. Some law enforcement officials argue that drug users will seek out batches of drugs that contain fentanyl or that are known to have killed people, as that demonstrates the drugs’ potency.

While that is certainly true for some number of drug users, research suggests that they are a minority. Most are exposed to fentanyl inadvertently — it’s difficult to know just what is in the drugs they are buying (many dealers don’t know themselves), one more risk in a dangerous pursuit of a high.

For long-time drug users, their continued use underlines the grip of addiction and the agony of withdrawal: They know it could kill them but do it anyway. Casual drug users are also at risk of fentanyl poisoning, particularly with increased reports of fentanyl-adulterated cocaine.

9. **So shouldn’t we just stop prescribing opioids?**
No.

Opioids are a vital component of modern medicine that have measurably improved the quality of life for millions of people, particularly cancer patients and those with acute pain. But their efficacy in treating chronic pain is less clear, especially when weighed against the risks of overdose and addiction.

Though prescription opioid consumption has been decreasing in the United States since 2010 or 2011, it remains high. According to the International Narcotics Control Board, if the amount of opioids prescribed per year were averaged out over each person living in America, everyone would get about a two-week supply. (Or a three-week supply, according to the C.D.C. Different ways of measuring what counts as a daily opioid dose give different values.) Either way you count, it’s higher than anywhere else in the world.
At the same time, some chronic pain patients now struggle to fill their prescriptions. Solving the opioid problem requires controlling prescription opioid distribution while maintaining access for patients with legitimate medical needs. Suddenly removing access to opioids from those who are dependent on them to function could easily push people to illicit opioid sources, like heroin or counterfeit pills.

10. What can be done?
There’s no silver bullet.

Experts agree fixing the opioid epidemic will take a combination of solutions. But it’s a question of priorities: Which approaches will be most effective and most efficient? What is the best use of resources?

Officials want to use state prescription drug monitoring programs to reduce the supply of prescription opioids that end up being used recreationally while maintaining adequate access for current chronic pain patients. More broadly, experts say we need to improve the way our medical system manages pain. Remember the 12 million people we said took prescription painkillers outside of medical use? Roughly two-thirds of those did so to relieve physical pain. A more holistic approach to pain treatment would lessen the need for opioids.

On the treatment side, experts stress the importance of having treatment readily available for those who are already addicted. Often that means going to where the people are, not waiting for them to seek out treatment themselves. And addiction treatment doesn’t just mean counseling or an inpatient clinic. Studies show the most effective treatment for opioid addiction often requires opioid medications like methadone or buprenorphine.

In the meantime, widespread distribution of naloxone — an overdose antidote — will save lives in acute cases.

There isn’t agreement about other possible measures that could help. Public health experts advocate things like safe injection sites, where people could use drugs under medical supervision, and drug checking services that people could use to test drugs for fentanyl, but many in law enforcement remain reluctant to adopt such measures.
11. Will the commission’s recommendations help?

Maybe, but only if they’re adopted.

The commission laid out a series of recommendations in its interim report, with a final report expected in October.

Some of the recommendations — like enhancing prescription drug monitoring programs and mandatory physician education on the dangers of opioids — are aimed at prevention. Some — expanding access to and funding development of medication-assisted treatment, eliminating Medicaid barriers to in-patient addiction treatment and enforcing laws that prevent health insurance companies from limiting mental health coverage — are aimed at treatment. The commission’s report also called upon the president to mandate that naloxone be carried by every American law enforcement officer.

Of course, these are only recommendations. It’s up to the president and the various executive agencies to implement them. Experts know how to attack the problem. It’s just a matter of having the will to put those policies into practice.

Mindfulness, Hypnosis Can Quickly Ease Acute Pain in Hospital Patients

Mindfulness training and hypnotic suggestion may drastically reduce severe pain in hospital patients, according to new research published in the Journal of General Internal Medicine. The University of Utah study is the first to investigate the effects of mindfulness and hypnosis on acute pain in the hospital setting.

After receiving a single 15-minute session of one of these mind-body therapies, patients at the University of Utah Hospital in Salt Lake City reported an immediate reduction in pain levels similar to what one might expect from an opioid painkiller.

“It was really exciting and quite amazing to see such dramatic results from a single mind-body session,” said Dr. Eric Garland, lead author of the study and director of the University of Utah’s Center on Mindfulness and Integrative Health Intervention Development.

“Given our nation’s current opioid epidemic, the implications of this study are potentially huge. These brief mind-body therapies could be cost-effectively and feasibly integrated into standard medical care as useful adjuncts to pain management.”

The study involved 244 participants who had reported unmanageable pain due to an illness, disease or surgical procedure. Volunteers were randomly assigned to receive a brief, scripted session in one of three interventions: mindfulness, hypnotic suggestion or pain coping education. The interventions were provided by hospital social workers who had completed basic training in each type of treatment.
All three methods of intervention reduced patients’ anxiety and increased their feelings of relaxation; however, patients who participated in the hypnotic suggestion intervention and the mindfulness intervention experienced a 29 percent and 23 percent reduction in pain, respectively.

Patients receiving the two mind-body therapies also reported a significant decrease in their perceived need for opioid medication.

In contrast, patients who participated in the pain coping intervention experienced only a 9 percent reduction in pain.

“About a third of the study participants receiving one of the two mind-body therapies achieved close to a 30 percent reduction in pain intensity,” said Garland. “This clinically significant level of pain relief is roughly equivalent to the pain relief produced by 5 milligrams of oxycodone.”

Previous research by Garland suggests that multi-week mindfulness training programs may be an effective way to reduce chronic pain symptoms and decrease prescription opioid misuse. The new study added to Garland’s work by revealing the promise of brief mind-body therapies for people suffering from acute pain.

Garland and his interdisciplinary research team plan to further investigate mind-body therapies as non-opioid means of reducing pain by conducting a national replication study in a sample of thousands of patients in multiple hospitals around the United States.

Source: University of Utah

Related Articles:
- Using Mindfulness to Overcome Pain, February 6, 2014
- Mindfulness Training Helps People with Chronic Pain Reduce Opioid Use, June 29, 2017
- Mindfulness Found to Reduce Opioid Use, December 8, 2014

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**How to stop the deadliest drug overdose crisis in American history**

The opioid epidemic could kill hundreds of thousands in the next decade. But America can beat it.

*Vox*

Aug 1, 2017, by German Lopez


The scale of America’s opioid epidemic is shocking.

It is the deadliest drug overdose crisis in US history. In 2016 alone, drug overdoses likely killed more Americans in one year than the entire Vietnam War. In 2015, drug overdoses topped annual deaths from car crashes, gun violence, and even HIV/AIDS during that epidemic’s peak in 1995. In total, more than 140 people are estimated to die from drug overdoses every day in the US. About two-thirds of these drug overdose deaths are linked to opioids.

Yet so far, there’s been a lack of policy action to end the opioid epidemic. Much of what has been done has focused on reducing the amount of prescription painkillers out there, yet the latest federal data shows prescriptions were still three times what they were in 1999. Other prevention efforts have focused on stopping heroin and fentanyl from entering the US, but they have so far failed to make a dent in the flow of these drugs.
The only major bill passed by Congress on the crisis appropriated $1 billion to drug treatment over two years — far from the tens of billions a year that studies suggest the crisis actually costs. And Congress could still revive a health care bill that, by repealing Obamacare, would cut access to drug treatment for potentially millions of people struggling with drug addiction.

But even if Congress does appropriate the money to attack the crisis, do we know what to do with it? Opioid addiction is a complex, stubborn problem — and history is littered with policies meant to fight drug use that only made the situation worse.

Related: When a drug epidemic’s victims are white

So I reached out to drug policy and public health experts across the country for answers. My questions: If we dedicated every resource needed to deal with opioids, what should we do? And looking at addiction more broadly, how would we not just stop the current epidemic but prevent the next crisis?

What’s important to understand, experts said, is that the opioid epidemic is in fact the story of two crises — which Keith Humphreys, a Stanford University drug policy expert, explained as the dual problems of “stock” and “flow.”

On one hand, you have the current stock of opioid users who are addicted; the people in this population need treatment or they will simply find other, potentially deadlier opioids to use if they lose access to painkillers. On the other hand, you have to stop new generations of potential drug users from accessing and misusing opioids.

This is what much of the public discussion about the opioid epidemic has wrong. The two sides of the epidemic are often described as if they’re in conflict: One side pushes for more action on cracking down on the supply of opioid painkillers, while the other insists that the real solution is to massively expand drug treatment. The truth is that policymakers need to look at both, because each represents a unique population with different needs.

If you understand this, you can start to slowly peel back the solutions necessary to solve the epidemic — and why the proper responses can quickly get so complicated. They demand that we balance several big issues: the lessons of the opioid crisis, the needs of pain patients, and the enormous shortfalls in how the country approaches addiction and its underlying causes. They ask that Americans truly begin to think of addiction not as a moral failure — as has been entrenched in US society for decades — but as a real medical problem. And they will require a massive public investment to meet the big health care and socioeconomic needs facing millions of Americans.

That investment, however, will need to come soon. Because there’s another alarming statistic: If the opioid epidemic continues unabated, one high-end forecast by STAT estimates that 650,000 more people will die from opioid overdoses in the next 10 years — more than the entire population of Baltimore.

Here’s what we’ll need to do to stop that from happening.

1) Prevent new generations of opioid users

A recent report from the Centers for Disease Control and Prevention (CDC) produced an alarming statistic: “In 2015, the amount of opioids prescribed was enough for every American to be medicated around the clock for 3 weeks.”

This proliferation of painkillers is the root of the current drug crisis — and one of the first issues policymakers need to address to stop it from getting worse.

The opioid epidemic began in the 1990s, when doctors became increasingly aware of the burdens of chronic pain. Pharmaceutical companies saw an opportunity, and pushed doctors — with misleading marketing about the safety and efficacy of the drugs — to prescribe opioids to treat all sorts of pain. Doctors, many exhausted by dealing with difficult-
to treat pain patients, complied — in some states, writing enough prescriptions to fill a bottle of pills for each resident. The drugs proliferated, landing in the hands of not just patients but also teens rummaging through their parents’ medicine cabinets, other family members, friends of patients, and the black market.

Eventually, some painkiller users moved on to other opioids, like heroin or fentanyl and its analogs. Not all painkiller users went this way, and not all opioid users started with painkillers. But statistics suggest many did: A 2014 study in JAMA Psychiatry found 75 percent of heroin users in treatment started with painkillers, and a 2015 analysis by the CDC found people who are addicted to painkillers are 40 times more likely to be addicted to heroin.

In response to all of this, different levels of government have focused on preventing the overprescription of opioids with various policy levers. Some states have limited how many opioids doctors can prescribe. The federal government put some opioids on a stricter regulatory schedule. Law enforcement has threatened doctors with incarceration and the loss of their medical licenses if they prescribe opioids unscrupulously.

And the CDC released guidelines that, among other proposals, ask doctors to avoid prescribing opioids for chronic pain. The agency noted that the evidence for opioids treating long-term, chronic pain is very weak (despite their effectiveness for short-term, acute pain), while the evidence that opioids cause harm in the long term is very strong. In short, the risks vastly outweigh the benefits for most chronic pain patients.

The result is opioid prescriptions have declined since 2010. But there’s still a lot of work to be done: In 2016, there were enough pills prescribed to fill a bottle for every adult in the US. And in 2015, the amount of opioids prescribed per person was more than triple what it was in 1999, according to the CDC.

Given that, some experts have proposed stricter measures. A recent report from the National Academies of Sciences, Engineering, and Medicine issued several proposals to the Food and Drug Administration (FDA), including that the agency conduct a review of opioids already on the market and strengthen its post-approval oversight of opioids — while also considering the potential harms of yanking opioids from patients who really need them.

The report said, “Steps to this end should include use of Risk Evaluation and Mitigation Strategies that have been demonstrated to improve prescribing practices, close active surveillance of the use and misuse of approved opioids, periodic formal reevaluation of opioid approval decisions, and aggressive regulation of advertising and promotion to curtail their harmful public health effects.”

Ideally, doctors should be able to get painkillers to patients who truly need them — after, for example, evaluating whether the patient has a history of drug addiction. But doctors, who weren’t conducting even such basic checks, are now being pressured to give more thought to their prescriptions. The hope is this will prevent new generations of people getting addicted to opioids.

There are limits to prevention: With the existing population of opioid users, cutting them off from painkillers could be dangerous. Although they shouldn’t be a first-line treatment, opioids can be the only source of relief for a few chronic pain patients. If someone is suddenly yanked from a high dose of opioids, they could undergo painful withdrawal. (This is why experts say careful tapering is necessary for a patient getting off opioids — to ensure the process is as painless as possible.) And people who lose access to painkillers could decide that rather than deal with pain from withdrawal or chronic conditions, they’re going to get other opioids — such as heroin and fentanyl, which are deadlier than painkillers and would likely lead to even worse outcomes.

That’s why, experts say, it’s a mistake to only focus on curtailing prescriptions.
“Let’s say you only focus on curtailing overprescribing to prevent people getting addicted, but you do nothing to expand treatment,” Andrew Kolodny, an opioid policy expert at Brandeis University, said. “Then heroin and fentanyl will keep flooding in, and overdose deaths will remain at historically high levels until the generation that became addicted ultimately dies off.”

2) Make addiction treatment easier to access than opioid painkillers and heroin

The primary problem with the opioid epidemic is simple: It is much easier to get high than it is to get help.

“For the people who are addicted, you want the treatment to be much easier to access than prescription opioids, heroin, or fentanyl,” Kolodny said.

He drew a comparison to how New York City dealt with tobacco. In his telling, the city took a two-prong approach: It made tobacco itself less accessible — by banning smoking in public spaces and raising taxes to make cigarettes much more expensive. But it also made alternatives to tobacco more accessible — by opening a phone line that people can use to get in touch with a clinic or obtain free nicotine patches or free nicotine gum.

This is similar, Kolodny argued, to what the US should do with opioids.

So far, the US has tried to make opioids less accessible with prevention strategies, as outlined above.

But the country hasn’t done much to increase access to alternatives to opioids — specifically, medication-assisted treatment, when medicines like methadone, buprenorphine, and naltrexone are used to reduce opioid cravings. There are still places with no treatment clinics whatsoever, much less affordable options.

According to a 2016 report by the surgeon general, just 10 percent of Americans with a drug use disorder obtain specialty treatment. The report attributed the low rate to severe shortages in the supply of care, with some areas of the country lacking affordable options for treatment — which can lead to waiting periods of weeks or even months.

Congress has added some spending to addiction care (including $1 billion over two years in the 21st Century Cures Act), but it’s nowhere near the tens of billions every year that Kolodny and other experts argue is necessary to fully confront the crisis. For reference, a 2016 study estimated the total economic burden of prescription opioid overdose, misuse, and addiction at $78.5 billion in 2013, about a third of which was due to higher health care and drug treatment costs. So even an investment of tens of billions could save money in the long run by preventing even more in costs.

“Crises in a nation of 300 million people don’t go away for $1 billion,” Humphreys said, referring to the Cures Act funding. “This is the biggest public health epidemic of a generation. Maybe it’s going to be worse than AIDS. So we need to go big.”

So what exactly would all that money go to?

For one, it should go to treatment that has strong evidence behind it. For opioids, that means, above all, medication-assisted treatment.

There is currently a stigma against this kind of treatment — particularly, that using medications, especially opioids like methadone and buprenorphine, to treat opioid addiction is simply substituting one drug with another.

Health and Human Services Secretary Tom Price echoed this myth earlier this year, saying, “If we’re just substituting one opioid for another, we’re not moving the dial much. Folks need to be cured so they can be productive members of
society and realize their dreams.” (A spokesperson for Price later walked back the statement, saying Price supports all kinds of drug addiction treatment.)

But this fundamentally misunderstands how addiction works.

The danger isn’t whether someone is merely using drugs; most Americans, after all, use caffeine or alcohol regularly throughout their lives with few problems. According to the definition in the Diagnostic and Statistical Manual of Mental Disorders, drug use transforms into addiction when habitual drug use begins hurting someone’s function — by, for example, leading them to steal or commit other crimes to obtain heroin, or, in the worst case scenario, resulting in death.

While medication-assisted treatment does involve continued drug use, it turns that drug use into a safer habit. When taken as prescribed, medications like methadone and buprenorphine can eliminate someone’s cravings for opioids and withdrawal symptoms without producing the kind of euphoric high that heroin or traditional painkillers can. It addresses the core problem of addiction, even if in some cases it does mean a patient will have to use a certain drug for the rest of his life. But the alternative isn’t a drug-free patient; the alternative is a continually relapsing patient — one who has to salve their addiction with dangerous street drugs.

This isn’t just hypothetical. Decades of research have deemed medication-assisted treatment effective for treating drug use disorders, with several studies finding it can cut mortality among opioid addiction patients by half or more. The CDC, the National Institute on Drug Abuse, and the World Health Organization all acknowledge its medical value. Experts often describe it as “the gold standard” for opioid addiction treatment — and agree that it needs to be made much easier to obtain.

More money could also go to programs that make attract more doctors and create more infrastructure for addiction care.

Anna Lembke, an addiction doctor who wrote Drug Dealer, MD, a book on the opioid crisis, told me of an innovative solution to the problem: what she calls an AmeriCorps for addiction treatment. She explained, “Why don’t we recruit these young people and say, ‘Hey, we’ll pay back your med school loans, in part, if you spend a couple years in rural West Virginia treating people with addiction’? We need to come up with creative ways like that to bring people into the workforce.”

Dr. Leana Wen, the health commissioner of Baltimore, suggested changing the structure of how care is provided. She envisions widespread emergency room services not just for physical health, as is already common, but also for mental health, including addiction.

“In the ER, people will often come in seeking help for their addiction,” Wen said, drawing from her own experience as a doctor. “But we will tell them that, unfortunately, we’re unable to get them into a treatment slot for three weeks or a month. … That individual, if they’re unable to get treatment that day at the time that they’re requesting, may have no other choice but to go out and use drugs [to avoid withdrawal] and maybe overdose and die.”

3) If we can’t stop people from doing drugs, we can make it less dangerous

An unfortunately reality with drugs is that addiction is tenacious. Even if policymakers got everything right on the treatment and prevention front, there are simply going to be some situations in which people will use and get addicted to drugs anyway.

So the goal shouldn’t be solely to prevent and stop the use of dangerous drugs but also to limit the harms attached to these substances.
One example: prescription heroin.

The method, which has been successfully tried in several countries, is simple: A certain segment of opioid users are going to use heroin no matter what. For whatever reason, traditional therapies just aren’t going to work for them — just like some treatments for, say, heart disease or cancer don’t work for some patients. So if that happens, it’s better to give them a safe source of the drug they’re seeking and a safe place to inject it, rather than letting them pick it up on the street — laced with who knows what — and possibly overdose without medical supervision.

The evidence backs up the approach. Researchers credit the European prescription heroin programs with better health outcomes, reductions in drug-related crimes, and improvements in social functioning, such as stabilized housing and employment. Canadian studies also deemed prescription heroin effective for treating heavy heroin users. A review of the research — which included randomized controlled trials from Switzerland, the Netherlands, Spain, Germany, Canada, and the UK — reached similar conclusions, noting sharp drops in street heroin use among people in the treatment.

Consider the story of John Pinkney, a patient at the Providence Crosstown Clinic in Vancouver, Canada. Pinkney, now in his 50s, traces his drug use back to the age of 6, when he began using Ritalin to treat his ADHD. As a child, Pinkney was shuffled from home to home, and his adoptive parents were violent. As a teenager, he ran away and lived on the streets — losing his Ritalin prescription and turning to harder drugs to fill the void. As an adult, he went to prison for robberies he committed to buy heroin.

He tried treatment, including medication-assisted therapy. Nothing worked, and he kept using drugs. His life started tough, and it wasn’t getting better.

Then Pinkney ended up at the Crosstown Clinic, where he now gets heroin — paid for by government insurance — two or three times a day. He doesn’t have to steal to get the drug anymore. He now has the stability he needs to maintain a part-time job, live in an apartment with furniture and a TV, and do some advocacy work. As he recently told me, “You know, it’s like I got my life back.”

In other areas, there are many possible steps to reduce harm among the segment of the population that continues using illicit drugs. Needle exchange programs could let people trade in used syringes for new ones, reducing the risk a needle will carry HIV, hepatitis C, or some other disease. Supervised injection facilities could provide a place for drug users to inject illicit substances, with medical staff ready in case something goes wrong.

The opioid overdose antidote, naloxone, could be made much more accessible — not just to first responders but also to friends, family, and perhaps even out in the open in busy public streets.

In Baltimore, Wen in 2015 issued a standing order for naloxone, letting anyone in the city get the drug without a prescription from a doctor. With more funding, she would like to see that expanded further so naloxone is also affordable or free for everyone — an idea she describes, using naloxone’s brand name, as “Narcan for all.”

“In Baltimore city alone, our everyday residents have already saved over 950 lives in the last two years,” Wen said. But “we are limited in our efforts because of resources. We simply don’t have the money to buy Narcan for everyone who may encounter someone who’s overdosing.”

Although there’s a need to do more research on what kinds of strategies work best, there is a lot of evidence out there showing these kinds of harm reduction strategies work to save lives.
One concern with harm reduction strategies, echoed by anti-drug groups like the Drug Free America Foundation, is that removing some of the risk to using harder drugs will perhaps make some people more likely to use dangerous substances.

But this simply has no foundation in the evidence. For example, a 1998 study from researchers at Johns Hopkins University found needle exchange programs generally reduced the spread of HIV without increasing drug use. A 2004 study from the World Health Organization, which analyzed two decades of evidence, produced similar results.

Harm reduction efforts will not prevent all deaths. They won’t make all heroin use safe. But they will reduce the amount of harm done by these drugs.

“Sometimes, [addiction] is just terminal,” Lembke said. “Even if it’s not and doesn’t lead to death, there are people who will never be able to get better.” She added, “We have a holier-than-thou, black-and-white thinking about it. It really is hard to embrace the idea that that’s the best we can do. But you know what? Sometimes the middle of the road is the best we can do for some people. Not everybody is going to overcome their addiction, write a memoir, become famous, [and] be on Oprah. That’s just not going to happen.”

4) Address the other problems that lead to addiction

With addiction, what you see is not always what you get. Behind drug use are issues that, at face value, may not seem related — what some experts call the root causes of addiction.

There’s a classic experiment behind this idea: the Rat Park. Some of the original experiments on cocaine and heroin addiction were conducted under animal testing settings in which rats were caged off and socially isolated, with drugs as their only real form of recreation. These experiments suggested the drugs were extremely addictive, leading rats to use them literally to their deaths.

So Bruce Alexander, a Canadian researcher, decided to see what would happen if drugs were instead offered in a bigger cage in which rats could interact with other rats. His results were striking: While rats in cramped, isolated cages preferred drug-laced water, rats in healthier, more social environments preferred plain water — even when the drug-laced water was made intensely sweet. The results suggest that it’s not just the presence of drugs but other variables that drive people to use these substances.

This has led experts in the addiction field to point to the many social, environmental, and psychological issues that can contribute to drug use. As Maia Szalavitz, a longtime addiction journalist and author of Unbroken Brain: A Revolutionary New Way of Understanding Addiction, put it to me, “Anything that makes you miserable is going to increase the risk of addiction for quite obvious reasons.” For her part, she said there are three major contributors to addiction: other mental health problems, past trauma, and existential and economic despair.

Leo Beletsky, a professor of law and health sciences at Northeastern University, said that this part of the issue needs much more attention in discussions about the opioid crisis. He told me that although opioid overprescribing may have contributed to the current epidemic, he believes that, among other issues, “changes in welfare policy, changes in the economy, and social isolation” played bigger roles. He points to the fact that the US has seen rises in other deaths of despair, such as suicide and alcohol-related deaths, as proof that something deeper has gone wrong in American life.

“We have a lot of complex problems in this country,” Beletsky said. “Without really addressing all of those physical, emotional, and mental health problems, just focusing on the opioid supply makes no sense — because people still have those problems.”
Some places have put such ideas into policy. Iceland built an anti-drug plan that focuses largely on providing kids and adolescents with after-school activities, from music and the arts to sports like soccer and indoor skating to many other clubs and activities. Iceland coupled this approach with other policies — setting drinking and smoking ages, banning alcohol and tobacco advertising, enforcing curfews for teenagers, and getting parents more involved in their kids’ schools — to further discourage and fight drug use.

Researcher Harvey Milkman told journalist Emma Young, who profiled Iceland’s experiment, that it’s “a social movement around natural highs: around people getting high on their own brain chemistry ... without the deleterious effects of drugs.”

As a result, Iceland, which had one of the worst drug problems in Europe, has seen adolescent consumption fall. The number of 15- and 16-year-olds who got drunk in the previous month fell from 42 percent in 1998 to just 5 percent in 2016, and the number who ever smoked marijuana dropped from 17 percent to 7 percent in the same time frame. In a similar time period, from 1997 to 2012, the percentage of 15- and 16-year-olds who participated in sports at least four times a week almost doubled — from 24 to 42 percent — and the number of kids who said they often or almost always spent time with their parents on weekdays doubled, from 23 to 46 percent.

Approaches will differ. Iceland, after all, is a fairly small, homogeneous country. What works there may not work in the US, and what works in some parts of the US may not work in others. But the general idea, experts said, is sound.

When I asked experts for specific proposals for dealing with root causes of drug addiction, each person seemed to have dozens of ideas: developing stronger social safety net policies, creating new job programs, offering better wraparound social services, better integrating mental health care with the rest of the health care system, encouraging non-drug sources of relaxation and entertainment, and on and on.

“It will really require rebuilding communities from the ground up,” Lembke said. “We have to help communities rebuild families. We have to give people meaningful work. We have to give people some opportunity for play — and by that I mean alternative sources of dopamine, so people have something else to replace the drugs or prevent them from turning to drugs in the first place.”

Not all experts are convinced. Humphreys, for instance, argued, “I think a lot of [these ideas] are worth doing because they’re worth doing — fighting inequality, enriching people’s lives, bringing jobs back to Pennsylvania and West Virginia. But I don’t think it would have a big impact with addiction.” He pointed out that British Columbia — which does a lot of the things experts want the US to do, from offering a stronger social safety net to prescription heroin to universal health care — is still suffering from a drug overdose crisis that killed a record 922 people in 2016.

When it comes to opioids, addressing the root causes of addiction will also require addressing chronic pain — the reason a lot of people were exposed to opioids in the first place. Given that the evidence on opioids’ effectiveness for treating chronic pain is very weak, part of the solution will require making alternative pain treatments much more accessible to help the 100 million US adults who suffer from chronic pain.

As Stanford pain specialist Sean Mackey previously told me, there are non-opioid options for dealing with pain, including non-opioid medications, special physical exercises, alternative medicine approaches (such as acupuncture and meditation), and learning how to self-manage and mitigate pain. (There’s also evidence for medical marijuana reducing
opioid overdose deaths, since cannabis can act as a painkiller. But Mackey is skeptical, pointing out there are hundreds of non-opioid medications already available.)

But to get these options, more patients will need to be able to see doctors like Mackey to help put them on the right treatment plan. Such specialists remain out of reach — too expensive, too far away — for many patients. This is a reason that opioids became so popular in the first place: It’s much easier to give someone a pill than to get them into an expensive, complicated pain treatment program. Addressing the faults of the health care system, from lack of local options to lack of insurance, would help in this area.

Opioids may still be a good answer for a few chronic pain patients. When prescribed carefully on a schedule that works to diminish the excessive buildup of tolerance, they can work for some people. But Mackey cautions that opioids should not be a first-line treatment due to the grave risks, and alternatives should be tried first.

If these ideas do work, they will take time. Rebuilding a community and restructuring the health care system are years- or decades-long projects; they’re not something we can do overnight. But addressing the root causes of drug use could at least help stop future epidemics, even if it’ll come too late for the opioid crisis.

We know what to do, but we need to dedicate the resources to do it

For me, the most surprising part of reporting out this story was that a lot of it really isn’t surprising. Experts tended to share a lot of the same ideas. There’s a lot of good research backing up most of the proposed solutions. Simply put, we know how to stop the opioid epidemic.

Yet we haven’t. Overdose deaths have climbed for years, and the official numbers for 2016 and 2017 are expected to be even worse.

I asked experts why. Time and time again, they had the same explanation: There’s still a lot of stigma surrounding addiction. While doctors and experts understand it is a disease, much of the public does not — and views addiction as a moral failure instead.

I get emails to this effect all the time. Here, for example, is a fairly representative reader message: “Darwin’s Theory says ‘survival of the fittest.’ Let these lost souls pay the price of their criminal choices and criminal actions. Society does not owe them multiple medical resuscitations from their own bad judgment, criminal activity, and self-inflicted wounds.”

Some lawmakers share this sentiment. Missouri state Sen. Rob Schaaf, a Republican, once remarked that when people die of overdoses, that “just removes them from the gene pool.”

Perhaps as a result of this kind of attitude, there’s just not that much attention paid to the opioid epidemic. The issue was often drowned out during the 2016 presidential campaign by scandals and gaffes, particularly Hillary Clinton’s emails. It’s seldom come up in politics this year, as a record number have continued dying. And the public doesn’t seem to be putting much, if any, pressure on lawmakers to do anything about it. As New York Times columnist Nicholas Kristof noted in his recent op-ed, opioids are “a mass killer we’re meeting with a shrug.”

Perhaps the solution here is to educate people on the basic realities of addiction and why it needs our attention. The public needs to understand, as Lembke put it, that “if you see somebody who continues to use despite their lives being totally destroyed — losing their jobs, losing loved ones, ending up in jail — nobody would choose that. Nobody anywhere would ever choose that life. So clearly it is beyond this individual’s control on some level.”

People like John Pinkney in Vancouver don’t want to go to prison. They don’t want to lose their jobs. They don’t want to burden their friends and families. They don’t want to spend all their waking moments thinking of ways to chase down a
drug — just to feel okay for a few minutes or hours. They don’t want to spend their lives taking from more than giving to society. This is something that, for whatever reason, has afflicted them.

The ideas experts cited won’t stop all drug addiction forever. But they could save up to hundreds of thousands of people in the next 10 years, letting more Americans live the free, happy, productive lives that we all aspire to have.

**Getting Less Than 7 Hours of Sleep May Lead to Obesity, Study Finds**

![CBS Seattle](http://seattle.cbslocal.com/2017/07/28/sleep-obesity-diabetes-relationship-study/)

Consistently missing out on a full night’s sleep is detrimental to one’s health in different ways and may help contribute to obesity, according to a new study by the University of Leeds in England.

Researchers studied more than 1,600 adults’ sleeping and eating patterns. The participants also had their weight, waist circumference, and blood pressure levels recorded. The study’s findings revealed that those who reported getting less than seven hours of sleep each night have larger waists than those who get more sleep. The difference between those with six and nine hours of sleep was three centimeters on waist circumference.

“Because we found that adults who reported sleeping less than their peers were more likely to be overweight or obese, our findings highlight the importance of getting enough sleep,” said Dr. Laura Haride, lead researcher, via the University of Leeds. “How much sleep we need differs between people, but the current consensus is that seven to nine hours is best for most adults.”

Those who slept less also had less good cholesterol, which removes fat from the body.

“The number of people with obesity worldwide has more than doubled since 1980,” said Greg Potter, researcher on the study. “Obesity contributes to the development of many diseases, most notably type 2 diabetes. Understanding why people gain weight has crucial implications for public health.”

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**Circuit resistance training is an effective means to enhance muscle strength in older and middle aged adults: A systematic review and meta-analysis**

![McMaster](https://www.mcmasteroptimalaging.org/full-article/he/circuit-resistance-training-effective-means-enhance-muscle-strength-older-middle-32623)

Aug. 1, 2017

Abstract

BACKGROUND: Physical exercise, particularly resistance training (RT), is proven treatment to reduce the accelerated decline in muscle strength exhibited by older adults, but its effect is hindered by low adherence rate, even under well-structured programs.

OBJECTIVE AND DATA SOURCES: We investigated the efficacy of circuit resistance training (CRT) on muscle strength, lean mass and aerobic capacity in older adults based on report in MEDLINE, EMBASE, ClinicalTrials.gov and Cochrane electronic (through 8/2016). Study eligibility criteria: middle and older aged men and/or women who followed a structured program, assigned to CRT. Study appraisal and synthesis methods: Out of 237 originally identified articles, 10 articles were included with a total of 362 patients with mean: age -64.5 +/- 7.4 years; 3 +/- 1.15 sessions/week; session duration 41.8 +/- 15.9 min.

RESULTS: Upper body strength modestly increased, by 1.14 kg (95% CI; 0.28-2.00), whereas larger increment was seen in lower body strength (11.99; 2.92-21.06). Higher program volume (>24 sessions) positively influenced upper body strength and aerobic capacity.

LIMITATIONS: (1) variability in the studies' validity; (2) relatively low number of studies.

CONCLUSION: CRT is a valid alternative to conventional RT. Its shorter duration and lower intensity relative to traditional RT, may increase adherence to training in older adults.

Exercise in early life has long-lasting benefits

ScienceDaily
Date: July 31, 2017
https://www.sciencedaily.com/releases/2017/07/170731114710.htm

Source: Frontiers

Summary: The researchers found that bone retains a "memory" of exercise's effects long after the exercise is ceased, and this bone memory continues to change the way the body metabolizes a high-fat diet.

The researchers, from the Liggins Institute at the University of Auckland, found that bone retains a "memory" of exercise's effects long after the exercise is ceased, and this bone memory continues to change the way the body metabolises a high-fat diet, and published these results in Frontiers in Physiology.

The research team compared the bone health and metabolism of rats across different diet and exercise conditions, zeroing in on messenger molecules that signal the activity of genes in bone marrow. Rats were either given a high-fat diet and a wheel for extra exercise in their cage, a high-fat diet but no wheel, or a regular diet and no wheel. In the rats given a high-fat diet and an exercise wheel, the early extra physical activity caused inflammation-linked genes to be turned down.

High-fat diets early in life are known to turn up, or increase the activity of other genes that cause inflammation. Inflammation is the body's natural self-protective response to acute infection or injury, but the ongoing, low-grade inflammation linked to high-fat diets can harm cells and tissues and raise the risk of obesity, heart disease, cancer and other diseases.

Exercise also altered the way the rats' bones metabolised energy from food, changing energy pathways that disrupt the body's response to a high-calorie diet.
"What was remarkable was that these changes lasted long after the rats stopped doing that extra exercise -- into their mid-life," says Dr Justin O'Sullivan, a molecular geneticist at the Institute. "The bone marrow carried a 'memory' of the effects of exercise. This is the first demonstration of a long-lasting effect of exercise past puberty. The rats still got fat, but that early extra exercise basically set them up so that even though they put on weight they didn't have the same profile of negative effects that is common with a high fat diet."

Dr O'Sullivan says this may help scientists understand why, even though obesity and diabetes are often linked, some people with obesity do not develop diabetes. "It also strongly emphasises the health benefits of exercise for children."

Dr O'Sullivan's co-investigators were PhD student Dharani Sontam, Professor Mark Vickers, and Professor Elwyn Firth, all from the Liggins Institute.

With rising rates of overweight and obesity in children, it is important to understand the effects of these conditions on bone health, says Professor Vickers, an obesity specialist. "Obesity is governed by many genes. This work highlights the utility of small animal models in teasing out gene-environment interactions in health and disease."

Professor Firth, who studies bone development, explains that childhood and adolescence are periods of rapid bone growth. "If you reach optimal bone mass early in life, you're less likely to suffer from broken bones or other bone-related problems as an adult. Load-bearing from exercise and higher bodyweight is good for growing bones, but this and other evidence shows that if the extra weight comes from higher body fat mass, bone development may be subnormal," he says. "Bone metabolism strongly influences energy metabolism in the body, and metabolism -- what you do with energy from diet -- is the central crux of why some children and adults become obese."

The team hopes to repeat the experiment to see if the changes persist into old age, and if varying the exercise -- when it begins, how much the rats do, and how long they do it for -- could alter other genes, affecting other aspects of fat metabolism beneficially.

**Key Points:**

- Researchers from the Liggins Institute at the University of Auckland have found that bone retains a "memory" of exercise's effects long after the exercise is ceased, and this bone memory continues to change the way bodies metabolise a high-fat diet.
- Rats were either given a high-fat diet and a wheel for extra exercise in their cage, a high-fat diet but no wheel, or a regular diet and no wheel. In the rats given a high-fat diet and an exercise wheel, the early extra physical activity caused inflammation linked genes to be turned down. Exercise also altered the way the rats' bones metabolised energy from food, changing energy pathways that disrupt the body's response to a high calorie diet.

Story Source: Materials provided by [Frontiers](https://www.frontiersin.org). Note: Content may be edited for style and length.


Mindfulness training helps decrease impulsive and binge eating and increase physical activity

https://www.mcmasteroptimalaging.org/full-article/es/mindfulness-training-helps-decrease-impulsive-binge-eating-increase-physical-1633


Review question
Does mindfulness training help people with overweight and obesity lose weight, decrease impulsive and binge eating and increase physical activity?

Background
Obesity is a common condition that can result from many factors, including eating impulsively, binge eating, overeating in response to stress or depression, and physical inactivity. Research has suggested that these factors can be controlled with mindfulness training, which teaches people to be more conscious and aware of their present thoughts, feelings and experiences. Mindfulness can also help to reduce stress and depression, which are major contributors to binge and impulsive eating. Practicing mindfulness may help people recognize and reduce their food cravings, feel more motivated to exercise, and enjoy physical activity. The aim of this review was to measure whether mindfulness training improves weight loss, eating patterns and physical activity for people with overweight and obesity.

How the review was done
This is a review of 12 randomized control trials, including a total of 626 participants. All 12 studies were combined in a meta-analysis.

All participants were adults with overweight or obesity (body mass index ≥ 25)

Study participants received some form of mindfulness training focused on eating behaviour, stress reduction and/or physical activity (e.g. training workshops, instructional manuals, supportive phone calls and group therapy sessions).

Researchers measured changes in participants’ body mass index (BMI), impulsive / binge eating habits and/or physical activity.

Results were compared to control groups who did not receive any mindfulness training.

What the researchers found
Mindfulness training decreased impulsive and binge eating and increased physical activity among participants. However, over the study period, people who received mindfulness training did not lose any more weight than those in control groups. Studies with longer follow-up periods (up to 6 months) showed greater impacts on weight loss and the authors suggest more research is needed to determine the long-term effects of mindfulness training.

Conclusion
Mindfulness training appears to be an effective way to help people with overweight and obesity manage impulsive or binge eating and increase physical activity.
A multi-week regimen may be an effective complement to traditional therapy for depression, multiple studies suggest. People who suffer from depression may want to look to yoga as a complement to traditional therapies as the practice appears to lessen symptoms of the disorder, according to studies presented at the 125th Annual Convention of the American Psychological Association.

"Yoga has become increasingly popular in the West, and many new yoga practitioners cite stress-reduction and other mental health concerns as their primary reason for practicing," said Lindsey Hopkins, PhD, of the San Francisco Veterans Affairs Medical Center, who chaired a session highlighting research on yoga and depression. "But the empirical research on yoga lags behind its popularity as a first-line approach to mental health."

Hopkins' research focused on the acceptability and antidepressant effects of hatha yoga, the branch of yoga that emphasizes physical exercises, along with meditative and breathing exercises, to enhance well-being. In the study, 23 male veterans participated in twice-weekly yoga classes for eight weeks. On a 1-10 scale, the average enjoyment rating for the yoga classes for these veterans was 9.4. All participants said they would recommend the program to other veterans. More importantly, participants with elevated depression scores before the yoga program had a significant reduction in depression symptoms after the eight weeks.

Another, more specific, version of hatha yoga commonly practiced in the West is Bikram yoga, also known as heated yoga. Sarah Shallit, MA, of Alliant University in San Francisco investigated Bikram yoga in 52 women, age 25-45. Just more than half were assigned to participate in twice-weekly classes for eight weeks. The rest were told they were wait-listed and used as a control condition. All participants were tested for depression levels at the beginning of the study, as well as at weeks three, six and nine. Shallit and her co-author Hopkins found that eight weeks of Bikram yoga significantly reduced symptoms of depression compared with the control group.

In the same session, Maren Nyer, PhD, and Maya Nauphal, BA, of Massachusetts General Hospital, presented data from a pilot study of 29 adults that also showed eight weeks of at least twice-weekly Bikram yoga significantly reduced symptoms of depression and improved other secondary measures including quality of life, optimism, and cognitive and physical functioning.

"The more the participants attended yoga classes, the lower their depressive symptoms at the end of the study," said Nyer, who currently has funding from the National Center for Complementary and Integrative Health to conduct a randomized controlled trial of Bikram yoga for individuals with depression.

Elsewhere at the meeting, Nina Vollbehr, MS, of the Center for Integrative Psychiatry in the Netherlands presented data from two studies on the potential for yoga to address chronic and/or treatment-resistant depression. In the first study, 12 patients who had experienced depression for an average of 11 years participated in nine weekly yoga sessions of approximately 2.5 hours each. The researchers measured participants' levels of depression, anxiety, stress, rumination
and worry before the yoga sessions, directly after the nine weeks and four months later. Scores for depression, anxiety and stress decreased throughout the program, a benefit that persisted four months after the training. Rumination and worry did not change immediately after the treatment, but at follow up rumination and worry were decreased for the participants.

In another study, involving 74 mildly depressed university students, Vollbehr and her colleagues compared yoga to a relaxation technique. Individuals received 30 minutes of live instruction on either yoga or relaxation and were asked to perform the same exercise at home for eight days using a 15-minute instructional video. While results taken immediately after the treatment showed yoga and relaxation were equally effective at reducing symptoms, two months later, the participants in the yoga group had significantly lower scores for depression, anxiety and stress than the relaxation group.

"These studies suggest that yoga-based interventions have promise for depressed mood and that they are feasible for patients with chronic, treatment-resistant depression," said Vollbehr.

The concept of yoga as complementary or alternative mental health treatment is so promising that the U.S. military is investigating the creation of its own treatment programs. Jacob Hyde, PsyD, of the University of Denver, gave a presentation outlining a standardized, six-week yoga treatment for U.S. military veterans enrolled in behavioral health services at the university-run clinic and could be expanded for use by the Department of Defense and the Department of Veterans Affairs.

Hopkins noted that the research on yoga as a treatment for depression is still preliminary. "At this time, we can only recommend yoga as a complementary approach, likely most effective in conjunction with standard approaches delivered by a licensed therapist," she said. "Clearly, yoga is not a cure-all. However, based on empirical evidence, there seems to be a lot of potential."

Story Source: Materials provided by American Psychological Association (APA). Note: Content may be edited for style and length.


Exercise may reduce metabolic syndrome risk in workers who sit all day

Reuters Health, August 4, 2017, by Will Boggs MD
http://uk.reuters.com/article/us-health-dementia-risk-idUKKBN1AN255

Regular exercise outside of work can reduce the risk of metabolic syndrome in people whose jobs have them sitting most of the time, according to a small study from Brazil.

“If you have a sedentary occupation, especially in a sitting position for hours, you should move yourself out of work at least 150 minutes per week in a moderate intensity to mitigate the detrimental effects of sedentary behavior at work,” Eduardo Caldas Costa from Federal University of Rio Grande do Norte in Natal told Reuters Health.
Sedentary behavior has been associated with an increased risk for metabolic syndrome - a cluster of unfavorable markers including abdominal obesity, high blood pressure and low HDL “good” cholesterol - which, in turn, is associated with an increased risk of developing heart disease and type 2 diabetes.

The researchers investigated whether Navy workers who spent about eight hours daily seated, mostly in administrative duties, had different risks for metabolic syndrome based on their activity levels outside of work.

All the workers were men, ranging in age from 26 to 42. Out of 502 workers included in the final analysis, 201, or 40 percent, did not achieve at least 150 minutes per week of moderate-vigorous activity. Nearly half, 48 percent, were overweight and almost 19 percent were obese.

After adjusting for age, time in the job, body mass index (BMI) and tobacco use, researchers found the sedentary workers who met the physical activity recommendations were only about half as likely to have metabolic syndrome, compared to those with lower activity levels.

Workers with higher activity levels were also less likely to have abdominal obesity, high blood pressure and low HDL.

Even those who increased their activity slightly (the “insufficiently active” group) had lower blood pressure than workers who remained sedentary off the job, researchers reported in the Journal of Occupational and Environmental Medicine.

“Sedentary occupation workers should break up prolonged sitting time at work as much as they can in order to reduce the risk for cardiovascular and metabolic diseases,” Caldas Costa said by email. “Be involved in regular physical activity out of work, including leisure time, domestic activities, and active transportation (i.e., walking and/or cycling).”

Only the physically active group, he added, and not the insufficiently active group, had a reduced risk for metabolic syndrome compared to the sedentary group. “Therefore,” he said, “it seems that probably there is a minimum quantity of physical activity that can mitigate the detrimental effects of sedentary behavior at work.”


Midlife Behaviors May Affect Your Dementia Risk
Of greatest importance are diabetes, blood pressure and smoking, researchers say

Aug. 7, 2017, by Dennis Thompson, HealthDay Reporter

Your heart health in midlife may determine your risk of developing dementia in old age, a new 25-year study suggests.

Middle-aged folks who smoke or have diabetes or high blood pressure are more likely to have dementia as they grow older, said lead researcher Dr. Rebecca Gottesman.

“All of those risk factors were associated with increased risk of dementia overall in this study,” said Gottesman, a professor of neurology with Johns Hopkins University in Baltimore.
Moreover, the dementia risk associated with diabetes is nearly as high as the risk that comes from carrying the APOE-e4 gene, a known genetic risk factor for Alzheimer's disease, Gottesman said.

The investigators tracked nearly 15,800 participants in the Atherosclerosis Risk in Communities (ARIC) study. This is a U.S. National Institutes of Health-funded project designed to track the effect of hardened arteries on people's long-term health.

Participants were recruited between 1987 and 1989, and tracked over 25 years, undergoing a periodic battery of medical examinations that included tests of their thinking and memory abilities. During that time, about 1,500 were diagnosed with dementia.

"Risk factors for heart disease previously have been associated with brain problems, including dementia," Gottesman said. "It's particularly important to look at middle age because it looks like this is when the risk is greatest."

The study doesn't show a direct cause-and-effect relationship. Still, researchers found that certain heart risk factors were individually associated with dementia, including:

- Diabetes (77 percent increased risk of dementia).
- High blood pressure (39 percent increased risk).
- Pre-high blood pressure (31 percent increased risk).
- Smoking (41 percent increased risk).

Anything that does harm to the heart and blood vessels in middle age could hamper the body's long-term ability to support brain function, said Keith Fargo. He is director of scientific programs for the Alzheimer's Association.

"The brain uses a tremendous amount of energy and nutrients compared to other organs in the body, and it's the circulatory system that carries oxygen and glucose and other nutrients into the brain," Fargo said. "Anything that interferes with that process is going to be a challenge to the brain. Although the brain is very resilient, like any other organ in your body, it can only take so much abuse."

Heart risk factors also could make a person more likely to suffer "silent" mini-strokes that promote dementia, Gottesman said.

Finally, hardened arteries might make it more difficult for the body to flush toxins out of the brain, she added.

In a previous study of ARIC participants, Gottesman's team found that heart risk factors in midlife were associated with higher levels of beta amyloid, a gummy protein that accumulates in the brains of Alzheimer's patients.

It's possible that strong blood flow is better at flushing beta amyloid out of brain cells, particularly in middle-aged people, Gottesman suggested.

Even if you failed to address these risk factors in middle age, you can still help your brain by adopting a heart-healthy lifestyle in old age, Gottesman and Fargo said.

"I would say it's never too late, but the earlier the better," Fargo said. "There are things you can do at any point in your life to reduce your risk."

The study also found other factors that appear to influence dementia risk:

- Black people had a 36 percent increased risk compared with whites.
Those who did not graduate from high school had a 61 percent increased risk compared with high school graduates.

People carrying the APOE-e4 gene had a 98 percent increased risk compared with those who do not carry that gene.

The study results were published online Aug. 7 in JAMA Neurology.

More information: For more on lifestyle changes to improve brain health, visit the Alzheimer’s Association.

SOURCES: Rebecca Gottesman, M.D., Ph.D., professor, neurology, Johns Hopkins University, Baltimore; Keith Fargo, Ph.D., director, scientific programs, Alzheimer’s Association; Aug. 7, 2017, JAMA Neurology, online

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'Loneliness Epidemic' Called a Major Public Health Threat
Social isolation tied to increased risk for premature death, research suggests

Aug. 7, 2017, by Robert Preidt

Loneliness may be more hazardous to your health than obesity -- and a growing number of Americans are at risk, researchers report.

About 42.6 million American adults over age 45 are believed to suffer from chronic loneliness, according to AARP.

"Being connected to others socially is widely considered a fundamental human need -- crucial to both well-being and survival. Extreme examples show infants in custodial care who lack human contact fail to thrive and often die, and indeed, social isolation or solitary confinement has been used as a form of punishment," said Julianne Holt-Lunstad. She is a professor of psychology at Brigham Young University in Provo, Utah.

"Yet an increasing portion of the U.S. population now experiences isolation regularly," she added during a presentation Saturday at the annual meeting of the American Psychological Association (APA) in Washington, D.C.

Holt-Lunstad presented results of two large analyses. In one, researchers analyzed 148 studies that included a total of more than 300,000 people. Those studies linked greater social connection to a 50 percent lower risk of early death.

The researchers also reviewed 70 studies involving more than 3.4 million people to gauge the impact of social isolation, loneliness and living alone on the risk of premature death. The conclusion: The effect of the three was equal to or greater than well-known risk factors such as obesity.

More than one in four Americans lives alone, more than half are unmarried, and marriage rates and the number of children per household are declining, according to U.S. Census data.
"These trends suggest that Americans are becoming less socially connected and experiencing more loneliness," Holt-Lunstad said in an APA news release.

She said there is strong evidence that social isolation and loneliness increase the risk of early death more than many other factors.

"With an increasing aging population, the effect on public health is only anticipated to increase. Indeed, many nations around the world now suggest we are facing a 'loneliness epidemic.' The challenge we face now is what can be done about it," Holt-Lunstad said.

Possible solutions, she said, include getting doctors to screen patients for social isolation, and training schoolchildren in social skills. Older people should prepare for retirement socially as well as financially, she added, noting that many social ties are related to the workplace.

Holt-Lunstad also suggested that community planners include spaces that encourage people to gather together, such as recreation centers and community gardens.

Research presented at medical meetings should be viewed as preliminary until published in a peer-reviewed journal.

More information: The Campaign to End Loneliness has more on loneliness and health.


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Less sugar quickly improves health of overweight kids, adults

Glucose metabolizes 20 percent in the liver and 80 percent throughout the body, while fructose metabolizes 90 percent in the liver and converts to fat faster than glucose.

A new study shows that the health of overweight children and adults would improve drastically and quickly if they reduced their sugar consumption. File photo by Curioso/Shutterstock

Research shows overweight children and adults can significantly and quickly improve their health by consuming less sugar.

The study, published in the August edition of The Journal of the American Osteopathic Association, or JAOA, found that improved health can be seen in less than two weeks with reduced sugar consumption.

Reducing or eliminating fructose, especially high-fructose corn syrup, or HFCS, from the diet can avert obesity, fatty liver disease and type 2 diabetes.
Fructose accelerates the conversion of sugar to fat. Glucose metabolizes 20 percent in the liver and 80 percent throughout the body, while fructose metabolizes 90 percent in the liver and converts to fat 18.9 times faster than glucose.

"Fructose provides no nutritional value and isn't metabolized in the brain. Your body converts it to fat, but doesn't recognize that you've eaten, so the hunger doesn't go away," Dr. Tyree Winters, an osteopathic pediatrician focused on childhood obesity, said in a press release. "Many young patients tell me they're always hungry, which makes sense because what they're eating isn't helping their bodies function."

HFCS can be found in 75 percent of packaged foods and drinks due to the fact that it is cheaper and 20 percent sweeter than raw sugar.

Fructose starts the metabolic pathways that convert to fat and is stored in the body.

"If we cut out the HFCS and make way for food that the body can properly metabolize, the hunger and sugar cravings fade. At the same time, patients are getting healthier without dieting or counting calories," Winters said. "This one change has the potential to prevent serious diseases and help restore health."

**Better hearing, less constipation and other surprising benefits of exercise**

August 9, 2017, by Robert J. Davis


- Numerous studies have linked regular exercise to a lower risk of colds
- Regular exercise improves the ability to fall asleep, as well as sleep duration and quality

Periodically, we see reports that scientists are closer to developing a pill that would mimic the benefits of exercise.

The truth is that no medication or supplement even comes close to exercise for being able to do so much for so many people -- or probably ever will.

While we've all heard that regular exercise can improve heart health and strengthen muscles, it can also enhance the quality of your life in a number of ways. Five such benefits may surprise you.

**Sounder sleep**

The headline of a survey by the National Sleep Foundation said it best: "Exercise is good for sleep." In the poll of 1,000 people, those who exercised the most vigorously reported the best sleep quality overall. And they were less likely than non-exercisers to say that in the past two weeks, they had experienced problems such as trouble falling asleep or waking during the night.

These findings are supported by a review of 66 studies on exercise and sleep. It concluded that regular exercise is comparable to sleep medication or behavioral therapy in improving the ability to fall asleep, as well as sleep duration and quality.
Researchers aren't sure why, but they suspect that physical activity may help by affecting body temperature, metabolic rate, heart rate or anxiety level, among other things.

Because exercise also revs up your body, conventional wisdom has it that exercising in the evening can interfere with sleep. But research in young adults as well as older people has failed to support this assertion.

Of course, everyone is different, so it's possible that nighttime exercise may make it harder for you to sleep. But the only way to know is to try. You may be pleasantly surprised at what a little pre-bedtime sweat can do for your sleep.

**Fewer colds**

You may have heard fitness buffs claim that they never get sick. This may seem like baseless -- not to mention annoying - - boasting, but there is scientific truth to it. Numerous studies have linked regular exercise to a lower risk of colds.

For example, a study that followed 1,000 adults for three months found that those who did aerobic exercise at least five days a week were about half as likely to develop colds as those who didn't exercise. And when exercisers did catch colds, they had fewer and less severe symptoms than their couch-potato peers.

These studies, which show associations but not cause and effect, are corroborated by randomized trials on exercise and colds. In one such experiment, sedentary postmenopausal women were assigned either moderately intense exercise (such as brisk walking) five days a week or once-a-week stretching. By the final three months of the 12-month study, those doing regular exercise reported having substantially fewer colds than the stretchers.

Research in animals and humans suggests that exercise chases away colds by boosting the immune system. At the same time, very intense activities may suppress immunity by increasing levels of the stress hormones cortisol and adrenaline.

That perhaps explains why, in one study, runners who participated in a Los Angeles marathon were nearly six times more likely to get sick in the week after the race than runners who did not participate.

Though this is a potential issue for elite athletes or people who do marathons or triathlons, the level of activity among most exercisers -- even if it's vigorous -- is far more likely to keep colds at bay than bring them on.

**Healthier eyes**

When you hear about a connection between exercise and eyesight, maybe you picture those eye exercise programs that promise to sharpen your vision. But that's not what we're talking about. Instead of moving your eyes, the idea is to move your feet.

Research shows that people who are physically active have a lower risk of cataracts. For example, a study of nearly 50,000 runners and walkers found that those who exercised most vigorously were 42% less likely to develop cataracts than those who exercised the least vigorously. Exercisers who fell in the middle in terms of intensity were also at reduced risk, though to a lesser degree.

The same researcher found a similar benefit regarding age-related macular degeneration, a leading cause of vision loss also known as AMD, in a study of nearly 42,000 runners. The more people ran, the more their risk of the condition declined. A different study, which followed roughly 4,000 people for 15 years, showed that participants who were physically active were less likely to develop AMD than those who weren't active.

Scientists aren't sure why exercise protects against cataracts and age-related macular degeneration. One possibility is that it reduces inflammation, which is associated with both conditions.
Cataracts and AMD have also been linked to risk factors for cardiovascular disease, including elevated blood sugar and triglycerides, which regular exercise can improve. Further, some research suggests that people who are overweight or obese are more prone to cataracts and AMD, so physical activity may help by preventing weight gain.

**Enhanced hearing**

You heard it here first: Exercise may be good for your hearing. A study of more than 68,000 female nurses, who were followed for 20 years, found that walking at least two hours a week was associated with a lower risk of hearing loss. Other research has linked higher fitness levels with better hearing.

Exercise may protect against hearing loss by improving blood flow to the cochlea, the snail-shaped structure in the inner ear that converts sound waves into nerve signals that are sent to the brain. What's more, it may prevent the loss of neurotransmitters, which carry those signals between nerve cells. Exercise may also help by reducing the risk of diabetes and cardiovascular disease, both of which are linked to hearing loss.

Of course, blasting music into your ears while you exercise could have the opposite effect and do damage to your hearing. Noise-canceling headphones are a good option because they reduce the need to turn up your music as much. But don't use them while exercising on a busy road. By being unaware of approaching traffic, you could be subjecting yourself to a risk far more serious than loud music.

**Better bathroom habits**

The place to start, naturally, is No. 1: Though high-impact activities such as jumping or running can cause women to leak urine, research shows that moderate exercise may decrease the risk. For example, a study of middle-aged female nurses found that those who were physically active had lower rates of urinary incontinence than women who were inactive. A study of older nurses by the same team of researchers yielded similar findings.

A urinary problem familiar to many middle-aged and older men is nocturia, the need to get up more than once a night to pee. Often, the cause is an enlarged prostate, a condition known as benign prostatic hyperplasia. Exercise can help prevent nocturia or reduce its severity.

In a large study of men with benign prostatic hyperplasia, those who were physically active for an hour or more per week were less likely to report nocturia than those who were sedentary. Likewise, a study of sedentary older men found that after eight weeks of daily walking, they urinated less frequently during the night.

Another common bathroom-related problem for both men and women is constipation, which exercise can help improve as well. In a study of 62,000 women, those who reported daily physical activity were nearly half as likely to experience constipation as women who exercised less than once a week. A randomized trial involving inactive middle-aged men and women with chronic constipation found that those assigned to a 12-week exercise program were able to poop more easily.

Exercise helps by decreasing transit time. That's how long it takes food to move through the digestive tract -- not, as it sounds, the amount of time it takes to get to work. Alas, a shorter commute is one benefit that exercise may not have -- unless, of course, biking to work is faster for you than driving in heavy traffic.

Adapted from "Fitter Faster: The Smart Way to Get in Shape in Just Minutes a Day" by Robert J. Davis with Brad Kolowich Jr.
Why Inflammation in Your Mouth May Raise Your Risk of Cancer

TIME Health, Aug. 8, 2017, by Amanda MacMillan
http://time.com/4891340/inflammation-mouth-breast-cancer/

Women with gum disease are 14% more likely to develop cancer than those with healthy teeth and gums, according to a study published in Cancer Epidemiology, Biomarkers & Prevention. The link appears to be strongest for esophageal cancer, but associations were also found between poor oral health and lung, gallbladder, breast, and skin cancer.

The study looked at data from nearly 66,000 postmenopausal women, ages 54 to 86, who were followed for about eight years. At the start of the study, they completed a health survey and reported whether they had ever been diagnosed with periodontal disease, an inflammation off the gums that can lead to tooth loss.

Gum disease is caused by sticky, bacteria-laden plaque that forms on teeth. In the early stages, known as gingivitis, the gums can be swollen and bleed easily. Daily flossing and brushing can usually reverse gingivitis. If plaque is left on teeth, it can progress to periodontal disease, which is inflammation around the teeth that causes gums to pull away and form pockets, which can trap more food and bacteria. With time, the bacteria, inflammation, and body's immune reaction can damage teeth and supporting bone structures, which can lead to tooth loss.

During the study's follow-up period, about 7,100 of those women developed cancer. Overall, those with a history of periodontal disease were more than three times as likely to develop esophageal cancer—and nearly twice as likely to develop gallbladder cancer—than women without. Their risk for lung cancer, skin melanomas, and breast cancer was also increased by 31%, 23%, and 13%, respectively.

Periodontal disease is more common in people who smoke and drink, which are also risk factors for several types of cancer. And in the new study, women with periodontal disease were more likely to report a history of smoking, exposure to secondhand smoke, and alcohol consumption.

But even among non-smokers, gum disease was still associated with a 12% increased risk of developing cancer overall. For some types of cancer, the link to gum disease did disappear when the researchers factored out smoking habits. For other types—like melanoma and cancers of the gastrointestinal tract—the connection remained.

This isn’t the first study to suggest that gum disease is associated with certain cancers, but few studies—and none on older women—have calculated an overall increased risk. The researchers focused on this population because risks for gum disease and cancer both increase with age, and because a link had already been established in men.

Researchers don’t know for sure why gum disease and cancer are linked, says senior author Jean Wactawski-Wende, dean of the School of Public Health and Health Professions at the State University of New York at Buffalo. But she and other researchers believe that bacterial pathogens in the oral cavity may play a role.

“These pathogens can travel to different parts of the body through your saliva, and they come in contact with your stomach and esophagus when you swallow, or end up in your lungs through aspiration,” says Wactawski-Wende. When gums become inflamed and infected, pathogens—or disease-causing toxins—can also permeate the tissue and enter the blood stream, and travel to other parts of the body as well.
Previous studies have shown that these pathogens may play a direct role in the formation of cancer tumors and other inflammatory health issues throughout the body. Gum disease has also been tied to obesity, diabetes and cardiovascular disease, but it’s not clear whether gum disease contributes to these conditions or vice versa.

The study authors point out that they were only able to find an association, not a cause-and-effect relationship, between gum disease and cancer risk. And it’s possible that gum disease in the study was under-reported, they add, since they relied on survey responses rather than a doctor’s or dentist’s exam.

But the large study size and the strength of their findings make a good argument for more research, they say. In fact, they’re currently studying the oral microbiome—the type and variety of mouth bacteria—of women with gum disease, and they plan to see if there are any patterns or links to the cancers the women may develop in the future.

The study also makes a good argument for taking care of those pearly whites, says Wactawski-Wende—and the gums that keep them in place.

“Between this and other studies, we’ve seen a link between periodontal disease and heart disease, diabetes, and now cancer, so it seem to me that it would be prudent to recommend maintaining good oral health,” says Wactawski-Wende. “That involves brushing and flossing, but also seeing a dental professional who can monitor and clean your teeth, and who can prevent periodontal disease or treat any cases that do arise.”

Heart Health Ignored by Many With Type 2 Diabetes
New evidence review reconfirms patient guidelines

Aug. 8, by Robert Preidt

Taking steps to prevent heart disease is crucial for people with type 2 diabetes. But most diabetic adults in the United States aren’t meeting recommended guidelines, health officials say.

In a new report, researchers confirm that "cardiovascular risk reduction is critically important for the care of patients with diabetes, with or without known [heart disease or heart disease] risk factors."

Drugs such as cholesterol-lowering statins, aspirin and blood sugar-lowering medications plus lifestyle approaches should be considered for all type 2 diabetes patients, according to the Aug. 7 report in the Journal of the American College of Cardiology.

Suggested lifestyle approaches include exercise, good nutrition and weight management.

For the report, researchers from New York University Medical Center examined evidence behind the guidelines for preventing heart disease in people with type 2 diabetes.

Diabetes is a major risk factor for heart disease, which is the most common cause of death in diabetes patients.
About one-third of Americans may have type 2 diabetes by 2050, the U.S. Centers for Disease Control and Prevention predicts. This means diabetic patients will make up a growing segment of heart disease patients.

Greater adherence to recommended guidelines could significantly reduce the risk of heart disease among these patients, the study authors said in a journal news release.

More information: The U.S. National Heart, Lung, and Blood Institute has more on diabetes and heart disease.

SOURCE: Journal of the American College of Cardiology, news release, Aug. 7, 2017

Artificial Sweeteners Trick the Brain: Study
Sugary taste can cause a heightened metabolic response, researchers say

HealthDay News, Aug. 11, 2017

New research may help explain the reported link between the use of artificial sweeteners and diabetes, scientists say.

Researchers at Yale University School of Medicine say that in nature the intensity of sweetness reflects the amount of energy present. But in modern-day life, the body's metabolism is fooled when a beverage is either too sweet or not sweet enough for the amount of calories it contains.

That means that a sweet-tasting, lower-calorie drink can trigger a greater metabolic response than a drink with higher calories, they said.

"A calorie is not a calorie," explained senior author Dana Small, a professor of psychiatry.

"The assumption that more calories trigger greater metabolic and brain response is wrong. Calories are only half of the equation; sweet taste perception is the other half," Small said in a university news release.

When a "mismatch" occurs, the brain's reward circuits don't register that calories have been consumed, the researchers said. Many processed foods have such mismatches, such as yogurt with low-calorie sweeteners.

"Our bodies evolved to efficiently use the energy sources available in nature," Small said. "Our modern food environment is characterized by energy sources our bodies have never seen before."

Small and her colleagues said the study may help explain the link between some artificial sweeteners and diabetes discovered in previous research. The topic remains controversial, however, and experts agree more research needs to be done.

The study was published Aug. 10 in the journal Current Biology.

More information: The U.S. National Library of Medicine has more on artificial sweeteners.
Just 5 Percent of Daily Salt Gets Added at the Table
Processed foods, restaurant meals account for most sodium intake in average U.S. diet, study shows

May 8, 2017, by Steven Reinberg, HealthDay Reporter

Tossing out the salt shaker may not be enough for your heart health. Most of the salt that Americans consume comes from processed foods and restaurant meals, a new study finds.

In a sampling of 450 U.S. adults, only 10 percent of salt, or sodium, in their diet came from food prepared at home. About half of that was added at the table.

Instead, restaurant meals and store-bought foods -- including crackers, breads and soups -- accounted for 71 percent of salt intake, the study found.

"Care must be taken when food shopping and eating out to steer clear of higher-sodium foods," said lead researcher Lisa Harnack.

For prevent harmful high blood pressure, Americans are advised to limit salt intake to 2,300 milligrams (mg) daily, said Harnack, a professor at the University of Minnesota School of Public Health. That's the equivalent of one teaspoon.

But, more than eight out of 10 Americans exceed this limit "by a mile," she said.

Food diaries from study participants showed that about 3,500 mg of sodium was consumed a day on average.

The report was published online May 8 in the journal Circulation.

Kathryn Foti, an epidemiologist who wasn't involved in the study, pointed out that high blood pressure is a leading cause of heart disease and stroke in the United States.

"Reducing salt reduces blood pressure and can help prevent cardiovascular disease," said Foti, of the Johns Hopkins Bloomberg School of Public Health in Baltimore.

"The most effective way to reduce salt is to reduce the content in commercially processed and prepared foods," added Foti, co-author of an accompanying journal editorial.

She said gradual, voluntary reductions across the food supply could have a large public health benefit.

"Reducing average sodium intake by as little as 400 mg per day could prevent up to 32,000 heart attacks and 20,000 strokes annually," she said.
The American Heart Association has launched a sodium-reduction campaign to encourage food companies and restaurants to reduce the salt in their products.

Harnack said food companies and restaurants that have pledged to comply "should be commended."

But, Foti added, doctors should step up their efforts by educating patients about where their salt actually comes from.

"While it's OK to encourage patients to go easy on the salt shaker, more importantly, physicians should emphasize product selection," Foti suggested.

She and Harnack recommended reading the Nutrition Facts panel on packaged foods.

Swap out the high-sodium items with lower-salt options, Foti advised. Salt content in many foods varies widely across brands, she noted.

In restaurants where nutrition information isn't posted, "consumers can request information about the salt content of menu items or ask how foods are prepared," Foti added.

"And of course, choosing more fresh foods, such as fruits and vegetables, can help you reduce the salt in your diet," she said.

The study involved 450 racially diverse adults, aged 18 to 74, living in Birmingham, Ala.; Minneapolis-St. Paul; or Palo Alto, Calif.

Between December 2013 and December 2014, the participants were asked to record their daily diet for four 24-hour periods. In addition, the study participants provided samples of salt equivalent to the amount they added at home.

Average salt consumption was over 50 percent more than the recommended 2,300 milligrams, the researchers found.

Salt added while cooking comprised only about 6 percent of sodium consumption, and salt added at the table from the salt shaker accounted for just 5 percent, according to the study.

Salt naturally found in foods made up about 14 percent of dietary sodium, while salt in tap water, dietary supplements and antacids made up less than 1 percent, according to the report.

More information: For more about salt in your diet, visit the American Heart Association.

SOURCES: Lisa Harnack, Dr.PH., professor and director, nutrition coordinating center, School of Public Health, University of Minnesota, Minneapolis; Kathryn Foti, M.P.H., epidemiologist, Bloomberg School of Public Health, Johns Hopkins University, Baltimore; May 8, 2017, Circulation, online

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