

A Holistic Approach



to Weight Management

FORWARD

A holistic guide to weight management

Welcome to a different approach to helping people manage their weight. The purpose of this guide is to provide a practical, evidence-based approach to weight management for use in conjunction with the booklet 'My Personal Approach to Weight Management'. Together they offer an alternative approach in tackling obesity which should be treated as a chronic disease requiring long term follow-up.

At the outset, I would like to express my appreciation to you for participating in this research project.

In summary, the contents of this booklet are divided into the following sections:

- background to obesity
- definition and measurement of obesity
- understanding the multifactorial nature of obesity
- implementing a holistic approach
- study protocol

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BACKGROUND TO OBESITY

Prevalence and health risks

The prevalence of obesity in the UK has trebled over the last twenty years (RCP, 2004) and if this rate continues by 2020 one third of adults will be obese. As these figures continue to rise, the cost burden to the NHS of caring for those who develop obesity related co-morbidities will also rise. It is well documented that obesity is a risk factor for hypertension, coronary heart disease, dyslipidaemia, obstructive sleep apnoea, asthma, stroke, osteoarthritis, gallstones, gastro-oesophageal reflux, infertility, lower extremity venous stasis, urinary stress incontinence and psychological disorders among others but the greatest risk is Type II diabetes where over 80% are overweight or obese.

Although hypertension may be picked up on routine examinations there is concern that even common co-morbidities such as type II diabetes and dyslipidaemia are not being diagnosed. To reduce the risk of this happening the following minimal measurements should be obtained as part of routine practice: weight, height, Body Mass Index, waist circumference, blood pressure, blood glucose and lipids.

Benefits of weight loss

Weight loss is an important aspect for prevention and treatment of co-morbid conditions where even a 5-10% weight loss has health benefits. The benefits of a 10% weight loss are shown in the following table from Jung, in SIGN (1996).

Mortality	20-25% fall in total mortality 30-40% fall in diabetes-related deaths 40-50% fall in obesity-related cancer deaths
Blood Pressure	Fall of approximately 10 mm Hg in both systolic and diastolic
Diabetes	Reduces risk of developing diabetes by >50% Fall of 30-50% in fasting glucose Fall of 15% in HbA1c
Lipids	Fall of 10% in total cholesterol Fall of 15% in LDL Fall of 30% in triglycerides Increase of 8% in HDL

However, a recent Health Technology Assessment (2004) systematic review, also involving Jung, has superseded SIGN and provided less dramatic but still significant results. It showed that a 10kg weight loss gave a 6.1mmHg fall in systolic blood pressure and a 5% drop in total cholesterol.

Activity 1

Approximately $\frac{1}{5}$ of UK adults are classified as having obesity. On the basis of this Information, estimate how many adults in your practice would come into this category. Insert the number in the box.

Can you identify at least one person from each of the following, who would benefit from 10% weight loss?

Blood pressure	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Diabetes	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know
Lipids	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> don't know

Approaches to weight management

The lack of good evidence from current interventions (Harvey et al, 2002) suggests that new approaches to weight management are required. Past weight management treatments have been prescriptive and narrow in focus although more recently the adjunct of behavioural therapy has slightly improved outcomes.

The use of the biomedical model where patients are given advice but fail to comply produces a sense of blame. For the purposes of this booklet, patients are called individuals to reflect both their individuality and active rather than passive participation in their treatment. Most individuals already blame themselves and feel very ashamed of their weight because obesity is stigmatised in our culture.

We, being part of that culture, must be able to set aside our own prejudices as identified in the Nursing & Midwifery Council (NMC). Doing so facilitates a caring, non-judgemental approach thus helping to diminish negative feelings and raise self-worth. Only then can we, in a much more holistic way, support and empower them in making decisions about realistic permanent lifestyle changes. Therefore, the focus is less on weight loss and more on long term weight management.

DEFINITION AND MEASUREMENT OF OBESITY

Before proceeding it might be helpful to define obesity and how it is measured. Obesity is defined as 'a consequence of energy intake exceeding energy expenditure over long periods of time' (Goldberg, 2003 p344). However, the influences creating this imbalance are multifactorial and this will be further explored in Section 3.

The most commonly accepted measurement used in clinical practice is the Body Mass Index (BMI) calculated in the following way:

Body Mass Index (BMI) = weight in kgs/height in metres sq

The levels of risk for BMI are shown in the following table:

World Health Organization Classification of adults by Body Mass Index

Classification	BMI (Kg/m ²)	Associated health risks
Underweight	<18.5	Low (but risk of other clinical problems increased)
Normal range	18.5-24.9	Average
Overweight	25.0-29.9	Increased
Obese Class I	30.0-34.9	Moderately increased
Obese Class II	35.0-39.9	Severely increased
Obese Class III	≥40	Very severely increased

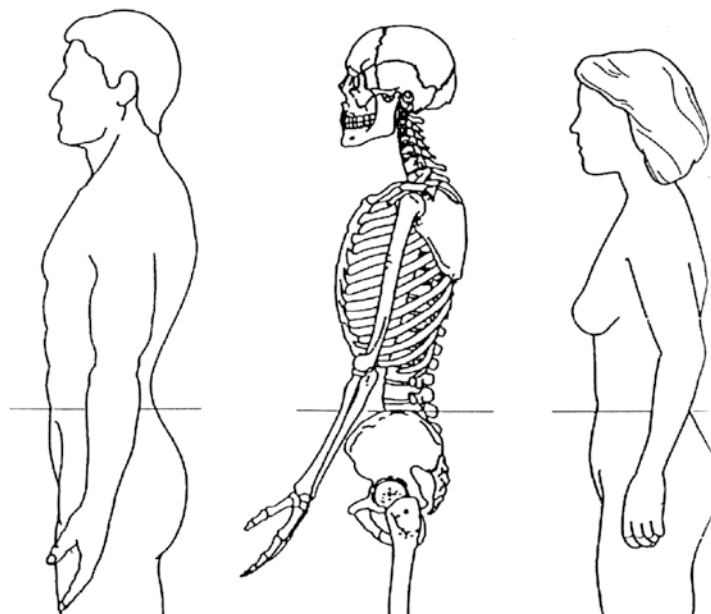
Although the above table gives the risk categories for Caucasians, it is not applicable to all races. For example, in the Asian population a BMI of 27.5 carries a comparable risk to those of a Caucasian with a BMI of 30.

While BMI is the best practical measure of obesity to date it is less reliable for those who are athletic and muscular. Muscle weighs heavier than fat and this may put them into the >30 BMI category. Therefore, body fat distribution also needs consideration as an important health risk assessment. Those who are 'apple shaped' (usually men), that is with mainly intra-abdominal fat, have a greater level of health risk than those who are 'pear shaped' (usually women) where fat is stored subcutaneously in the hips. Body fat distribution does change for women on reaching the menopause thereby increasing their health risk. It is, therefore, important to measure waist circumference particularly for a BMI<35. The following diagram from the National Institutes of Health (NIH, 1998) guidelines provides guidance on waist circumference measurement.

Measuring tape position for waist (abdominal) circumference

The following tips for measuring waist circumference were provided by WHO (1998)

- Have the individual stand with feet 25-30cm apart with weight evenly distributed
- Measure from the side not the front
- Remove the individual's clothing from around the waist
- Find the upper edge of the hip bone (the iliac crest) and the lower edge of the lowest rib
- Take the midpoint between these two levels
- Make the measurement horizontally at the midpoint level - whether the belly button is above or below
- Ask the individual to breathe in and then out gently, breathe in again and then out - then make the measurement



In those with BMI > 35 the health risks are known to be already high and it can be more difficult to measure waist circumference accurately. The levels of risk are shown in the following table:

Waist measurement

	Increased Risk	Substantial Risk
Men	>94cms (37in)	>102cms (40in)
Women	>80cms (32in)	>88cms (35in)

Activity 2

Work out the BMI for an individual who weighs 105.5kgs and has a height of 1.64m. What grade/class of BMI would this put them into and what level of co-morbidity risk would they have? What do you think their waist circumference measurement would be?

☐ 96cms ☐ 101cms ☐ 104cms ☐ any of them

People with the same BMI will have different waist circumferences depending on their body fat distribution. Therefore, in activity 2, while any of the waist measurements could be correct, it would be more accurate to have ticked the box 'any of them'

UNDERSTANDING THE MULTIFACTORIAL NATURE OF OBESITY

The increasing awareness that obesity is multifactorial has intensified the need for the exploration of a holistic approach to management. These factors include genetic, neuroendocrine, drug induced, emotional, social and environmental factors. A deeper understanding of these factors by both professional and individual will enhance the therapeutic relationship.

Genetic and neuroendocrine factors

The genetic contribution in the development of obesity is estimated to be between 25 and 40% (Thorikild et al 1994). Only a tiny fraction of this is linked to specific obesity syndromes such as Laurence-Moon-Biedl and Prader-Willi or single gene defects such as leptin deficiency. It seems that, more commonly, several genes are implicated in obesity development by their effect on appetite or the way nutrients are dealt with by the body (Caterson and Broom, 2001). These genes influence the functions of the regulatory systems of the body and differ between individuals. They create an interaction between the hypothalamus and fat cells, through a network of signalling pathways, thereby effecting energy homeostasis.

The ventromedial hypothalamus regulates appetite and satiety, therefore, any malfunction or injury may cause hyperphagia (Bray, 1998). In addition, it is now recognised that adipose tissue has an endocrine function as well as being an energy store (Hauner, 1996). Known endocrine causes of obesity such as hypothyroidism are, however, still relatively rare with Cushing's syndrome even more so.

Having an understanding that weight gain is not purely a lack of self-control is helpful in reducing feelings of guilt and self-blame. Those who feel better about themselves are more confident about managing their weight appropriately.

Familial Tendencies

Susceptibility to obesity also runs in families where one or both parents are overweight or obese. This is evidenced in twin and adoptees studies where there was a close correlation of body weight between the twins and their biological parents but not between adoptees and their adopting parents (Price et al, 1987; Stunkard et al, 1990).

Another common trait sometimes found in families is a low metabolic rate resulting in a tendency towards obesity (Bogardus, 1988). The resting metabolic rate (RMR) accounts for around 70% of the energy expenditure and differs by as much as 30% between individuals of the same age, sex and body weight (Kanarek and Marks-Kaufman, 1991). It provides energy for the maintenance of all body cells including involuntary muscle contractions. The remaining 30% of energy expenditure is divided between thermogenesis required for the ingestion, digestion and absorption of food and physical activity.

Nevertheless, for the majority who are already obese the RMR is actually higher due to their increased body mass but slows down with a reduced food intake (Garrow, 1978) resulting in difficulty in maintaining weight loss. When this occurs, individuals feel frustrated, but understanding that weight loss is like 'steps and stairs' may help maintain motivation.

Life Stage Influences

There are certain stages in life when there is a greater risk of becoming obese. The first of these occurs even before birth where under-nutrition in pregnancy can lead to obesity in later life for offspring (Goldberg, 2003) as can a high birth weight (Parsons et al, 1999). Being born into economic deprivation and a low socio-economic situation adds to the obesity risk (Rosmond et al, 1996; Jeffery and French, 1996).

In adulthood, women are particularly at risk during pregnancy, the menopause and retirement, while men are more at risk during their late thirties (DOH, 1995). A common link between the

genders is a small increase in weight gain in smoking cessation (Flegal et al, 1995). In the survey carried out to provide evidence for this guide, changing jobs and leaving school or home were also given as times when weight problems started.

While everyone is different, greater awareness of these possibilities will enable you to help individuals to be better prepared to deal with these 'at risk' times.

Psychological and emotional factors

While researchers in the 1960s and 1970s suggested that depression was a cause of obesity recent work has indicated that it is more likely to be a consequence. However, those with a higher BMI are more likely to gain weight if depressed (Stunkard et al, 1991) or suffer from seasonal affective disorder (SAD). It is therefore important to be aware of this and carry out assessment or refer on if necessary.

Anxiety and depression can be related to feelings of anger and guilt. However, anger can be related to symptoms such as body pain or poor sleep. Guilt may be associated with cravings and loneliness. It is known that both men and women can be susceptible to overeating or binge eating in response to negative emotions (Costanzo et al, 1999).

There is evidence to suggest that inappropriate coping mechanisms for dealing with stress play a role in the development of obesity (McCann, 1990). Individuals who recognise the situations that trigger these emotions can be helped to work out appropriate steps to deal with them. These may include methods of stress relief and relaxation techniques. Those who are bored are usually less active. If they also experience body dissatisfaction, then they are more likely to feel guilty. On the other hand, it could be due to mobility problems.

These various possibilities demonstrate the need for a person centred approach. Weight loss has a very positive affect on an individual by reducing negative feelings and increasing positive feelings such as pride and confidence.

Drug induced factors

When drug treatment is required, particularly for mental health problems, managing weight is sometimes compromised as a number of drugs are implicated in weight gain. Psychiatric medications, particularly the older tricyclic (TCA) and monoamine oxidase inhibitor (MAOI) antidepressants have this side-effect. Although newer selective serotonin reuptake inhibitors (SSRIs) initially have a minimal weight loss effect, in the long-term they may also cause weight gain (Schwartz et al 2004). Mood stabilising and antipsychotic drugs, while having a lesser effect than antidepressants, are also associated with weight gain.

Amongst other drugs implicated in weight gain are antiepileptic drugs such as valproate and carbamazepine; antidiabetic drugs such as insulin and sulfonylureas; and steroids such as glucocorticoids and oestrogen. (Bray, 1998). Therefore being aware of what medications are being taken is important as alternative treatment may be available.

Lifestyle

Of all the multifactorial influences on obesity perhaps the most influential is related to our way of life, which has dramatically changed in the past few decades. In relation to food our eating patterns have completely altered. The popularity of eating out, take-away and ready cooked meals, and the opportunity to purchase convenience foods and snacks 24 hours a day has inevitably led to a higher food consumption. This goes a long way in explaining the 50% rise in fat intake over the last 50 years (Prentice and Jebb, 1995). Since satiety signals are stimulated only after 'passive over-consumption' has occurred (Blundell, 1995) meaning that a lot of food has been eaten before the signals of feeling full are activated and dietary fat converts more efficiently to adipose tissue than carbohydrate or protein this has contributed to the obesity epidemic.

There is also encouragement to consume high calorie soft drinks. Alcohol over-consumption is perpetuated by 'happy hours' that aid the culture of binge drinking. Social conventions,

aggressive advertising and a higher standard of living all influence a greater energy intake at a time when energy output has diminished.

In both the home and work situations the physical effort required for daily tasks has been dramatically altered with mechanisation and technology. Leisure time has also been overtaken by technology, with television and computer games further encouraging a sedentary existence. In addition, the increasing reliance on the car for personal transport has compounded this problem. Nowadays, the individual has to make a deliberate choice to be active.

The causes of obesity are therefore multi-factorial and interlinked. With the increasing research being carried out comes a realisation of the complexity of this disease so making a holistic approach seem appropriate.

Activity 3

Think of several individuals who have a weight problem. For each one, make a list of what you think influences their weight. After you have done this, look at the lists again and identify any differences between the individuals.

IMPLEMENTING A HOLISTIC APPROACH

The information already covered combined with the following data will assist you to implement a holistic approach to weight management. This provides an opportunity to educate as well as support individuals in an empathic way.

In addition to feeling understood by others, they themselves need to understand what influences their weight, therefore, explaining the causes of obesity helps them to realise that they are not entirely to blame for their weight problems. This approach is reflected throughout the booklet 'My Personal Approach to Weight Management' provided for individuals. It provides the opportunity for them to take the lead in how they are going to manage their weight.

To this end, the intention is that the booklet be given to individuals to complete at home. This will allow them, at their own pace, to start thinking about how their weight affects them. In addition to being their own record it provides the basis for their next and subsequent visits. However, you may have to assist some individuals in completing the booklet.

The following information is designed to familiarise you with the booklet 'My Personal Approach to Weight Management' and its implementation. It takes you through the various sections, which correspond to those in the booklet. To further your understanding there are two case studies included on pages 8 and 9.

Sections 1-5

These sections obtain background information and introduce the opportunity to educate and address misconceptions about weight management.

The first two sections help to assess whether the main cause is likely to be environmental or genetic. If they have ticked 'problems in childhood' it is important to follow that up by exploring if there was a history of abuse or neglect, and if this has not been addressed to discuss the possibility of referral with the individual and other members of the practice team.

The third section raises the issue of obesity related health problems. It may be that when individuals identify their symptoms in the 'Weight Management Map' you may suspect that they have some, as yet, unidentified co-morbidity and want to follow that up. Section four focuses more on their social situation. Knowing the household set-up gives an important insight into the possibilities or problems for implementing change.

In section five, information about past weight history gives further insight into past failures and successes and gives a baseline to inform future care. Expectations of weight loss are often unrealistic and this sometimes explains past failures. Even health professionals have unrealistic expectations of weight loss adding to both the individual's sense of failure and their own frustration. This needs to be addressed as past experience colours beliefs about future success or failure.

Section 6

After giving background information the individual is encouraged in this section to think about more wide-ranging, in-depth, personal affects on their weight management. The format, which is based on the concepts of mind mapping, is designed to help identify links between social, emotional, spiritual and physical influences on weight management. Once identified, goals can be set to implement change.

When the individual returns with the completed first six sections of 'My Personal Approach to Weight Management' you should review the contents together so providing an opportunity to educate, support and motivate in an empathic way.

Assess the 'Weight Management Plan' on page 7 and the decisions by the individual on page 8. Although individuals usually know themselves what they need to do sometimes they require assistance to focus on some issues. This can be achieved through the use of open questions or counselling skills. Other individuals, however, could have deeper problems which may surface when approached with empathy. Should this occur your professional judgement will aid you in any decision about onward referral.

Section 7

This section moves the individual into thinking about how to implement change. Assist the individual to take the decisions from page 8 and insert them into 'My Action Map'. Use a pale purple shape for each decision. Sometimes people have high expectations of themselves and set too many goals. To encourage success rather than failure it is best to set small achievable goals and not target too many at one time. However, goals can often be interlinked and this will be seen as the map is completed.

To attain each goal in the blue oval, decisions have to be made about what actions might achieve that goal. These actions should be written or drawn in the corresponding yellow box. In that box there is also an area to record the progress of each action. Below the progress heading are four boxes to enter dates under which progress is recorded. This can be in any format the individual prefers. Pictures, such as facial expressions portray whether or not success has been achieved, and these can have more impact than a tick or cross, as can different colours. It depends entirely on the preferences of the individual as this booklet is their personal map (although for research purposes it will be either collected or photocopied at the end of the study).

Extra copies of 'My Action Map' are provided for use as and when you feel there is a need. Another copy of a 'Weight Management Map' is included for re-assessment at the end of three months. However, should the individuals circumstances change, and you feel there may be other goal priorities, it can be used at that time.

Activity 4

The complexity of weight management is illustrated by the following case studies of weight loss and weight gain. It is suggested that you read through case study 1 and use the information provided to make out a 'Weight Management Plan' (copies are provided in your folder)

Case study 1

The first is a single woman, in her twenties, who lives alone. She weighed 121.6kgs (BMI 44.1) but over six months increased her weight by 13.4kgs. Her grandparents, parents and brother all had weight problems, and while her own weight problem started in puberty it was also stress related. This reflects the fact that she suffered from Polycystic Ovary Syndrome (PCOS) and depression.

In relation to the PCOS the symptoms of bloating and sleep disturbance worsened along with her anxiety levels. Anxiety levels were also linked to greater body dissatisfaction and shyness and may be why she stopped swimming. This could indicate a link with societal pressures to be thin. Physical symptoms such as breathlessness, sweating, heartburn and bladder problems also became more troublesome.

There appeared to be high expectations of weight loss for although she thought that 1-2lbs weight loss a week was what she should be aiming for she felt that 3-5lbs could be achieved. However, as she gained weight she missed appointments probably because she felt more angry and guilty with herself for failing.

Activity 5

Once you have completed the 'Weight Management Plan' think about likely links between the different aspects and decide on possible goals. Take these goals and insert them into 'My Action Map' (copies are provided in your folder). Try to think what actions the individual might decide upon to achieve each goal. Now take it a step further by anticipating what the outcomes might be and complete the progress section.

Having completed case study 1 repeat the process for case study 2.

Case study 2

The second case study is of a married man, in his thirties, with two children. This minibus driver weighed 158kgs (BMI 43.8) and lost 25.9kgs over a six month period reducing his level of risk considerably by changing from being grossly obese to Grade (Class) II obesity. Unlike the previous individual, apart from his brother, there was no family history of weight problems and his obesity began in adulthood when he left home. Therefore, it would appear, that rather than a high genetic component, the influence was environmental.

This suggestion is further evidenced by the very low levels of activity, for in addition to a sedentary occupation he watched between 21 and 40 hours of television a week. Moreover, he lost most of his weight during the first three months when he only watched television for 5 to 10 hours a week, but when he went back to watching over 21 hours again he lost only a further 1.9kgs. It seemed that this was related to boredom. He was not a very active man but did increase his levels of walking and do-it-yourself. It seemed that dietary change was also an important factor.

He did suffer from sciatica. His pain levels were difficult to control and he suffered from sleep disturbance. However, his asthma and blood pressure improved while his mobility increased. The symptoms of sweating and skin problems also improved.

He had very strong internal beliefs and his levels of anger dramatically fell when weight loss was significant but rose again slightly when little progress was made. However, unlike the previous case study, he suffered less guilt, which was perhaps why he was less depressed. On the other hand, the support he felt he had from his wife, family, friends and colleagues may have helped him feel less guilty.

Having familiarised yourself with the process of the booklet, you may find the following additional information also helpful for practice. It identifies links between various aspects of weight management and contains information from the survey carried out to inform this guide.

Symptoms

Are the symptoms related to any existing or possible undiagnosed co-morbidities? For example, does a female who has abdominal bloating and poor sleep need to be asked about menstrual irregularities and hirsutism perhaps indicating Polycystic Ovary Syndrome.

Sleep appears to be a major problem for a significant proportion of individuals with obesity. Although this is often related to body pain it can be associated with hunger and cravings. This may result in individuals eating excessively during the night in secret. To regain control of their eating they need to learn to distinguish between hunger and cravings. The same applies to cravings at other times of the day.

Skin problems were highlighted as an area that requires attention as individuals with skin disorders may become isolated and lonely. This has a knock on affect for their weight management, so dealing with the skin problem may be the starting point.

Mobility

Mobility can be considerably reduced. Everyday activity such as getting in and out of the bath or tying shoe laces may cause problems. A number of questions can be raised. Is the mobility level associated with a co-morbidity or purely the result of weight? For example, is breathlessness on activity due to asthma or the effort of moving around? If mobility is limited because of joint pain, is there a need for onward referral to physiotherapy or rheumatology?

Activity

It is known that people overestimate their activity levels. Therefore asking about inactivity as well as activity may give a more accurate picture without seeming to be interrogating. Individuals who watch television for long periods of time tend to be much less active generally and do not participate in more strenuous activities.

Those who are more active are less bored, less dissatisfied with their bodies and have fewer mobility problems. Realisation of the benefits of activity on other aspects apart from weight loss, such as sleep and feelings, may encourage individuals to be more active.

Eating and drinking

Those who do not eat breakfast often overcompensate later in the day, particularly in the evening. An explanation of how the body reacts can help to alter this pattern. Like physical activity, it is the balance of the types of food that is important rather than foods being bad or good.

However, eating outside the home or having ready made meals means that the content of food is often difficult to assess. Food labels are an indicator of contents when shopping but to be useful often require explanation. As well as content there needs to be an awareness of portion sizes as manufacturers encourage increased consumption by providing bargains such as multi-packs of snack foods and two for the price of one items.

Feelings

People often exhibit negative emotions, (for example "I feel I'm not worth the bother"), and repeated failure exacerbates these feelings, particularly for perfectionists. These feelings may be a hangover from childhood experiences such as one man who was "bullied at school", or the result of stigmatization leading to loneliness. As a result, people will not go swimming or to the gym because of being "generally ashamed of my body's appearance".

Body satisfaction

Body satisfaction can influence how people, especially women, feel and react. One woman explained "everything seems to jiggle and this upsets me then I turn to food for comfort. Then I feel guilty then I eat more to try to make myself feel better (vicious circle)". In this situation more appropriate coping mechanisms need to be explored.

Beliefs

How people view themselves and their place in the world influences how much control they feel they have over what they do. If they do not value themselves then weight management will be very difficult, raising their self-esteem is therefore important. They may entirely blame themselves for their situation, for example, "I have high expectations which I often don't meet hence the guilt/anger".

On the other hand, they may have difficulty taking responsibility and blame weight gain on their genes or health. As one woman put it "As my weight gain is related to my thyroid problems I feel my control is limited - this isn't really understood". While hypothyroidism does make weight control more difficult, and should be acknowledged so that individuals feels understood, they should also realise that they can still achieve weight loss. Discovering people's beliefs influences the approach you need to take.

Support

Feeling supported in weight management is important to most people as it is in other areas of health. For those in the position of providing food for the family this is not always easy. Families can be antagonistic to changing eating habits as well as supportive.

The same applies to friends who may even try to sabotage attempts at weight loss "Some friends tend to buy me drink when they know I'm on a diet, one leads to another then your resolve goes". Identifying supporters and potential saboteurs is therefore crucial to planning care. Activity levels are also influenced in this way.

Women, in particular, often find the pressure of family commitments influence their weight. One woman illustrated this when she wrote "Mother has been ill - hospital etc - quite frustrating - she doesn't make an easy patient". Others feel that work pressures are a factor "Change of job (+boss) is removing most frustrations from my day".

Contacts

For some individuals, due to past experience, or perhaps depression, contact with others may be limited. One man who had a wife and two children isolated himself because, as he said, "I really have closed myself off from having any sort of contact with many things as it becomes too hurtful".

It appears then that obesity is indeed complex and therefore challenging for health professionals. But nurses, in particular, are well placed to deal with these challenges. The 'weight management map' reflects the complexity and individuality of issues, and provides a basis for consultations and planning holistic care.

Before introducing individuals to this approach to weight management you will have the opportunity to discuss any points/questions with me (Jenny Brown) in more detail. There is also a suggested reading list and websites at the end of this booklet for more in-depth information.

Activity 6

Now that you have read through this booklet, think about what you have learned and what you would still like to know. Make a list of each.

Identify areas of your nursing practice where weight management could be incorporated into individual care? What changes could you make?

Now that you have completed the activities you may want to use the experience to do a practice profile which can be used for PREP purposes.'

STUDY PROTOCOL

Practical aspects of data collection

It is suggested that you keep individual records in the folders provided. Details of weight, height, BMI, waist circumference can be recorded on the page already in each folder. You are asked to photocopy certain pages from the booklet 'My Personal Approach to Weight Management' once the individuals have completed them. Exact details are given for each appointment in the bullet points on pages 12 and 13.

Physical baseline measurements are required to identify those eligible for the study. While physical measurements are an important part of assessing change, the holistic approach focuses more on the individual. Therefore, even carrying out measurements requires sensitivity towards the feelings of the individual with obesity by the provision of space and privacy. Ideally, adequate equipment such as large or armless chairs, long tape measure, large blood pressure cuff and scales that record at least up to 200kgs should be available.

Once an initial weight has been obtained a long term target weight can be set. The charts (provided in your folder) give calculations for 10% weight losses. While the overall aim for the individual is to reach that 10% goal and maintain that weight loss, they would only be aiming for a 5% weight loss during the three months of this study. The conversion charts (provided in your folder) are for quick reference to enable you to give individuals information meaningful to them.

The short-term aim for weight loss should be a realistic 1-2lbs a week. Remind them that losing 1lb a week means a weight loss of 52lbs (23.6kgs) in a year. If following weight loss there is weight gain, looking at the overall picture can be encouraging. If weight is static sometimes waist measurement will have decreased. The use of a colour coded measuring tape helps demonstrate the level of risk to individuals, and a reduction in waist measurement helps motivation.

However, it is very important that changes in all the other aspects of weight management be taken into account as this takes the focus away from simply weight measurement. There is always something positive that can be highlighted.

Recruitment

After we meet to discuss recruitment you are invited to enrol at least five individuals, preferably within the month. Whether or not you recruit individuals who are new to weight management is your choice. Include adults (age >18) who are categorised as obese (BMI>30). It would be good to have a mix of males and females of different age groups but it will depend on your area of work. Ideally, after obtaining written informed consent, ask individuals to come fortnightly. If this is not possible, please see them a minimum of three times over the 3 month study.

If some individuals you approach are not ready to consider undertaking appropriate weight management this should be accepted as their choice. If this happens, they should be given information and the assurance that they can come back when they feel ready. Ideally, you should make another future appointment for reassessment or raise the subject at later consultations if they attend regularly for other reasons.

Recruitment procedure

- identify individual
- give information sheet and consent form to take home
- make return appointment

At return appointment

- individuals and nurse sign and date consent form
- ensure individuals know what is required for the research (eg number of visits)
- document physical measurements in nursing notes
- give 'My personal approach to weight management' booklet and explain contents
- ask individuals to complete sections 1-7 on pages 1-8 at home (or with you)
- make next appointment

Next appointment

- document physical measurements in nursing notes
- calculate and document target weight
- go over sections 1-6 completed by the individual
- explore with them the links on their 'Weight Management Map' on page 7
- review the actions decided on page 8
- set goals and actions to achieve goals on page 10
- encourage individuals to think about rewards for success
- make next appointment
- photocopy pages 2,3,4,5,7,8 and 10 of 'My personal approach to weight management' booklet for nursing notes

Following appointments

- document physical measurements in nursing notes
- reinforce goals, actions, achievements and rewards
- set new goals and actions if appropriate
- make next appointment
- photocopy page 10,11 or 12 as appropriate of 'My personal approach to weight management' booklet for nursing notes

Second last visit

- as 'following appointments' but ask individual to complete the blank 'Weight Management Map' at home for the last visit

Final study visit

- document physical measurements in nursing notes
- reinforce goals, actions, achievements and rewards
- keep or photocopy 'My personal approach to weight management' booklet
- ask the individual to complete and return a weight management satisfaction questionnaire
- discuss with individual whether they want to continue with this approach, return to previous weight management approach or current practice approach if no previous experience (whichever is appropriate)
- thank individual for taking part in study

Thank you for participating in this research project

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Notes

Useful websites

Websites are extremely useful for accessing additional information but be aware of their quality and when they were last updated.

Association for the Study of Obesity (ASO)

www.aso.org.uk/

This website provides more in-depth fact sheets for professionals about various aspects of obesity. Fact sheets are also provided for the individual trying to manage their weight. In addition, there are useful links to other websites and reports about obesity.

HEBS

www.hebs.scot.nhs.uk/learningcentre/obesity/index.cfm

This is a very practical website where the psychological assessment, in particular, complements the approach taken in this booklet. The range of information includes recipes that are attractively displayed.

National Institutes of Health

www.nhlbi.nih.gov/guidelines/obesity/ob_home.htm

The guidelines on this website provide excellent in-depth practical information about physical assessment, activities and foods. In the public section there is a quiz about portion sizes that you might like to try.

Notes

Notes

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