

# **Clinicians' and Consumers' Perspectives of Obesity Treatments**

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*A qualitative investigation of Clinicians' and Consumers' views of  
obesity treatments in New Zealand*

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## ABSTRACT

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**Background:** Obesity is associated with an increased risk of many non-communicable diseases, including cardiovascular disease, diabetes and cancer. Currently in New Zealand almost one third of all adults are classified as obese or having a Body Mass Index (BMI) of over 30kg/m<sup>2</sup>. Rates of obesity in New Zealand and around the world continue to rise, despite attempts from many suffering from obesity to lose weight. Traditionally, methods used by those trying to lose weight have involved increasing physical activity (energy expenditure), and decreasing the amount of calories consumed in the form of food and beverages (energy intake). It is now recognised that owing to various biochemical and genetic differences between individuals, some may find it easier to lose weight than others. Nevertheless, health professionals and sufferers alike are awakening to the multi-faceted nature of this disease and therefore the need for a multi-faceted treatment approach. In the present study, consumers and clinicians shared their thoughts about the barriers to and enablers of the effectiveness of current obesity treatments, and their suggestions for the future.

**Objective:** The overall aim of the present study was to investigate the similarities and differences between clinicians' and consumers' perspectives of obesity treatments, in order to contribute to the existing body of literature and to develop hypotheses for future research.

**Design:** An observational design for data collection, and a thematic analysis technique to analyse data were used in the present qualitative study. A total 61 participants were recruited including 32 'clinicians' and 29 'consumers'. Eight focus groups were conducted, recorded and transcribed verbatim before analysis. All data were analysed using thematic analysis, a 'bottom-up' approach to identifying key themes. NVivo qualitative software was used to organise the data and to assist with the generation of codes throughout the analysis.

**Results:** The participants in this study agreed that obesity treatments could be improved by increased psychological intervention, including efforts to reduce the impacts of obesity stigma; tailored educational materials and treatment campaigns to meet the needs of ethnic minorities; and initiatives that promote enjoyment, strength of community, and long-lasting follow-up and support. Barriers to the achievement of obesity treatment success included the influence of distorted nutritional messages within food marketing and media advertising on consumers' perceptions of healthy food; and the overall lack of reliable treatment initiatives for those seeking behaviour change and thus weight management.

**Conclusion:** Consumers and clinicians alike are exasperated and discouraged by the lack of effectiveness of obesity treatments. Feelings of frustration, anger, hopelessness and desperation resonated from both sides of the patient/provider fence throughout this explorative study. However, despite this apparent negativity, consumers especially illustrated a persistent defiance to overcome their battles with weight. Overall, clinicians appeared to lack a defined treatment pathway for the treatment of obesity. This warrants further investigation before a multi-disciplinary approach to treatment can be achieved.

## PREFACE

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The present study describes findings from larger study the findings of which are reported in: ‘Understanding Clinician and Consumer Perspectives of Obesity: Expanding Knowledge of the Causation and Treatment of Obesity (1). The larger study aimed to understand consumers’ and clinicians’ perspectives of the causes of obesity and its treatment. The primary supervisor of the present study Dr Jane Elmslie (Clinical Senior Lecturer, Department of Psychological Medicine, University of Otago Christchurch and Clinical Leader of Dietetics, Specialist Mental Health Services, Canterbury District Health Board) and secondary supervisor Dr Ria Schroder (Research Fellow, National Addiction Centre, Department of Psychological Medicine, University of Otago Christchurch) were involved in all aspects of this larger study including the study design, participant recruitment, data collection and analysis.

The candidate (Leanne Curgenvan) was responsible for performing a subsidiary/secondary analysis on the original data, focussing solely on perspectives of obesity treatments.

Specifically:

- Analysis of focus group data in the form of written transcripts.
- Coding and theme development using NVivo Qualitative Analysis Software, using a thematic analysis technique.
- Completion of full thesis research and write-up, with assistance and guidance from supervisors Dr J Elmslie and Dr RN Schroder, and in accordance with specifications outlined as per the MDiet course.

## LIST OF TABLES

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Table 1 Summary of themes - Barriers to effective treatments .....	32
Table 2 Summary of themes - Enablers of effective treatments .....	55
Table 3 Summary of themes - Future treatment initiatives.....	67

# LIST OF FIGURES

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Figure 1 Overview of Thematic Analysis .....	28
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## **LIST OF ABBREVIATIONS**

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BMI	Body Mass Index
MOH	Ministry of Health
NZMA	New Zealand Medical Association
NDAs	Non-Dieting Approaches
OECD	Organisation for Economic Co-operation and Development
VLCD	Very Low Calorie Diet
WHO	World Health Organisation

## GLOSSARY

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Atkins <sup>TM</sup>	‘Atkins’ refers to a low-carb dietary regimen otherwise known as the ‘Atkins Diet’. Named after its developer, Robert Atkins.
Body Mass Index	Body Mass Index is defined as the body mass (in kilograms) divided by the height (in metres) squared. It is currently a recognised measure amongst health professionals for classifying underweight, normal weight, overweight and various classes of obesity.
Non-Dieting Approaches	Non-Dieting Approaches to weight management focus on awareness of bodily hunger and satiety, rather than set restrictions of certain types or quantities of food.
NVivo	NVivo qualitative software is a computer programme developed by QSR International, designed to assist qualitative researchers to organise and manage large volumes of data.
Orlistat <sup>TM</sup>	Orlistat is a prescription drug marketed under the trade name ‘Xenical’, for the treatment of obesity.
Overeaters Anonymous <sup>TM</sup>	An international 12 step recovery programme for people with eating disorders.
Pasifika	Pasifika is a collaborative term referring to the indigenous people of the Pacific Islands.
Pisupo	The Pasifika term for a salt-cured meat product, known in New Zealand as ‘corned silverside’.



Rosemary Conley™

Founded by Rosemary Conley, this dietary regimen promotes low fat foods with an emphasis on calorie control and exercise.

Slimfast™

A calorie restricted dietary regimen consisting of mostly meal replacements such as shakes and non-food supplements.

Weight Watchers Pure  
Points System™

A calorie controlled dietary regimen that effectively converts calories in food into a total daily ‘points’ allowance.

# TABLE OF CONTENTS

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Abstract .....	ii
Preface .....	iv
List of Tables.....	v
List of Figures .....	vi
List of Abbreviations.....	vii
Glossary .....	viii
Table of Contents .....	x
Acknowledgements.....	xii
1 Introduction .....	1
2 Literature Review .....	3
2.1 Literature search .....	3
2.1.1 Inclusion criteria.....	3
2.1.2 Exclusion criteria .....	4
2.1.3 Search criteria .....	4
2.1.4 Search results .....	5
2.2 Clinicians' Perspectives of Obesity Treatments .....	5
2.2.1 Barriers to providing effective obesity treatments in primary care .....	5
2.2.2 Enablers of effective obesity treatments in primary care.....	8
2.2.3 Treatment enablers in intervention studies .....	9
2.2.4 Barriers to and enablers of obesity treatments in non-primary care settings.....	10
2.3 Consumers' Perspectives of Obesity Treatments .....	11
2.3.1 Barriers to effective obesity treatments in primary care.....	12
2.3.2 Suggestions for treatment in primary care .....	13
2.3.3 Barriers to weight loss maintenance.....	14
2.3.4 Barriers to and enablers of effective treatment in intervention studies .....	15
2.3.5 Psychological barriers to obesity treatments.....	17
2.3.6 Conclusion .....	18
3 Objective Statement .....	20
4 Methodology and Methods .....	21
4.1 Methodology.....	22
4.1.1 Study design .....	22
4.2 Methods .....	23
4.2.1 Participant selection.....	23
4.2.2 Recruitment.....	24

4.2.3	Data collection.....	25
4.2.4	Data Analysis .....	26
4.2.5	NVivo Qualitative Data Analysis .....	29
5	Results .....	30
5.1	Definition of obesity treatment .....	30
5.2	Participant characteristics .....	31
5.3	Barriers to effective treatment .....	32
5.3.1	Theme 1. Internal struggles.....	32
5.3.2	Theme 2. Judgement and discrimination.....	39
5.3.3	Theme 3. Overcomplicated, overstretched and ineffective .....	45
5.3.4	Summary .....	54
5.4	Enablers of effective treatment .....	55
5.4.1	Theme 1: Holistic approach.....	55
5.4.2	Theme 2: A long term relationship.....	61
5.4.3	Summary .....	66
5.5	Future treatment initiatives .....	67
5.5.1	Theme 1. Laying the foundations.....	67
5.5.2	Theme 2. Relapse prevention .....	72
5.5.3	Summary .....	78
6	Discussion.....	79
6.1	Main Findings .....	79
6.2	Similarities .....	80
6.3	Differences .....	82
6.4	Strengths and Weaknesses .....	84
6.5	Implications for Future Research .....	85
6.6	Conclusions .....	86
7	Application of Research to Dietetic Practice.....	87
	List of References .....	89
	Appendix A. Review of Clinician studies .....	93
	Appendix B. Review of Consumer studies.....	102
	Appendix C. Focus group interview schedule .....	111
	Appendix E. Participant information sheet .....	113
	Appendix F. Recruitment letter template .....	114
	Appendix G. Participant consent form.....	116

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# 1 INTRODUCTION

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Obesity is a major risk factor for non-communicable diseases such as cardiovascular disease, diabetes, musculoskeletal disorders and cancer (2). Globally, obesity has more than doubled since 1980 (3). In New Zealand, approximately one-third of adults over the age of 15, are classified as obese, or having a Body Mass Index (BMI) of greater than or equal to  $30\text{kg/m}^2$  (4), and those living in the most deprived areas of New Zealand are nearly twice as likely to be obese (4). It is now estimated that 46% of Maori adults and 67% of Pasifika adults are obese (4). New Zealand ranks third only, behind the United States of America and Mexico on the OECD obesity prevalence scale (5).

Obesity itself has been described as a consequence of ‘calorie retention’ caused by chronic positive energy balance (6) implying that the solution to reversing it is straight forward. However, the aetiology of this positive energy balance is comprised of an overwhelmingly complex set of factors (6). ‘Energy balance’ is most simply thought of as ‘energy in’ via consumption of food and beverages, equalling that of ‘energy out’ by way of physical activity and other physiological processes that vary widely amongst individuals (7). Aside from the biochemical aspects, a range of other factors impact on an individuals’ energy intake and energy expenditure such as other health conditions, and psychosocial, socioeconomic, environmental and cultural influences (8).

Research into the causes of obesity, has exposed a complex set of challenges with regard to its treatment. In New Zealand, the Ministry of Health (MOH), recommends a multifactorial approach involving healthy eating, exercising and behavioural change in order to promote weight loss (9). These guidelines along with clinical practice guidelines published in several other countries are based on extensive research into obesity treatments from a mainly quantitative perspective, and are designed for use by health professionals. The New Zealand Medical Association (NZMA) released a position statement in 2014 in response to the

inadequacy of current treatments in New Zealand to prevent further increases in obesity rates (10). A recent review of obesity prevention efforts across Australia and New Zealand reports little progress being made blamed largely on the failure to *implement* already established preventative (such as those outlined in national guidelines) and regulatory policies (11). The NZMA cites obesity as being a national problem, with treatment responsibility lying in the hands of all New Zealand citizens, as it does ultimately affect us all (10). Aside from the detrimental impacts of non-communicable diseases to an individuals' and families' physical and psychological well-being (12), the economic costs of providing health care for an obese person are 30% higher than treating a non-obese person (10).

This present study uses data from a larger qualitative study aiming to explore clinicians' and consumers' perspectives of obesity including their views of potential causes and treatments. The focus of this thesis is to present the rationale, methodology and findings of the present study in answer to two research questions:

1. What did participants perceive as the components of successful weight loss initiatives?
2. What did participants identify as barriers to successful weight loss and weight loss maintenance?

The overall aim of this study was thereby to investigate the similarities and differences between clinicians' and consumers' perspectives of obesity treatments, in order to contribute to the existing body of literature and to potentially provoke interest for future research.

## 2 LITERATURE REVIEW

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This section presents a review of the literature relevant to the aims and objectives of the present study. This review aims to provide a background and contextual review of qualitative journal articles, exploring clinicians' and consumers' beliefs and attitudes to various aspects of obesity treatment. Focus group studies were prioritised for review as this collection method was used in the present study.

### 2.1 LITERATURE SEARCH

#### 2.1.1 Inclusion criteria

The literature search was limited to focus group studies, published between 2004 and 2015. Only articles published in English were considered. The search was designed to capture articles involving all aspects of obesity treatment with the following exceptions: paediatric obesity, bariatric patients and bariatric surgery, obesity during pregnancy and pharmacological weight loss treatments such as Orlistat™.

Studies were included in the final review if 'clinicians', 'consumers' and 'obesity treatments' could be defined according to the following criteria: 'clinicians' were defined as health professionals involved in delivering obesity treatments across various health care settings, including but not limited to general practitioners (GPs), physicians, nurses, dietitians, nutritionists, addiction clinicians, psychologists, and eating disorder clinicians. 'Consumers' were defined as adults (aged 18 or over) with a BMI  $\geq 30\text{kg/m}^2$  with or without weight related comorbidities. The author aimed to include only consumer studies specifically involving obese people as non-obese individuals (BMI  $\leq 30\text{kg/m}^2$ ) may have different opinions of treatment. 'Obesity treatments' were related to clinicians' and consumers' experiences of various weight loss initiatives, including but not limited to commercial or community

programmes, research based interventions, and weight management counselling in and outside of primary care.

Mixed methods studies that did not use focus groups as their main method of data collection were considered, as these could yield reliable findings if the focus group techniques were well described, and findings were reported in detail.

### **2.1.2 Exclusion criteria**

Studies that did not provide adequate description of analysis techniques specific to focus groups or detailed accounts of findings, were excluded. To enable only views of consumers with obesity ( $BMI \geq 30 \text{kg/m}^2$ ) to be considered in line with the research objectives studies that did not provide information about patients' weight status, in the form of individual or average weights or body mass indices were also excluded.

### **2.1.3 Search criteria**

The literature search was conducted via comprehensive searches of the following electronic databases: CINAHL, Medline (OvidSP), Google Scholar, Scopus, EMBASE, PsycINFO (Ovid SP), and the University of Otago Library Catalogue. Search terms included: addiction clinician\*, addiction specialist\*, attitude, 'attitude of health personnel', belief, clinician\*, consumer\*, counsel\*, dietitian\*, doctor\*, eating disorders\*, general practitioners, GP\*, family physician\*, healthcare consumer\*, health care consumer\*, nurse\*, nutritionists, obes\*, opinions, overweight, patient\*, perception\*, physicians, psychology, social values, qualitative, qualitative research, value. Search terms with an asterisk indicate that these terms were 'truncated' to enable wider searching for words or phrases relevant to the study aims to be searched.



Abstracts of resulting articles were screened to ensure that only those meeting the inclusion criteria for this literature review were selected. Additional articles were identified by scanning reference lists of articles already collected.

#### **2.1.4 Search results**

Eleven studies investigating the perceptions of clinicians, met the inclusion criteria for this review. Of these, eight examined clinicians' thoughts about obesity treatments in primary care settings, and intervention studies set in a primary care context. Two studies explored clinicians' views of obesity treatments outside primary care. Ten studies exploring consumers' perceptions of obesity treatments were included; six explored consumers' thoughts about specific interventions or obesity treatment programmes, and four investigated consumers' opinions of obesity treatments within primary care.

Studies are summarised in Appendices A and B for clinicians and consumers respectively.

## **2.2 CLINICIANS' PERSPECTIVES OF OBESITY TREATMENTS**

Six studies were identified which explored clinicians' perspectives of obesity treatments in primary care. Study participants ranged in number from 9 to 35, and contained a mix of experience levels – including general practitioner trainees and teachers (13), physicians (14-16), physician assistants (14, 16), trainee physicians (17), nurse practitioners (14, 16), general practitioners (15, 17, 18), and paediatricians (14, 16). Two studies investigated primary care providers' (GPs', nurses' and health-care assistants') thoughts of weight management intervention studies (19, 20) and two studies sought to explore clinicians' perspectives of weight management practices outside of primary care settings (21, 22).

### **2.2.1 Barriers to providing effective obesity treatments in primary care**

Studies revealed several themes concerning clinicians' views of the major barriers to weight management counselling. For the purpose of this literature review, these themes were

separated into what clinicians believed to be the main barriers for themselves or their primary care practice, and those they believed were barriers for their patients.

### ***2.2.1.1 Clinicians' perceived barriers***

An overarching barrier from the clinicians' perspective was the view that they were under-resourced to treat obesity (14-19). The lack of resources included insufficient time in consultations to address weight related issues, poor coordination and use of external resources and inadequate training in nutrition, weight loss counselling and behaviour modification.

Lack of time available in clinician consultations to address weight management was compounded by the frequent need to address other comorbidities (14, 15, 17). Gudzone et al (18) explored how 26 GPs communicated with their patients about weight management.

Discussions from the five focus groups revealed that some avoided bringing up the issue of weight at all, owing to the need to address other health priorities in the patient encounter.

Poor coordination and use of external resources refers to both the clinicians' inability to effectively use weight management education materials and guidelines, and to refer to external weight management services, owing to lack of infrastructure and lack of knowledge about which services exist (14, 16). Several studies revealed that clinicians in primary care viewed weight counselling and the use of recommended guidelines for treating obesity as ineffective (13-17). This was the result of either their own lack of training, specifically inadequate knowledge or skills to interpret guidelines (14, 16), lack of time in the patient encounter to deliver treatment messages (14), or problems with the treatments themselves (15, 19). Alexander et al (15) asked 11 GPs and 6 physicians about their views of the US Preventative Task Force guidelines (2004) (23) for the screening and treatment of adult obesity in primary practice. Focus groups revealed that most of the participants found the guidelines too vague and were therefore reluctant to use them. A study by Leverence et al (14) investigated 10 clinicians' views of obesity counselling in the brief primary care encounter

and compared these to recommendations found in 3 prominent obesity guidelines (24-26). Lack of time in consultations combined with lack of patient motivation to change behaviours, deterred clinicians from using guidelines and weight counselling techniques (14). A study by Ware et al (19) asked 36 clinicians from 3 primary care practices in England whether they thought primary care practices should be involved in the delivery of weight loss treatments. Clinicians in this and one other primary care study reported despite their willingness to be able to offer weight loss treatment to patients, scepticism around the efficacy of current weight loss strategies, prevented them from investing limited resources into their provision (19{Sussman, 2006 #374}).

Clinicians in some primary care practices reported a lack of external services such as community weight loss services/dietitians/psychologists/health educators to which they could refer patients for obesity treatment (14). Sussman et al (16) used the same study sample as Leverage et al (14) to investigate clinicians' approaches to offering preventative weight loss counselling in the primary encounter. Participants in this study reported both a lack of external services to refer patients to as well as a lack of infrastructure connecting these with primary care, prevented them from being able to offer further treatment to their patients (16).

#### ***2.2.1.2 Clinicians' perceptions of patient barriers***

External factors such as those concerning the environment, societal norms and government policy also feature in the literature as barriers to clinicians' success in providing obesity treatments (13, 15-17). Hong et al (17) assessed the attitudes of 49 physicians and trainee physicians to their patients' personal and environmental barriers to physical activity, particularly walking, in 5 focus groups. Despite agreeing that walking was the most suitable and practical form of exercise for their obese patients, they acknowledged the existence of unsafe neighbourhoods, lack of footpaths and parks and the evolution of a society where it is necessary to drive everywhere. Clinicians in the study by Sussman et al (16) found

counselling for diet and exercise to be ineffective, given the multitude of social, economic and environmental barriers their patients felt prohibited them from adhering to treatment recommendations. Clinicians in two other studies suggested that societal norms such as leading a sedentary lifestyle (17) or the high proportion of obese people in society making obesity appear more normal (15) were un conducive to obesity treatments. In light of this, some clinicians discussed the need for a change at the societal or governmental level in order to help facilitate effective obesity treatments (14-17).

Patient motivation and readiness to change were two significant barriers that influenced whether or not clinicians believed their patients' would have success with obesity treatments (13, 14, 16, 17). Clinicians in the study by Leverence et al (14) reported patient motivation was a major barrier to addressing weight with their patients, and argued that beyond providing education, there was little they could do to change behaviour in unmotivated patients.

### **2.2.2 Enablers of effective obesity treatments in primary care**

Factors that enabled clinicians to provide effective obesity treatment were less commonly reported in the literature. In some instances this was because studies were more focussed toward eliciting views on barriers to obesity treatment, whilst in others clinicians may have felt more strongly about what does not work than what does. It is evident some clinicians felt they had a very important role to play in the treatment of obese patients (13, 15, 17). This inclination to help however, was in many cases up against some persistent barriers, that over time impacted on clinicians' confidence and belief that there was anything they could do (14, 17).

Gudzune et al (18) explored how clinicians encouraged their patients to lose weight in the primary care setting. Clinicians in this study had at least four patients enrolled in the Hopkins POWER (Practice-based Opportunities for WEight Reduction) randomised controlled trial, although this study sought predominantly to investigate clinicians usual practices with the

treatment of obese patients. A major finding from this study was the perceived motivational power of providing regular, positive reinforcement to patients, even if achievements were small. Being realistic about weight loss by letting the patient know that they will 'fall off the wagon' occasionally was also considered an important aspect of weight loss counselling. Clinicians found encouraging patients to relate their weight loss journey to other areas of their lives where they had to overcome challenges to be an effective way of helping patients visualise their capability of success. This and two other studies found clinicians preferred to encourage patients to focus on improving health rather than worrying about weight, especially when in some cultures, being overweight was considered aesthetically pleasing (16, 18). Gudzone et al (18) found this approach was effective in primary care for reducing an obese person's anxiety and negative emotions connected to the issue of 'weight'. It should be noted some clinicians in this study acknowledged they had changed the way they communicated about weight loss with patients following learning of their patients' experiences in the POWER trial.

Hong et al (17) found that when faced with patients' lack of motivation, some clinicians felt it was helpful to encourage patients to come up with their own goals and solutions to problems, providing them with ownership and control over their treatment.

### **2.2.3 Treatment enablers in intervention studies**

Two studies investigated clinicians' views of a web based weight management programme (19) and a weight loss programme involving 'health coaches' as the main providers of treatment and counselling (20).

In 2012, Ware et al (19) collected 36 primary care physicians', nurses' and health care assistants' views of a web based programme aimed to enhance delivery of weight management treatment to patients. The 'POWeR' programme (Positive Online Weight Reduction) allowed patients to utilise weight loss resources online over a six month period.

Overall, clinicians in this study viewed the programme as a positive step toward effective patient care, as it provided a cost effective way to track patients' progress and collaborate with other health professionals, without the need to invest more resources in existing primary care services. They did however, voice concern about the appropriateness of the programme's online design for older adults and the socio-economically disadvantaged.

Bennett et al (20) asked the same study participants as the study by Gudzone et al (18) to elaborate on their thoughts of the effectiveness of the 'POWER' (Practice-based Opportunities for WEight Reduction) trial in 2014. The POWER trial was a randomised controlled trial with two behavioural weight loss intervention arms: a 'remote' arm using telephone calls to make contact between health coaches and participants, and an 'in person' arm that included both face to face individual and group sessions, as well as telephone contact. Clinicians in this study valued the one-on-one counselling approach offered by health coaches and the ability to discuss their patients' progress with someone involved directly in their treatment. It appeared the 'remote' approach was perceived as both convenient for patients who lived far away, and for clinicians with limited space in their practices for weight loss counselling. It should be noted the actual qualifications or profession of the 'health coach' was not mentioned in this study.

#### **2.2.4 Barriers to and enablers of obesity treatments in non-primary care settings**

Three studies were found investigating clinicians' perceptions of obesity treatments outside of the primary care setting (21, 22, 27), and interestingly, all involved dietitians.

Dietitians are uniquely trained to provide advice for people with nutrition related illness in clinical, community and public health settings. Weight loss counselling is one area of a dietitian's expertise, therefore it was surprising to find only three studies reporting dietitians' views of obesity treatment (21, 22, 27). Chapman et al (21) and Marshessault et al (22) utilised the same study sample of 104 Canadian dietitians, to investigate approaches to

counselling in adults seeking weight management advice. In 2005, Chapman et al (21) conducted 15 focus groups of 3-13 participants each, across 7 Canadian cities with dietitians working in clinical, industrial, private and commercial sectors. The authors found that overall, the dietitians preferred to promote a 'healthy living' approach with individualised recommendations for treatment outcomes as opposed to focussing only on weight loss.

Marshessault et al (22) investigated dietitians' thoughts on the use of Non-dieting Approaches or NDAs. Of those that reported using NDAs in practice, there was some conflict about which methods of weight loss counselling were considered NDAs and which were not. For example, some dietitians felt educating about portion size imposed too many restrictions to be considered an NDA, while others felt this was necessary especially for patients who had little concept of healthy eating or meal planning. Overall, the majority of dietitians felt NDAs were an important tool for emphasising the importance of a healthy lifestyle approach to weight loss, rather than one of restriction or 'dieting'.

Stone and Werner (27) held focus groups with 23 Israeli community dietitians in 2012, to investigate the levels of professional stigma this group attached to their obese patients. Despite feeling determined to help their patients, the dietitians were frustrated in having to deal with difficult patients who did not follow their advice or tried but still failed to make any behavioural changes (27). These feelings were also demonstrated by clinicians in other studies (14, 17). Negative feelings could be inadvertently relayed to patients by ending session times earlier, expending less energy and effort in consultations and using negative tone in verbal communication and body language. Some of the dietitians described their feelings of inadequacy and powerlessness if unable to help their patients (27).

### **2.3 CONSUMERS' PERSPECTIVES OF OBESITY TREATMENTS**

Ten studies investigated the views and opinions of consumers towards weight loss treatments. Focus group participants ranged in number from 11 to 25 and were all identified as

overweight or obese at the time of focus groups according to either the participants' individual or group mean BMI of  $\geq 30\text{kg/m}^2$ , with the following exceptions: Ostberg et al (28) recruited participants for focus groups *after* they had completed a weight loss intervention, with all classified as obese at *commencement* of the intervention; Fogel et al (29) recorded a BMI range of 24.4-43 at time of study, and as the study focussed on a weight loss group it could be assumed that at least some of the participants were obese.

Six studies involved specific weight loss interventions or programmes (28-33), and four explored the contribution of primary care providers to effective obesity treatments (34-37)

### **2.3.1 Barriers to effective obesity treatments in primary care**

The prominent theme revealed by consumers across the four studies concerning obesity treatments in primary care was an overall lack of support from their primary care provider. Specifically, consumers expressed frustration that clinicians' lacked time and/or expertise to discuss issues with weight (34, 36). Consumers also felt that some clinicians' blamed them for their obesity (34), and were judgemental in their counselling approaches (34, 35). Consumers felt their obesity was often neglected in favour of other co-morbidities (36), and when it was addressed, it was done so in conjunction with a co-existing medical condition (34, 35, 37). In 2010, Maltreud et al (34) purposively recruited 13 participants from a Norwegian rehabilitation centre offering lifestyle advice for people with obesity. Participants in this study were upset not only by the lack of direct support from their primary care provider, but also the primary care providers' insufficient knowledge of other referral services for obesity treatment to which they could go for help.

Feelings of shame and embarrassment when discussing obesity with primary care providers were voiced as significant barriers to obesity treatment. In 2009, Ely et al (36) conducted 6 focus groups, of between 4 and 9 participants each, with 31 women living in rural Kansas, USA. The participants described instances where they had not been forthcoming to speak



about their weight even though it was something they wanted their primary care provider to address. They explained that their reluctance to voice the issue, was mostly due to feelings of embarrassment and anxiety about their condition. Given the sensitive nature of obesity for some patients, the way in which primary care providers approached obesity was highlighted in three studies as requiring caution (34, 35, 37). Ward et al (35) conducted focus groups with 43 African American participants in Philadelphia, USA. The aim of this study was to uncover primary care provider behaviours that participants viewed as either encouraging or discouraging of weight loss. Participants reported clinicians who constantly prodded them to lose weight without appropriate encouragement and recognition of prior attempts, were detrimental to both their self-esteem and the patient-provider relationship. Participants in this study expressed a strong dislike for the word 'obese', similar to the 2008 study by Thomas et al (37), associating this word with someone who is lazy and unclean (35, 37). Some participants also felt that instead of the clinician simply assuming, they should consult with them about whether they want to or are ready to lose weight (35).

Thomas et al 2008 (37) recruited 17 African American and 13 white women to explore their perceptions of obesity, including what they believed to be an ideal body image, the health risks associated with obesity and their experiences of treatment by their primary care clinician. Despite most of the African American women in this study acknowledging the association between increases in weight and exacerbation of health problems, they disagreed with their primary care clinicians' recommendations with respect to their 'ideal' body size. African American participants reported guidelines for body size were too low and unrealistic, and commented on both their own and family members' satisfaction with their larger size.

### **2.3.2 Suggestions for treatment in primary care**

Participants in three studies offered their suggestions for improving obesity treatment in primary care (34-36).

In light of the complexity of treating obesity alongside other medical conditions, and time constraints in the clinician encounter, participants of the study by Ely et al (36) suggested that so long as their primary care providers were still regularly involved, obesity could be overseen by other health professionals at their primary care centre (36). Participants of this study also suggested using their primary care centre as a community resource for weight loss given the scarcity of such resources in their rural community (36).

Participants of another study asked for weight management advice to be more regular and specific, including tailoring the advice to the individual, providing tools or options for treatment, explaining how much weight needs to be lost and how this would improve other medical conditions (35). Similarly, participants of the study by Maltreud et al (34) wanted weight management to be on their GPs agenda, and wished for alternative obesity treatment options to be arranged if not offered directly by their GP.

### **2.3.3 Barriers to weight loss maintenance**

Participants in several studies reported previous attempts at weight loss without lasting success, citing the substantial amount of effort required to achieve successful weight loss combined with juggling the complexities of busy lifestyles (28, 29, 31). The attainment of knowledge around healthy eating, was negated by the time it took to analyse new foods and decide how to put them together (31, 32). The added cost of purchasing 'healthier' foods (32, 37), and access to suitable places to purchase these was also a source of frustration (28). Incorporation of an exercise routine to fit around family, work and other health commitments was another challenge (31, 32), with some also struggling with the added burden of costs associated with both transport and membership to exercise facilities (32).

### **2.3.4 Barriers to and enablers of effective treatment in intervention studies**

Six studies reported consumers' opinions of interventions designed to promote and/or sustain weight loss. These included interventions promoting lifestyle change (28, 30, 31), weight loss 'diets' (32), a weight loss support group (29), and mindful eating (33).

All six studies included a group component, whether this involved meeting regularly to exercise, participate in dietary or behavioural change education, or share stories of previous weight loss attempts or experiences of living with obesity (28-33). Participants described the benefits of the empathy and support (30), motivation and encouragement (33), feelings of acceptance (29), improved self-confidence (33), accountability (28, 32, 33), and the safety associated with being in a group environment (28).

In 2009, Fogel et al (29) investigated members' perceptions of an established weight loss group aimed at promoting well health amongst lesbian women. The study participants especially valued the group environment as a place of safety and connectivity with others of the same sexual identity. In 2011, Ostberg et al (28) reported the views of 19 men and women after completion of a 12 month Very Low Calorie Diet (VLCD) and lifestyle advice weight loss intervention. Participants expressed feelings of solidarity and community provided by the group environment, which was starkly different to how they had felt when attempting weight loss before on their own.

Five of the six intervention studies involved a lifestyle change component, based on either changing current exercise and/or eating behaviours (28-31), or focusing on concepts of mindful eating (33).

Two studies by Gallagher et al (30, 31) in 2012, focussed on the same lifestyle change intervention, the 'HEELP' (Healthy Eating and Exercise Lifestyle Programme), part of a larger cardiac rehabilitation and diabetes education programme. The studies investigated the 35 participants' views on the principles and efficacy of the programme in achieving weight

loss (30), and delved more deeply into their personal experiences of weight management, both prior to and during the HEELP (31). Participants of these and a study by Kidd et al (33) emphasised the importance of establishing routines as part of re-programming existing eating behaviours (30, 31, 33). Self-monitoring devices such as pedometers and food diaries were found to be valuable for helping promote motivation and to provide an objective measure to track progress (30, 31). Kidd et al (33) conducted one focus group with a total of 6 women following completion of an eight week mindful eating intervention, initially involving 12 participants. The women found that by increasing awareness of relationships with food, they were better able to identify problem areas in their eating habits and work toward changing behaviours (33). In contrast to studies where participants enjoyed the ability to objectively monitor their progress (30, 31), participants in this study appreciated the non-restrictive and intuitive nature of the weight loss programme (33).

Two studies investigated participants' thoughts of interventions that focussed largely on dietary changes alone (28, 32). Ostberg et al (28) held focus groups with 19 participants who had completed a year-long VLCD and lifestyle advice intervention. The VLCD component consisted of an 800kcal/day meal replacement regime for three months. Herriot et al (32) explored consumers' perspectives of four popular commercial weight loss programmes, as part of a six month multi-centre randomised controlled trial in England. At the conclusion of the 'Diet Trials' study the researchers facilitated four diet specific focus groups with 14 of the initial 32 participants. The groups included a low carbohydrate group (Atkins™), portion controlled healthy eating (Weight Watchers Pure Point System™), meal replacement (Slimfast™) and low fat diet and exercise group (Rosemary Conley™).

Participants in the study by Ostberg et al (28) were pleased at the ability of the meal replacement regime to produce weight loss, something many had struggled to achieve for years. However, following completion of the VLCD component of the intervention, participants struggled to maintain their weight loss, blaming this on a lack of support, external

events and stress of everyday life, similarly to how they had felt before the start of the intervention (28). The need for intensive support and monitoring on meal replacement diets was highlighted by participants of the Slimfast™ diet group in the study by Herriot et al (32), with the majority planning to discontinue with the dietary regime after the intervention period was over. In contrast, participants of the somewhat less restrictive Rosemary Conley™ and Weight Watchers™ groups of this study intended to continue with the diets after the intervention was finished (32).

### **2.3.5 Psychological barriers to obesity treatments**

The majority of studies exploring consumers' experiences of various obesity treatments, uncovered significant psychological barriers identified as detrimental to weight loss success and maintenance.

Several studies reported participants' sabotaging their own attempts at behavioural change in order to preserve cultural traditions such as the giving and acceptance of food (31, 32, 36).

Participants described feelings of anxiety resulting from having to eat differently to the food preparer or others in the household (31, 36, 37). Low self-confidence as a result of multiple failed weight loss attempts (28, 29, 31), combined with a tendency to eat in response to emotional cues (28, 37) meant that maintaining weight loss was also a constant struggle.

Participants in the study by Ostberg et al (28) explained how the avoidance of certain foods was attributed to losing quality of life, as favourite foods were the source of such enjoyment and comfort (28). Participants of this and a study by Thomas et al (37) described how their relationship with food was likened to an addiction, with relapses and weight gain leading to feelings of hopelessness and depression, and in turn leading to more eating as the cycle continued (28, 37). Participants of two studies indicated how they preferred to isolate themselves from society in order to avoid the repercussions of obesity stigma, and described

how this often resulted in their lack of attendance or adherence to obesity treatments such as weight loss groups (28, 29).

### **2.3.6 Conclusion**

The studies discussed here provide an insight into the views of clinicians and consumers concerning a variety of approaches to obesity treatment.

Across all studies, clinicians described feelings of frustration at the lack of progress being made both by their individual patients and the health profession as a whole toward successful obesity treatments. A move toward drawing the focus of treatment outcomes away from weight loss as such was suggested in order to combat the ‘taboo’ topic of overweightness largely a result of obesity stigma in modern society. The possibility of a web-based programme for offering regular support and guidance to obesity treatment seekers was discussed as a potential remedy to relieve over-stretched and under-resourced primary care services attempting to tackle treatment. Of the handful of suggestions around facilitators of treatment, importance was placed on the existence of a strong support network and/or trusting relationship with the treatment provider. Clinicians across several countries appealed for increased government assistance to help create societal change and promote healthier communities.

A common theme amongst consumers’ was the integral role of support persons in their ability to provide accountability, reassurance, motivation and companionship during the various stages of obesity treatments. The majority of consumers described instances of increased support as beneficial for treatment adherence, only to be followed by periods of loneliness and reverting back to old habits as support ceased. The difficulty of achieving and sustaining weight loss was attributed to busy lifestyles, lack of personal resources and the internal conflicts they faced when trying to enforce behavioural change. Repeated failed attempts at weight loss left consumers feeling hopeless and desperate, some likening the struggle to that

of trying to give up an addiction. The studies revealed that whilst the majority of consumers were ready to try obesity treatment recommendations, owing to past experiences of weight cycling and repeated weight-gain they held little hope of success.

The studies reviewed here varied in quality with notable limitations including a lack of transparency in reporting data analysis techniques, small study and focus group size, and potential influences of interviewer bias. Strengths included the use of pre-tested interview guides, clear descriptions of study limitations and analysis of data by multiple researchers enabling discussion and collaboration of ideas.

In conclusion, the studies reviewed provide an expansive portrayal of the attempts to date to explore clinicians' and consumers' thoughts of obesity treatments. However, to the author's knowledge, there have been no other focus group studies conducted in New Zealand, and only one other qualitative study (38), exploring perspectives of clinicians and consumers in New Zealand. To this end, the purpose of this literature review was to report the main findings from focus group studies to date and therefore establish a contextual basis of international studies for comparison with a findings from the present study and moreover a New Zealand perspective.

### 3 OBJECTIVE STATEMENT

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The area of clinicians' and consumers' perspectives of obesity treatments in New Zealand is largely under-researched. As New Zealand now has the third highest prevalence of obesity in the world, further investigation into the perceptions of clinicians involved in the treatment of obesity and the consumers affected by it, is justified.

Furthermore, in light of the ineffectiveness of current treatments to date, the question must be asked: What are we missing?

Therefore, objectives of the present study were four-fold:

1. To investigate, analyse and report clinicians' and consumers' perspectives of obesity treatments in New Zealand.
2. To describe any similarities or differences in opinion between *and* within clinician and consumer groups with respect to the barriers, enablers and future treatment options for obesity treatments.
3. To compare and contrast findings from the present study with findings from previous studies in relation to consumers' and clinicians' perspectives of obesity treatments.
4. To generate hypotheses for future obesity treatment research and better understand the shortcomings of current treatment approaches.



## 4 METHODOLOGY AND METHODS

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This chapter describes the research methodology and methods in this study. Explained in detail are both descriptions of and the rationale underpinning the selected study design, participant recruitment procedures, data collection, and data analysis methods.

The present study describes findings from a larger study, the findings of which are reported in: ‘Understanding Clinician and Consumer Perspectives of Obesity: Expanding Knowledge of the Causation and Treatment of Obesity (1)’. The larger study aimed to answer three research questions:

1. What were participants’ views of the causes of obesity with particular emphasis on psychological determinants?
2. What did participants perceive as the components of successful weight loss initiatives?
3. What did participants identify as barriers to successful weight loss and weight loss maintenance?

The focus of enquiry of this thesis, was participants’ perspectives of obesity and its *treatment*, therefore only the latter two questions applied to the data analysed for this thesis. Topics of further interest, also covered in this thesis, included participants thoughts for potential future treatment initiatives, perceptions of ‘binge-eating’, ‘compulsive over-eating’, ‘addiction’ and mental health issues and their relationship with obesity, as described in the full interview guide, Appendix C.

## **4.1 METHODOLOGY**

### **4.1.1 Study design**

An observational design for data collection, and a thematic analysis technique to analyse data were used in the present qualitative study.

The researchers sought to capture the complexity of participants' perceptions of obesity and to explore similarities and differences of opinion between and within different participant groups. The rationale for this, was that at the time of data collection, the New Zealand literature was virtually devoid of similar studies, leaving this an area largely under-researched and therefore warranting a thorough exploration of all aspects of the participants' thoughts about treatment. Qualitative methodology was chosen as it encourages the development of rich interpretive data, enabling an in-depth understanding of the study participants' views on obesity (39), as well as allowing the examination and analysis of underlying meanings and patterns within the different data sets (40).

Focus groups using semi-structured interview questions offered the researchers a chance to obtain accounts of events and experiences through the eyes of the participants, while attempting to minimise researcher bias in the data collected (41, 42). Focus groups are a useful method of encouraging discussion about a common experience, and they have the added bonus of capturing participants' 'real-life' vocabulary in a 'real life' social context (42, 43). The researchers considered this method to be advantageous over others, such as one-on-one interviews, as focus groups support a less interrogative and confronting environment, allowing enhanced disclosure about particularly sensitive topics as thoughts are legitimised by other members of the group (42). From the researchers' perspective, this method also enabled a wealth of information to be collected in a relatively short timeframe (44).

## **4.2 METHODS**

### **4.2.1 Participant selection**

The researchers sought two groups of participants, ‘Clinicians’ and ‘Consumers’. For the present study, ‘Clinicians’ were defined as people working clinically in health care settings with people around eating and/or addiction. ‘Consumers’ were defined as people who had lived or were currently living with obesity or people who knew someone living with obesity. Four groups of clinicians were recruited including ‘Eating Disorder Clinicians’, ‘General Practitioners and Nurses’, ‘Addiction Clinicians’ and ‘Dietitians’. Four groups of consumers were recruited including ‘All Ethnicities’, ‘Maori Ethnicity’ or ‘Maori’, ‘Pacific Island Ethnicity’ or ‘Pasifika’, and a ‘Self-help’ group. Rationales behind the selection of each group of participants related to either personal or professional experience with obesity and/or addiction, or the potentiality to offer diverse opinions on a range of obesity treatments. Additionally, Maori and Pacific Island ethnicities were purposively selected due to the prevalence of high rates of obesity within these groups in New Zealand, and therefore the importance of their views to this study.

#### **4.2.2 Recruitment**

Participants were recruited via a mixture of sampling methods – initially, general public advertisement was used to recruit both consumers and clinicians through community newspapers. In order to increase numbers, after public advertisement, researchers made contact with professional networks. Email network lists were used to recruit clinicians, enabling the identification of a large number of potential participants (45). Purposive sampling involves the researcher actively selecting participants based on certain qualities or experiences (45). In this case, the researchers contacted various key members of the Maori and Pasifika community, who then recruited participants for the researchers. Finally some snowball sampling helped to ensure adequate numbers were recruited in the General Practitioners and Nurses, Maori, and Dietitian groups, as new potential participants were recommended by already recruited participants (45). For the full study advertisement, participant information sheet and recruitment letter template see Appendices D, E and F.

Participants were eligible for involvement in the study if they were over 18 years of age, were able to attend their respective focus group at the scheduled meeting time, and agreed to the terms outlined in the consent form (Appendix G).

Participants' genders were recorded to allow comparison of responses between males and females, and ethnicity data was only recorded by criteria for participants in the Maori, and Pasifika groups. The researchers did not collect further demographic data as such information was not considered necessary for the purposes of the study.

Participants were reimbursed for their time with fuel vouchers. A copy of each transcript was sent to a consenting representative of each respective group, to allow member-checking of transcription accuracy. Participants' names in all transcripts were changed to preserve anonymity.

### 4.2.3 Data collection

Eight focus groups, lasting approximately 1-2 hours each, were conducted for the present study. Six focus groups were held at the National Addiction Centre in Christchurch, where the two primary researchers RS and JE were based. The Eating Disorder Clinician group took place at the hospital where the majority of these participants worked, and the Maori group at a central city Diabetes Centre, also familiar to the participants. Participants were asked to rate their preference of three possible meeting dates for their particular group, with the date of majority attendance chosen as the date for the focus group. Interested participants who were not able to attend at this time, were thanked for their cooperation thus far and where requested, provided with a copy of the study findings.

The focus groups consisted of four 'clinician' based: Addiction Clinicians (n=4), Eating Disorder Clinicians (n=14), General Practitioners and Nurses (n=5), and Dietitians (n=9), and four 'consumer' based groups: All Ethnicities (n=10), Maori (n=5), Pasifika (n= 7), and a 'Self-help' group of those with previous experience of attending weight loss groups or diet programmes (n=7).

All focus groups were facilitated by one of the primary investigators (RS) a research psychologist with an interest in addiction, and scribed by the other investigator (JE) a clinical dietitian and research fellow. The facilitator had extensive experience as a qualitative researcher working in the addiction research field, and was an experienced focus group facilitator. Focus group dialogue was transcribed by an independent transcriber.

An interview guide was used to structure questions for the focus groups, and to provide prompts for further discussion on topics of interest.

All focus groups were audio taped and transcribed verbatim. A consenting member from each focus group checked the transcripts for transparency of data and accuracy of transcription.

#### 4.2.4 Data Analysis

All data were analysed using thematic analysis, a ‘bottom-up’ approach to identifying key themes in the data (44). Thematic analysis has been described as a method for ‘identifying, analysing and reporting’ themes or patterns within the data’ (46). There is some debate in the literature as to whether Thematic Analysis should be considered a method in its own right, owing to its processes commonly being used *within* other more traditional methods such as grounded theory (44). For this reason, some consider it more of a generic ‘core skill’ used to perform other qualitative methods (47). However, thematic analysis in its own right, *is* regarded as a relatively easy to use set of procedures that can be effectively used to find and summarise key findings in large bodies of qualitative data (40, 46). The process of thematic analysis is a recursive rather than linear one, where progression through each phase is accompanied by revisiting phases before and after it (46). It is considered that an analysis is incomplete if it results in many different themes, therefore the author must make difficult decisions on which patterns of data to eliminate and which to include in the final group of themes (48). It is important to note, as it is the researcher’s responsibility to allow generation of themes driven by the data, it is impossible to entirely eliminate biases based on the researcher’s understanding, knowledge and experience within the subject area (40). The process as it was used in this thesis, is outlined below.

Firstly, the transcripts were read and re-read by the author, to allow familiarisation with the contextual nature of the data. The transcripts were then read line by line with actual phrases and meanings interpreted by the author to be of importance to research objectives, allocated into initial codes using NVivo10 qualitative software (49). As this process continued, further codes were created with the addition of sub-codes to enable linkages of similar concepts in a hierarchical fashion. Themes were generated after multiple revisions of the established codes. This process included re-reading, re-allocating and re-naming codes, and then assessing their relevance to the research objectives and overall study aims, resulting in the formulation of

main themes. Often, selected fragments of data related to more than one code, and were therefore allocated to each one the author considered they applied to. This process is known as over-lapping and is a common occurrence when using a thematic analysis approach. Likewise, other fragments of data were not coded at all as they were deemed not relevant (50). As the process continued, the intention was to reduce overlapping codes and refine themes, by reviewing the data encapsulated by each code and assessing its relevance to the emerging theme (50). As codes were further refined, a 'thematic map' was generated to enable the author to see the relationship between main themes and sub-themes, as well as to provide an overall 'picture' of the analysis (50). The final part of the analysis involved reviewing themes to identify any areas of conflict or agreement, specifically between groups of clinicians and/or consumers within the same theme and across different themes. The creation of superordinate themes allowed patterns of meaning across different themes or sub-themes to be grouped together (50). For an illustrative version of this process, adapted from Braun and Clarke (50) see Figure 1.

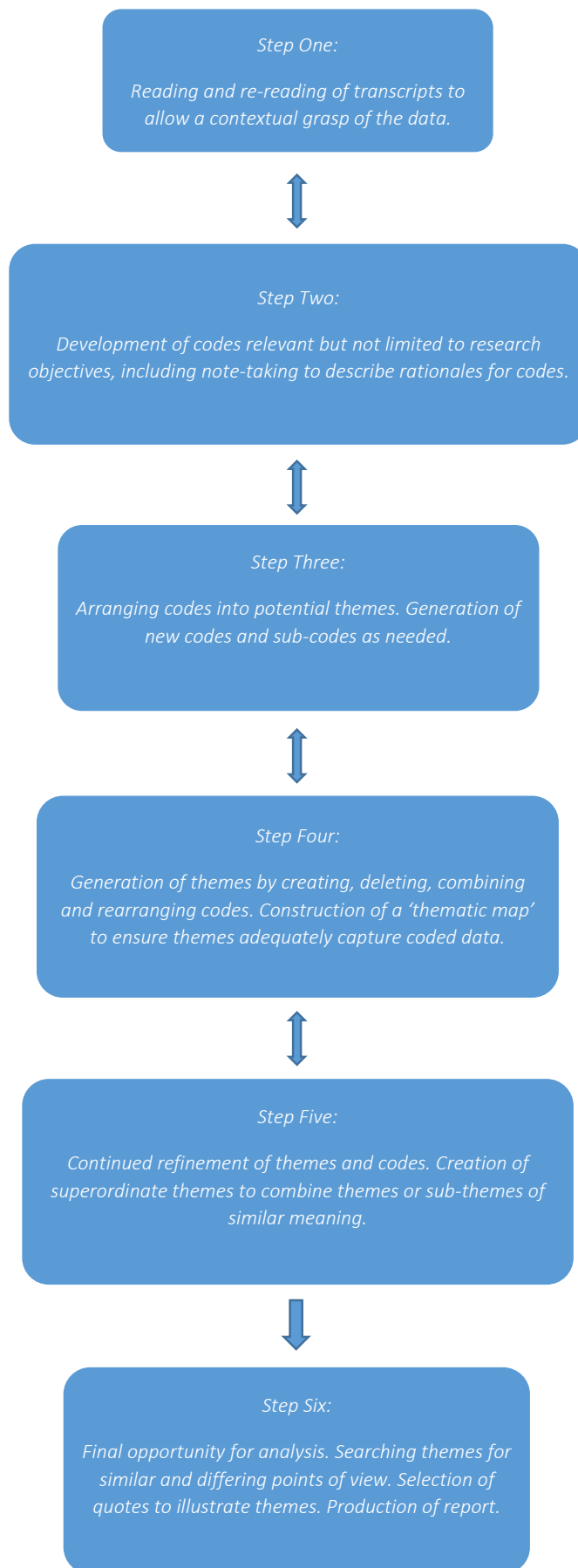


Figure 1 Overview of Thematic Analysis



#### 4.2.5 NVivo Qualitative Data Analysis

All data transcripts were analysed using NVivo10 Qualitative Analysis Software (49). Transcripts were uploaded into the software as separate documents and then coded individually. The aim of the data analysis was to provide a rich description of participants' perceptions of obesity treatment in New Zealand, rather than a detailed account of one or more themes (44, 50). Therefore, all fragments of data relating to obesity treatment were coded. As the facilitator encouraged free flowing discussion in the focus groups, inevitably participants' sometimes discussed topics out of the intended order with respect to the focus group question schedule. The author paid close attention to read the surrounding context of coded data fragments to ensure it was *treatment* the data fragment referred to and not another element of discussion. Following the processes outlined by the thematic analysis technique, main themes and sub-themes were generated from the data. These were then compared using a combination of coding queries accessible in the NVivo Software, to identify and analyse patterns occurring between or within themes.

## 5 RESULTS

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This chapter presents the findings from the eight focus groups, and is divided into four main sections. The first section includes definitions, participant characteristics, and an overview of findings, and the following three sections outline and describe main themes. As is consistent with thematic analysis, all findings are presented as themes, each with their own set of sub-themes (40). Within these sub-themes, points of view of consumers and clinicians are displayed separately.

The first section outlines both the internal and external barriers clinicians and consumers believed stood in the way of successful obesity treatments. The second section describes factors participants believed enabled or facilitated the success of obesity treatments. The third and final section illustrates the desired future initiatives clinicians and consumers would like to see with regards to obesity treatments.

Summaries at the end of each section outline the main similarities and differences found between the thoughts and opinions of clinicians and/or consumers in relation to the themes discussed.

Quotes are presented either in their entirety or as extracts from original quotes depending on relevance to the theme. For brevity purposes, not all quotes pertaining to each theme were included in this section, rather selections were made from transcripts to include those best suited to add depth and meaning to the prevailing theme. All participants have been given pseudonyms to protect their identities.

### 5.1 DEFINITION OF OBESITY TREATMENT

Obesity is defined by the World Health Organisation (WHO) as ‘abnormal or excessive fat accumulation that may impair health’. This ‘abnormal’ or ‘excessive’ level of body fat is

determined by a body mass index (BMI) of greater than or equal to 30 kg/m<sup>2</sup>, although owing to the fact that different people may have more or less fat than others for the same body weight the WHO recommends it as a 'rough guide' (3). Therefore obesity is by in large, considered a disease of the physical body, and 'treatment' is currently aimed at treating the physical condition, or in other words excess weight. There are two widely recognised methods of achieving weight loss, which are to increase physical activity (energy expended) or to reduce energy intake. Therefore, with weight loss as the overall desired outcome of treatment, barriers and enablers of treatment are factors which either obstruct or facilitate weight loss and/or maintenance. In this study, the researchers aimed to explore the psychological determinants of obesity treatment, with an emphasis on food addiction, as this is a widely under-researched area in New Zealand. Although the majority of thoughts and opinions around obesity treatment related to weight loss and maintenance, the author was careful to include and interpret any references made to food addiction and other psychological aspects of treatment. Theme generation focussed on participants' views around aspects of treatment, and generally fell under one of three sets of themes: barriers to treatment, enablers of treatment and future treatment initiatives.

## **5.2 PARTICIPANT CHARACTERISTICS**

Participants were 90% female, with males present in only three focus groups: General practitioners and Nurses (n=2), Maori (n=2) and Pasifika (n=2). The researchers did not record any further participant demographics as they were not necessary given the research objectives.

### 5.3 BARRIERS TO EFFECTIVE TREATMENT

This section includes three themes, covering both the internal (thoughts, beliefs, attitudes) and external influences (environment, economic situation, accessibility of effective weight loss treatments) consumers and clinicians felt prevented the success of obesity treatments.

‘Barriers to effective treatment’ in the context of these study findings addressed aspects of obesity treatment participants have experienced either personally or observed from a clinical perspective. It covers aspects of treatment that are perceived as failing to effectively treat those with obesity or to make losing weight more difficult. The author was careful to distinguish between ‘barriers’ to weight loss and ‘causes’ of weight gain, as without acknowledgment of the context in which these two different concepts were discussed, they could easily be confused. Themes and sub-themes for this section are displayed in Table 1.

*Table 1 Summary of themes - Barriers to effective treatments*

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<b>Theme 1: Internal struggles</b>	Emotional eating
	Ambivalence toward treatment outcomes
	Unrecognised addiction
<hr/>	
<b>Theme 2: Judgement and discrimination</b>	Oppressive society
	Insensitive Prejudice
<hr/>	
<b>Theme 3: Overcomplicated, overstretched and ineffective</b>	Misinformation
	Inadequate resources (time, money)
	Scepticism of current treatments

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#### 5.3.1 Theme 1. Internal struggles

This theme represents the perceived psychological battles faced by consumers in the pursuit of weight loss.

### 5.3.1.1 *Emotional Eating*

Emotional eating describes the use of food to subdue negative emotions, and was often spoken of by consumers as both a cause of obesity, and a barrier to treatment. In other words, although comfort eating was typically regarded as being a cause of weight gain in the past, consumers also described using food to ease existing negative emotions associated with all manner of upsetting life experiences.

#### **Consumers**

Participants described eating food as a reaction to negative situations, typically as a coping mechanism to deal with stresses of daily life. It appeared for some, this response could easily lead to a situation where they felt they had no control over their actions.

*Money is a big...stress is a big thing and family problems are big things that make you eat and...(unclear)... Nerolie. Self-help.*

*...it is very hard and so if I get down or upset or, you know, if I've got chocolate biscuits, which I don't have in the house anymore because I would just eat the packet, you know, it's something I like to do and it's a comfort for me but you know too if you eat another one of those biscuits and you are going to be in real trouble. Charlotte, All Ethnicities.*

Although eating food gave temporary relief to pain or discomfort, it almost always induced feelings of guilt and remorse afterwards. Participants described being torn between the pleasure of eating and the anguish they knew they would subsequently experience.

*Yeah and it's self-destructive and then as we of course put on weight we get told that then that's negative so then we've got the guilty....the pleasure, oh I have food, and then it's the vicious cycle then you feel bad because you've eaten and then you reward yourself with more food because you need to feel that feeling good again which you get from food, which is also your....(unclear)....weight which is also the thing to make you feel good...Tara, Self-help.*

*I find because it makes it feel good for about 5 seconds, it takes the pain... Brenda, All Ethnicities.*

## Clinicians

Clinicians typically viewed consumers' reliance on emotional eating as a highly charged, uncontrollable, and in some cases an addictive response to distress and pain.

*I remember one woman saying to me once cos she had an addiction as well and she said, you know I can give up drinking but I can't give up the food and so that was really....that was a real line for her, for her food was an addiction but that was a continuation of the addiction but she could give up the alcohol and stay away from....get alcohol out of the house but should couldn't do that with food....give her that emotional support. Sally, Eating Disorder Clinician.*

Some clinicians also perceived patients' emotional eating to be a type of self-prescribed therapy for symptoms of mental health conditions that were triggered by something other than the appetite stimulating effects of common psychotropic drugs.

*Well we do get people with depression who certainly indulge in chocolate eating to comfort eating because they feel that that helps their depression and they need to treat themselves, so that is part of it, even though the SSRI's that they are on are not implicated in weight gain they will use that reward....Terry, Dietitian.*

*I guess the same comes down to mental health issues, what is it about mental health issues that make people gain weight. And that's without taking tricyclics and lithium and all the other obesogenic medications that people take. There is something about poor mental health that also...we think it's linked to comfort eating but maybe there's something else there in between. Kerry, GP.*

General practitioners questioned whether some patients' emotional eating behaviour particularly of sweetened foods, provided some physiological relief from pain.

*I'm sure that there is some connection between sweet food or sugary food and comfort of some sort....distraction from pain....Kerry, GP.*

### 5.3.1.2 *Ambivalence toward treatment outcomes*

Ambivalence to weight loss depicts an underlying resistance to change owing to fear of life after weight loss, and a belief that achieving weight loss maintenance would not be the end to all of life's problems. It also describes deeply rooted cultural preferences of Maori and

Pasifika towards larger figures as a sign of health and beauty, and the significance of giving and receiving food in upholding important cultural traditions.

### **Consumers**

Several participants in the Self-Help group, expressed reluctance to sustain a significant amount of weight loss, for fear of gaining unwanted attention or the prospect of having to deal with negative emotions unrelated to their weight.

*... my weight was kind of my security blanket, I knew...there was so many things...I'd say, oh when I lose weight, you know, I'll be able to get that guy, I'll be able to...I'll take up salsa dancing, I'll do all these things when I lose weight and deep down you then get scared – all these things – if you lose weight you are going to have to deal with these and I know my weight, I know who I am now, what if I'm different, what if when I've lost the weight people still don't like me, I still can't get that guy, then it's not my weight, it's me and, you know, that's a scary thing so then deep down and then you kind of just go, ooh maybe not or I'll try and you'll try but not to the extent you need to and then you go, oh I tried that it didn't work, it's not me it's that thing, so there is just so many different reasons I think as to...and that is the big thing is tackling your inner demons and your inner reasons on why you do the things you do which you still...I'm still in a state of battle. Tara, Self-Help.*

Others, having lost weight in the past felt being thin did not necessarily make them feel healthy or happy, despite the torment they forced themselves to endure to avoid regaining weight.

*I have been fat all my life, as a baby, the baby photos have my skinny brother and me as the big fat baby all my life and the past three years I've lost 70 kilos by myself really I suppose, even though sort of Weight Watchers. Is it the answer to everything? No. Does it make you entirely happy? No. And is it still a daily battle? Yes, it is still a constant struggle... Karlie, Self-Help.*

*... about being overweight, you know they weren't being nasty or anything, but they just said, you know, is there a reason why you prefer to be overweight? And I actually had to think about it and what came to my mind absolutely scared the hell out of me, I didn't want to be attractive to men, I've been hurt so badly... Charlotte, All Ethnicities.*

Participants in the Pasifika group discussed how traditionally their culture associates a level of attractiveness to different magnitudes of 'weight'. Achieving weight loss appeared to be of

less importance to this group as culturally, larger figures were seen as a sign of health and beauty. Maori participants agreed this concept also had significance within their culture.

*You know for some in Tonga, if you see, say the size of you, nice and slim island girl, you know Tongan girl, slim is ugly, is too skinny, but if you see somebody like Naiah or Tene, oh she's beautiful.... (all laughing). Ernie, Pasifika.*

It should be noted however, participants in the Pasifika group agreed there was a 'limit' to how big someone could be and still be seen as attractive, although it was unclear in this context what size that would be.

Both Maori and Pasifika groups talked about the value of food within their respective cultures. Participants in both groups agreed that food was a central component of social occasions, whether it be a large gathering or a visiting guest to their house. For Maori, the ability to offer food to guests and loved ones, was of paramount importance to preserving cultural traditions.

*It is a pleasurable thing...and for Maori it's part of their culture. If you have people visit the first thing you do is feed them. Fay, Maori.*

Participants in the Pasifika group discussed cultural obligations to both give and to receive offerings of food, but emphasised the importance of being able to offer an abundance of food as an indication of wealth status.

*And it's a shame, it's a real shame because as Malo said, it's the first question, you say like I attended a wedding, you know the first question I go back and discuss with my family say oh how was the food? It's like it's a shame for the host if they cannot, not enough food, it will put shame to them which means it tells other people that they're not wealthy, they're poor so that's the main thing they need to focus, is there enough food you know. Tene, Pasifika.*

The abundance of food choice in New Zealand encouraged purchasing of non-traditional food items, often being higher in fat and sugar. Participants viewed the majority of these non-traditional foods as unhealthy and uncondusive to weight loss, however, in keeping with tradition, if offered they were obliged to accept.



*...but one thing I've noticed that is very common, very common amongst all of us is that food is something that is central to us in terms of fellowship. Most things are measured on food, (All Agree)... at a wedding for instance, the focus is on food, make sure there's enough food, to avoid embarrassment ....so there is always a tendency to make more than necessary...and I mean in huge quantities which then people are expected to eat....therefore people always eat more than they need leading to obesity.....It's the same concept and it's worse here in New Zealand with a lot more choice on foods. Malo, Pasifika.*

### **5.3.1.3 Unrecognised addiction**

This sub-theme represents the perceptions of untreated food addiction as a barrier to losing weight. It also explores the premise of food addiction (whether it exists), and whether it is thought of as a cause of obesity or a barrier to treatment. The participants in this study were not asked to define food addiction, therefore the term refers only to the participants' perceptions.

#### **Clinicians**

Generally, clinicians were receptive to the premise of untreated or undiagnosed food addiction as a barrier to losing weight. However, there appeared to be a large degree of uncertainty amongst clinicians as to what actually constituted a food addiction. Discussions typically sought to clarify the difference between a food addiction, uncontrollable eating, compulsive over-eating or binge-eating, and general over-eating.

*I do think it's definitely a behaviour, ...(unclear)...I do think for most it is actually an addiction. And I think people actually initially get a buzz from it but then feel really guilty afterwards, if you talk to anybody who has an eating disorder, they say it makes them feel good initially, they think it's going to satisfy something in them, one cigarette ...(unclear)...without nicotine, so they must be getting something from it to do it and then most of the time when we talk, they feel really bad afterwards. For some who have the addiction that they want to vomit or they want to take laxatives but for others they just sit and feel more guilty and then they say I'm going to eat more because they think well ....(unclear).... I'm actually full now anyway so I'll just eat... Linda, Nurse.*

Dietitians in particular were reluctant to accept food addiction as an area of treatment for obesity, as it had not yet been defined within their scope of practice.

*... we get a lot of referrals for inpatients and it will say it's binge eating but we never ever have it written as addicted and when you talk to the patients they don't express it as an addiction, they express it as they are bingeing, which is eating....yeah an eating problem, I mean we do get the others who do have some eating disordered behaviour as well and maybe purging with that and so we need to make that assessment to see what is driving that bingeing and what the thinking is around it, but addiction is not something that...it is not termed as addiction, for our referrals anyway. Terry, Dietitian.*

Some dietitians were concerned that without proper diagnosis, food addiction could become an excuse for those not willing to attempt conventional behaviour change treatments.

*So the food addiction thing, I think, links into a compulsive over-eating and compulsive kind of behaviour, so it is going to be a cluster of people that you might want to label that but when the conference was on last year, I mean, the media hype about food addiction as being the new thing, really it's dished out to the public and to other health professionals who don't understand and then it is another reason for people to not make any kind of change at all, now I think it is quite dangerous. So I think there is going to be a small number of people that it is going to be relevant to and you need to get the definition before it goes out to the public, you need to know what it is. Kylie, Dietitian.*

## **Consumers**

The vast majority of the All Ethnicities and Self-help groups felt that untreated food addiction was responsible for at least some of their inability to lose weight. The participants described various reasons why they considered their relationship with food to be addictive. Some attributed the addiction to their genetic heritage, others as a progression from pleasure to dependency.

*Actually at some point it did, I think...isn't that the measure of addiction, I mean food, the comfort of food, the warmth of food or the, you know, the sweetness, the pleasure of it, it was a reward, so at some point it was but then it gets...now to me it's complete addiction... Marie, All Ethnicities.*

Some participants described feeling an intense drive to eat despite a huge desire to lose weight.

*I occasionally will (binge eat). It's like you are almost being possessed. Tara, Self-Help.*

*... I'm not eating because I'm hungry, I'm not eating...but I want that reward but it is just way out of my control at times, you know, it's just like I've got to eat it, I've got to have something, I don't feel right, you know, and trying to say no I'm not. Marie, All Ethnicities.*

The fact that food addiction was largely unrecognised within both health circles and wider society was a source of added frustration and recognised as an additional barrier to treatment, as they were not able to access the same level of treatment other addicts were entitled to.

*I still can't believe that there is still argument that food is an addiction. I mean if you look at the actual definitions of addiction, I mean clearly food would meet that, you know, you can't control it use it for long time whatever the definition is. Marie, All Ethnicities.*

*Now, we all know how many drug addiction places is there around the town and, I mean, it is the same thing in my book, I'm addicted to food, somebody else is addicted to cocaine, my husband is an alcoholic... Bobby, All Ethnicities.*

### **5.3.2 Theme 2. Judgement and discrimination**

This theme describes the impact of obesity stigma on consumers' willingness to both attempt and adhere to treatment. Clinicians and consumers alike recognised the impact of societal pressure to be thin on low self-esteem already experienced by many with obesity. Consumers were reluctant to attempt weight loss treatments due to feeling inferior in the company of thinner figured counterparts. Some consumers felt health professionals themselves bought into obesity stigma which they felt affected the quality of treatment they received.

#### **5.3.2.1 Oppressive society**

The impact of obesity stigma on self-esteem and self-worth resulted in people with obesity feeling both isolated and unwelcome within their own social networks/societies. Consumers found clinical terminology used for diagnosing their obesity shaming and offensive as a result of the slandering of these clinical terms in both society and the media. Consumers expressed how stigma affected their willingness to both seek out and to receive treatment for fear of being shamed or guilt-ridden.

## Consumers

Participants in the Self-Help and All Ethnicities groups felt immense pressure from society and the media to be the 'perfect size'. Participants frequently illustrated how the constant reminders in the media of the ideal physique, affected their self-esteem and sense of self-worth. Some felt society shunned their larger sizes and perceived them to be lazy and gluttonous.

*...they just look at us then and they just think, you are scoffing food all day, you don't do anything and it is not true and I think, you know, society as a whole has got to look at us that we're people, we've got rights and some people might choose to be overweight, others may not have any control. Charlotte, All Ethnicities.*

*The media creates, you know, the perfect size, you've got to be the perfect size...(unclear)...and they've noticed with models being too skinny and collapsing and dying, but I always try to show girls that you don't have to be the perfect size, you know, accept you for you, you know, but the media out there are really, really horrible and they really hone in on it. Brenda, All Ethnicities.*

Participants explained how they felt like outcasts in their own society, and that this impacted on their willingness to attend weight loss facilities.

*You go to a gym and you have got a small cramped space and you just feel so conspicuous and everyone else is like the perfect size ten and you're the only fat one there as they say and you want to run out of the room. Sharee, All Ethnicities.*

Participants in both the Maori and Self-help groups explained how reaching out for help with weight loss could be a very shameful experience.

*I think one of the things I'm personally really aware of is the shame around asking for help, it's the shame involved, and the years and years of therapy that I've had nobody has ever said to me, nobody has ever said or suggested that it might be that something that I might like to address would be my weight issues but nobody sort of ever got alongside me and said could there be some connection? And I've always been, I mean it's ridiculous to be ashamed because you're out there to be seen anyway, but the actual bringing up of those issues, to talk and talk therapy, is extremely difficult, for me has been, but on the other side of it, it has also been completely ignored by anybody I've ever seen, any psychiatrist, psychologist, therapist of any sort, doctor, nobody says to me, you'll be alright. Delia, Self-help.*

The impact of societal stigma appeared to have a flow on effect into what consumers perceived as acceptable clinical terminology for describing their obesity. The majority of

consumers viewed clinical descriptions of their overweightness such as ‘obese’ and ‘morbidly obese’ disturbing and offensive. Participants felt these terms were over-used in society for describing unattractive and unhealthy individuals in a non-clinical sense and for depicting extremes of overweightness, which they did not relate to. It appeared the over-use and misrepresentation of these terms in the public arena had tarnished their acceptability for use by medical professionals.

*The other thing is that I feel that the media have bought into this sort of let's bash people who are overweight thing that's going on at the moment and the issue of using that term is used sneakily in the media, you know, nobody will own up and say, well I'm saying that, it's just, you know, the health department, the government, the whatever, you know, a group are using it and I have to say that if I think of what I think when I see the word obese or hear it, is I never apply it to myself, I apply it to people that we've all seen who are really disabled and yet I know that I'm obese... Delia, Self-Help.*

*I think when you described obese, you almost....it's like those American people that have to be cut out of a house, who are rotting to the bed and when you are talking about obese you almost think of someone who's given up on life and is that massive that, you see these documentaries, that's what the vision of obese, I know I'm obese, but that's what I look at obese, really obese, morbidly obese is like and that's horrible. Leila, Self-Help.*

For some, the negative images and connotations associated with these terms affected their receptivity to treatment in consultations with health professionals.

*I just look at them (when they say obese) and switch off quite frankly. I just switch off. Cassie, All Ethnicities.*

*It also feels a little bit as if the morbidly obese phrase...very punitive as if morbidly bad driver, no hope for this, morbidly obese... Karlie, Self-Help.*

At least one participant described feeling shocked and offended at seeing clinical terminology used as descriptors in their medical notes.

*At one stage I asked to get it and to read it so they had to copy it for me and I was horrified to see that my description was as an obese woman, an obese middle-aged woman with greying hair, you know, a very depressed middle-aged woman was a descriptor, as if that had anything to do with my depression and it was never referred to later... I can remember sweat breaking out on my face when I read that feeling so shocked really and more frightened that I was being, you know, described in that way... Delia, Self-Help.*

## Clinicians

Clinicians perceived the obesity stigma in society to impact on obese people's self-esteem and enthusiasm towards treatment. The growing number of publications warning about the health risks of being overweight were thought to be instilling fear and guilt into even healthy weight members of society, let alone their obese counterparts. Clinicians were concerned that media images portraying seemingly effortless and rapid weight loss, caused obese people to feel inferior as they were unable to meet the same unrealistic goals.

*And if you read the magazines, photos of people, three days after having baby back to normal weight, hasn't she done well, then this person hasn't done well at all if she still got her pregnancy weight. Kerry, Eating Disorder Clinician.*

*Guilt unfortunately isn't the answer either, the more we read and write about obesity, the more guilty, the population gets about the problem. We're already bad enough about cholesterol, I mean skinny people coming in ....(unclear)....and having their cholesterol taken every year. And I say, you've only had that taken a couple of years ago and it was three so why are we doing it again, you know. A lot of the publicity is just engendering guilt I'm afraid. Kerry, GP.*

Eating disorder clinicians described how they felt societal attitudes towards people with obesity damaged the low self-esteem many with obesity already experienced. Like consumers, clinicians' felt people with obesity were shunned by society, and treated as having a condition that is a direct result of their lack of self-control.

*So it is actually related to acceptance and how you can get someone to accept themselves if everybody in society now is going no, no, no we don't accept you. Nancy, Eating Disorder Clinician.*

*...you know if you make someone feel shit it is really hard to get well isn't it, I think that needs to shift as well, there's too many, you know, fight the obesity epidemic kind of thing. Sally, Eating Disorder Clinician.*

### 5.3.2.2 *Insensitive prejudice*

Previous experiences of clinicians' hurtful attitudes in response to their obesity took participants in this study by surprise. Consumers felt discriminated against because of their size both at a personal and a professional level. Despite this, consumers also formed opinions

of health professionals based on their current or former size and their ability to treat obesity. Specifically, some consumers felt obesity treatments were more effective if the treatment provider had themselves successfully lost weight in the past.

### **Consumers**

Consumers from all four focus groups recalled unpleasant encounters with health professionals that left them feeling shocked, emotionally undermined and blatantly insulted, in an environment they normally associated with safety and support.

*just been diagnosed with type II diabetes and I had to go and see the nurse at my doctor's surgery and just her whole attitude, you know, wasn't what a health professional should be and as I was going out the door, she just said to me, well I hope to see less of you next time and I sort of feel you can't say that to me, you know. Charlotte, All Ethnicities.*

*I had a car accident, had to go and have a hysterectomy. The surgeon said to me after the surgery, he said, walked into my room and he said I hate you bloody fat women, he said, I couldn't even cut it out, I ended up having to rip it out, and if you die of cancer later on in your life don't blame me... Bobby, All Ethnicities.*

Some consumers indicated that although they believed health professionals 'disapproved' of their overweight size, they did not expect to be confronted with such abrupt and personal remarks.

*Isn't it shocking that health professionals would actually say, I mean, okay, they might have these underlying bias but to actually say to someone some of the things they have said to people in this room is absolutely....I got treated when I was pregnant and had to go for a scan and one woman was hideous because she was just so rude, she said there's no point, I can't see anything through all that fat. Marie, Self-Help.*

At least one participant in the All Ethnicities group felt mistreated as health professionals frequently overlooked specific medical complaints, instead blaming the participants' size before performing a thorough assessment. Participants were not only upset by this, but were concerned that this would eventually lead to a serious misdiagnosis.

*Totally, if that was one message I could get through, it would be you've been ignoring a whole raft...(putting all health problems down to weight ) you know, it's kind of like if I said cancer, so everything is put down to cancer, but, certainly, just about*

*everything is put down to my size. I have got to say I have a great doctor now but that's another issue. Marie, All Ethnicities.*

Participants in the All Ethnicities group expressed some reluctance to receiving weight management treatment from others who had perceivably not had to lose weight themselves.

Some participants were clearly put off by thin figurines in the position of offering weight loss treatments.

*Like when you go to the gym, or even over the road, I've been trying to get a Well clinic, there are a lot of very overweight nurses, and some of the skinny educators who are into lycra and, oh yes, they are bringing happy weights from the...and they have just been told to take a long walk off a very short pier because it is not helpful for us and it is quite clearly shown that they do not understand. Felicity, All Ethnicities.*

There were noticeable feelings of frustration and resentment at the perception that 'thin' people were exempt from remarks about their physique, unlike those who were overweight.

*What gets my heckles up is, you've got a reasonably slim person telling you what you should be doing and all you see is this, you know, person with a nice body and then you sort of think, well are you anorexic, you know. I mean imagine if we went saying to real skinny people, you must be anorexic, I mean there would be an outcry because anorexia is treated as an illness. Charlotte, All Ethnicities.*

## **Clinicians**

Clinicians acknowledged aspects of society they believed oppressed obese peoples' confidence and therefore their inclination to attempt obesity treatments. Clinicians explained how after observing the struggles others around them faced to lose weight, they became more aware of the complexities surrounding weight loss for their patients. It appeared that for some experiences with weight loss outside of their professional lives enabled them to identify with the stigma felt by people with obesity.

*I guess the other thing that doesn't support the stereotypes in my mind is the belief that it's self-control because that's a strong stereotype, that there is something wrong with you that's why this is happened and if you just had more self-control, because, I mean, I believed in diets like everyone else until I started working here and learning more and I've been watching my friends and, in fact, those who had gone on*



*diets and lost weight have gained more and wound up weighing more. Zoe, Eating Disorder Clinician.*

Some clinicians spoke of how they felt let down by other health professionals for mistreating patients and dismissing health complaints due to their larger size.

*... you were saying self-control and this idea around stereotypes, it is interesting for me to assess somebody who had been to see three medical specialists because they were clinically obese and had physical health complications and every single person said to them, there is nothing we can do for you until you lose weight and it is about self-control, perpetuated for this person their sense of failure and their sense of not being listened to and what do I do from here. Surinah, Eating Disorder Clinician.*

### **5.3.3 Theme 3. Overcomplicated, overstretched and ineffective**

This theme represents current trends within modern society and the formation of a confusing and high pressure environment ultimately disadvantageous for those suffering from obesity.

These trends include the ever-expanding wealth of information of varying credibility surrounding ‘healthy eating’, and the increasingly rushed society, lacking time, money, and resources to focus on obesity treatments.

#### **5.3.3.1 Misinformation**

This sub-theme conveys the detrimental impact of the increasing availability of nutrition information available to both clinicians and consumers.

#### **Clinicians**

The majority of clinicians agreed that overall people are confused about which food products are recommended for health, due to the excessive availability of conflicting nutrition information. Dietitians in particular felt the food environment had become increasingly complicated, with an overabundance of food outlets stocking low cost energy dense foods, and disingenuous food marketing claims alleging health benefits easily misinterpreted by well-meaning consumers. Dietitians appeared fed up at the wide variety of ‘nutrition experts’

and consumer groups they had to contend with to ensure patients received accurate nutrition information.

*A large component of my work is just wading through all they have done before and what that's left them with and some of that might be from health officials as well, incorrect information, so when you might be doing something cognitively, for example, I mean the strength those behavioural changes, the strength of the help you give a person is only going to be worth the accuracy of the information that is given. I mean, what's the point in doing cognitive restructuring if the information is incorrect. Kylie, Dietitian.*

Some dietitians' believed exaggerated nutritional claims on food and beverage packages lead consumers to believe the more they consumed the better for their health, which was often the opposite of the truth.

*...if it's a little bit good then lots is even better and it is those messages, there's Nutella telling you and people are very gullible, if they hear that message enough that something is good for you, oh I must get that it's good for us... Terry, Dietitian.*

Clinicians expressed frustration that consumers were not only being misled but also extorted at the hands of so called nutrition experts who only appeared to be interested in the consumers' money.

*They don't say to eat three meals and three snacks and then you don't get so hungry, and it is easier to not have six biscuits, you might have one, but that's not said, that doesn't give anybody any money or, you know, it feels like it is driven by people who are going to get an advantage of driving one aspect of it rather than the sensible stuff. Zoe, Eating Disorder Clinician.*

GPs and nurses suggested that it wasn't only members of the public that found the abundance of nutritional information overwhelming, they too found it difficult to interpret.

*Now there's not a lot of simple facts in diet, in nutrition, you can't say this is definitely so and it's not going to change over the next 30 years, because actually if we look back there's been a lot of change, and so it's much harder to give simple messages on nutrition. Kerry, GP.*

## Consumers

The majority of consumers found the oversupply of nutritional health messages around food left them constantly questioning what they should and shouldn't be eating. Ultimately this lead to feelings of frustration and hopelessness.

*... so I always taught my grandchildren to drink water and milk now I hear the milks not good for you, and then they say some of the waters not good. What is good and what is not good? Nerida, Maori.*

*I figure in this day and age, depending on what you read or who you talk to, you can do nothing right. At the end of the day, you can do nothing right. I for a long time...you know diet jellies and diet sodas as I've got a sweet tooth and they have no calories and fill you up and then the next thing everyone says, oh these diet things with all the artificial sweeteners, oh they so bad for you... have butter but not too much because at least it's natural and then don't have margarine because of the chemicals or....you get thrown all these different, conflicting views and opinions from so many different people and you just think, God what am I mean to....you know, one person says eat five small meals, the other person says eat three big meals... Tara, Self-Help.*

Some participants were discouraged to observe trained nutrition experts struggling to agree on dietary advice.

*The comment that you made about the dietitian, I had the same problem when I went to the Diabetes Centre, the dietitians who were treating me were arguing over which procedure and what should be...(unclear)...and it is like, well if they are arguing and they can't make up their minds, how can I expect to figure it out for myself if they are at loggerheads over, you know, what I should eat and what I should not eat and here's professional people fighting over, you know, she should be doing this and she should be doing that and it is a really confusing message you know. Brenda, All Ethnicities.*

### 5.3.3.2 Inadequate resources

This sub-theme portrays the belief amongst clinicians and consumers that busy lifestyles made it increasingly difficult for people to achieve weight loss success. Clinicians believed some consumers struggled to find time to prepare and money to purchase healthy foods.

Consumers elaborated on the clinicians' views, citing financial constraints as prohibiting them

from being able to afford healthy foods, attend exercise facilities and adhere to commercial weight loss programmes.

### **Clinicians**

Dietitians thought consumers were becoming increasingly impatient with weight loss expectations and demanding when it came to treatment. They felt some consumers neglected to put in the necessary effort to prevent unwanted weight gain, expecting to be able to reverse it with minimal effort.

*Well, normal... people don't want self-control, the whole plastic society, where you buy food like you buy clothes, what will I have today and then they go to the dietitian or to Weight Watchers and just expect to buy weight loss, they don't realise that you can't buy weight loss, there's actually a few steps to go, but everyday that's what they want, why I am not losing weight fast enough? I just say, you are not coming here to buy weight loss, you are coming here to get help with how to do it. Kylie, Dietitian.*

Clinicians believed consumers were drawn to ready-made food products as they were less expensive and more convenient than preparing meals from scratch. Some participants expressed concern that the increased intake of these food items would be ultimately adverse for weight management as they often contained added fat and sugar. It was felt that often people were unaware of the poor nutritional quality of convenience foods and their impact on weight gain, and therefore were influenced almost solely by price.

*...you just add this and that to it rather than doing it from scratch, so there is something about, I don't know whether it is true about New Zealand population, society, things have to be quick now, so for it to be quick it is going to be the food that is maybe got a little bit more saturated fat and a little bit more sugar in it and those types of foods, so I don't think in reality that those fast are actually cheaper, they're easier, they're quicker... Meredith, Eating Disorder Clinician.*

*Of course carbohydrate things are a lot cheaper than a lot of the other foods you can buy. It's those sort of things, lack of knowledge, oversupply of food, oversupply of convenience foods and all the other things that we know about...Kerry, GP.*

Those living in low income areas were thought to experience elevated costs of healthy food items, often making convenience foods the only choice.

*What is going on with supermarkets in Christchurch and east Christchurch, the fruit and vegetables are more expensive there than in the wealthier suburbs? Wendy, Dietitian.*

*....probably from a public health point of view, particularly in east Christchurch area, which we know is low decile, low income family, there is not a decent supermarket within an actual distance for those families to get access to food. They are up against so much in terms of...even before they start... Belinda, Dietitian.*

## **Consumers**

Despite good intentions, the majority of consumers recalled being unable to initiate or continue with obesity treatments owing to financial constraints. Consumers from all focus groups told of various occasions where a lack of money had prevented them from adhering to treatment regimens such as attending exercise or commercial weight loss groups.

*My counsellor, she was quite big and we use to sit there and discuss what's stopping you getting help and it used to come down to the same thing, half the time its finances or assistance or... Brenda, All Ethnicities.*

*See we had a few Maori people on the Optifast diet that we have here, but they've fallen off the track or whatever you like to call it, because they just can't keep up with the finance or with their budget, they can't afford it, it's something like \$60 a week. Nerida, Maori.*

Participants with families indicated the difficulty of satisfying both wants and needs with regards to the provision of food. Participants across all consumer groups believed it was more expensive to purchase 'healthy food', and in some cases were forced to buy cheaper, lower quality foods, just to have enough to go around.

*People are saying oh Pacific Islanders are obese, it's true but they don't look behind it. We can't afford to eat the healthy food, that's a fact. We work because we need to feed the family and feed our families the cheapest which is unhealthy food. Tene, Pasifika.*

The responsibilities of looking after a family, also meant that when unexpected circumstances arose, money was distributed elsewhere rather than on weight loss plans.

*They manage sometimes but they don't manage when something comes up in the whanau, like one of our kuia said my moku was feeling quite sick and I had to weigh up whether to take him to the doctor and get some medication or worry about me*

*with my Optifast, she said so naturally I'm going to look after my mokopuna first and that's just a natural thing with whanau, any family, look after the little ones first and don't worry about your own self, it's a hard road for them, for some of them, to try and keep up with it. Nerida, Maori.*

### 5.3.3.3 *Scepticism of current treatments*

This sub-theme explores the perceived ineffectiveness of current obesity treatments, from conventional weight loss treatments such as healthy eating and exercise to the more rigorous nature of commercial diet programmes.

#### **Consumers**

Some participants described the inability to change their body size despite long and arduous periods of physical activity. The lack of results despite efforts were not only disheartening, but they didn't help the perception they thought others had of them of leading sedentary, gluttonous lifestyles.

*I work for security in the weekends and I'm like walking around if I'm at the Harvey Norman building, I'm walking around that site for ten hours a weekend, five hours on Friday night and five hours on Saturday night, and people go to me, you're security the weight should just fall off you, but I'm walking, I'm watching what I eat, you know, and people still have that mentality out there, you know. Brenda, All Ethnicities.*

The lack of trust for conventional weight loss treatments also stemmed from fruitless attempts to improve the nutritional quality of their diets. One participant felt the term 'healthy eating' used by health professionals was a deceitful term used to disguise an otherwise minimalistic and restrictive diet.

*... but when they say healthy eating this is how to eat healthily, no, they are talking about tiny little bits of things with fruit and vegetables, it's a diet by another name, so it is just now they've got...by the way diet is just die with a t on the end. Marie, All Ethnicities.*

Several women protested at the futility of their attempts to lose weight by cutting out or reducing perceivably problem foods. Frustration was evident as their male counterparts appeared to lose weight easily using the same tactics.

*My husband who's not fat and he eats dips and...(unclear)...but he has put on a wee bit of weight and then he became pre-diabetic with diabetes and so he cut out his biscuits and he cut out his fizzy drinks and not much else and within four weeks he had lost 10lbs and I did exactly the same, I cut out my biscuits, which were chocolate biscuits, I didn't drink any lemonade, I cut right back on ice-cream and only had chocolate once a week and I lost 1lb. Now that was soul destroying because why do men lose weight easier than women? Nerolie, Self-Help.*

Whilst participants had mixed opinions of commercial diet programmes, the majority appeared to struggle with the concept of having to incorporate often over-bearing sets of rules and regulations into existing lifestyles.

*I have just been through the same as quite a few nurses on the floor that I work have lost weight going to Weight Watchers. I went to three meetings and I just got in such a state, I tore up the books in the end. All time of day thinking about bloody food and I thought, how's this healthy? Felicity, All Ethnicities.*

## **Clinicians**

The majority of clinicians believed that part of the reason they saw so many unsuccessful attempts at weight loss is because overall, there is a lack of knowledge amongst health professionals of how to treat obesity.

*That's been one of the hard things of, I think, about actually handling obesity. And certainly we all know that the more we diet the more we gain weight, so there's not much help anyway, you know... I don't know if they've done all the research (unclear)...we should have a more research based approach acknowledging that we don't yet have all the answers and we probably have given some wrong answers in the past. Kerry, GP.*

GPs and nurses questioned the effectiveness of traditional weight loss techniques, such as eating less and increasing exercise.

*I know anecdotally you see patients of mine, they will be eating very well and they'll take up, do something like taking up exercise and they'll boom and bust it, that might be one of the causes, they'll do six days a week of exercise and they'll find even*

*though, and they'll find suddenly they've only lost 0.2 of a kilo when they should have lost 1kg or something with all the energy input and output they should have done...and that shows you it's not that simple, it's shows you there's a biochemical or a fluid balance system in there that is actually changing. Kerry, GP.*

*... it's not the energy in and energy out any more. So they were sort of saying is that actually, is it that simple, maybe it's not that simple. Linda, Nurse.*

Eating disorder clinicians voiced concern around the current medical approach focussing too much on weight loss, rather than concentrating on what they believed should be a more holistic approach.

*I do think it goes back to having a better understanding of what are the reasons for obesity and I think to pay far more attention to the psychological and having quite a holistic approach. Surinah, Eating Disorder Clinician.*

Some clinicians felt the lack of definitive approaches to obesity treatment led health professionals to try desperate measures such as very low calorie diets, or alternatively, to delay treatment for other medical conditions until the patient had managed to lose a set amount of weight.

*They're tried everything and they have got to this point where they persisted, they're lost the weight, it doesn't stay off, what do they do? And that is what lead to the introduction of doctors to put patients on 600 calories and it just doesn't work. Freda, Eating Disorder Clinician.*

Clinicians had mixed perceptions about the quality of some commercial weight loss programmes. Some clinicians reported referring patients wanting to lose weight to Overeaters Anonymous™, although there were mixed perceptions about the effectiveness of this programme for treating all people with obesity.

*The same reason AA doesn't work for everybody. ...there are differences, being overweight sometimes is a symptom, it's a symptom so what's the point of treating the weight if the cause is something totally like addiction as opposed to....Delwyn, Addiction Clinician.*

Dietitians were frustrated that many commercial diet programmes promoting healthy lifestyles and healthy eating, were not delivered by trained health professionals. Furthermore



dietitians felt programmes that required consumers to purchase additional supplements or food products on top of membership fees were exploitative.

*...I think do all exploit and Weight Watchers is the best, obviously the best by quite a long way because they do actually have something that they could teach but a lot of the leaders don't actually teach it, so people don't necessarily get the right information but they do sell junk food in terms of their snack options and Jenny Craig is much worse at that and they've got quite a low energy intake on their diet yet they are cramming in this junk food where they should be getting people to eat more healthy food and possibly just using ordinary junk food that they prefer to eat and not being so precious about their own product and then SureSlim, I've had huge arguments with them they just can't validate anything they do at all and it's atrocious that could cause... eating disorders and eating problems because they're the ones I have the most problems with. I see huge numbers of people from SureSlim and they are seeking desperate help coming out of that programme. Kylie, Dietitian.*

Dietitians expressed further concern at the suitability of messages some diet programmes offered for the sustainability of long term weight loss. They believed the restrictive nature of some guidelines required an unrealistic level of commitment from consumers.

*A lot of the marketers, you know the mainstream solutions, whether they be a ten week challenge at a gym or Sure Slim or something where they take your blood test and you spend a thousand dollars and buy some product or whatever. They just don't seem sustainable, which seems illogical...that that not actually going to...if somebody can't stick at something, if it is going to be depriving or it's going to be physically exhausting, it seems counter-productive. Laura, Dietitian.*

There was an overall lack of trust amongst dietitians of the methods used by typical diet programmes to promote weight loss amongst their clients. The philosophies of some diet programmes were likened to that of a dictatorship, where consumers were 'told' what weight they should be and what they should eat to achieve this. This attitude conflicted with the dietitians' views that treatment outcomes should be driven by the patients' own motivations and goals rather than the expectations of others.

*... so it is still this idea that somebody else is telling you what your body needs and they are working out the weight your body should be at and they don't know the genetic make-up and it is still buying into this whole idea too of, you know, if you are sad or you're down, you've had a relationship break-up, or something is going on, or you are overweight or something, you need to be happy, the first step is get your life in order and part of getting your life in order is getting down to that right weight...Sally, Dietitian.*

#### **5.3.4 Summary**

Clinicians and consumers acknowledged a variety of factors they perceived had an adverse impact on the effectiveness of obesity treatments. The barriers identified, were generally recognised by both types of participants, although consumers described these as lived experiences whereas clinicians provided a more second hand view.

The first theme in this section described the psychological aspects of obesity that both suppress attempts at obesity treatments and work against their success. Both consumers and clinicians acknowledged the detrimental effects of unaddressed psychological needs on both the chances of weight loss success and maintenance.

The second theme described the oppressive nature of obesity stigma. Clinicians and consumers discussed the impact of a judgemental and discriminatory society on the self-esteem of those with obesity and the resulting reluctance of consumers to seek obesity treatments due to feelings of shame and embarrassment.

The third theme in this section portrayed thoughts of an increasingly complex and confusing environment surrounding obesity treatments. Conflicting nutritional messages in media publications, financial constraints and doubt around the effectiveness of current treatments resulted in feelings of frustration from both types of participants.

The following section outlines factors clinicians and consumers view as facilitators to successful obesity treatments.

## 5.4 ENABLERS OF EFFECTIVE TREATMENT

This section explores two themes outlining participants' perceptions of weight loss treatment facilitators. 'Enablers of effective treatment' in the context of these study findings include factors clinicians and consumers have found helpful both for losing weight and for maintaining weight loss, encouraging positive behaviour change and strengthening supportive relationships. Themes and sub-themes for this section are displayed in Table 2.

*Table 2 Summary of themes - Enablers of effective treatments*

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<b>Theme 1: Holistic approach</b>	Readiness to change
	Previous attempts at weight loss
	Collaboration among Clinicians
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<b>Theme 2: A long term relationship</b>	Support and persistence
	Trust and rapport

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### 5.4.1 Theme 1: Holistic approach

This theme considers the need for a wider approach to obesity treatment, focussing on not only the physical condition but also the emotional and psychological aspects.

#### 5.4.1.1 *Readiness to change*

Clinicians and consumers agreed that a person's readiness to change was influential in deciding when to initiate treatment. Careful consideration of a person's mental and emotional health, as part of a thorough assessment, was believed to be crucial for developing effective treatment plans.

## Clinicians

Clinicians discussed the importance of assessing a patients' willingness to attempt weight loss. It was generally accepted that beneficial treatment outcomes were more achievable if a patient was motivated and ready to change behaviours.

*And for my patients, a lot of them have seen dietitians before, or tried other diets and they haven't worked, but it doesn't mean that this is not going to work, they are still trying hard this time around and, as you say, there might be something slightly different, their way of thinking might be different, they might be in a different stage, it might be more important to them, so, I mean, there is always going to be hope for them. Tracey, Dietitian.*

*...it's an individual thing, it depends whether you've hit the nail on the head first time, right at the time, right at the point where that person wants to change and how determined they are. Kerry, GP*

Clinicians working with mentally ill patients felt it was particularly important to ensure patients understood how medications may affect weight control, and to help them factor these extra obstacles in to a healthy lifestyle. The timing of these discussions was carefully considered so as not overburden patients with multiple health priorities.

*I was going to say in terms of the psychotropic medications, I always say that...we often get clients saying they blame their medication and so you have got to start at the point where they are not blaming their medication, that's my perception is that once that blame is there, then there is nothing, it's hopeless, I can't do anything about this problem perception, so I always say, it's really good to have an understanding about how these medications work and it may make it more difficult for you to lose weight as fast as you're wanting but there are many, many things that we can do together to help you lose this weight, so once they shift that blame away and realise they can do something and that it really is that personal responsibility, but then we have to also take into account whether with their illness are they actually capable at this stage of their illness of actually being able to put that responsibility in to play. Terry, Dietitian.*

*... The usual thing of being depressed at the same time and things and I find that it's very difficult to deal with and then at other times when their lives are better sorted out one can actually start tackling some of the issues... Keith, GP.*

## Consumers

Participants in the All Ethnicities group agreed it was important to be in a good 'head space' to achieve weight loss. Specifically, participants talked about learning to accept themselves as a person worthy of success and as having the ability to achieve it. This concept of self-acceptance was considered to be a cornerstone in the participants' weight loss journey, achieved through a process of reflection and self-realisation.

*I have found that if you can learn to like yourself, I hated myself, but I have learnt to like myself and I've gone back over the years what I've done and what I haven't done and I have made some very bad choices, but I do like myself now and that, I've found, has been a big help in a lot of things. Cassie, All Ethnicities.*

*The most important thing I think is learning that you are important, you know, that you have to look after yourself, that was a biggie.... Waylyn, All Ethnicities.*

### 5.4.1.2 Previous weight loss attempts/motivations

Both clinicians and consumers highlighted the importance of identifying and understanding deeply engrained emotions associated with food and previous attempts at weight loss. Often, this included confronting the reasons for behaviours detrimental to weight loss.

## Clinicians

Dietitians in particular felt especially strongly about discussing the patients' previous attempts at weight loss. Thoughts and feelings associated with previous attempts whether successful or otherwise, provided valuable insights for understanding how patients viewed the often complex nature of treatment.

*I think sometimes you think, say a referral from the....(unclear)....what attempts have they made to control their weight in the past because that can be quite...whether they have considered it an issue themselves and their feelings of success in having to control food intake to reduce weight, how successful have they been? Have they stopped and started a lot of different programmes? Do they come with a sense of failure, oh well, I don't really want to be here, it's the same old, same old? So I think that is something that comes to mind prior to you seeing the person, what have actually they done themselves. Deidre, Dietitian*

Others found obtaining a detailed weight history from patients helped to identify when weight became a problem for the patient, and any other life events that may have contributed to weight gain. Uncovering the reasons for weight gain highlighted areas that warranted attention in terms of treatment.

*...and I think exploring their weight history and quite often they can pinpoint the time that their weight started to become a problem for them. Lots of my patients aren't working and they have either had to give up work because of their joint problems or they have retired and that's been a turning point for them in their lives where they are spending a lot more time at home, they don't have a routine anymore, they don't have as much money and so I think that's a turning point for my patients. Tracey, Dietitian.*

*There's lots of issues as to why they aren't using that control and that, you know, part of our job is to uncover those and help them with change and that actually brings the topic to treatment options but that's about the stages of change too.... Terry, Dietitian.*

Encouraging patients to share their motivations for losing weight was considered fundamental to establishing treatment objectives. Both Eating Disorder clinicians and dietitians discussed the importance of a thorough assessment to determine each individual's motivations for weight loss. Treatment goals guided by the clinician could then be set according to the patients' motivations.

*But I think that's what a good assessment is about its about teasing that out and I think that it is important to understand that...what people's goals are and what our goals are and I think it is important in terms of things like, if somebody's goals, you know, the reason I'm here to lose weight is because I can't go ahead in my life until I've done that, then that's what you need to be kind of unpacking because it might their relationships and they need to do that at the weight they are, versus maybe somebody wants to lose ten percent which is realistic but because they are dying then that's, you know you can do some of the other things that you were talking about despite whatever the weight is but the physical health goals are probably important. Surinah, Eating Disorder Clinician.*

The depth of information shared from patient to clinician in order to uncover motivations for weight loss could extend far beyond the patients' relationship with food. Some clinicians felt obesity could be treated by helping a patient to understand what it was they wanted to achieve in life, rather than focussing on weight loss as a treatment outcome.

*For me and my work and working with people in those situations, it's tricky because I would have said to try not to have an overt weight loss goal, however if that's what someone desires, so I sort of just play this game of kind of being supportive but actually just wanting the fullness of their life. I am thinking of a man I worked with who...big life history and ended up...was hospitalised with depression and ended up staying within this house for two years, not leaving this house and a lot of that was to do with body shape and becoming very, very big and just his life shrinking and for him it is a really full picture of connecting with other people, of becoming active again, of forming community, of looking at his past, looking at how he deals with sadness and looking at his family culture and the patterns around food, you know, just a really full picture rather than, I mean he has had for years people saying, you are going to die, you need to lose weight, that message hasn't worked and so I think, I mean, holistic...there has to be more that someone is desiring than just weight loss because it is not going to work out. Laura, Eating Disorder Clinician.*

## **Consumers**

Consumers also felt it was helpful to identify the reasons underpinning their relationship with food. Participants described this as a process of self-discovery and careful thought into behaviours that affected their weight.

*Yes it is and you are able to get control once you realise why you do things. Maureen, Self-Help.*

*but I think what has been different this last time round and actually losing it, I've kept it off two and a half years now, is dealing with the emotional...the reasons why I do things and learning to...which is easy to say but hard to do and I still constantly slip up but you have got to keep getting back on, is learning why we do the things we do and why we eat and why we don't eat, why we exercise, why we don't exercise and then learning to understand the triggers so when those triggers come up we can recognise them for what they are and go, okay, instead of, you know, I'm feeling I want to eat so instead of going and eating this biscuit, I'm going to ring a friend or I'm going to go out for a walk or distraction, I'm going to, you know, take up a hobby, like keep your hands busy and keep your mind busy and.... Tara, Self-Help.*

### **5.4.1.3 Collaboration amongst Clinicians**

The majority of clinicians' agreed that collaboration amongst health professionals was important to ensure patients received a comprehensive obesity treatment care plan.

## Clinicians

General practitioners and nurses acknowledged their role within the health care system as a first point of call for many people with weight issues. General practitioners felt they were best placed to initiate the weight loss, whilst nurses felt they were better suited to provide education and support services.

*We can get, we can help people get the motivation to start, if you pick somebody that is ready to start, probably, but we can't actually do the work ourselves because it is a very specialised area I think....It's more like smoking, it's more like getting them started, than it is being able to actually do the therapy ourselves...I think we can work as the initiator and motivator. Kerry, GP.*

Some nurses felt that with nutrition training themselves, they could provide basic nutrition education and support to assist weight loss patients. In addition, nurses accessed nutrition experts such as nutritionists and dietitians through the public health service to obtain accurate and up to date nutrition education resources that could then be passed on to patients.

*I was on the initiation program with Robyn King, the nutritionist, yeah I think that was identifying that, I think nurses identified and perhaps even general practice identified that we needed to know more about nutrition... we looked at nutrition, we looked at motivation, we looked at level of activity, and we looked at self esteem, and it was a six week course. But not just the six week course I think, gave us that knowledge, it also gave us knowledge to work on a one to one basis with clients as well. I think giving the knowledge to the nurses has been great, the other thing we do more, and again it depends very much on each practice, diabetics, we work closely with them and we also work closely with their nutrition. Linda, Nurse.*

*I rely on dietitians of course to be up to date with all the nutritional stuff and be able to pass it on to the rest of us I think... I guess we had our dietitians who do clinicals every now and again and to bring us up to date...the last one was about pulses and breakfast diets but also working alongside a dietitian we can say, we can compare notes about a patient and say this isn't working for this person, do we have any other suggestions or could we see them again to give them a guideline...Teresa, Nurse.*

The services of a dietitian to work one-on-one with patients seeking obesity treatment was considered especially valuable when the scope of nutritional intervention required exceeded the capabilities of general practice staff.

*We're blessed at our medical centre in the fact that we do have a dietitian on board one day a week and very often I will try and get people to go and see Sally, in this*



*case, and see if she can help them in ways which I can't, They have a much greater knowledge, they're great people for that, really wonderful. And of course with the push these days on cholesterol and diabetes it's really important that we try and get these people motivated but sometimes it's very very difficult, and just as you say Keith sometimes you have to sort out the smoking situation, the home situation, and then maybe some of them have got diabetes, (unclear)... So it's been my push for the past couple of years to try and get people to walk maybe just that little bit further, to the next bus stop or whatever. How successful it's been, I've got no way of measuring. Teresa, Nurse.*

Both dietitians and GPs acknowledged that outside of dietary intervention, psychological input was an important element of treatment for some obesity sufferers, particularly those needing extra encouragement and motivation or with deeply engrained emotional attachments to food.

*There's even high stress levels, I saw somebody else today and basically it was a referral to a psychologist. I mean it was stress because it brought him to his eating which brought him to his high blood sugar, you know. Nelly, Dietitian.*

*It's called motivational and positive psychology approach. I think it's very helpful and it's the other prong of the ultimate treatment I think. Kerry, GP.*

## **5.4.2 Theme 2: A long term relationship**

This theme illustrates the need for trusting and supportive relationships between consumers and the clinicians involved in their treatment. The importance of stability and accountability, in both professional and other supportive relationships were recognised for enhancing the longevity and success of obesity treatments.

### **5.4.2.1 Long term support and persistence**

Consumers and clinicians agreed that long term support was an essential component of weight loss management programmes.

## Consumers

The majority of consumers felt regular and long-lasting follow up was essential for sustained weight maintenance. Participants recalled experiences where they had been successful at losing weight only to regain it when their support system ceased to exist.

*So for me from Samoa, I had a friend, and we used to walk Hagley, I was struggling at first but then I lost 30kgs you know, then when he left for America I just stopped, I just got lazy and I just stopped walking even though I put all the weight back. I was in a near death situation, I had a kidney infection at the hospital and I was in a coma for about a week, I came out of it but still you know I lost 50kgs eating hospital food. That shows me you know I can do it. Ernie, Pasifika.*

The type of support perceived as beneficial to those attempting weight loss, could vary from an organised exercise group, a paid personal trainer, or simply an individual with whom the participant had a close relationship.

*I definitely agree with the support and that's one...I mean it cost me as my personal trainer he was...you know whenever anyone else said anything, he was there, all the time he would remember, oh you know, how are going this week? ...unconditional support from, you know, when you know they are not going to give up that they are constantly, oh well you had a bad day, tomorrow. Tara, Self-Help.*

The persistent motivation provided by support networks was key in ensuring participants stayed on track with their weight loss goals. Some participants spoke of their support person guiding them towards a healthy lifestyle, but allowing them to make their own decisions when it came to treatment. This included feeling accepted and comfortable to work at their own pace without pressure to meet others' expectations.

*Allowing people to work at their own pace, non-pressuring, supportive and persistent... but finally it was because he said to me, you're an intelligent woman you will find what's going to work for you ...and because he was supportive and he didn't push me, it was kind of like okay I've just got to keep on trying till I find something that will work for me exercise-wise... and I think that the Green Prescription, and I was reading and that how they do have someone to find the exercise that is right for you, even if it's sitting down and moving your arms, but it needs to be someone each week checking in with you, encouraging you to keep trying a different form until you can find something you can stick to because the humiliation of keeping on dealing with that, it's so off putting to keep on trying. Marie, All Ethnicities.*

Participants discussed how a support network could provide much needed encouragement and reassurance to persist with behaviour change. It appeared brief, frequent interaction with support people and the celebration of small successes went a long way towards maintaining motivation.

*It's a pat on the back from time to time as well. Fay, Maori.*

The opportunity to connect with others facing the same challenges was experienced with both group and online support programmes. The development of camaraderie within these networks contributed to a sense of safety that enabled participants to openly discuss their feelings regarding their obesity. Online support groups provided both anonymity and round the clock support.

*... but it was really very helpful going along every week and we would take ourselves off for afternoon tea afterwards but we'd walk back into town and we'd have our afternoon tea and had what we fancied and then we would go home but we would have had support, we talked about what we ate, what problems we were having, you know, what our life was like and it was really, really helpful. Maureen, Self-Help.*

*I also got involved a lot with online support groups and forums because, surprise, there's people all over the world in the same boat, that go through the same things and being able to when I was feeling lonely or bored being able to jump on the computer and talk to people who didn't know me and weren't there to judge me because they were going through the same things and to be able to just talk so openly and honestly... Tara, Self-Help.*

Maori participants identified with the importance of support networks in obesity treatments as being similar to the concept of whanau and togetherness central to them in their culture.

*Maori are simple, Maori are, their whole concept is whanau/hapu/iwi. And we're all one and we all look after each other but that's our makeup, that's our makeup. Nerida, Maori.*

*I think it's the support that they get from the group, I think that group is so important to them. Fay, Maori.*

## **Clinicians**

Clinicians acknowledged their role in providing support to patients attempting weight loss, but felt they were not always able to provide adequate follow up services. Long term support components in weight management programmes were regarded as essential for ensuring patients maintained motivation and continued to adhere to treatment.

*And also the regular follow-up, like, I've got the beauty of being able to see my patients weekly or fortnightly at least and then we do group sessions, but I think the ones that come more regularly are quite simply doing the best and my own contract only goes for a year after the people have their surgery, they don't get seen by a dietitian again, so that's what worries me, they going to have that lack of follow-up and could quite easily slip back into their old habits, so I think it needs to be followed through a lot further than what I am doing... Tracey, Dietitian.*

Some dietitians emphasised that alongside support networks, it was important consumers were able to motivate and support themselves for success at weight loss maintenance. Self-monitoring behaviours such as keeping food records and regular weighing were thought to be helpful for maintaining motivation and staying on track.

*In an ideal world you want people to be self-directed and self-reliant, in the real world I think they are not because there are always so many temptations out there and you talk about food records and keeping people on track and it's very easy for an apple to become an apple, human behaviour will do that and so the real world is, you do probably need that. Wendy, Dietitian.*

### **5.4.2.2 Trust and rapport**

Clinicians acknowledged the importance of taking the time to build trusting relationships with patients undergoing obesity treatments.

## **Clinicians**

Clinicians believed the development of strong rapport between patients and those offering obesity treatments was central to the long term effectiveness of treatment. The establishment

of trust between clinician and patient was seen as essential for ensuring the receptivity of the patient to treatment advice.

*I do believe that some one on one, stuff does work and I think relationships are really important, and having that relationship with that client, they trust you, and they know you and the fact that you have actually got some evidence behind what you're actually saying. Linda, Nurse.*

A trusting relationship was thought to be invaluable for encouraging patients to disclose often sensitive information relevant to treatment. However, some clinicians were concerned that in their services, there was often not a lot of time to do this as well as they would like.

The very first thing I think is developing a rapport because it doesn't matter what information you give them or whether you are blimmin' helping them to fulfil their goals or not, if you haven't developed that rapport right at the beginning and they don't have confidence in you as a practitioner or somebody who can actually help them achieve the goals they have come for, you are kind of stumped from square one, so it is about developing that rapport and, you know, developing some...discuss their common ground and feeling their way with...yeah and giving that time and that trust and giving that time to them in the beginning to actually search out those things and, unfortunately, as health professionals we don't have a lot of time, so the time thing actually becomes pretty critical and it is about being efficient with that.  
*Terry, Dietitian.*

As GPs and nurses saw the same patient multiple times for various medical reasons, they recalled being able to regularly document stages of their patients' weight loss journey or readiness to change in medical notes. This helped reassure the patient of the clinicians' awareness and understanding of their journey with weight and behaviour change.

*...but the value of something like that is really important. I sometimes look at these things, and you've got to see them at the right time and motivationally, when people say I just don't know what to do, I would certainly mark days in the notes quite happily so that I can actually back them up each time, when they come in for other things and so they'll actually come back... Keith, GP.*

Clinicians found the ability to show empathy and relate to patients helpful for building rapport. The development of empathy required clinicians to be able to let go of their preconceptions around obesity.

*As a practitioner it is tricky because I feel like I am affected by those stereotypes, you know, I am not immune to judging someone and I almost have to catch it and hold it*

*and the reality is when I have worked with clients when I discover the contextual information about their life, and I go, shit, you know like this isn't laziness, this isn't slothfulness, you know, nobody is doing this, it is actually a whole cocktail of factors going on and it also helps me to challenge assumptions which I know, you know, I have learnt, that you know, things like that I have clients who are very healthy and fit, you know, they are actually fit and active... Laura, Eating Disorder Clinician.*

### **5.4.3 Summary**

Overall, clinicians and consumers agreed on many facilitating aspects of obesity treatments.

However, clinicians' perspectives made up the overwhelming proportion of themes presented in this section.

Both types of participants highly valued a holistic approach to treatment as being the most effective in encouraging and sustaining the success of obesity treatments. Participants agreed treatment initiatives should focus on more uncovering reasons for over-eating, rather than concentrating solely on weight loss as an outcome goal.

Clinicians and consumers recognised the need for regular contact with support networks throughout obesity treatments. The opportunity to establish trusting and long lasting relationships with patients, was believed to make patients more willing to adhere to clinicians' treatment advice. Similarly, consumers appreciated the accountability and reassurance provided by regular communication with those involved in aspects of their treatment.

The following section outlines participants' perspectives of desired future treatment initiatives.

## 5.5 FUTURE TREATMENT INITIATIVES

This section represents clinicians' and consumers' desired future outcomes for obesity treatments. The suggestions portrayed here reflect the previous experiences of clinicians and consumers and often relate to improvements or modifications to existing treatment options. However, recommendations for new approaches to treatment are also reported.

The following section encompasses two overarching themes. The first theme offers opinions relating to necessary components for initiating successful obesity treatments. The second theme refers to beliefs around relapse prevention, in other words prevention of behaviour change reversal or weight re-gain. It includes the perceived need for increased government funding and support for the longevity and success of obesity treatment services. Themes and sub-themes for this section are presented in Table 3.

*Table 3 Summary of themes - Future treatment initiatives*

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<b>Theme 1: Laying the foundations</b>	Education
	Psychological input
	Focus on enjoyment

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<b>Theme 2: Relapse prevention</b>	Strength in numbers
	Multi-level support

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### 5.5.1 Theme 1. Laying the foundations

This theme outlines several elements clinicians and consumers believed would contribute to the initial effectiveness of obesity treatments.

#### 5.5.1.1 Education

Both clinicians and consumers believed education to be a fundamental part of future obesity treatment initiatives.

## Consumers

Participants in the Maori and Pasifika groups suggested initiating healthy eating and physical activity education to younger age groups. It was thought that by delivering healthy lifestyle education earlier, future obesity complications might be prevented in the growing population.

*I believe prevention is the best cure so if we can teach our people to eat healthy and go back to basics, and step up their physical activity like get off the couch or chuck the TV out the window one of the two, things like that, if we can educate them in that way that's why this has helped me today it will be wonderful. Nerida, Maori.*

*And my point was Ernie, I think the first thing you raised was your concern about your children...so helping your children learn about healthy food and good eating habits is a good start.. Malo, Pasifika.*

Furthermore, these two groups also recognised the importance of obesity treatment programmes to be designed according to specific cultural needs. The use of native languages were recommended to ensure effective communication of health messages to all members of their respective population groups.

*To the whole living, it's no use trying to teach me something if you can't understand Maori, and no use teaching me something if I can't understand English, cos you know, you can't get through to the people. Eric, Maori.*

*I think the other thing that is so relevant to our people is there's so much advertisement about how to improve the Pacifica way of health and the eating habits but any interpretation of the information into our language, what's the point of saying we want the Pacifica health, the peoples' health to achieve in a better way but how they can understand if the writings are all in English so we need some interpretations... our language has got lots of words that can relate to the same thing, but it's just picking up the right words that can be very effective to people... Becky, Pasifika.*

Participants in the Pasifika group were especially interested in learning how to prepare traditional pacific island foods more healthily. It was thought rather than changing what they ate entirely, they could benefit from learning how to reduce the fat content of their favourite foods.

*I'm talking more about our own pacific food like Samoa, there's a lot of fat in a lot of Samoan food like our favourite is pisupo you know, we need to learn how to cook healthy pisupo you know. We can still eat pisupo but maybe not straight from the*



*can. The way we found out how to cook pisupo healthy is put it in the microwave first, you know, take it out of the can, put it in the microwave, drain the oil and throw that oil out, and then use the actual meat. So that's what I'm talking about. Tene, Pasifika.*

## **Clinicians**

Dietitians in particular agreed with the notion of both delivering healthy eating education to younger generations, and the importance of learning to prepare healthy meals from scratch.

Participants in the GPs and nurses group suggested providing education to expectant mothers in the hope that they would then pass healthy messages down to offspring and other member of their family.

*One of the things I would love to see is home economics back in schools and for children to be given the skills to be able to prepare food and I think that if we can get a generation that can cook again, that we might see some of our problems easing off a little bit. I think there is a reliance on frozen foods, which are getting more and more....(unclear)...in the freezer and takeaway foods which is leading to our obesity problem. Gillian, Dietitian.*

*I believe, I sort of work by a health promotions philosophy, an underpinning health promotions philosophy where by prevention I believe is probably much better, hopefully than cure...and have always supported the idea that if we start working back from the time the woman's pregnant until the time she delivers and see her through the...see that child through its life and chart information and be there for...to extend knowledge, then we will hopefully be able to influence eating habits of that family and that child. Linda, Nurse.*

### **5.5.1.2 Psychological input**

This sub-theme describes proposed ideas to treat the psychological aspects of obesity including treatment for food addiction.

## **Consumers**

Consumers were eager to obtain treatment for the emotional and psychological issues they believed made them over-eat. Participants emphasised the importance of this aspect of

treatment to focus solely on the internal struggles they faced, rather than the achievement of weight loss.

*Well, I was just thinking that you need really clever people who are not looking at the body of the person, like looking at the mind and the soul and the history and the conditioning of the person because I spend a lot of my time sitting in the car or I look at people who are overweight and I just know that they are suffering and I know that there is not one single person who isn't suffering and that sort of suffering comes from somewhere and it's unaddressed. Delia, Self-Help.*

Some participants felt there was a need for specific treatment services for those suffering from food addiction. Participants discussed the existence of various other addiction treatment services in the community and suggested the development of a similar service for food addicts.

*I think it would be good to have a residential, or an outpatients sort of longer term thing so that...I think, secondly, it would be great to have ready access to someone doing counselling or this psychotherapy work about addiction and dealing with the underlying issues. Marie, All Ethnicities.*

*I work in the addiction field and I talk to people every day who have tried and fallen off and I've talked to people who say, oh I've done the Salvation Army, I've done Hanmer Clinic, I have done this, I've done Rotorua, I've done this, I've done that, I've done Salvation Army three times and those services are provided, you know, have revolving doors. The detox services have revolving doors and I sort of live in this weird world where I talk to people about how to look after themselves and I don't do it myself and it is an absolute parallel, I mean, just swap one thing for another and so walk and live in this weird parallel universe but, you know, in a service which does look after people, when they fail, fall off, or however you like to put it, that's there, I mean, but people who overeat, and we all overeat, there's no two ways of saying it, we do all overeat, we are all overeaters, you know, we are doing that on our own, you know, trying, falling, trying falling, Delia, Self-Help.*

## **Clinicians**

Clinicians felt psychological support was necessary for some patients such as those with low self-esteem and suffering from poor mental health symptoms. Participants in the GPs and nurses group recommended dealing with psychological issues before attempting to target weight loss.

*If you've got someone who is depressed and got a whole pile of negative thoughts, you can't even really think about them trying to drop their weight because it's not just their weight that they are perceiving, it's a whole pile of issues about themselves and so in that group, weight is not something I would focus on. Keith, GP.*

### **5.5.1.3 Focus on enjoyment**

This sub-theme illustrates the desire for obesity treatments to be enjoyable so that they can be incorporated into everyday life.

#### **Consumers**

Consumers felt there was a need for physical activity groups that specifically catered for larger bodied people. Participants believed they would feel more comfortable exercising in an environment with others they could relate to with regards to their obesity. A priority for these groups was for exercise to be fun and enjoyable. Exercise instructors who were approachable and with whom participants could build a trusting and supportive relationship were also believed to be important in creating a safe and welcoming environment.

*I would love to be able to go somewhere where there was some music and they were big, big people and they all perspired and we had fun with movement and then we could sit and talk about what was affordable food, what is good food, how do you grow a vegetable garden when you have got stuff all money, you know... Felicity, All Ethnicities.*

*I sort of feel our people are very ...(unclear)... a demand for something everyone can enjoy. Kyle, Maori.*

*If an environment can be created where they feel safe and that you feel safe, that they will never be given up on and all that remains is the persistence, like you said keep on going. Karlie, Self-Help.*

#### **Clinicians**

Clinicians agreed that physical activity as part of obesity treatment initiatives should be enjoyable for participants. Some clinicians believed encouragement of physical activity was initially more important than nutrition intervention.

*...I know a couple of people who work within gyms who aren't weighing people, who are talking about sustainable exercise, enjoyment of exercise and that is....yeah and some of those community development models and the community strategies, which are actually about pleasure and fun and in a non sort of fascistic way. Laura, Eating Disorder Clinician.*

*I wish they would just leave the food alone and work on the activity, you know, I think the push/play thing is great, you know, put out the active and that whole message is great but leave the food alone. Isobelle, Eating Disorder Clinician.*

## **5.5.2 Theme 2. Relapse prevention**

This theme outlines participants' ideas to establish new and strengthen existing support networks as part of future obesity treatments.

### **5.5.2.1 Strength in numbers**

This sub-theme recognises the desire for a collaborative approach within communities and between consumers and clinicians working towards successful treatment of obesity.

#### **Consumers**

In order to foster successful obesity treatment outcomes, Participants in the Pasifika group believed they needed to change their attitudes to food within their communities. Participants in this group prioritised the well-being of their peers and fellow community members and therefore believed in a unified approach to obesity treatments. Some participants suggested assuming a leadership approach to encourage healthier eating amongst peers and workmates.

*For me for example morning tea, just have fruits or sandwiches, we're not going to have meat pies etc(all talking together)...and We should be up front about it and say we are starting this new change and this is what we're going to be doing from now on, that's the change in attitude that I believe we can do. Malo, Pasifika.*

Participants believed they could motivate each other to adhere to treatment recommendations by providing accountability and support in numbers.

*I was just thinking about some basic, practical stuff you know. I think what people can do is checking on each other's menu and point out the bad food to stop and*

*suggest healthy food instead etc and continue the checking process...call each other and support them thru this process. Malo, Pasifika.*

Recruitment of prominent church members and community groups to rally behind the proposed shift in attitudes was thought to be an effective way of communicating their message to a wide variety of Pasifika people. Participants believed the involvement of such influential community leaders would provide strength and credibility to their ideas.

*I think we should go up higher now like, we've had enough of this kind of bantering....at this level....every church should be involved now, they're key people, they're the ones that preach us our community to change our attitudes..... Tene, Pasifika.*

*Go out into the Community groups, go out to different Community groups, you know you have the Fijian community, the Samoan, the Tongan, like just talking to them you know. Because some, I know that sometimes when you say we go, there's a talk on about say for instance diabetes, it's that shame that we have, oh why should we go, people might say I'm fat, but I mean if we all go out there and support each other, (talking together)....and just help...yeah people understand....support each other. Naiah, Pasifika.*

The majority of consumers agreed they would be more successful at sustaining obesity treatments if they had access to long term support services. Whether the support service offered a one-on-one or group approach, the key desired element to these services was persistent and long-lasting guidance. A group facilitator to motivate and persevere with participants throughout their treatment process was thought to be integral for the success of this approach.

*I found group support was more helpful than one on one because....but you needed a strong leader to the group, you know, there's a good social worker and she was brilliant because she sort of, you know, stopped us if we were going over the top or something, you know. Maureen, Self-Help.*

*... I also like what Karlie says about not giving up, and it's not us giving up because we don't, if we gave up we wouldn't try all the different things, it's the medical staff giving up, it's them saying, oh come on, we've tried this again and again and again. I've been to dieticians, I've been all over the place and every one of them has given up... Katie, Self-Help.*

*It's the support that we need. Nerolie, Self-Help.*

A one-one-one approach was preferred by some participants who revealed they were less comfortable in group situations, especially given the often sensitive nature of obesity counselling.

*Delia touched on something before that you were asking a while ago was talking with people about inner things. Sometimes you don't want to open up in a group, you want to just be one on one so you feel comfortable about opening up. I actually have social phobia and to be in a group is very hard for me to do. Katie, Self-Help.*

Some participants believed that regular contact with a support person could also be useful when they were feeling vulnerable or unsure about treatment recommendations. It was thought that access to positive encouragement and reassurance could help participants overcome obstacles and temptations and provide recognition of achievements.

*Exactly, so that's what I'm saying it's that unconditional support but you've got to pay for it and so if there was something that was free that, you know, even if it was a helpline, you could ring up and be, like you know, I've had this, encouraging, positive support...is that, you know, you've had a bad day and like you were saying the other day is yeah may be you had four chocolate biscuits today but, hey, at least it wasn't six.....Tara, Self-Help.*

Participants discussed feeling constantly vulnerable to slipping back into bad habits and felt they would be more likely to adhere to obesity treatments if they had somebody regularly checking up on them. Some participants felt they needed constant reminders to motivate them to comply with treatment advice.

*Well, the stimulation of say I'm watching you, I'm coming to you every day to make (sure) you're eating this, to make sure you're cooking this because...Eric, Maori.*

*A phone call a week you know, to families, you know say are you cooking your meals and things like that you know. Ernie, Pasifika.*

*So well what's the point, the thing is I try to stay healthy with the pills and everything and I'm struggling with the mentality of being gospel to what the dieticians and everyone says to me. I got that fine, but what about in the wee small hours when you know nobody's here, all these guys are sleeping who have been telling you something so you cheat, that's the trouble, you cheat. Eric, Maori.*

## Clinicians

Clinicians also valued the idea of long-lasting support services as part of obesity treatments. It was emphasised that follow up needed to be both ongoing and regular. Dietitians in particular believed each patients' follow up arrangement needed to be specific to their individual needs. They agreed with consumers' idea of offering both individual and group support components.

*So that mostly diet stage I was referring to before, the intervention stops at six months or one year and then there might be a follow-up two years later but there has been no intervention in the meantime so that's not a fair assessment because they've been on a diet and then off a diet, that's not evaluating whether that diet worked or that programme worked. It would only be feasible for that five years that person was following, so I think we have generally got an idea but then the question comes up as to whether that's done in a group situation or an individual situation because every person's relapse prevention, I believe, needs to be done individually and also their initial assessment, so I am very keen for individual intervention at the beginning and then perhaps lock into a group for extra support and maybe wider education....(unclear, siren in the background)...but you need to....(unclear)...into a dietitian later down the track and get that definitive foods that suit that person or their body size, their medical conditions for ever after and then they will kick in but there is no system that the government is providing for that at this point. Kylie, Dietitian.*

It was proposed for treatment interventions to start with a one-on-one component before progressing to a group support network for continued follow up. However, it was recognised that this progression would be subject to the patients' willingness and confidence to enter a group situation.

*It also depends on their confidence, how not everybody likes participating in a group situation and they may hold back but on a one to one they feel freer about discussing their issues and their questions and being heard but, personally, I like the idea of the individual, I agree with Kylie, individual intervention and also that relapse prevention but once they have got that confidence and they may be doing quite well, then following up with a group of like-minded individuals, people who are...(unclear)...the same progress....(unclear, people talking at the same time)... Terry, Dietitian.*

### 5.5.2.2 Multi-level support

Multi-level support refers to clinicians' and consumers' call for government intervention to ensure the effectiveness and sustainability of obesity treatment services.

## Clinicians

Government intervention to make less processed foods more financially desirable than processed foods was discussed as a way of influencing consumer spending toward healthier foods. Dietitians believed that when faced with financial constraints, consumers were likely to purchase low cost nutrient poor foods which were typically deleterious to weight loss.

*It is becoming back to economics that they have, I mean for many people it is economics and you are going to have to look at the whole thing of making basic foods more affordable compared to the so-called processed foods. Deidre, Dietitian.*

*... the good food is more expensive than, you know, this milk versus coca cola thing, there is just so much that the government could do. Absolutely, money-wise, obviously in an ideal world if we had our way that would be the way it was, it would be free and, you know, fruit and vegetables would be subsidise and you would be able to afford them. Tracey, Dietitian.*

Clinicians felt obesity sufferers would benefit from government intervention to reduce the amount of advertising allowed by the food and dieting industries. It was believed industry advertising bombarded those struggling to lose weight with unsubstantiated health claims. Ultimately, clinicians felt vulnerable patients were unable to resist temptations of ‘miracle’ weight loss offers and the latest convenience food, owing to the manipulative effects of persistent advertising.

Dietitians in particular felt out-numbered and over-powered by food industry giants working against them and their work with obese patients.

*I think we're at the point now where we actually do need to go a equality level of the cost of living without them being regulated and like just as an example of the food and submission that we looked at, it was strongly in favour of industry, no matter, it's about the industry claim that we have got to give people choice but they are now misinformed by the industry to make that choice because there are 400 dietitians in New Zealand and fifty billion dollars in the industry. I think it needs to become a government intervention. Belinda, Dietitian.*

*I agree, in fact, that even came back to one of the earlier questions about control, about people having control and I thought that advertising have it out there as to what is available, what else can I eat? Oh, something else that has come up on TV, and in a way that impacts on their control as well because you don't know what you don't know and if suddenly it is flashed up on television and you think, oh, that*



*sounds good, I think I'll try that, so advertising is another really crucial area where I think... Gillian, Dietitian.*

Some clinicians suggested taxing the dieting industry in hope that high prices would deter consumers from subscribing to controversial weight loss programmes and supplements.

*The government...(unclear)... became aware that cigarettes were paid for people, they started to tax the cigarette industry, maybe one day it will be recognised that the dieting industry needs to be taxed at a high level. Unidentified Eating Disorder Clinician.*

## **Consumers**

The majority of consumers felt overwhelmed by the associated costs of adhering to obesity treatments. Many believed they simply could not afford to obtain 'healthier' foods or access exercise facilities. Participants suggested increased government funding to support low cost or free access to exercise facilities for those wanting to increase their activity.

*...which is one of the reasons why I'm loving this thing is it is trying to find out, you know, what would work and I think maybe even health professionals that's where a lot of them struggle because they don't know themselves and they kind of...or they don't have, you know it is kind of shooting the messenger, but they don't have the funding and it needs to start with the government, is the government like SPARC when people are crying out, you know, I want to lose weight, I want to try, I am trying but I just can't afford to, and when, you know, maybe there needs to be a lot more funding from the government for things like that. Tara, Self-Help.*

Some consumers suggested the availability of financial assistance for those seeking to treat the underlying psychological aspects of their obesity. Participants proposed allocation of government funding to enable access to addiction treatment services and increase support to existing obesity treatment services.

*But even the simple thing is that with Winz, and even for people who are earning, like we do earn, but I've got two children, is that if I want to get counselling, I need to be paying for it. If it could be acknowledged as a disability and get a contribution, I don't think it needs to be handed to me, I think that I need to acknowledge my part in it, but I think it should be made easier to get the assistance that I need to do. Marie, All Ethnicities.*

*Wellbeing. Wellbeing, that covers a lot. Wellbeing and to ask Helen for some more money to help people to monitor a group. That's the...to overcome the mental... Eric, Maori.*

*Well the government doesn't come down on people who are addicted to alcohol, to drugs, they say well this is the funding for that, why can't they widen the addiction funding to cover food, I'm mean they cover sex addiction and alcohol and new drugs, gambling, why can't it also include food addictions and then that would make it that Ministry of Health area....Katie, Self-Help.*

### **5.5.3 Summary**

The ideas presented in this section reflect both consumers and clinicians desires for improved obesity treatment initiatives. Two areas of treatment were highlighted, emphasising the perceived importance of solid foundational components to treatment and the need for ongoing follow up.

Three elements were identified as being essential as part of a strong base for successful obesity treatments. Clinicians and consumers believed healthy lifestyle education components of treatment programmes should be tailored to individual needs and if possible implemented early in life. An increase in treatment focus around the psychological aspects of obesity was suggested by both types of participants as they agreed this area was largely overlooked. A move toward enjoyable treatment initiatives was recommended by clinicians and consumers in order to ensure behaviour changes were sustainable.

Prevention of weight re-gain was identified as requiring a major focus for obesity treatment programmes in future. Both clinicians and consumers believed this could be achieved by the establishment of longer follow up periods to existing treatment programmes, encouragement of strong and supportive relationships around treatment, and a push within communities to change attitudes towards healthy living. However, it was felt that accessibility to such treatment programmes would be limited without increased government funding to support them.

## 6 DISCUSSION

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This chapter discusses the major findings from the present study in relation to comparable existing literature where focus group methodology was used. The first section summarises the main results of the study: barriers to treatment, enablers of treatment and future treatment initiatives. The second and third sections discuss the similarities and differences between the present study findings and those from prior research. Subsequent sections outline the strengths and weaknesses in the present study, the implications for future research and finally the conclusions of this research project.

### 6.1 MAIN FINDINGS

This section provides a brief summary of the main findings. Interestingly, the majority of clinicians and consumers in this study held very similar views around obesity treatments.

Participants in this study agreed that obesity treatments could be improved by increased psychological intervention, including efforts to reduce obesity stigma; and initiatives that promote enjoyment, strength of community, and long-lasting follow-up and support. In the present study barriers to the achievement of obesity treatment success included the influence of distorted nutritional messages within food marketing and media advertising on consumers' perceptions of healthy food; and the overall lack of reliable treatment initiatives for those seeking behaviour change and thus weight management.

The present study was unique in that it offered a multi-dimensional view of clinician and consumer perspectives of obesity treatments. The study design allowed a comparison of both clinicians' *and* consumers' thoughts concerning obesity treatments whereas previous studies have focussed on the opinions of either clinicians *or* consumers. This study also involved both primary care and secondary care clinicians, enabling an analysis of clinicians' opinions from several different disciplines.

## 6.2 SIMILARITIES

This section discusses the areas of agreement between the present study and previous studies, concerning consumers' and clinicians' perspectives of obesity treatments.

Perhaps the most mentioned facilitator of successful obesity treatments in the eyes of consumers in the present and other studies, was the inclusion of support initiatives as part of obesity treatments. Consumers in the present study appreciated the stability and companionship that followed the establishment of a regular, communicative relationship with a treatment provider or fellow treatment seeker. Consumers in previous studies frequently recalled instances where they had been a part of some kind of group support network, whether this was a group weight loss programme (29) or part of an intervention study (28, 33). The opportunity to develop friendships, share experiences, and above all, feel included, were in stark contrast to how many consumers reported living their lives (28, 29). Consumers in the present study suggested that future treatment initiatives should include exercise groups specifically designed for 'fat' people, emphasising their desire to be surrounded by people facing the same issues as themselves. Similarly, lesbian participants in a study by Fogel et al (29), preferred attending weight loss groups designed for sexual minorities, over heterosexual weight loss groups where they had previously felt ostracised. However it should be noted that unlike other studies advocating the benefits of group support, the primary investigator in the study by Kidd et al (33), facilitated the mindful eating intervention, and moderated the focus groups, which may have introduced an element of interviewer bias.

Consumers in this study, reported feelings of low self-esteem owing to their inability to control their relationship with food, and the impacts of obesity stigma forcing them to isolate themselves from society. These negative emotions were for many, the driving forces behind their tendencies to over-eat. Participants in other studies shared similar feelings of hopelessness and depression, following multiple failed attempts at weight loss regardless of

their race (28-30, 37). Maori and Pasifika participants in the present study, and African American participants in other studies (35, 37) reported feeling ashamed because of their size, even though each of these groups discussed the social desirability of fuller figures within their respective cultures (28-30, 37). It appears there is an upper acceptable limit at which size indicating health, wealth and beauty begins to represent an undesirable picture of poor health and unattractiveness. The element of ‘safety in numbers’ provided by a focus group situation in the study by Fogel et al (29), may have helped initiate discussion around these more sensitive topics, that may not be so readily disclosed in one-on-one interviews (44).

Clinicians in the present study also acknowledged the effects of obesity stigma on patient self-esteem and subsequent willingness to attend or adhere to obesity treatments. Clinicians referred to the importance of assessing a patients’ current state of psychological well-being and subsequent ‘readiness to change’ prior to approaching the concept of obesity treatment with the patient. General practitioners and dietitians in particular reported holding back on weight related conversations until they felt the patient was emotionally and mentally ready to tackle the issue. Similarly, clinicians in other studies were tentative in their approach to the topic of weight management with their patients (15, 16, 18, 19). Clinicians in one study (15) reported either waiting for the patient to ask for weight management advice, and in another, some clinicians avoided the issue altogether for fear of upsetting particularly sensitive or fragile patients (18). Given the oppressive and hurtful nature of obesity stigma in society, there is little wonder clinicians are keen to distance themselves from any such association when providing treatment to patients. This could explain why clinicians in the present and several other studies preferred to relate the topic of weight loss to improved treatment outcomes for other medical conditions (15, 16, 19).

However, from the consumers’ perspective, clinicians’ attempts to preserve patient dignity, are mostly likely doing just the opposite. According to consumers in the present and many other studies (30, 31, 34-37) their preference is for obesity treatment to be addressed

separately from the treatment of other conditions. Consumers expressed feeling ashamed and embarrassed about their weight and were therefore reluctant to voice concerns to their clinician (34). Participants in a study by Gallagher et al (31) told researchers they wished their GP had brought up their weight sooner. This presents a very difficult situation for primary care clinicians especially as they consider themselves in the present and other studies in the literature to be responsible for the initiation of obesity treatments (13, 14).

Clinicians in the present study discussed the potential for obesity treatment outcomes to be directed at improving well-being rather than the attainment of 'weight-loss'. Again, this change of treatment focus was similar to other studies, and is most likely a consequence of the 'taboo' that has emerged surrounding discussions of weight loss, (18, 21, 22). Clinicians discussed employing this tactic in the hope that with improved lifestyle behaviours, patients would lose weight anyway (21).

### **6.3 DIFFERENCES**

The present study revealed some interesting differences concerning both consumers' and clinicians' perspectives of obesity treatments.

One of the most notable differences between clinicians and consumers in the present study and those in other studies in the literature related to perceptions around the adverse impacts of the increasingly complicated environment surrounding nutritional information. Clinicians in particular claimed that disingenuous health claims advertised by the food and dieting industries, as well as reports in the media advocating the benefits of the latest 'health' food products, are over-shadowing the evidence-based advice provided by health authorities and health professionals.

Consumers in the present study felt overwhelmed by the abundance of conflicting information, and reported being dubious about the safety of normally trusted commodities

such as fresh water. They were asked specifically about their perceptions of ‘problem foods’, and whether there was such a thing. To the author’s knowledge this specific question was not asked in other studies and perhaps in the present study this was enough to generate conversation around food items/products in general and the growing confusion around what actually constitutes a ‘healthy’ food. Similarly, clinicians in the present study suggested imposing regulations around food and diet industry marketing in an attempt to deter consumers from paying money for products that had no evidential backing to improve their health. This, was also not suggested in other studies.

Both clinicians and consumers in the present study suggested food addiction as a possible treatment focus, with consumers adamant this affliction was at least partly responsible for their inability to control their relationship with food. Consumers believed there should be treatment services available for their addiction as there are for people suffering from drug or alcohol addiction. Although the interview guide used to facilitate focus groups for the present study contained a prompt for discussion around ‘addiction’ and its role in obesity, participants in the Self-help, All Ethnicities, Eating Disorder Clinician and Addiction Clinician groups brought up the concept of food addiction before any prompting by the moderator was needed. Participants in all other groups, except the Dietitian group agreed food addiction could be a potential area for treatment. Whilst participants in two other studies (28, 37), did describe their uncontrollable behaviours towards food as being similar to addictive behaviour, neither study mentioned the need for treatment aimed at addressing food addiction specifically. Again this is likely because one of the primary research aims in the present study was to obtain clinicians’ and consumers’ perspectives of *treatment* including participants’ desires for future treatment initiatives. Other studies (28, 37) focussed on views of weight management experiences with primary care providers and perceptions of a VLCD weight loss trial respectively. The recognition of a future requirement for treatment of food addiction amongst

some clinicians in the present study and not others, is also an important area of disagreement between the different disciplines highlighted in the present study.

There was a clear discrepancy between clinicians in this study, as to the best approach for obesity treatments. For example some felt it was best to encourage patients to increase their physical activity over improving dietary quality, and some spoke about referring patients to commercial weight loss programmes whereas others (dietitians in particular) thought this idea was inconceivable. The fact that this study, unlike others allowed a direct comparison of the perspectives of clinicians from a variety of differing obesity treatment settings highlights the lack of a definitive treatment pathway for the management of obesity. It will be important to address this in future, particularly to ensure that consumers receive consistent advice from clinicians. Whilst the clinicians in the present study believed in collaborative approach to obesity treatment it is obvious that if they are not all 'singing from the same hymn sheet' the advantages of this approach will be minimal. This finding also points to the fact that obesity is multifactorial and that most disciplines deal with only certain aspects of obesity treatments at a time, hence the need for a unified multi-disciplinary approach.

#### **6.4 STRENGTHS AND WEAKNESSES**

The qualitative nature of this study allowed for a level of in-depth personal data that could not have been achieved by quantitative methods. Further strengths included a thorough data collection and analysis method utilising the skills of an experienced moderator, and a data analyst (the author) new to the area of clinician and consumer perspectives of obesity treatment and therefore less likely to impose researcher bias on results. Following data collection, the researchers contacted nominated focus group representatives to check the accuracy and credibility of the focus group transcripts. The large study sample and diverse nature of the focus groups allowed for a comprehensive insight into the thoughts and opinions of many different individuals.



There were also some limitations to this study. Firstly, the data analyst was not involved in data collection. This means they had to interpret participants' comments as they were *written* without the help of audio or visual cues such as body language and gestures. Furthermore the data analyst was largely inexperienced in the process of thematic analysis. Another possible limitation is that some participants in the Maori and Pasifika groups worked in health care, and this may have influenced theirs' and other group members' responses. Whilst not all groups were aware of the co-moderator's occupation (dietitian), the knowledge of this may have influenced responses. Additionally, both moderators were slim and this may have affected responses especially from obese consumers. However, it was not obvious to the author that either the moderators' occupations or body size appeared to influence participants' responses in this study. Finally, the lack of demographic data recorded for participants may affect the applicability of the findings.

## **6.5 IMPLICATIONS FOR FUTURE RESEARCH**

The objectives of this research project were to investigate, analyse and report clinicians' and consumers' perspectives of obesity treatments. At the time of data collection in 2008 this topic was largely under-researched in New Zealand, and remains so today. As global rates of obesity continue to rise, the results of this study reveal, clinicians and consumers feel quite helpless to stop this trend. Findings from the present study highlight the existence of similarities and differences in opinions when compared to the international literature. It would be interesting to further assess the validity of the present findings by conducting a study focussing solely on uncovering participants thoughts about obesity treatment, with an emphasis on future treatment initiatives. Similarly, it would be useful to investigate both primary and secondary care clinicians' use of current treatment pathways, using perhaps a vignette or case study model where clinicians describe the actual process of treating patients with obesity. The present study only begins to reveal the complexities faced by both

consumers and clinicians when attempting to either seek or provide obesity treatments, and thus further research aimed at more specific aspects of current treatments would be useful. Finally, given that the data collected for this study is over 7 years old, an account of participants' current perspectives would be valuable.

## **6.6 CONCLUSIONS**

Overall, the study transcripts reveal that consumers feel they have been let down by the failure of health professionals and government bodies to provide accessible treatment options for an illness they (consumers) perceive to be for the most part, out of their control. Whilst consumers accepted a level of personal responsibility for their weight, the real struggles in achieving and maintaining weight loss were evident in their discussions around the psychological battles they faced, specifically emotional eating and the relentless pressure from society to be thin. Clinicians agreed that the services currently available were unable to accommodate the complex nature of obesity. Overall, clinicians appeared to lack a defined obesity treatment pathway and clinicians from different disciplines had different ideas on the outcomes for treatment.

## **7 APPLICATION OF RESEARCH TO DIETETIC PRACTICE**

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This research provides an insight into the complexities involved with treating obesity, both for dietitians and other clinicians.

The approach of dietitians in the present study, was to encourage and enable patients to achieve a 'caloric deficit' through improved dietary quality and behaviour change.

Unfortunately, from the dietitians' point of view, patients faced many barriers, to adherence to treatment recommendations. Typically these included patients' perceived lack of time, money, motivation and self-determination, and the general confusion caused by the mixed nutritional messages provided by unqualified 'nutritional experts'. Dietitians themselves also faced barriers to providing effective treatments. Most frequently mentioned were the time absorbing conversations often required during dietetic consultations to help demystify false nutritional claims and messages for patients.

These findings highlight the need for the dietetic profession to provide consumers with clear, evidenced based advice around healthy eating and its application to weight management.

Dietitians are currently employed in a range of settings, but are generally thought of by other clinicians as being 'rare as hens' teeth'. Consequently, the messages dietitians provide to patients and the lay public, are unheard or ignored. Evidenced based nutrition messages and advice currently provided in dietetic treatment, are being lost in a myriad of cleverly marketed and unsubstantiated health claims in the media. In the future, dietitians must state their claims more frequently in the media, thereby counteracting the 'loud voices' of those unqualified to provide nutrition education. However, before this can occur the differing opinions concerning obesity treatment within the dietetic profession will need to be addressed and the possibility of specialist training or a defined scope of practice explored.

The results of the present study highlight other clinical disciplines' mixed opinions of dietitians. This is a very real concern and most likely a result of the lack of exposure many clinicians in the present study seemed to have working with dietitians. General practitioners and nurses in the present study often spoke about their general lack of training, but willingness to offer obesity treatment services within a primary care setting. Dietitians are extremely rare in primary care, but could be enormously valuable working in a dedicated primary care team offering obesity treatment.

The results of the present study also highlight the detrimental effects of untreated psychological issues on patients' ability to lose weight and maintain a lower weight. There is room for dietitians to up-skilled in the provision of psychological guidance, over and above what is currently taught in the MDiet training programme. Alternatively, further education could be provided outside as part of professional development or a higher qualification for those wanting to enhance their knowledge and counselling abilities.

The dietetic profession could and should play an integral part in the fight against obesity. Dietitians could lead the development of successful obesity treatment initiatives and by doing so could act as advocates for those suffering from obesity. For this to be possible, the dietetic profession needs to develop a consistent approach to the dietetic management of obesity, and become more effective and valued nutrition and behaviour change experts. The presence of dietitians in primary care settings would enable a wider range of clinicians and consumers to work with dietitians and therefore provide a more effective obesity treatment approach aimed at both treatment and prevention.

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## APPENDIX A. REVIEW OF CLINICIAN STUDIES

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	Author, Date, Journal, Location	Aims	Study Design and Methods	Participants and Recruitment	Obesity Treatment Context	Findings	Limitations	Strengths
1	<b>Alexander et al 2006</b> American Journal of Health Promotion Duke University. North Carolina, USA.	To examine clinicians' perceptions of overweight and obesity. Specifically, how general practitioners (GPs) and physicians view the United States Preventative Services Taskforce (USPSTF) guidelines, for treating obesity, why weight loss discussions are not conducted regularly, and how they talk to their patients about weight loss. Pilot study.	2 focus groups separated by profession: 11 GPs and 6 physicians, (50 minutes each) conducted by a social psychologist.  Data analysed according to grounded theory methodology.  Four coders openly coded transcripts, and compared themes within and between transcripts. Once agreement of themes were reached, each coded the transcripts again separately before regrouping and comparing to initial themes.	17 participants (11 general practitioners and 6 physicians).  No information on recruitment method.	Clinicians' perceptions of the USPSTF guidelines, and their approach to obesity treatment in primary care.	Obesity can only be addressed at a nationwide level. High proportion of obese makes it more normal to be overweight. Scarce resources, low outcome expectations, lack of training. Reluctance to follow USPSTF guidelines. Some prefer to counsel overweight rather than obese – more chance of treatment success. Either wait for patient to bring up weight or link it to another comorbidity. Educate bits at a time, 'dig deeper', refer to nutritionist or other medical specialist.	Academic setting, may not be generalizable.  No evidence of 'member checking' of transcripts.  No detail on recruitment method.  Brief recognition of limitations.	Focus groups separated by type of practice to look for similarities and differences between physicians' beliefs on weight loss.  Focus group questions provided.  Thorough analysis process.  Moderator's occupation provided.

2	<p><b>Bennett et al 2013</b> Journal of General Internal Medicine The John Hopkins University. Baltimore, USA.</p> <p><i>Same study set as Gudzone et al (ref), different research aims.</i></p>	<p>To investigate thoughts of general practitioners (GPs) towards the 'POWER' (Practice-based Opportunities for WEight Reduction) trial and its effectiveness for promoting weight loss.</p> <p>Secondary aim – to explore if GPs thought the programme could be up-scaled and used in other areas effectively.</p>	<p>5 focus groups, 3 to 8 participants per group (60 minutes each), held close to the end of the 24 month 'POWER' trial.</p> <p>2 investigators used the first focus group to develop initial codes and a coding template which were used to code the remaining four transcripts (modifying as required). Discrepancies in codes looked at by a third investigator. Final themes discussed among all members of study team.</p> <p>Thematic saturation reached after analysing four of the five transcripts.</p> <p>GPs recruited via personal invitation (87% response rate).</p>	<p>26 participants from 6 practices.</p> <p>Participants had at least 4 patients enrolled in the 'POWER' trial.</p>	<p>Hopkins 'POWER' trial – an RCT with 2 behavioural weight loss intervention arms – 'Remote' and 'In person'.</p>	<p>GPs believed their patients had confidence in the programme as they were referred by their GP – trusting relationships.</p> <p>Minimal GP burden, most done by health coach (main provider of obesity treatment).</p> <p>Patients need positive feedback</p> <p>One on one counselling with health coach valuable.</p> <p>Telephone weight counselling convenient for patients and GP with limited space.</p> <p>Up scaling: more accessible communication i.e. online, integration of coaches</p> <p>feedback into existing medical records; main barrier to implementation would be cost.</p>	<p>No evidence of 'member checking' of transcripts.</p>	<p>One of the study investigators who is a GP but not part of the POWER study team moderated all groups, using a semi structured moderator guide (pilot tested).</p> <p>Moderator's occupation and gender provided.</p> <p>Detailed account of limitations provided.</p>
3	<p><b>Chapman et al 2005</b> Journal of the American Dietetic Association. Vancouver, Canada.</p>	<p>To investigate Canadian dietitians' approaches to counselling adult clients seeking weight loss advice.</p>	<p>15 focus groups, 3-13 participants per group (120 minutes each).</p> <p>Participants were recruited across seven states in Canada.</p>	<p>104 participants (dietitians working in clinical, private, commercial and industry sectors).</p>	<p>Weight management techniques used by dietitians.</p>	<p>Overall consensus was to encourage patients toward 'healthy living'.</p> <p>Individualised treatment goals encompassing behavioural change, physical outcomes and psychological well-being.</p>	<p>Data collected may have been affected by bias as dietitians effectively interviewed other dietitians about their</p>	<p>Focus group facilitators completed a two day training course on how to conduct focus groups.</p>

		<p>Focus groups aimed to collect responses to 2 hypothetical patient scenarios.</p> <p>Focus groups were facilitated by 2 dietitians and observed by a research based dietitian. Discussions tape-recorded and transcribed verbatim.</p> <p>12 of the dietitians involved in data collection were involved in data analysis. Codes developed from first 2 transcripts then used as coding templates for the remaining transcripts. Each of the 12 analysts independently coded all transcripts and then met via monthly conference calls to discuss.</p>	<p>Recruited via notices in dietetic newsletters and electronic mailing lists.</p>		<p>Discussions emphasised healthy eating over physical activity.</p> <p>Weight loss goals as outcomes for treatment depended on whether achievement of such would benefit the patients' physical health.</p> <p>Weight loss sometimes considered a 'bonus' of behavioural change strategies intended to improve health outcomes.</p> <p>Information gathering essential – motivations, previous experiences etc.</p> <p>Advice and education provided to patients was determined by outcomes of thorough patient assessment.</p> <p>Healthy eating education often focussed on what foods patients <i>could</i> eat rather than what they could not.</p> <p>While psychological input was deemed highly important, many felt they were not qualified to give such advice.</p>	<p>professional experiences with weight management.</p> <p>Data analysis technique not specified.</p>	<p>Focus group interview guides were pilot tested.</p>	
4	<p><b>Gudzune et al 2012</b></p> <p>Patient education and counselling. Johns Hopkins University</p>	<p>To explore how primary care providers' communicated with patients about weight management.</p>	<p>5 focus groups (60 minutes each, 3-8 PCPs per group), held close to the end of the 24 month 'POWER' (Practice-based Opportunities for WEight Reduction) trial.</p>	<p>26 participants (PCP's) from 6 practices.</p> <p>Participants had at least 4 patients</p>	<p>PCP communication to patients about weight management in practice.</p>	<p>Lack knowledge, use standardised messages or materials.</p> <p>Some avoided weight conversations entirely.</p> <p>Keeping the patient focussed on something positive -</p>	<p>The POWER trial and its focus on weight loss may have influenced how these PCPs communicated about weight loss.</p>	<p>Used a pilot tested semi-structured interview guide for the focus groups.</p>

	School of Medicine. Maryland, USA.	Secondary aim - to help tailor interventions to improve counselling techniques perhaps to move toward the 5A's framework or Motivational Interviewing.	2 investigators used the first focus group to develop initial codes and a coding template which were used to code the remaining 4 transcripts (modifying as required). Discrepancies in codes looked at by a third investigator. Final themes discussed among all members of study team.  PCPs recruited via personal invitation (87% response rate).	enrolled in the 'POWER' trial.		motivating, praising, acknowledging success Connect with patients, share own experiences - let them know they will fall off the wagon 'Partnering' relate to something else they have had success with. Acknowledge day to day life when planning treatment. Set short realistic goals. Reframe into being 'healthy' – take the focus off the weight	Limitations discussed.	
5	<b>Hong et al 2012</b> Family Medicine. Texas, USA.	To assess family physicians' understanding and perceptions of the personal and environmental motivators and barriers to physical activity.  Part of a larger research project investigating relationships between environment and physical activity among overweight and obese patients.	5 focus groups, 6-15 participants per group, (45 minutes each).  Focus groups were audiotaped as well as notes taken by 2 researchers.  Initial coding of transcripts conducted by members of research team (does not say how many), until a consensus on themes was reached. Transcripts were then independently coded by 2 members of the research team (80% inter-rater reliability),	49 participants (35 family physicians and 14 trainee physicians) operating out of 4 clinics and a practice based research network.  Emails sent to all family physicians and house officers of 4 clinics linked with 2 research universities and 1 practice based	Family physicians' and house officers' perceptions of walking environments and their suitability for weight loss.	Physicians are aware of guidelines but many didn't bring this up in consults. Perceived ineffectiveness in counselling, inability to address environmental issues, time constraints in medical encounter. Agreed that environments were important for walking and reported patients often brought these up as barriers. Thought walking was an ideal form of exercise for overweight patients.	Limitations not discussed.  One focus group was not audio-taped due to a technical failure.  Themes coded using the 'interview guide', no mention of qualitative analysis technique.	Pre-developed and piloted interview guide used to moderate focus group discussion.  Clear description of recruitment technique.

			and disagreements discussed by all members of research team.	research network.				
6	<b>Jochemsen-van der Leeuw et al 2011</b> Family Practice Amsterdam. The Netherlands.	To assess the attitudes and other factors that influence the willingness and ability of general practitioner (GP) trainees, GP trainers and teachers to treat obesity in primary care.	4 focus groups separated by qualification (i.e. GP trainers, teachers, first and third year GP trainees), 5-7 participants per group (45 minutes each).  Focus groups facilitated by a single moderator and observed by a single researcher. Audiotaped and transcribed; observer's notes and descriptions of discussions were also included in the analysis.  2 researchers allocated statements to categories based on introductory questions. Categories were then divided into positive and negative statements. This analysis was repeated and the final decision on categorisation was reached after researchers reached agreement.	25 participants (7 first year GP trainees, 6 third year GP trainees, 5 GP trainers and 7 teachers).  Purposive sampling method using alphabetical lists of all potential participants.	Attitudes of GP trainees and trainers towards obesity treatment in primary care.	All groups consider the government responsible to give advice on how to live healthily. Responsibility of community also; stop portraying slim people as role models. Negative emotions (first year trainees), why are you doing this to yourself? GP trainers, disappointed and despondent – patients always return to their old habits. First year trainees think they can only give simple advice or refer to dietitian Third year trainees believe patients should be encouraged to set their own goals. GP trainers believe a collaborative approach to restore enthusiasm in obesity treatments. First year trainees think patients don't accept responsibility for their weight.	Minimal quotes used to illustrate findings.  Qualitative analysis technique not specified.	2 researchers analysed the data independently.

7	<p><b>Leverence et al, 2010</b> Family Practice. Amsterdam, The Netherlands. <i>Same study set as Sussman et al (ref), different aims.</i></p>	<p>To investigate clinicians' approaches to and broader views about counselling for prevention and treatment of obesity in primary care.</p> <p>This study involved both individual interviews and focus groups as data collection methods. This review details aspects of this study relevant to focus groups.</p>	<p>2 focus groups, 3-7 participants per group (90 minutes each) conducted in a practice based research network.</p> <p>Purposive sample based on factors considered likely to influence clinician approaches to obesity related counselling.</p> <p>A theoretical framework developed based on findings from interviews was presented to participants of focus groups. The purpose of this was to guide focus groups and to refine and validate preliminary findings from interviews.</p> <p>Exploratory analysis of interviews and focus groups using Immersion/crystallisation techniques for data analysis.</p>	<p>10 participants, (6 GPs and physicians, 2 Paediatricians and 2 Mid-level practitioners – physician assistants or nurse practitioners).</p> <p>Purposive sampling based on 'factors considered likely to influence clinicians' approaches to obesity related counselling'.</p>	<p>Obesity treatment and counselling in primary care.</p>	<p>Believe they have an Important role to play in obesity treatments.</p> <p>Selectively screening those most important to 'treat' help with time constraints.</p> <p>Prefer to relate obesity treatment discussions to a co-existing complaint.</p> <p>Prefer to use low intensity counselling most appropriate – a lot of time and effort to work regularly with patients, especially if they know they won't see them for 3 months.</p> <p>Lack of resources (weight management services).</p> <p>Low patient motivation is a huge barrier.</p> <p>Problem needs to be addressed at community/social level.</p> <p>Cultural influences.</p> <p>Should address the whole family.</p> <p>Need for environmental modifications.</p> <p>Patients list multiple barriers to exercise</p> <p>Current obesity treatments do not work.</p>	<p>Clinicians serving predominantly low income minorities, therefore extrapolation of study findings are limited.</p> <p>Findings from both interviews and focus groups are reported indiscriminately.</p>	<p>Pilot tested interview schedules.</p> <p>Thorough description of data analysis.</p> <p>Data analysis occurred concurrently with data collection, so points of interest that emerged in earlier interviews could be purposively addressed in following interviews.</p>
8	<p><b>Marchessault et al, 2007</b> Canadian Journal of Dietetic</p>	<p>To investigate Canadian dietitians' use of non-dieting and size acceptance</p>	<p>15 focus groups, in 7 different Canadian cities, 3-13 participants per group (120 minutes each).</p>	<p>104 participants (dietitians working in clinical, private, commercial and</p>	<p>Dietitians' opinions of using NDAs and SAAs for weight management.</p>	<p>Important to help clients establish a healthy relationship with their bodies and food.</p>	<p>Data collected may have been affected by bias as dietitians effectively</p>	<p>Focus group questions provided.</p>

	practice and research. Canada.	approaches (NDAs and SAAs) in the context of weight management.  This study was part of a larger study involving focus groups and a survey to explore Canadian dietitians' approaches to counselling adults seeking weight management advice.	A team of 12 analysts coded 24 of the 104 transcripts, and identified broad themes. The rest were coded by 2-3 analysts.  3 analysts independently coded for NDAs and SAAs. Prevailing themes were compared and discussed before reaching a consensus.	industry sectors).  Recruited via electronic mailing lists and articles in dietetic newsletters.		Importance of enjoyment and pleasure and a well-rounded view of food – 'it means not restrictive eating'. Many avoided a good food bad food dichotomy, but suggested limiting certain foods.  Some thought 'size acceptance' was important for their heaviest clients. Some thought it could make clients complacent about their weight loss, others thought it provided hope to those who were unlikely to achieve sustained weigh loss. Belief that if lifestyle practices improved weight loss would ensue.	interviewed other dietitians about their professional experiences with weight management.  Data analysis technique not specified.	All researchers attended 2 day training session on focus group methodology.
9	<b>Stone and Werner, 2012</b> Qualitative Health Research. Israel.	To explore and define the different dimensions of professional stigma attached to obese patients by dietitians.	4 focus groups, 6 participants per group (90 minutes each).  Content analysis. Group to group validation techniques – only included themes that were mentioned by all 4 groups, were mentioned by more than one in each group and were met by a consistent amount of 'energy' and 'enthusiasm' by all participants in each group.	23 participants, (dietitians working in a community setting).  Snowball recruitment technique. Head dietitian in each Health Maintenance Organisation contacted regional dietitians, who then contacted	Dietitians in private practice.	Felt obese patients are responsible for their own excess weight. Patients who blame their circumstances on external factors are hard to deal with. Positive feelings of pity (at the start of treatment) progressed to negative feelings of anger towards their patients.  Aware of their feelings of anger, try to not let it affect the treatment they give. Frustration when patients do not achieve weight loss,	Group to group validation technique may miss out important themes if they are not mentioned by each group.	Moderators guide for focus groups provided.

				fellow dietitians in their region.		despite this, determined to help their patients.		
10	<b>Sussman et al 2006</b> Annals of Family Medicine. New Mexico, USA.	To investigate factors that influence clinicians' decisions to include preventative counselling in the brief primary care encounter – using obesity as a case example.  This study used a mixed methods design involving individual interviews and focus groups as methods of qualitative data collection, and a survey for collecting quantitative data. Only aspects of this study pertaining to the focus groups are reported in this review.	2 focus groups, 10 participants per group (90 minutes each).  A theoretical framework developed based on findings from interviews was presented to participants of focus groups. The purpose of this was to guide focus groups and to refine and validate preliminary findings from interviews.  Exploratory analysis of interviews and focus groups using immersion/crystallisation techniques for data analysis.	10 participants (6 general practitioners and physicians, 2 paediatricians and 2 mid-level practitioners – physician assistants or nurse practitioners).  Purposive sampling based on 'factors considered likely to influence clinician approaches to obesity related counselling'.	Clinicians in primary care.	Most agreed not to focus on weight loss but anything that improved health (almost none used BMI as a measure). Reluctance to use national obesity treatment guidelines as they perceive their counselling approaches to be ineffective, and they don't believe diet and exercise counselling is effective. Patients' motivation will influence whether clinicians bring up weight counselling. Clinicians are keen to learn counselling techniques that address patients' motivations. Lack of suitable referral resources or programmes owing to organisational structure of the practice and community. Majority are searching for a 'teachable moment' – often ends up being related to another condition.	Unclear whether published responses from clinicians were extracted from focus groups, interviews or from survey.	To identify a full range of relevant responses the authors sampled by clinician type, location (rural/urban) and years of practice.
11	<b>Ware et al 2012</b> Informatics in Primary Care.	To explore primary care providers' (PCPs') experiences of delivering weight management services and their	5 focus groups, 4-11 participants per group (39 - 72 minutes each) conducted by 2 facilitators.	36 participants (19 practice nurses, 14 physicians, 1 administrator and 2 health	PCPs experiences of offering of weight management and their	Primary care should be involved, but secondary to treating disease. This was debated i.e. why wait until when disease occurs.	Recruitment method not specified.	Thorough description of analysis methods.



University of Southampton, England.

perceptions of a web based weight management programme - 'Positive Online Weight Reduction' (POWeR) to aid service delivery.

Data analysed using inductive thematic analysis to identify recurring themes within the data.  
Coding was informed by constant comparative analysis consistent with Grounded theory 'lite.'

care assistants) working in primary care. Participants recruited from 5 different practices (3 urban, 2 rural) across 3 primary care trusts in England. Recruitment method not specified.

perceptions of a web based programme.

Under-resourced (i.e. scales do not go up high enough; no time in consults).  
Scared of offending patients.  
Use common sense as a treatment platform, or what has worked for them personally in the past.  
Hopeful that a web based programme could enhance access to obesity treatments although not suitable for all patients – without internet access  
Web-based programme would give treatment focus, 'all sing from the same hymn sheet'.

Topic guide provided framework for focus group discussion – included in article.

## APPENDIX B. REVIEW OF CONSUMER STUDIES

Author, Date, Journal. Location.	Aims	Study Design and Methods	Participants and Recruitment	Obesity Treatment Context	Findings	Limitations	Strengths
1 <b>Ely et al 2009</b> Health Education Research. Kansas, USA.	To explore weight control, beliefs, attitudes and knowledge amongst rural Kansas women.  Secondary aim was to explore the roles of the participants themselves, primary care practice teams, and communities around weight control.	6 focus groups, 4-9 participants per group, (90 minutes each).  Qualitative analysis with an iterative process and standard techniques, involved coding data and grouping codes into themes.	31 participants, (white women, BMI over 30kg/m <sup>2</sup> ).  Participants were recruited from 3 communities in separate counties in rural Kansas.  Recruited by their primary care provider.	Consumers' experiences of obesity treatments in primary care and their own experiences with weight control.	Overall lack of support from PCP - weight related to other co-morbidities and GP time constrained in consult; lack of resources for dietary change (adequate for physical activity). Distance to commercial weight control programmes. Sharing/cultural influences.  Desire for weight raised more often in consults. Would accept weight advice from another clinician if their GP followed up. Could use primary care centre as community resource. Group support-inclusiveness, accountability.	Records not kept on those who refused to participate, but most were said to be owing to scheduling conflicts.  Weak description of data analysis techniques.	Same focus group coordinator for all groups.  Transcripts coded by external transcriptionist and then verified by 2 of the authors who were present at all groups.
2 <b>Fogel et al 2009</b> Women and Health. Tennessee, USA.	To describe obesity treatment experiences of self-confessed overweight lesbians in a weight loss group.	2 focus groups, 7 participants per group, (60 minutes each).  Data collection and analysis began using	14 participants, (self-identified Lesbians, 13 white, 1 African American (AA), BMI range 24.14 – 43.53kg/m <sup>2</sup> ).	Organised weight loss group. Weekly weigh in, education, lifestyle changes promoted by the	Stigma associated with being a minority sexual identity contributed to their reluctance to attend conventional obesity treatment programmes.	First 14 members to sign up for study were used as the study sample, possible bias as more opinionated	Focus group questions listed in article.  Research assistant took notes to gather

		<p>a phenomenological approach. As elements of grounded theory emerged, a theoretical framework was developed to guide the rest of the analysis.</p> <p>Focus groups analysed using a Template Analysis style. 3 researchers independently analysed all transcripts then compared for reliability.</p>	<p>Current membership in weight loss group for at least 2 months.</p> <p>A lesbian group functioning under a commercial brand name.</p> <p>Weight loss group predominantly Lesbian but some gay men and straight women also attended the group.</p>	<p>weight loss company.</p>	<p>Some feminist views on body image – some don't see being overweight as problem.</p> <p>Appreciated the connectivity of group of like-minded people – safety, acceptance.</p>	<p>people would have signed up sooner.</p>	<p>other forms of group interaction.</p> <p>Content of focus groups analysed by 3 researchers.</p> <p>After focus groups, primary investigator contacted half of the participants for a half hour telephone interview to make sure content had been captured correctly.</p> <p>A qualitative research expert coded a section of the data coded by the 3 researchers.</p>	
3	<p><b>Gallagher et al 2012</b> International Journal of Nursing Practice. Sydney, Australia.</p>	<p>To describe participants' perspectives of a multi component group based weight loss supplement, to cardiac rehab programmes.</p>	<p>4 focus groups, 6-11 participants per group, conducted in a metro hospital in northern Sydney.</p> <p>Interviews transcribed and thematically analysed using a</p>	<p>35 participants (19 'intervention plus maintenance completers', 16 'intervention only completers', 25 men, 10 women, 31 white, other ethnicities not specified, mean</p>	<p>Healthy Eating and Exercise Lifestyle Programme (HEELP – group based, multidisciplinary and founded on behavioural</p>	<p>Valued group based structure.</p> <p>Found recognising their obesity as a problem and committing to managing their weight empowering.</p> <p>Personal invite was confronting but valued - confirmed they were at risk.</p>	<p>No information on those who dropped out.</p> <p>Focus group duration not reported.</p>	<p>Focus groups conducted by someone independent of the HEELP – helps to reduce response bias.</p>

		general inductive approach.	BMI 31kg/m <sup>2</sup> , BMI range 27-38kg/m <sup>2</sup> .  Participants have either heart disease or diabetes, and have completed a cardiac rehab or diabetes education programme.  Recruited by mail invite at end of HEELP. 70% response rate yielded:	change principles).  Principles of nutrition and exercise, self-management strategies, behaviour change principles and problem solving.	Felt supported as part of the intervention, but would like to be able to include partners in information sessions. Pedometer and food diary helpful. Helpful to tackle one area of treatment at a time i.e. exercise before dietary changes - helped build confidence in one area. Repetitive messages highly valued. Exercising at the hospital – felt safe that help was nearby. Personalised and trusted advice from clinicians.
4	<b>Gallagher (2) et al 2012</b> Nursing and Health Science. Sydney, Australia.	Participants' perceptions and experiences of maintaining weight loss while participating in a study	Same as above.  Same study sample, except this study focussed on the participants personal experiences of following a weight loss programme, rather than their thoughts on the programme itself.	Views of weight management. Participants were part of a weight management trial (HEELP), and had one or more co-existing health conditions.	Emphasised the complexity of weight management, juggling work, family, current health conditions, gym costs and lowered self -esteem from previous weight loss attempts. Inconsistent advice from clinicians complicated attempts at weight management. Requires a lot of time and planning to implement a behavioural change, label reading, planning meals etc. Traditional family and cultural values. Participants found it difficult to adhere to dietary

					<p>recommendations e.g. to restrict salt <i>and</i> lower food intake.</p> <p>Other health conditions strongly motivated them to make changes, these restricted range of exercise.</p> <p>Importance of recognising self-worth.</p> <p>Wished clinicians had brought up their weight sooner.</p> <p>Exercising as a group was enjoyable.</p> <p>Liked using pedometers.</p> <p>Focus on exercise first, more immediate benefits.</p> <p>Simple messages i.e. portion control, fresh over processed.</p>			
5	<p><b>Herriot et al 2008</b> Journal of Human Nutrition and Dietetics. Surrey, UK.</p>	<p>To investigate consumers' perceptions of dieting experiences, 6 months after completion of a randomised controlled trial (RCT) of 4 commercial weight loss programmes.</p>	<p>4 diet specific focus groups, 3-4 participants per group, (60 minutes each), 6 months post intervention.</p> <p>Semi structured interview format.</p> <p>Transcripts analysed using classical 'long table approach' (Kruger &amp; Casey 2000). Analysed by a researcher and</p>	<p>14 participants (2 men, 12 women, mean BMI 32kg/m<sup>2</sup>).</p> <p>32 participants were involved in the intervention, however only those that were allocated to a 'diet' group, i.e. not the control, were invited to attend focus groups after</p>	<p>Participants' perceptions post intervention of a RCT analysing 4 commercial diet programmes -. 'Atkins', 'Weight Watchers', 'Slimfast' and 'Rosemary Conley (low fat diet and exercise)'.</p>	<p>Psychological barriers - eating to emotional cues, depression, lack of willpower, boredom, and wrong frame of mind.</p> <p>Lifestyle barriers – work and family commitments.</p> <p>The majority of Slimfast and Atkins dieters were planning to stop the programme. The Atkins group felt they would 'use it again' when they needed to lose weight.</p> <p>Participants liked the exercise component of the</p>	<p>Study only interviews those that had lost weight, i.e. those that hadn't probably didn't want to be interviewed.</p>	<p>Focus groups conducted by a moderator who was not involved in the primary study.</p> <p>Interview guide provided.</p>

			reviewed by the moderator.	completion of the intervention.		Rosemary Conley group as it motivated them to increase activity levels further. Weight Watchers and Rosemary Conley dieters intended to follow the diet post trial – cited the need however for continued support to maintain motivation. Participants appreciated the support of others going through the same experience.		
6	<b>Kidd et al 2013</b> Archives of Psychiatric Nursing. Ohio, USA.  <i>This was a mixed methods study involving a focus group and individual surveys at the end of the 8 week intervention. Study details and findings relating to the focus group are presented in this review.</i>	Mindful eating (ME) pilot study. To test the efficacy of an 8 week mindful eating based eating intervention on psychosocial variables, and to explore the lived experiences of ME as it related to eating behaviours.	1 focus group, 6 participants, (90 minutes).  Audio recordings transcribed verbatim and coded using NVivo 9.0 software.  The primary investigator and a co-investigator analysed the data using a phenomenological approach (Giorgian method).	6 participants (women, BMI over 30kg/m <sup>2</sup> ).  Participants had completed an 8 week ME intervention.  Participants were recruited as part of convenience sample from one inner city housing community and two urban clinics (that provide healthcare to uninsured persons).	8 week mindful eating based eating intervention on psychosocial variables.  Weekly group sessions, education about applying the ME principles. Assigned homework and readings from a book about ME they were given to discuss at each session.	Participants felt that 8 weeks wasn't long enough put what they had learned to use  Participants appreciated the one on one recruitment approach method.  When comparing feelings of when they ate 'mindlessly' participants felt more 'normal' knowing others do it too.  ME was a burden at first, having to think all the time, but as they progressed with the intervention it wasn't so bad. Some found that as ME increased, they began to appreciate other things such as other people and the environment more.  Liked the non-restrictive nature of the intervention.	Focus group participants may have been reluctant to offer negative comments as primary Investigator facilitated it.	Exclusion criteria provided. Interview questions provided.  Study facilitated by a dietitian with ME experience, a psychiatric nurse specialist (with experience in eating disorders) and the primary investigator

						Focusing more on healthy eating rather than trying to control eating.		
7	<b>Maltreud et al 2009</b> Scandinavian Journal of Primary Health Care. Norway.	To explore consumers' perceptions of their GPs' management of their weight problem.	2 focus groups, 5-8 participants per group, gender specific, (90 minutes each).  Recruited from a Norwegian rehabilitation centre offering lifestyle programmes for people with obesity.  Data analysed using a systematic text condensation approach.	13 participants, (5 men and 8 women, BMI over 40kg/m <sup>2</sup> or over 35kg/m <sup>2</sup> with additional weight related problems).  Most participants had a lifelong history of considerable overweightness.	Consumers' perceptions of weight management in primary care.	Participants wanted their weight problems to be put on the agenda, i.e. not just addressed quickly at the end of a consult, but actually explored properly. Need follow up. GPs to be aware of judgement and unintended blame, and acknowledge underlying causes of weight gain. Patients reluctant to bring up weight due to embarrassment or shame. GPs lack knowledge – to treat problem, or of referral services. Participants think GPs don't believe their food intake.	Focus groups gender specific.  Data analysis conducted by two authors collaboratively.	
8	<b>Ostberg et al 2010</b> Scandinavian Journal of Public Health. Sweden.	To explore patients' experiences of a Very Low Calorie Diet (VLCD) randomised control trial and subsequent corset treatment in a primary care setting and to explore their perceptions of factors influencing weight control.	5 focus groups, 3-5 participants per group, (60-90 minutes each).  One group with 2 men, 3 groups with women only (n=3,5,5) and 1 gender mixed group (2 men, 2 women)	19 participants, (2 men, 17 women, BMI over 30kg/m <sup>2</sup> ).  Participants recruited via advertisement of referral to participate in the intervention. A year after the intervention's	12 week VLCD randomised controlled trial intervention in a primary care setting.	Weight loss maintenance - constant struggle; you have to start over every single day. Relapses/weight gain leads to feelings of hopelessness - leads to more eating. Lack of confidence in their own abilities – likening the new behaviour like trying to give up cigarettes or alcohol, an addiction.	Authors note that those that did not contribute much in the focus groups may have had special characteristics, such as not having lost weight, but this was not found out for sure for ethical reasons.	The moderators for the focus groups were not involved in the original VLCD study and were not primary care staff, meaning participants may be more likely to share their real thoughts rather than being biased

		Although data was collected for the corset treatment aspect of this study, it was not evaluated due to lack of compliance.	Focus groups facilitated by a moderator and an observer who asked additional questions at the end.  Data analysed using grounded theory methodology	commencement, participants for focus groups were invited by mail and then after a week, by telephone.  VLCD (800kcal/day and drink at least 2.5L per day of non-caloric beverages) for 3 months (followed by a dietitian and nurses at weeks 1, 2, 4, 6 and 9, at week 12 dietitian recommended an individualised calorie reduced diet), followed by 9 months of lifestyle advice.		Participants thought it was helpful to recognise their weight as a problem. Felt being part of a study made it easier to refrain from cheating Group VLCD situation helpful – share experiences, accountability, competitive arena; in contrast implied temporary period of safety - very easy to go back to old habits. Other helpful factors for maintenance: booking further appointments with dietitians etc, buying home scales, and maintaining contact with others from the group. Participants wanted extended support from healthcare. Cookery groups were proposed to deal with the new way of cooking things.	'All subjects received healthy lifestyle advice throughout the whole study' – not specified what this was.	by having the trial facilitators present.
9	<b>Thomas et al 2008</b> Journal of Cultural Diversity. Georgia, USA.	To explore the perceptions of black and white women on body image, social perceptions of obesity, knowledge of health risks, <b>perceived helpfulness of primary care</b>	6 focus groups, race specific (3 white, 3 black, 60-90 minutes each) with race-matched facilitators, conducted at an academic medical centre. .	30 participants (women, 17 black, 13 white, BMI over 30kg/m <sup>2</sup>  PCPs referred participants to study investigators who then contacted them for	Perceived helpfulness of primary care providers (PCPs) for weight management.	Dislike word obese – negative connotations Unhelpfulness of PCPs towards weight loss, i.e. mentioning the need to lose weight but not saying why or how. Often relating it to other co morbidities (i.e. obesity ends up being associated with nearly all co-morbidities).	No description of data analysis technique. Simply states themes were defined via an iterative process.  Number of participants per	Race matched facilitators – a strength as this may have allowed a freer flowing discussion about any racial differences in perceptions of



		providers (PCPs), self-efficacy, weight loss attitudes and behaviour.		recruitment into focus groups.		Cultural differences - white women want help from people that used to be obese, i.e. have been in their position before). Black women cited barriers to access – to exercise facilities, stores to purchase healthy foods, time and money	focus group not reported.	obesity treatments.  Included reasons for non-participation, citing lack of transport, childcare, illness.
10	<b>Ward et al 2009</b> Journal of General Internal Medicine. Philadelphia, USA.	To explore obese urban African Americans' of their primary care providers' role in the treatment of obesity and to identify certain provider behaviours that may motivate or hinder attempts at weight loss.	8 focus groups, 2-12 participants per group, (75-90 minutes each).  Data analysis was an iterative process based on grounded theory methodology.	43 participants, (16 men, 27 women, BMI over 30kg/m <sup>2</sup> self-reported height and weight).	Consumers' perceptions of the role of primary care providers (PCPs) in weight management.	Participants did not like their PCP to attribute all of their health problems to their weight – without actually addressing a specific complaint. Wanted treatment towards their complaint as well rather than just brushing it off with 'you need to lose weight'. Participants do not want their obesity to be ignored – address the issue with what is most pertinent, identify the most important health issue that could be helped by weight loss Participants want PCPs to ask if they want to discuss their weight first. Manner and timing - physician being respectful, having empathy, being non-judgemental. Acknowledgement of both small amounts of weight loss and failed attempts.	Small focus groups, at least one with only two participants.	Focus group questions provided in Appendix.  Focus groups were gender specific to allow for differences in gender perceptions.  African American facilitator with prior qualitative research experience.  Overweight people excluded as the authors thought their views would differ to that of obese patients. Also excluded those that had a

Need specific advice i.e.  
individually discuss with  
patient's how much weight  
they 'should' lose, what  
obstacles they have  
encountered before.

medical  
contraindication  
to exercise.

## APPENDIX C. FOCUS GROUP INTERVIEW SCHEDULE

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### Understanding Clinician and Consumer Perspectives of Obesity Interview Schedule

General welcome and introduction of study

Explanation of Group Rules

Confidentially

Respect for others views

Recording so please try to speak clearly and one at a time

First time speak say name and position/profession

Id of Group Rep

General Topics to cover:

- **Perceptions of overweight and weight loss**
  - We are going to talk a lot about the terms obesity and weight loss, would like to start discussions today by getting you each to tell me what you think about when you think about a person being overweight/obese.
  - How do you define someone who is overweight/obese?
  
- **Causes of obesity**
  - Tell me about how/why you think people initially become overweight/obese?
  - How much control do you think people who are overweight have over their eating?

*[If not mentioned by participants above ask directly]*

Tell me about the role that you think:

- Binge eating and compulsive overeating play in the development and maintenance of obesity.
- Mental illness and addiction play in the development and maintenance of obesity.

- What about problem foods – is there such a thing, what are they and how do they contribute to obesity (weight gain or inability to lose weight)?

- **Components of successful weight loss initiatives**

- You have been chosen to be part of this study either because you treat people who are obese, you have experience of being obese or someone you know and care about has experience of being obese. Would like to take some time now to hear about your ideas about what works to help people lose weight/maintain weight loss.

If you were trying to encourage someone to lose weight what are types of things would you suggest they do?

*[If not mentioned by participants above ask directly]*

- What are your views on the idea of lifestyle change as a part of weight loss initiatives? Tell me about how you think this works and how achievable you think this is?
- What are your ideas about self help groups and diet clubs. How do you think these work and how effective are they in helping people lose weight and maintain their weight loss?
- What sort of outcomes should weight loss initiatives be aiming for?

- **Barriers to successful weight loss and weight loss maintenance**

- What barriers do you think there are to losing weight and keeping weight off?

Closing

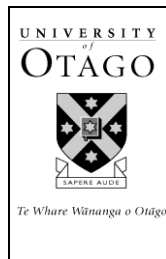
Handing in consent forms

Collecting vouchers

For consumer FG's – identifying anyone interested in being involved in our pilot treatment trial.

## APPENDIX E. PARTICIPANT INFORMATION SHEET

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### **Understanding Clinician and Consumer Perspectives of Obesity**

Are you interested in sharing your ideas and/or experiences about how people become obese and useful ways of treating obesity?

If so, you should contact us!

We are interested in talking to:

**Clinicians who work with people with obesity or over eating issues**

and

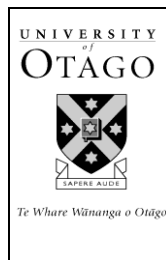
**people who have lived, or currently live, with obesity (either your own, or a close family members).**

We would like to find out what you think causes and maintains obesity and what you think are good treatments for obesity.

We will be running a number of focus groups to gather this information. If you are interested in being involved in this study or would like to find out more about it, please contact Dr Ria Schroder from the Department of Psychological Medicine, University of Otago, Christchurch on 364 0480 or 0800 233 428 or by email on [ria.schroder@otago.ac.nz](mailto:ria.schroder@otago.ac.nz).

## APPENDIX F. RECRUITMENT LETTER TEMPLATE

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[date]

Dear [name of potential participant]

Re: Understanding Personal Experiences of Obesity Study

Thanks so much for contacting me about our study. We will be running four consumer groups starting in March. The four groups we will be running are for:

**People of all ethnicities with obesity**

11/3/08 at 6-8pm

13/3/08 12-2pm or 4.30-6.30pm

**People with or without obesity who have attended self-help groups (Overeaters Anonymous) or diet clubs (Weight Watchers, Jenny Craig) etc.**

18/3/08 at 6-8pm

20/3/08 12-2pm or 4.30-6.30pm

**Maori People with obesity**

25/3/08 at 6-8pm

27/3/08 12-2pm or 4.30-6.30pm

**Pacific People with Obesity**

1/4/08 at 6-8pm

3/4/08 12-2pm or 4.30-6.30pm

You may find that you fit more than one of these categories so if you could ring me and let me know which group(s) you would prefer to attend and the times you could attend then I would really appreciate it. When we have a time that is most suitable to the majority of participants I will let you know definitely what time the focus group will be. In the meantime, if you are able to, it would be great if you could keep all these times free so you don't miss out on being involved.

I have also enclosed an information sheet to provide you with more details about the study. Look forward to hearing from you soon.

With many thanks.

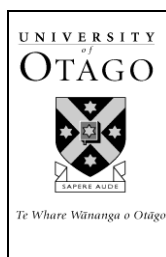
Dr Ria Schroder

Research Fellow

National Addiction Centre

# APPENDIX G. PARTICIPANT CONSENT FORM

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## CONSENT FORM

### Understanding Clinician and Consumer Perspectives of Obesity

I have been invited to take part in the study investigating clinicians' and consumers' perspectives of the causes and treatment of obesity.

I have read and understood the information sheet dated 14 February 2008. I have had an opportunity to discuss this study and ask questions about it. I am satisfied with the answers I have been given.

I have had enough time to consider whether to take part, and to discuss my decision with a person of my choice, and the researcher.

I know whom to contact if I have any questions about the study.

I understand that:

- My taking part in this study is voluntary (my choice)
- I am free to withdraw from the study at any time for any reason, without adversely affecting my present or future treatment
- My participation in this study is entirely confidential, and no information that could identify me will be used in any reports on this study

I agree to keep the names and identities of all participants

in the focus group I attend confidential

Yes/No

I consent to the focus group being audio taped

Yes/No

I consent to take part in this study.

Yes/No

I wish to receive a copy of the results of this study:

Yes/No

Please provide an address you would like these results sent to:



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I consent to the use of my data for future related studies, which have been given ethical approval from a Health and Disability Ethics Committee Yes/No

I \_\_\_\_\_ (full name) hereby consent to take part in this study.

Date: \_\_\_\_\_ Participant's  
signature: \_\_\_\_\_

Project explained  
by:

---

Project  
Role:

---

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

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Investigators' Contact Details

**Principal Investigator:**

Professor Doug Sellman

**Co-investigators and Focus Group Facilitators:**

Dr Ria Schroder and Dr Jane Elmslie

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Department of Psychological Medicine  
University of Otago, Christchurch,  
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Ph (03) 364 0480  
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