



The use of support people to improve the weight-related and psychological outcomes of adults with obesity: A randomised controlled trial



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ABSTRACT

Objectives: To investigate whether training individuals from the personal networks of adults with obesity in the skills of motivational interviewing enhances the anthropometric and psychological outcomes of a cognitive-behavioural weight loss intervention.

Methods: Adults with obesity ($N = 201$) were randomised to participate in 26 sessions of cognitive behaviour therapy (CBT) for weight loss either alone (CBT-A) or with the addition of a support person (CBT-SP). Outcomes were assessed at the end of the 12-month intervention and at a follow-up one year later.

Results: Analyses indicated negligible additive effect for the CBT-SP versus the CBT-A condition, although the quality of the patient's relationship with their support person predicted the anthropometric outcomes. Across conditions, significant improvements were observed for all anthropometric (weight, body mass index, and waist circumference) and psychological (self efficacy, weight-related quality of life, weight satisfaction, and binge eating) variables between baseline and post-treatment, and baseline and the follow-up.

Conclusions: The benefits of the cognitive-behavioural weight loss program were found to extend to psychological variables. Yet the lack of evidence for the additive benefits of including support people in treatment suggests a need to develop more effective training programs for support people in weight management.

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1. Introduction

Traditional behavioural programs for adults with obesity have been successful in producing weight loss, although this is typically followed by weight regain after treatment cessation (Butryn, Webb, & Wadden, 2011). In an attempt to improve outcomes, these programs have been augmented by the inclusion of cognitive components designed to target the dysfunctional cognitions related to unhealthy weight control behaviours. While still few in number, combined cognitive-behavioural interventions for adults with obesity have yielded some promising results. For example,

cognitive treatment has been found to enhance certain outcomes attained by a behavioural approach such as greater reductions in shape and weight concerns and binge eating (Nauta, Hospers, & Jansen, 2001; Nauta, Hospers, Kok, & Jansen, 2000). In terms of weight-related outcomes, Werrij et al. (2009) found that a cognitive-behavioural program resulted in a significant reduction of 1.36 BMI points at the end of treatment, with this reduction fully maintained one year later. Other cognitive-behavioural programs, however, have not resulted in sustained weight loss. For instance, while Cooper et al. (2010) found that the majority of their participants (greater than 70%) attained a clinically-meaningful amount of weight loss at the end of a 24-session, 44-week, one-to-one cognitive-behavioural program, these initial weight losses were followed by weight regain in the period after treatment, with a regain of almost 90% of lost weight three years after treatment.

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Thus, while promising, investigating modifications to cognitive-behavioural interventions for adults with obesity is warranted to not only improve their effectiveness (especially in terms of consistently yielding weight-loss maintenance over the long-term) but also their scalability so that they can be made available to wider sections of the affected population. Unfortunately, there is typically a trade-off between these requirements, with the most effective interventions in terms of long-term weight loss entailing highly intensive and/or extended interventions (Middleton, Patidar, & Perri, 2012). While ongoing patient-provider contact has therefore been recommended as the most effective strategy for long-term weight management (Butryn et al., 2011), this does not provide a feasible solution to the obesity problem given the substantial demands this approach places on healthcare services.

Optimising the social support for weight management from non-professionals (such as family members, friends, colleagues, weight loss group members, and community members, referred to henceforth as 'support people') has the potential to improve both the effectiveness and scalability of weight loss programs. Specifically, utilising support people to augment the input provided by health professionals capitalises on the established effectiveness of social support for weight loss and maintenance (Greaves et al., 2011), without necessitating the intensive and long-term involvement of formal healthcare systems. Indeed, in certain circumstances support people can match (Leahey & Wing, 2013) or even exceed (Israel & Saccone, 1979) the outcomes attained through therapist contact. This may be due in part to the fact that support people can be present when and where most of the dynamics regarding eating and physical activity occur.

Despite the potential for support people to improve the effectiveness and scalability of lifestyle interventions for obesity, there are also limitations associated with such an approach. One limitation is specific to those interventions in which the support people themselves are seeking to lose weight. Here it has been found that the inclusion of support people only increases the weight-loss maintenance of individuals with obesity if the support people are themselves successful in losing weight (Gorin et al., 2005). Yet this strategy is of limited utility since only a minority of the participants with obesity in the Gorin et al. (2005) study had support people who were successful at weight loss, and not all available support people will be in need of weight loss themselves.

A more general limitation pertaining to the utilisation of support people to assist weight management is their use of strategies that may be ineffective or even exacerbate the individual's problems with weight control. For instance, one study found that the cluster of patients who did not experience a weight loss of at least 5% of initial body weight were differentiated from those who did on the basis of the former's *higher* involvement of friends in making dietary changes (Yank et al., 2014). Similarly, Wing and Jeffery (1999) found that higher family support for healthy eating, as well as for physical activity, predicted less weight loss from baseline to 10 months. Such findings are perhaps not surprising given that the use of ineffective strategies for supporting individuals with obesity in weight management has been found to be pervasive, while access to effective forms of support appears minimal. For instance, in a study by Zwickert and Rieger (2014), the vast majority of participants with obesity reported that members of their social support network utilised unhelpful strategies in relation to the participant's weight, such as engaging in controlling behaviours (e.g., offering unsolicited dietary advice or pressuring the individual to diet) that are known to interfere with the individual's motivation to manage their weight and success in doing so (Gorin, Powers, Koestner, Wing, & Raynor, 2014; Ryan & Deci, 2000; Silva, Vieira et al., 2010; Silva, Markland et al., 2011; Teixeira, Silva, Mata, Palmeira, & Markland, 2012; Williams, Grow, Freedman, Ryan, & Deci,

1996). Also highlighting how the greater involvement of family and friends may actually hinder weight management are the results from a study by Kiernan et al. (2012) in which it was found that 90% of women with obesity rarely or never experienced effective support for healthy eating from their friends, with 78% reporting the same lack of access to effective support from their family. Thus, in their utilisation of ineffective forms of weight management support, and limited access to effective forms of support, the greater involvement of family and friends in weight management may actually exacerbate the individual's difficulties with weight control.

In contrast to ineffective forms of support for weight management, motivational interviewing is a form of interaction designed to build an individual's intrinsic motivation to change (Miller & Rollnick, 2013). A growing evidence base supports its effectiveness in obesity, with a meta-analysis of 11 randomised controlled trials finding that motivational interviewing demonstrated a medium effect size for weight loss over and above the control conditions, and that higher amounts of weight loss were seen in those trials which utilised motivational interviewing as an adjunct to group-based behavioural weight loss programs (Armstrong et al., 2011). However, to our knowledge, no previous research has addressed teaching motivational interviewing skills to the support people of individuals with obesity. Preliminary work suggests that interventions informed by motivational interviewing are helpful in the context of eating disorders. Specifically, interventions have been designed to teach the carers of individuals with eating disorders communication skills so that they can enhance the individual's motivation to recover (Goddard, Raenker et al., 2013). For instance, carers are taught to elicit intrinsic motivation for change through strategies such as developing a relationship based on warmth, acceptance, affirmation and emphasising autonomy; discussing the reasons for and against change; and building self-efficacy for change (for a more detailed description, see Table 1 in Goddard, Raenker et al., 2013). These carer interventions have been found to be generally well-received by individuals with anorexia nervosa who have positive attitudes towards involving carers in their care and believe this benefits their recovery (Goddard, Macdonald, & Treasure, 2010). This approach has also been found to result in significant reductions in carer distress (Hibbs, Rhind, Leppanen, & Treasure, 2015), with carer distress known to predict patient distress and eating disorder symptoms (Goddard, Salerno et al., 2013). Thus the present study investigates whether the weight loss and maintenance outcomes in adults with obesity participating in a cognitive-behavioural weight management program can be improved by including support people trained in motivational interviewing strategies. It is anticipated that by employing a unique strategy to alter the social context of obese patients (i.e., producing motivationally-skilled support people), individuals with obesity will have the requisite support to more effectively manage their weight both during and after treatment.

In addition to assessing weight-related outcomes, a secondary aim of the present study is to investigate the psychological outcomes of patients with obesity. Lasikiewicz, Myrissa, Hoyland, and Lawton (2014) note in their systematic review of 36 studies focused on psychological outcomes that there has been less investigation of the potential psychological versus medical benefits of weight loss programs. Yet attention to psychological outcomes is paramount given that various indices of psychological distress (such as impaired health-related quality of life [Rieger, Wilfley, Marino, Stein, & Crow, 2005], poor body image [Schwartz & Brownell, 2004], and binge eating [de Zwaan, 2001]) are elevated in populations with obesity, and that psychological constructs (such as low self-efficacy [Elfhag & Rössner, 2005], poor body image [Haines, Kleinman, Rifas-Shiman, Field, & Austin, 2010], and binge

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