

UNIQUE BARRIERS AND NEEDS IN WEIGHT MANAGEMENT FOR OBESE WOMEN WITH FIBROMYALGIA

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Research Question: The aim of this study was to identify barriers, needs, and preferences of weight management intervention for women with fibromyalgia (FM).

Theoretical Framework: Obesity appears in higher rates in women with fibromyalgia compared to the population at large, and no study to date has taken a qualitative approach to better understand how these women view weight management in relation to their disease and vice versa.

Methodology: We designed a qualitative interview study with women patients with FM and obesity.

Context: Women ($N = 15$) were recruited by their participation in a fibromyalgia treatment program (FTP) within the year prior.

Sample Selection: The women approached for the study met the following inclusion criteria: confirmed diagnosis of FM, age between 30 and 60 years ($M = 51 \pm 6.27$), and body mass index (BMI) ≥ 30 ($M = 37.88 \pm 4.87$).

Data Collection: Patients completed questionnaire data prior to their participation in focus groups ($N = 3$), including weight loss history, physical activity data, the Revised Fibromyalgia Impact Questionnaire (FIQR), and the Patient Health Questionnaire 9-item (PHQ-9). Three focus group interviews were conducted to collect qualitative data.

Analysis and Interpretation: Consistent themes were revealed within and between groups. Patients expressed the complex relationships between FM symptoms, daily responsibilities, and weight management. Weight was viewed as an emotionally laden topic requiring compassionate delivery of programming from an empathetic leader who is knowledgeable about fibromyalgia. Patients view themselves as complex and different, requiring a specifically tailored weight management program for women with FM.

Main Results: Women with FM identify unique barriers to weight management, including the complex interrelationships between symptoms of FM and health behaviors, such as diet and exercise. They prefer a weight management program for women with FM that consists of an in-person, group-based approach with a leader but are open to a tailored conventional weight management program. Feasibility may be one of the biggest barriers to such a program both from an institutional and individual perspective.

Key words: Fibromyalgia, obesity, qualitative, weight management, women

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Abbreviations: FIQR, Fibromyalgia Impact Questionnaire; PHQ-9, Patient Health Questionnaire (PHQ-9).

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Fibromyalgia (FM) is a debilitating chronic pain condition affecting 2–6% of the US population. It is characterized by widespread pain, tenderness, and various other problematic associated symptoms, including fatigue, morning stiffness, unrefreshing sleep, and cognitive symptoms, resulting in physical and psychological impairment and reduced quality of life (QOL).^{1,2} FM symptoms invasively affect nearly every area of life and make even the simplest daily task appear insurmountable. Many women seem to be left with little energy or motivation to tackle more complex tasks such as weight management. It maybe that due to the FM symptom profile and various psychosocial factors that obese women with FM need specific approaches in weight management programs.

The prevalence of obesity is increasing in the United States and about one-third of the overall population is classified as obese.³ The rates of obesity and severe obesity among patients with FM exceed the prevalence of obesity in patients in the general population. About half of patients with FM are obese, and 25%

of FM patients meet the criteria for severe obesity.⁴ A number of problematic associations arise in obese FM patients, including increased FM symptom severity, impaired QOL, more tender points, poorer physical functioning, and increased sleep difficulties.^{5,6}

Although a common co-occurring condition in FM patients, few studies aim to identify and develop optimal treatment of obesity in FM patients. A pilot study examined the effects of a 20-week behavioral weight loss treatment on FM symptoms in 31 overweight and obese female women [body mass index (BMI) ≥ 25 kg/m²].⁷ Participants lost 4.4% of the initial body weight, and the weight loss treatment showed significant pre-post improvements on FM symptoms and QOL.⁷ Another study aimed to determine if an energy-restricted diet (about 1200 kcal/day) resulted in better outcomes over a six-month timeframe in obese patients with FM compared to a control group without dietary intervention.⁸ The study demonstrated significant improvement in FM symptoms as well as depression, sleep quality, and tender point count. However, there are no longitudinal data to support lasting effects of this intervention.

For weight management treatment, the combination of dietary changes, physical activity, and behavior therapy is recommended for any patient with a BMI ≥ 30 kg/m².⁹ Intensive weight management programs are costly and require substantial time commitments from the patients. Yet, only about 20% of overweight individuals are successful at long-term weight loss when defined as losing at least 10% of initial body weight and maintaining the loss for at least one year.¹⁰ These poor longitudinal outcomes suggest that there may be other barriers that are not addressed by current weight management programs developed for general populations. For different subgroups, such as FM patients, there may be unique needs for weight management programs.

With chronic pain, fatigue, and a multitude of other FM symptoms adversely affecting QOL, patients with FM often fear exercise and are sedentary. FM patients are significantly less physically active than healthy controls¹¹ and have high rates of comorbid depression.¹² Factors associated with depression (e.g., low motivation) impede motivation to participate in or continue with a weight management program. This phenomenon may be particularly pronounced if a weight management program fails to include modules, intervention, or subtle awareness of these factors in its delivery.

To create an effective and successful weight management program for women with FM, it is important to understand underlying behavioral, psychological, physical, and dietary barriers; their readiness for behavior change; and their preferences for a program. To our knowledge, there has not been any study on barriers, needs, and preferences of obese women with FM for weight management. The goal of the current study was to go back to the source and find out directly from women with FM their needs and preferences for weight management programs and any barriers they can identify for their participation in such a program.

METHODS

Design

The current study was a qualitative analysis based on data gathered from focus groups ($N = 3$) conducted with obese

women with FM ($N = 15$). Distinct advantages emerge through the use of focus groups to collect qualitative data as opposed to one-to-one researcher–patient interviews.¹³ A focus group allows patients to respond to one another, which assists in reflection on thoughts and clarification, and it is an ideal method for exploring new ideas that arise in the conversation.

Patients

This study was approved by the Mayo Clinic Institutional Review Board and all patients provided written informed consent. Potential focus group patients met the inclusion criteria: (1) attendance in the fibromyalgia treatment program (FTP) within the prior year, (2) BMI of ≥ 30 , (3) 30–60 years of age, (4) diagnosis of FM based upon either or both of the American College of Rheumatology 1990¹ and 2010¹⁴ criteria, (5) residing in Minnesota, (6) agreed to the Minnesota Research Authorization, allowing contact for participation in studies, and (7) female gender.^{1,15} We included female gender^{1,15} only because FM is more common in women and because of the sensitive nature of obesity as a topic for the focus groups.

Recruitment, response, attrition, and enrollment. See Figure 1 for description of recruitment, response, attrition, and enrollment. In total, 19 patients were scheduled for the focus groups, with 15 attending (Focus Group 1, $N = 4$; Focus Group 2, $N = 5$; and Focus Group 3, $N = 6$).

Measures

Demographic and clinical characteristics. We collected demographic information and clinical characteristics from patients via medical chart review for the inclusion criteria and via self-report questionnaires. From the medical chart data, diagnosis of FM and participation in the FTP were confirmed. Patients reported height, weight, health status, marital status, ethnicity, education level, employment status, and quality of life.

Impact of fibromyalgia symptoms. The Revised Fibromyalgia Impact Questionnaire (FIQR)¹⁶ is a 21-item measure to assess the influence of fibromyalgia on patients over the previous week. Patients rate FM symptoms, difficulty with daily tasks, and impact of FM on an 11-point scale (10 being worst). Scores for each subscale are summed. Summed subscale scores for difficulty in function and symptoms are divided by a set value to weigh each subscale for a total score. The modified subscale scores are summed to create the total score, which ranges from 0 to 100, with a higher score indicating a greater impact.

Depression. The Patient Health Questionnaire 9-Item Checklist (PHQ-9; range: 0–27) is a diagnostic criteria-based measure of depressed mood. It is used to assess severity of depressive symptoms.¹⁷

Weight history. To characterize weight history, we asked patients to complete a questionnaire that focused on weight at different times in life and weight loss attempts. Patients

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