

## **PERSONAL AND RELATIONAL WELLNESS IN A COMMUNITY-BASED WEIGHT LOSS PROGRAM FOR WOMEN: IMPLICATIONS FOR WEIGHT LOSS PROGRAMS**

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### **Abstract**

The purpose of this research was to describe the participants' perspectives of a community-based weight loss program for women. Five focus groups were conducted with participants from the Weight Wise Women program in two community facilities in southeastern North Carolina. Focus group participants (N= 50) from three cohorts of the Weight Wise Women program were between 40-64 years of age, and all had a body mass index of > 25. Data analyses consisted of coding and organizing information from observations, notes and transcriptions into themes. Three broad categories emerged. The first, personal wellness, included learning, health, control over life, and self-efficacy and secondly relational wellness included social and peer structure, support from instructors, and collaboration. The final category was specific comments about the program. Participants viewed this program as an effective way to lose weight. Implications include suggestions for community weight loss programs that could improve participant experiences, outcomes and the health of the community.

### **INTRODUCTION**

Obesity is considered one of the most prevalent health problems for individuals and communities in the United States. In New Hanover County, 60% of adults surveyed were overweight or obese while 48.1 % of females were either overweight or obese (North Carolina State Center for Health Statistics, 2006). In Bladen/Brunswick/Columbus/Pender Counties, 63.2 % of adults surveyed were overweight or obese while 61.3% of females were either overweight or obese (North Carolina State Center for Health Statistics, 2006). Based on the rates of obesity in New Hanover County and Bladen/Brunswick/Columbus/Pender Counties, the need for a community-based weight loss initiative was established.

Community-based weight loss programs have been explored as an option for producing individual weight loss and as a way to address obesity in communities throughout the United States (Graffagnino et al., 2006; Paschal et al., 2004). Faith-based community programs such as weight loss programs held in churches have also been assessed as a way to combat obesity in communities

(Kim et al., 2008; Resnicow et al., 2005; Reicks, Mills & Henry, 2004). To address the community health issue of obesity, a free, 16 week community-based weight loss program designed by the CDC was offered between 2006 and 2009 to women in Brunswick and New Hanover counties. Participants were recruited by physician practices, community advertisements, and word of mouth. Inclusion criteria was a BMI > 25 and to be female, between the ages of 40 to 64. Permission of a health care provider was required if the participant had diabetes or had a history cardiovascular disease.

The Brunswick County program was housed in a municipal building. The New Hanover County program was held in a church, but was not a faith-based community initiative. The program was facilitated by a nurse and a former program participant, both of whom received training to lead the program. Facilitators taught participants about weight loss and management through lessons about nutrition and physical activity.

The concept of wellness has been used to describe the holistic health of individuals and is increasingly being used to discuss the well-being of communities as a whole. In this research, the concept of wellness is used to explore participant participation in a community-based weight loss program. Totikidis and Prilleltensky (2006) propose a community wellness model that identifies well-being on three levels: personal, relational, and collective. Personal well-being includes intrapersonal factors like physical health, love, competence and self-esteem. Relational well-being includes interpersonal factors like social support, affection, belonging, collaboration, respect for diversity and democratic participation. Collective well-being includes economic security, social justice, adequate health and social services, low crime, adequate infrastructure, and clean environment.

In this study, women's experiences with the Weight Wise Woman program were explored by applying two components of the community wellness model: individual and relational wellness. Totidis and Prilleltensky (2006) describe individual wellness as intrapersonal factors like physical health, love, competence and self-esteem and relational wellness as interpersonal factors like social support, affection, belonging, collaboration, respect for diversity and democratic participation.

Much research about weight loss for women is focused on the outcomes related to weight loss with less consideration of the participants' perspectives of the experience. In order to create effective weight loss programs for women, it is important to understand the individual's experiences with weight loss and the program. This is not only salient for formal weight loss programs, but may be essential information to help participants to be successful after the

program's completion. Therefore, the purpose of this research was to describe the participants' perspectives of a community-based weight loss program for women.

## **METHODOLOGY**

### **Weight Wise Women program**

The Center for Health Promotion and Disease Prevention at the University of North Carolina at Chapel Hill began developing Weight Wise Women in 2004 with funding from the CDC. Weight Wise Women is a 16-week behavioral weight loss intervention developed from several evidence based programs including the Diabetes Prevention Program (DPP), PREMIER, Weight Loss Maintenance (WLM) Programs, and the DASH diet. The program focuses on lifestyle behaviors with special emphasis on increasing fruit and vegetable consumption and lowering high calorie, high fat foods. Participants are encouraged to participate in a minimum of 150 minutes of physical activity each week. The program incorporates theories of behavior change by encouraging participants to set weekly achievable goals, build self-efficacy and confidence, and engage in group activities focused on problem solving. The weight loss program specifically addressed planning meals, overcoming psychological barriers to weight loss such as stress, balancing calorie intake with energy expended, increasing exercise, and overcoming negative social influences.

The Weight Wise Women participants observed in this study attended 1.5 hour sessions once a week for 16 weeks. Sessions typically consisted of three components: education, physical activity, and meal preparation. The program was facilitated by two females within the age range of program participants. One facilitator was a health professional with a background in nursing and health education and the other had training in education and weight loss programming. Both program facilitators were available during meetings and outside of the normal meeting times to answer participant inquiries.

### **Data Collection**

While triangulation of methods included observations and field notes, focus groups were chosen as the primary research method. Due to the number of participants (n=50), focus groups were the most time efficient and cost effective method of exploring the experiences of participants. During the 15<sup>th</sup> week of the program, five focus groups (one pilot) were held after the Weight Wise meetings. The focus group moderator conducted observations of the meetings held immediately before the focus groups (except for the pilot focus group) to understand group dynamics and to

take notes. Institutional Review Board approval was given for the focus groups and participants gave informed consent before participating in the focus group.

The focus groups were conducted by the focus group moderator and the co-moderator was responsible for distributing and collecting consent forms, creating a seating chart for participants and taking detailed notes during the focus groups. The interview guide that focused on questions about participants' experiences with the Weight Wise Women program included round robin check-ins and check-outs, which served as ice breakers and then summaries as well as 11 open-ended questions.

Examples of questions from the focus group guide were "What were your reasons for participating in the Weight-Wise Program?"; "What did you learn during the Weight-Wise program?"; "How did goal setting affect your participation in the program?" "What did you like most about the Weight-Wise program?" and "What was your greatest barrier to succeeding at weight loss?" While there was an interview guide with pre-set questions, the focus group moderator encouraged the discussion to flow naturally.

Information from participants was audio-taped and transcribed by the co-facilitator. The co-moderator used the seating chart and notes to help identify who made each statement. A debriefing session was held immediately after the focus groups that included the moderator and co-moderator. Notes taken by the moderator from meeting observations and during the focus group were expanded to more detailed notes after the focus groups were completed.

## **Sample**

Each participant was pre-screened before beginning the program. The women answered a series of self-report questions about their health history, diet, physical activity, and weight management behaviors, and psycho-social attributes. Height, weight, blood pressure, and body composition was also measured before and after the program. In the three cohorts of the Weight Wise Women program, 50 participants attended the focus groups. For the participants in Brunswick County, the mean age was  $55 \pm 7.1$ , and 77% of participants were white, 19% were black and 4 % were Hispanic, all had a high school diploma/GED or more education, 50 % earned between \$10,000-29,999, and a majority had health insurance. In New Hanover County, the mean age was  $54 \pm 6.7$ , 71% were white, and 29% were black, most had a High school diploma/GED or more education, 29% earned between \$10,000-29,999, and 75% had health insurance.

## Data Analysis

This study was conducted to achieve more complex understanding of the experiences of the women participating in the program. To accurately represent the participants' perspectives and to bolster internal validity, analyst triangulation (Patton, 2002) was employed by having three practitioners analyze data including the focus group moderator, a program evaluator and program assistant/co-moderator.

First, the program assistant/co-moderator transcribed the focus groups verbatim and referred to focus group seating charts to assure accuracy. Next, content analysis consisting of reviewing transcriptions to discover recurring themes (Patton, 2002) was employed by all authors. Each author read through transcripts independently and coded through line by line. Initial codes were recorded using the Comment tool in Microsoft Word. Based on patterns in the data, general categories involving individual experiences and their relationships to the group and instructors were identified. Based on these patterns, authors recognized components of the community wellness model. Authors re-read the transcripts and applied the community wellness model in analysis, which led to revised themes that were related to personal and relational wellness.

## FINDINGS

### Personal Well-being

Participants cited elements of personal well-being including the following themes: learning, health, control over life, and self-efficacy that resulted from participation in the program.

**Learning.** At the beginning of each focus group, participants were asked to describe their experience with the program in one word. Many participants said, "educational" or "enlightening." One participant described her feeling about the learning that took place in the program as "we now have informed consent on what we're doing to our bodies." Adams (2008) found acquiring knowledge through a weight loss program was essential for improving eating habits.

In all focus groups, participants reported perceived learning related to portion control, food labels, meal plans, healthy recipes, calorie /physical activity balance, fruit and vegetables, food journals and lifestyle changes. For example, one participant said "The foods that are good for you can also taste good. We had the samples, stuff I would have never sampled on my own." Participants expressed learning about balancing calorie intake with physical activity with statements like "Eat smart and move more, learn how to move more" and "If you're gonna lose anything you have to

burn more than you consume. It's just a simple concept but you know, if you just keep that mind all the time it works." Another woman summarized what many participants expressed as "I learned that you still can eat anything you want but it's basically portion control."

Focus group participants said they learned about planning meals through comments like "when you plan your meals you need to plan healthy meals, and be concerned about your calories because sometimes you eat all your calories in one meal if you don't plan" Another participant said "I've learned to pack my lunch to get me through the entire day."

Food journaling was a topic that participants discussed but they varied about whether they liked food journaling. Participants commented "Writing down the food is very important. That's part, a great part, of your success." Journaling seemed to help the participants understand the relationship of daily food intake and success.

Participants learned about making lifestyle changes through descriptions of the program like "It's not a diet. It's a life change, and they show us how" and "I liked the idea that it was based on changing your lifestyle as a whole rather than just do Slim Fast for a while." Herriot et al. (2008) found a predictor of successful weight loss, was a change in attitude from a 'dieting' to a permanent lifestyle change.

**Health.** The personal wellness component of health was a primary reason for participating in the program. One participant said "My reason for participating in this program is so that I can have longevity in life and be healthier." Another participant said "I want to avoid taking medications and I've been unsuccessful at losing any weight at all on my own and maintaining a correct weight and eating healthy seems to be the way to avoid the diseases that cause people my age to have to be on all kinds of medication." Another participant stated "There's a lot of satisfaction in ending the day knowing that everything you've taken in is healthy." Blixen, Singh and Thacker (2006) found "health" as the primary reason for participants' current attempts at weight loss. In Adams (2008) participants reported an improved sense of health and well-being as an outcome of participating in a weight loss program.

**Control over life.** With much agreement from the group, one participant purported "It just gives you a sense of control." Another participant statement was "I feel better. I had the knowledge before...and I'm back in control." Another women said her participation in the program gave her strength to say to restaurants servers, "You know, I really don't want that fried I want it baked. I don't want it sitting in grease." Another participant discussed the program as "You get to take

control over what you consume and you get to quantify that in a way that works for you and then you get to manage it so it's like running your own business."

**Self-efficacy.** Self-efficacy in general refers to an individuals' confidence in their ability to complete something. A participant discussed self-efficacy that she developed through the program as: My biggest accomplishment is that I now have the tools. I mean, ya'll have made me aware, this program has made me aware of what I need to do. So it's up to me to use these tools and I do have it and I'm motivated.

Other participants discussed self-efficacy as "You realize just from when you lose the first few pounds that it's only because of what you're doing and not any outside source. It's really up to you." Self-efficacy was also described as "no one's gonna do it for me and then when it works you have only yourself to thank." In Adams (2008) weight loss program participants reported strengthened self-efficacy. Reicks, Mills and Henry (2004) found that women felt more confident about maintaining program principles because of personal weight loss and the success of other group participants. Success was also defined by participants having an improved sense of health and well-being, as well as strengthening one's self-efficacy (Resnicow et al., 2005).

## **Relational Wellness**

Participants described components of relational well-being including social and peer structure, support from group, support outside of group and collaboration. Relational well-being includes interpersonal factors like social support, affection, belonging, collaboration, respect for diversity and democratic participation (Totikidis & Prilleltensky, 2006).

**Social and peer structure.** Reinforcement from other program members was significantly important for motivation. Participants liked that the program was comprised of a peer structure. A participant said "One thing was the age structure—it's peers," which was met with agreement from the focus group. She continued "It's not high school skinny minis and those that think they're fat and really aren't. There were criteria that had to be met and it made me feel more comfortable."

All participants cited support from the group as a significant, positive factor in their experience with the program. For example, one participant described support in the group as "fellowship," which was met with agreement from the group. Other participants agreed by saying "Here is a group and other programs don't have groups" and "It's just totally non-judgmental." Reicks, Mills and Henry (2004) found that confidence for losing weight was achieved with interaction with other group members sharing experiences, and being supported. The findings in

this study were also supported by Ely et al. (2009) who found that participants stated that group support and inclusiveness were essential to effective weight control programs.

Participants described liking weekly meetings through statements like “I don’t have a social life so this was nice for me. At least I have a group of women that I saw once a week” and “I met new people and that’s important to me.” Hayward et al. (2000) found that support networks were important to the women when joining organized weight loss programs.

**Support from instructors.** Support received from instructors was discussed often in the focus groups. One participant said “She encouraged us even if it (weight) was up a little bit or you didn’t lose as much as you wanted to; it was always you’ll do better next time.” Other participants commented on the instructors through statements like “they bring out good points and ask us questions” and “they were supportive.” Adams (2008) describes formal support as professional leaders/investigators and other women participating in a weight loss program.

**Collaboration.** Collaboration between participants and instructors influenced the program. A participant talked about collaboration as “I liked hearing the other people’s ideas and what they were doing. I just thought they were so creative and fascinating. You know, the support.” With agreement from the group, another participant added “Just hearing different eating plans or their recipes. It was just very encouraging and you just learned so much that you could take those things for yourself.” Adams (2008) discussed that participants negotiated support through compromise and/or mutual agreement.

### **Implications for community-based weight loss programs.**

The following suggestions for programming and implementation of community-based weight loss programs are based on participant feedback.

**Free or low-cost programs.** Community weight-loss programs may be more appealing to potential participants when they are offered for free or at a low-cost. In this study, participants purported that Weight Wise Women program was unique compared to other weight loss programs because of the cost and convenience. Participants noted the program was better than most because it was free. There were a wide range of reported incomes of participants, which were less than 10,000 to more than 70,000 dollars per year. Free to low-cost of programming would make the program accessible to all members of the community regardless of income.

As noted earlier, 50 % of participants earned less than \$30,000 per year. Therefore, the cost of a weight-loss program and the expense of eating healthy and exercising may have been a

significant concern from some participants. The Weight Wise Women program was originally designed for participants with a gross income less than or equal to 200% federal poverty level. Thus, the curriculum and facilitators were sensitive to participants' needs to eat healthy foods on a budget. In addition, facilitators were trained to help participants address barriers to weight loss associated with socioeconomic challenges through goal setting and problem solving.

**Convenience.** Community weight-loss programs should be convenient to participants. Through observations and notes, we observed that the Brunswick County group consisted of many participants that worked on the site where the meeting was held. This seemed to lead to increased morale, cohesiveness and participation in physical activity with each other on lunch breaks or after work. Because it seems to promote collective wellness, it may be helpful to locate community weight loss programs close to work or home with access to public transportation.

**Physical activity opportunities.** If possible, community weight-loss programs should include some type of physical activity. One way that members of the focus groups thought the program could be improved was through adding more physical activity opportunities and equipment. Turner et al. (2008) found in an interdisciplinary wellness program, the more exercise classes attended the greater weight loss. Throughout the program, participants were offered and given free passes to local gyms, however, very few participants used the passes. For many participants, cost was a concern and they may have felt that even if they tried the facility that they could not afford to join. In order to increase physical activity in communities, access to exercise and/or recreational facilities must be free or offered at low cost and communities must strive to increase green space.

## LIMITATIONS

One obvious limitation of this research was the convenience sample from five cohorts of the Weight Wise program and is not representative of all women in weight loss programs. However, facilitators of weight loss programs may find this study valuable as a model for learning about participant experiences and for planning intervention efforts for community-based weight loss program.

Another limitation of this study was the self-report method of data collection of participants that chose to participate. The responses may have been influenced by participants providing responses they deemed as favorable. This is especially important since they were invited by the programs facilitators to participate in the focus groups. The overall evaluation of the program also included pre/post surveys and biomedical outcome measures that will be reported after follow-up

data is collected. The qualitative data for the focus groups and quantitative data will be combined to provide a complete understanding of the effectiveness of this program.

### CONCLUSIONS/IMPLICATIONS

Community-based research has indicated the need for community-based programs that address nutrition and physical activity to decrease behaviors that put individuals at risk for obesity (Paschal et al., 2004). Participants that completed a structured community-based weight management program were found to lose weight and reduce cardiovascular risk factors (Graffagnino et al., 2006). Community-based weight loss programs implemented in church settings have successfully recruited and retained participants and have shown positive health behavior changes (Resnicow et al., 2005). Based on the participants' experiences, recommendations on how community weight loss programs may contribute to the management and prevention of obesity are provided.

In conclusion, findings from this study indicated that the benefits of participating in the program extended beyond weight loss and included both personal and relational wellness. This study provided the unique perspectives of the participants that can be used to improve the effectiveness of the program. Effective community-based weight loss programs have the potential to improve the health of individuals and may be a key component in decreasing obesity rates in our communities.

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