Using a Couple-Centered Approach to Facilitate Modest Weight Loss in the Overweight and Obese

by
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Abstract

Overweight and obesity contribute to the risk of heart disease, diabetes, and other serious chronic health problems. Among adults, married and cohabiting people represent the majority of the overweight and obese people in the United States. Modest weight loss of 5-10% of body weight contributes to a reduction of health risk factors. Nurse practitioners, traditionally health educators, may help their patients to appreciate the value of weight loss by using a couple-centered approach to facilitate behavioral adjustments that incorporate dietary changes and physical activity as a lifestyle toward improving overall health.
Using a Couple-Centered Approach to Facilitate Modest Weight Loss in the Overweight and Obese

The Overweight and Obesity Problem

Overweight and obesity are pervasive health problems in the United States. The prevalence of overweight and obesity has risen steadily over the past few decades. Results from the 1999-2002 National Health Examination Survey indicate that a record 65% of adults are either overweight or obese. This represents a dramatic 16% increase from the 1988-1994 age-adjusted survey. The Centers for Disease Control and Prevention (CDC) suggests that being overweight is associated with serious health conditions, including type 2 diabetes, hypertension, heart disease, stroke, certain cancers (breast, endometrial, prostate, and colon), osteoarthritis, sleep apnea, and breathing problems. Social stigma, discrimination, and psychological problems are also associated with obesity. The medical cost of obesity in the United States for the year 2000 was estimated to be $117 billion.

Body mass index (BMI), expressed as weight/height (squared), is commonly used to categorize overweight (BMI 25.0-29.9) and obesity (BMI >29.9). One of the national health objectives for Healthy People 2010 is to reduce the prevalence of obesity among adults to less than 15%. The rate of obesity, defined by a BMI of >29.9, has, however, risen from 23% in 1994 to 30% as of 2002 (NCHS, 2005). Concurrently, the proportion of adults aged 20 years and older who are at a healthy weight (BMI 18.5-25) decreased from 42% in 1988-1994 to 34% in 1999-2000.
Taking marital status into consideration, 71% of married men and 54% of unmarried men are overweight. In contrast, 50% of married women are overweight, compared with 53% of their divorced or separated counterparts. The statistics for cohabiting unmarried couples are less pronounced, but still significant, with 66% of unmarried men and 48% of unmarried women being overweight. Obesity rates for married people are similar to that for cohabiting unmarried people, 22% and 21%, respectively. Married men may benefit the most from weight loss since over 70% of them are overweight. Almost 50% of women, married or not, are also overweight and can benefit from weight loss.

Marriage and cohabitation are social institutions that by their very nature imply a sharing of environment and indeed life itself. It is therefore not surprising that couples experience many of the same disease states as a result of shared environment, similar diet and activity levels. Family nurse practitioners are in a unique position to intervene with couples by virtue of their family-focused educational preparation, preventative health focus, and traditional patient-teaching role.

Co-habitation and health concordance

Understanding the relationship between these social institutions and shared environments may assist the family nurse practitioner in identifying some of the causal factors that account for individual health risks. For instance, shared environment may account for the higher risk of coronary artery disease (CAD) of female partners of men with premature myocardial infarction. In fact, significant concordance has been identified between patient and spouse pairs for BMI, smoking history, exercise habits, and amount of fat and fiber in the diet. A cross-sectional study of 8386 married couples found that individual participants were significantly more likely to have asthma, depression, hypertension, hyperlipidemia, or peptic ulcer disease if their marital partner
had the same disease. After adjusting for age, smoking, and BMI, the findings suggested that diet or the pattern of physical exercise shared by couples played an important role in the cause of hypertension and hyperlipidemia. There was a strong correlation between married partners for BMI, even after adjusting for age. Similar studies of married couples confirm spousal concordance for obesity, blood pressure, blood glucose, and lipids. The authors suggest that screening spouses for overweight and related diseases needs to be considered.

A Canadian study reported significant spousal correlations for increasing overweight over the seven year period of the study involving 376 pairs of spouses. Spouses of individuals who became overweight had a 50-70% greater chance of also becoming overweight, relative to the general population risk. Cohabitation effects were found to be important in explaining these increases in BMI. A study examining cross-sectional and longitudinal associations between BMI, diet and exercise habits, and marriage in 2500 married people found that shared environment is at least partially responsible for the correlation between BMI and marriage. The researchers observed a weight gain among people who became married during the study. They concluded a plausible explanation for this was that marriage “increases cues and opportunities for eating because married people tend to eat together and thus reinforce each other for increased intake”.

**Weight loss**

Recent trends in the treatment of the overweight and obese have emphasized the benefits of a modest weight reduction of 5-10% of body weight. Lifestyle modification that leads to such modest weight loss has been shown to have a beneficial effect on cardiovascular risk factors associated with obesity. Modest weight loss can delay or prevent the appearance of type 2
diabetes or hypertension. Blood pressure can normalize with a 5% weight loss even without reaching ideal weight. A sustained moderate weight loss of 10% reduces insulin resistance and lipid values. Any disease associated with excess body fat is more easily controlled when moderate weight loss is achieved and maintained.

The value of modest weight loss should come as very good news to overweight couples, but the research on the value attributed by individuals to modest weight loss shows us otherwise. Patients often attach higher value to higher degrees of weight loss. The self-esteem and self-image of the overweight or obese person contributes to the devaluing of modest weight loss as they visualize themselves becoming thin and admired in society. One study of 397 obese patients found that they felt the need to lose 38% of their weight on average to achieve their self-imposed weight loss goal, and 25% to achieve a weight that was acceptable in their own mind. Another recent study revealed that only one-third of obese primary care patients valued modest weight loss.

Nurse practitioners in primary care may significantly influence patient health behavior. More than two-thirds of the typical NP visit involves communication and interpersonal activities with the patient. Nurse practitioners, traditionally advocates for preventative health, must help overweight and obese patients to understand the value of modest weight reduction. Changing health behavior is often a struggle. Patients need to understand the importance of incremental life-style change and have their confidence bolstered in order to implement that change. NPs have the skills and knowledge to empower patients to make the small but significant changes that are needed to lose 5-10% of body weight to improve health. When those patients have a spouse or partner, nurse practitioners should sensitively address the problem of overweight and obesity
as a couple’s problem rather than solely as an individual’s problem to facilitate permanent life-
style change.

**The Potential Benefit of a Couple-Centered Approach**

Behavioral changes to reduce weight and minimize health risk associated with overweight and obesity must be sustained long-term. This is very challenging for most people. Finding ways to help patients make permanent life-style change is essential. Changing our focus from the individual to the couple could help.

Health care providers typically have appointments with individual patients and, in the context of a limited amount of time, assess, diagnose, and counsel patients as individuals. Focus on individual care has impeded exploration of treating patients in their social context. Systems of social support are paramount to promoting long-term change. Having a partner who is cooperative and making the same changes can go a long way in reinforcing and supporting change in the individual patient. A supportive spouse can assist in overcoming barriers to change and may encourage the patient’s self-acceptance.

**Couples and lifestyle change: a review of literature:**

There is universal agreement that health-care decisions are made within the context of the family, although research studies that specifically focus on couples’ interventions and therapeutic life-style change are lacking. A systematic review of the literature for family involvement in weight control published in 2003 by the International Journal of Obesity found only 16 randomized studies on family involvement in weight management and interventions, with no studies identified after 1994. In those studies involving spouses, there was generally support for
couples being treated together, focusing on specific behaviors related to diet and exercise patterns instead of focusing only on goals related to weight loss. Considering the well-documented familial link to obesity and obesity-related illness, much can be done to further investigate the effectiveness of couples interventions and therapeutic lifestyle change.

The British Family Heart Study investigated the extent that changes in cardiovascular risk factors correlated among married couples following a one-year family-centered cardiovascular lifestyle intervention. The intervention targeted family systems instead of individuals and found that couples had a strong tendency to make changes together. Middle-aged couples in particular had the greatest benefit from making change together in terms of risk factor reduction. The men or women who achieved the greatest risk factor reduction tended to have spouses who had similarly favorable results. They concluded that lifestyle intervention targeting men and women as couples rather than as individuals could result in a greater reduction of cardiovascular risk factors through mutual reinforcement of lifestyle change.

Similarly, an intervention for cardiac risk reduction, Partners for Life, examined whether an ongoing, long-term relationship can be used to help patients with coronary artery disease adhere to lifestyle changes. The study’s approach to this problem was Cognitive Behavioral Couples Therapy. The main premise of this intervention is that there is a relationship between couple’s health and couple’s satisfaction, with improvement in one likely to positively affect the other. The intervention is also based on clinicians improving outcomes by including a partner into a treatment plan for long-term success. In addition, the needs of the partner are taken into consideration in order for treatment to be maximally effective, and couples are helped to cope with change. In practice, this means that the couples are taught to work together to change their physical and social environment as well as learn strategies to reinforce behavior in a positive
manner. Skills in stress management and couple communication are emphasized. The researchers believe that enlisting the most important relationship in a person's life will make a difference in long-term adherence to lifestyle change.

In response to the need of understanding how couples change together, a recent qualitative study conducted by advanced practice nurses involving forty long-term married couples sought to understand the communication and negotiation that occurs between long-term spouses in making health care decisions. Among the forty married couples examined, 73% stated they made their health-care decisions as a couple. Final decision makers concerning health care issues were the wives 60% of the time, with the women assuming a kind of “gate-keeper” role in the relationship. The majority of women wanted to change some aspect of their spouse's behavior, while men tended to assume a more passive role. The researchers concluded that it is important to explore decision-making patterns with a couple and include spouses in counseling and health promotion whenever possible. 23

Married older couples tend to be similar in their physical activity levels, especially as it relates to deliberate exercise behaviors. The explanation for this could be that people tend to choose mates that have similar interests or with similar socioeconomic or environmental advantage. The explanation may also lie in how partners initiate and sustain each other's behavior. 26

A qualitative study involving younger childless, dual-income earning couples in Great Britain 26 supports the thesis that cohabitation offers an opportunity for making healthful changes. Couples differed in methods of negotiating dietary patterns in their quest to live and eat together. The authors suggest that dietary counselors should ask questions to understand how food
decisions are made by couples. Counseling regarding these changes should take place within the context of the couple instead of the individual client.

These findings may not apply to all couples, but none-the-less they demonstrate that exploring the decision-making processes among couples and utilizing their strengths may help to facilitate change. With such congruence, social support will be realized, and long-term adherence to positive health behaviors, specifically diet and exercise patterns, will be more likely.

**How couples negotiate change**

Couples usually share decision-making processes in a dynamic, interactive, and on-going way. Decisions are hidden in everyday life and often do not occur deliberately, rather decisions are precipitated by the tasks and demands of daily living. Although there may be little attention to the process, couples communicate and make decisions continuously. In healthy relationships, there is less conflict involved in the decision-making process as time passes, signifying greater interdependence between the couple. They develop a “shared reality”. When changes must be made for the benefit of one person, a partner may automatically make adjustments in order to assist the other. For example, a person diagnosed with congestive heart failure will be prescribed a low sodium diet, and the partner will make adjustments in his or her own diet to be supportive.

Spousal influence is considered to be of primary importance in the couple decision-making process. It can be conceptualized as the result of the communication process through which partners are able to pursue their common goals and to describe their interactions in terms of the impact of one person’s life events on the other’s sphere. Influence over marital activities is one aspect of marital power, but it is can be intentional or non-intentional. It may include
persuasion, negotiation and bargaining, and compliance-gaining. It is most often reciprocal.\textsuperscript{28}

Even in traditionally male-dominated marriages, health behavior decision-making is shared to a large extent. Typically, with the passage of time the couple becomes more interdependent.\textsuperscript{23}

Most people desire to change something about their partner’s behavior. Various strategies that are employed include talking, reminding, watching, worrying, or controlling to name a few. The use of persuasion and negotiation are dominant, however, and are considered to be positive communication strategies. Resolution of conflict tends to be less emotional as couples are together longer. Effective persuasive communication creates a climate favorable to the desired change in behavior. Couples tend to compromise and seek equity in decisions.\textsuperscript{23}

As couples age, health problems for one or both partners arise, and couples may find themselves needing to make life-style changes to improve or maintain health. As health problems occur, one person may take on the role of the “patient” and the other takes on the role of the partner. This concept of support has been studied, and various conclusions about marital interactions have been reached. In a study examining the spouse’s role of support during recovery from a coronary heart disease event, different views of the spouse’s role emerged. These included the participative role, taking an active part in life-style changes in an empathetic and positive manner, the regulative role, controlling the partner’s behavior, communicating authoritatively, and the dissociative role, negative about changes and declaring a reluctance to be involved in the partner’s change of lifestyle. The three main themes of their findings were spouse support, communication patterns, and attitudes toward lifestyle changes.\textsuperscript{29}

Similarly, a study examining marital interaction in the process of dietary changes for diabetics identified three couple categories. Cohesive couples worked together and shared tasks, negotiated roles, and demonstrated flexibility with dietary changes. Enmeshed couples did not
share roles, and the non-diabetic spouse was responsible for managing the diet of the diabetic spouse, who remained passive and dependent. Disengaged couples had little effective communication, disagreed about the rules, did not share roles, and were inflexible about making dietary changes. Although only 40 couples were included in the study, the results indicated that the enmeshed spouse of the diabetic was more likely to be female, but the cohesive and disengaged couples did not show gender differences.\textsuperscript{30}

Couples who participate with each other’s lifestyle changes and demonstrate cohesiveness lend the most social support to make and sustain therapeutic lifestyle change. Weight loss induced by healthy diet and regular exercise is best accomplished in the setting of the family. The nurse practitioner in primary care can identify those patients who have a supportive relationship with a committed spouse or partner, provide informative counseling regarding the health benefits of modest weight loss, and facilitate mutual participation in making changes as a couple.

\textbf{Using a Couple-Centered Approach in Primary Care}

Assessment of the overweight or obese patient should include an evaluation of the social support system and ideally the presence of a spouse or partner. Spousal support has been shown to have a significant impact on adherence to dietary changes, food selection, and meal planning. The perceived significance placed on the importance of diet and exercise by the partner is as strong a predictor of the patient’s success as are the patient’s own perceptions.\textsuperscript{31} Therefore, it is important to assess the degree of such support when interviewing patients. The NP may start by including a social history in the initial assessment, taking note of the presence of a spouse or partner.
Determine the decision-making pattern of the couple for past health-related issues. For example, ask an individual if he or she usually makes decisions alone or if they rely on their spouse or partner to help in decision-making. If joint decision-making has been used in the past, it would be beneficial to include the partner in health-behavior counseling. Asking questions to gain understanding of a couple’s communication patterns will help the NP to determine if support is present. For example, use open-ended questions such as, “When your partner wants to change something about you, how does he or she go about it?”, or “In what way do you rely on your partner when it comes to improving your health?” When it has been determined that a patient has a partner with the potential to work cohesively on health issues, the NP can proceed to assess the level of readiness to change, as described by the Transtheoretical Model of Change.

The NP who matches interventions with readiness to change will have better outcomes, i.e. couples who consider and implement change together. The stages of change include precontemplation, when the patient is either ignorant of the nature or extent of the problem or unwilling to change; contemplation, when a weighing of the pros and cons of behavior change are considered; preparation, when a commitment to change is made, action, when the plan is implemented; and maintenance, when change is integrated as lifestyle. If a patient expresses ambivalence about a desire to make life-style changes, it would be premature to enlist help from a partner. This poses the risk of overwhelming the patient and instigating resistance to change. Instead, give the patient information about the benefits of modest weight reduction and regular exercise on overall health and well-being. Offer support, encouragement, and acknowledge that a decision to change can be made in the future. Reassure the patient that you have confidence that change is possible.
Inclusion of the spouse or partner is appropriate for the stages of change from contemplation through maintenance. At all stages, it is important to emphasize the "team approach" concept with the couple. This implies a shared responsibility for the life-style changes needed. The goal of including one's partner is to promote positive interaction, an attitude of togetherness, and common goal-sharing in the relationship in order to solidify the permanence of life-style change.18

The role of the NP in the change process is one of support, encouragement, and monitoring. The National Institutes of Health recommends a three-step approach for primary care providers focused on communication, assessing willingness to make lifestyle change and establishing goals.32

1. Set an effective tone for communication. Communicating empathy and acceptance without condescension is very important. Ensure that overweight or obese people feel accepted and understood. Solicit permission to discuss weight issues and use terms such as "excess weight" and "BMI" when describing obesity. Discuss weight in the context of general health and well-being.

2. Ask the patient if he or she would consider making lifestyle changes to lose weight and improve health. Ask about previous attempts to lose weight and current level of physical activity. Determine the barriers to successful change they are concerned about. It is at this point that determination of the level of social support from a partner could be evaluated.

3. Establish realistic goals with the patient. Discuss the importance of modest weight loss and encourage realistic goal-setting. Select a few measurable goals, such as losing 5 pounds in a period of 1-2 months, regular to moderate exercise 20 minutes per day on
most days of the week, limiting food portion sizes, and increasing fruit and vegetable intake to 4-5 servings per day.\textsuperscript{33}

Suggesting the inclusion of a spouse or partner to enlist support to control barriers could be easily integrated into a health promotion discussion. Several perceived barriers are commonly identified by couples contemplating change in diet or physical activity behavior. The first is a lack of knowledge. However, an increase in the degree of understanding of the needed changes in dietary and exercise patterns does not necessarily guarantee behavioral change. The two factors that more likely predict behavioral change are family support and availability of healthy foods, and will-power and social factors affecting food choice. Similarly, exercise behavior change was predicted by degree of family support and determination to get active in spite of feeling tired.\textsuperscript{34} The NP who emphasizes the importance of social support with a couple may facilitate their effort to change together.

Encourage the couple to discuss and plan meals, shop for food, and eat meals together as much as possible. Ask them to identify problem eating habits they think may be contributing to their weight problem. Common problem behaviors are eating while watching television, snacking throughout the day, eating after dinner, and overeating at social events. Guide them to discuss strategies to overcome their specific problem behaviors and how they will support each other. Keeping a food journal is associated with better adherence to a diet plan and should be encouraged.\textsuperscript{22}

Couples may enjoy exercising together, or may prefer to pursue their own exercise interests. Emphasize that exercise does not have to be difficult or unpleasant to be effective. Rather, it should be enjoyable and accessible. Brisk walking for 30 minutes on most days of the week should be encouraged. Obese patients often have to build slowly to reach this goal. Lifestyle
activities such as taking the stairs and parking the car farther away from the door contribute to burning more calories.\textsuperscript{22,35}

Initial weight loss is socially rewarding and reinforcing. Maintenance of weight loss for the long term is more challenging and couples will require more support. Advise the couple that successful long-term weight management is associated with a diet low in calories and fat, regular exercise, monitoring body weight, reducing portion sizes, eating breakfast, eating out fewer than three times per week, and watching television less than three hours per week.\textsuperscript{12} Refer patients to the many excellent government-sponsored web sites that have a wealth of information free to the public (see Table 1). It is most helpful to have a sheet of paper listing the web-sites to be handed out to the patient. For those couples that do not use the internet, the NP can develop and provide a set of educative materials.

Lifestyle change is a dynamic process and will require multiple encounters over time. Counseling may be initially integrated into routine preventative care visits, and reinforcement integrated with follow-up visits. Clear documentation of lifestyle change counseling is essential for reimbursement and continuity of follow-up visits. Documentation should include length of the visit, total time spent in counseling, and persons present. Offer to follow up with couples individually or together at a future appointment in one to three months after beginning their lifestyle change. Being available by phone or e-mail for questions and feedback can help them through the inevitable relapses that happen with any lifestyle change. Remind them that relapse is part of the process and they will learn from their mistakes.\textsuperscript{17}
Summary

Overweight and obesity are common among married and cohabiting couples. Health problems associated with weight gain can be at least partially alleviated by modest weight loss. A couple-centered approach to counseling and facilitating lifestyle change may be more effective than merely focusing on the individual patient in achieving and maintaining weight loss in the primary care setting. Nurse practitioners as health educators are in a unique position to intervene with a couple-centered approach.
Table I

Internet Resources for Providers and Patients

1. The Food and Drug Administration’s “How to lose and manage weight” site contains links to various governmental sites that contain helpful information on diet, exercise, and weight loss. Available at: http://www.fda.gov/oc/opa/com/hottopics/obesity.html

2. The US Department of Agriculture’s food pyramid site personalizes a diet plan according to age, gender, and physical activity. Sample menus and a diet tracker are included. Available at: http://mypyramid.gov/

3. The National Heart, Lung, and Blood Institute’s guidelines on obesity management and related publications are listed here with links, as well as free PDA programs related to obesity management and a BMI calculator. Available at: http://www.nhlbi.nih.gov/guidelines/obesity/ob_home.htm

4. The NHLBI’s education program for providers “Assessment and Management of Adult Overweight and Obese Patients”, free after registering. Available at: http://obesitycme.nhlbi.nih.gov/

5. The NHLBI’s web site “Aim for a Healthy Weight” with a link for patients that walks through self-risk assessment, diet and exercise plans, and a link for providers with helpful information on assisting patients in weight loss. Available at: http://www.nhlbi.nih.gov/health/public/heart/obesity/lose_wt/index.htm

7. The CDC addresses the need for physical activity and has a "barriers to being active quiz" which can be printed and used in practice. Available at:

http://www.cdc.gov/nccdphp/dnpa/physical/life/overcome.htm

References


