A Qualitative Study Comparing Commercial and Health Service Weight Loss Groups, Classes and Clubs.

Abstract

Background: Group-based interventions for weight loss are popular, however, little is known about how health service groups compare with the commercial sector, from either the participant or the group leader perspective. Currently health professionals have little guidance on how to deliver effective group interventions. The aim of this study was to compare and contrast leaders' and attendees' experiences of health service and commercial weight loss groups, through in-depth interviews and group observations.

Methods: Purposive sampling, guided by a sampling frame, was employed to identify diverse groups operating in Scotland with differing content, structures and style. Data collection and analysis took place concurrently in accordance with a grounded theory approach. Thirteen semi-structured group observations and in-depth audio-recorded interviews with 11 leaders and 22 attendees were conducted. Identification of themes and the construction of matrices to identify data patterns were guided by the Framework Method for qualitative analysis.

Results: Compared with commercial groups, health service "groups" or "classes" tended to offer smaller periodic fixed term groups, involving gatekeeper referral systems. Commercial organisations provide a fixed branded package, for "club" or "class" members and most commercial leaders share personal experiences of losing weight. Health service leaders had less opportunity for supervision, peer support or specific training in how to run their groups compared with commercial leaders **Conclusions**: Commercial and health service groups differ in access; attendee and leader autonomy; engagement in group processes; and approaches to leadership and training, which could influence weight loss outcomes. Health service groups can provide different group content and experiences particularly for those with chronic diseases and for populations less likely to attend commercial groups, like men.

Introduction

How health services can best support patients to lose weight is under debate. The UK National Institute for Health and Clinical Excellence (NICE) guidelines for preventing and managing obesity call for more interventions to be undertaken in 'real world' everyday clinical and non-clinical settings (National Institute for Health and Clinical Excellence, 2006). Studies should investigate how the setting, mode and source of delivery influence effectiveness and consider the value of corroborative qualitative evidence (National Institute for Health and Clinical Excellence, 2006).

In the UK, primary care obesity is under-recognized and under-treated (Laws and Counterweight Project, 2004). Few patients are referred to external sources of support and the majority of management is by brief, one-to-one, opportunistic and unstructured interventions from practice nurses. The extent to which group-based

interventions for weight management are applied in health service settings has not been quantified. In the private sector, commercial weight management groups are well established and some studies have explored the experiences of those attending them (Gimlin, 2007,Herriot, *et al.*, 2008,Hunt and Poulter, 2007,Tod and Lacey, 2004). In contrast health service groups are sporadic and little is known about the perceptions and experiences of those attending or running them. In the absence of health service groups, partnership schemes with commercial groups have evolved e.g. slimming on referral, and improved short-term weight loss outcomes have been reported (Hunt and Poulter, 2007,Lavin, *et al.*, 2006).

There are examples of effective group interventions in diabetes education (Deakin et al., 2005) and smoking cessation (Stead and Lancaster, 2005), however evaluation of effective group processes has received less attention. Groups offer the potential to reach more people and are a model of treatment that facilitates peer support. A systematic review of group versus individual treatments for obesity identified five randomised controlled trials, however they focused primarily on weight loss outcomes and provided little insight into characteristics and processes that might enhance effectiveness (Paul-Ebhohimhen and Avenell, 2009). For commercial groups there is some evidence for an effect on self reported behaviour (Pallister *et al*., 2009) and evidence of long-term weight loss for attendees (Heshka, *et al.*, 2003,Truby, *et al.*, 2006).

Health professionals intending to set up groups for weight loss are not currently guided by research evidence on how to organise and deliver the most effective programmes. In addition, the perceptions and experiences of those running and attending weight loss groups, and contrasts between the commercial and health service settings, have not been extensively explored. The aim of this qualitative

ethnographic study was to compare and contrast leader's and attendee's experiences of health service and commercial groups through in-depth interviews and group observations.

Methods

Semi-structured group observations and in depth interviews with group leaders and potential, current and recent past participants (defined as group attendance within 12 months) of health service and commercial groups were undertaken. One lay-led community group was included for comparison. The purpose of the group observations were a) to collect data to contextualize interviews, b) to recruit leaders and participants c) to triangulate between data sources to improve the rigor of our analysis (Mays and Pope, 2000). Group documents were used to inform and triangulate all stages of the study.

Sampling and recruitment

A sampling frame was constructed to purposively identify health service and commercial weight loss groups with diverse characteristics and processes, serving inner city, town and rural populations with a range of socio-economic profiles in Scotland. All except one of five commercial organizations and their group leaders agreed to participate. A lay-initiated group was included as a deviant case and to search for differing perspectives.

Following each group observation, all attendees were invited to volunteer for interview at a mutually convenient time and place. Participants were selected using a sampling frame to ensure maximum variation in gender, age, variety of groups

attended, length of attendance and degree of overweight. To understand the perspectives of overweight individuals not currently attending groups , adverts were posted in locality General Practices to recruit ex-group attendees and overweight individuals who did not regard commercial or health service groups as suitable. The study was approved by the Grampian Research Ethics Committee (Reference number 06/46) and data were collected from June 2006 to May 2007.

Data collection and analysis

The researchers developed a semi-structured interview topic guide and group observation tool, derived from a literature review and experience conducting group observations in another study (Hoddinott*, et al.*, 2009) and two pilot group observations and interviews. Observations about the venue, surrounding locality, age range, gender and number of participants, leader and attendee interactions, content and style and reflections on group processes were documented.

Five group attendees chose a telephone interview and all others were face-to-face. Audio-recorded interviews lasted 30-80 minutes, were anonymised and transcribed verbatim. The researchers independently reviewed five early transcripts to identify initial themes, and agree a coding index which was applied to all the transcripts and observation data using QSR NVivo 7. Participant selection, data collection and analysis then proceeded iteratively in accordance with the principles of grounded theory (Strauss and Corbin, 1990), through discussion at team meetings. Adjustments were made to the interview topic guide and sampling strategy to inform the emerging analysis and to search for disconfirming cases (Mays and Pope, 2000) thus alternative explanations were continuously sought. Interviewing ceased when theoretical saturation was reached for women's group participants and leaders, however fewer

men (attendees or leaders) were identified and theoretical saturation could not be met. Theoretical saturation occurred when no new relevant data emerged, the categories were well populated with data and the relationships between the categories were well established (Strauss and Corbin 1990). Towards the end of data collection, matrices were constructed in Microsoft Word with participants and leaders grouped according to commercial or health service group (rows) and key emergent themes (columns) guided by the Framework Method (Ritchie and Lewis, 2003). Matrices were examined for patterns and associations, which revealed important differences in the discourses used by commercial and health service group leaders and attendees. Data were then systematically searched to analyse these discourses and a typology of group styles was constructed.

Results

Group and participant characteristics

Table 1 details the characteristics of the observed health service, commercial and community groups. Of 13 group observations, one person led two of the health service groups and another led two of the commercial groups. For one of the health service groups the leader consented to an interview but no attendees volunteered to participate. This leader had recently finished running a men-only health service group, and whilst this group was not observed, to maximise sample diversity, two male attendees were recruited. Table 2 summarises the characteristics of the group leaders (n=11) and participants (n=22) who were interviewed and the type of group from which they were recruited. Of the 22 participants, 16 had experience of attending several different commercial groups, 10 had experience of a health service

weight loss intervention (one-to-one or group) and three had experience of groups that were neither commercial nor health service. One health service leader had past experience of attending a commercial slimming club. Some commercial leaders had past experience of attending other commercial groups but none had attended a health service group. No leaders described experience of working together e.g. where patients are referred by the NHS to commercial organisations. Predominantly middle aged women attended all groups unless advertised as for men only. Younger adults were observed more often at commercial groups which were more likely to be held in the evenings, whereas older people were more often observed attending health service groups. With one exception (where group numbers are restricted to less than 12 per session to allow for more intensive small group work), commercial groups were larger with 15-25 attendees and attendance was reported as constant over time. In contrast health service groups were small with 3-8 attendees and a reported tendency for attendance to decline with time.

Group organisation within health and commercial systems

The majority of health service leaders had initiated, organised and developed their own group programmes. This autonomy resulted in diverse group characteristics and styles. In contrast, commercial head offices initiated, set up and managed groups, with the leader focusing on delivering a fixed package. The majority of commercial groups had paid or volunteer assistants unlike the health service, where administrative support and back-up were rare. For most health service leaders, running weight loss groups was a small part of their job, with some giving up their own time which could result in ambivalence. In contrast, commercial leaders often reported that it was their

only employment and their enthusiastic descriptions of their role could be interpreted as vocational.

'I didn't realise I had quite a talent for it, I enjoyed it because I loved people, loved being able to help them, understanding them...great challenge because they do want to listen and they do want to take your advice as though it's God.' (Commercial leader 2)

Some health service leaders mentioned a lack of value and recognition from colleagues in relation to the time, commitment and effort required, and they felt the need to justify their work. They perceived the commercial sector as being better resourced.

'When you give the results [to others in the practice], people tend to put very hard criteria onto what's successful and what's not, you know they say....well if you're only helping a third of people losing weight up to 10%, well that's not very good, when in actual fact that's fantastic' (Health service leader 5).

Primary care leaders often provided attendees with health care outside the group setting and believed that this provided a more holistic service beyond weight management, particularly for patients with diabetes or hypertension. Attendees confirmed the broader focus on health. In contrast, commercial leaders focused on weight loss and marketing or selling their specific diets and branded support materials like magazines and food. They described formal policies of proactively 'phoning or writing to new members or those who were struggling or stopped attending.

Becoming a group leader

With one exception, all commercial leaders had personally experienced being overweight and successful weight loss was described as a key motivator in the transition from group member to leader. This rite of passage was not described by health service leaders and few had personal experience of being overweight. Perspectives on the relevance of leader personal weight experiences differed between commercial and non-commercial leaders, and between men and women attendees (Table 3).

Health service professional qualifications varied (Table 1) and becoming a leader ranged from being delegated by management to innovative champions. Providing training for staff new to running weight management groups was not a priority within some health service organisations.

'When I got into the new Practice Nursing role…and it was given to me [this big folder], and said would I like to do some weight management groups, no training or anything' (Health service leader 3).

Most commercial group leaders described similar unanimously positive training experiences, with no formal qualifications required unless they intended to deliver an exercise session. They described a standardised training package designed and directed by company head office, with regular top-up training events providing valued leader networking opportunities and peer support. They received on-going supervision including group observation and member feedback.

'I think one of the best parts of the training is, not the actual training but the fact that you can sit and speak to everybody and you can bat things off of each other.... So you can troubleshoot if you like between yourselves, because members are the same regardless of where you go in the country' (Commercial leader 1).

Health service leaders described varying self-directed experiential learning, predominantly on the job and in isolation without supervision or formal opportunities to share learning and fewer opportunities for peer support. Several described drawing on previous experiences of teaching students, of transferring knowledge and skills from their one-to-one clinical experience and from other courses including leadership training, motivational interviewing and presentation skills. Only one described generic group facilitation skills as part of health visitor training.

Differing values around group access and engagement

There were key defining differences in observed and reported access to groups, which reflected their underlying philosophies of marketing and promoting health (Table 4). Analysis of interview data revealed differing values about how time was spent in group meetings. Health service leaders perceived that they could offer attendees greater time, support and individual attention. Some attendees valued this, however several placed a higher value on a continuously available service which they could dip in and out of either with anonymity and minimal group engagement or with family and friends. Some perceived the health service as having inadequate resources to offer a weekly continuing service but described groups with limited sessions at a fixed time and place as inflexible.

'The hours probably wouldn't suit…..I mean I don't leave my work until five o'clock at night………it [the health service] would need to be more user friendly I think than it is just now' (Attendee 6. Commercial slimming group).

Some men preferred health service "men only" groups because they felt commercial groups were aimed at women and they were unsure if they would benefit from female group interactions.

'And it was good in as much as it wasn't like (names of commercial groups) which is predominantly women, with no disrespect, but I thought the atmosphere was a lot better and it was only a bunch of guys there' (Attendee 5. Men-only health service group).

Group purposes and processes

The main purpose of all groups was to help attendees to lose weight. An additional aim for commercial groups was making a profit through marketing their brand. For the health service additional aims included targeting hard to reach groups (deprived areas, men) and improving wider health outcomes through lifestyle change. When introducing our research we used the words "group" and "leader" or referred to the person "running the group". However, interviewees used a variety of terms to describe their respective groups including 'class' and 'club'. By comparing and contrasting discourses a typology of three group styles emerged (Table 5). Few of our observations strictly adhered to one style and there was overlap. Clubs and classes predominated in the commercial sector and groups and classes predominated in the health service. In the commercial sector leaders described themselves as class

managers, teachers, counsellors and consultants. Health service leaders were more likely to mention group facilitation, with some referring to teaching and counselling. Our observations revealed differing ambiences with health service groups tending to be more intense and participants mentioning a lack of 'buzz' which they perceived as due to the smaller size. All leaders were very committed, took an active interest in attendees' life stories and described 'giving a performance' which, as a consequence, could be 'emotionally draining'. A common frustration expressed by leaders in both sectors was that people were not taking responsibility and expected a 'quick fix'.

'They are expecting you to give them the answers and then almost as if it is our responsibility for them to lose weight' (Health service leader 4).

Weighing and exercising

Commercial groups focused more on the 'weigh-in' (Table 5) whereas health service groups varied, with some leaders deliberately not weighing to avoid what they perceived as a "parent-child relationship" and preferring a more interactive adult learning model. However attendees of both health service and commercial groups described being monitored or 'checked' by someone 'strict' as a significant motivator to attending and losing weight.

'It's a constant angel looking over you and that's what you are actually looking for. I know it is a bit ridiculous you know because we are all sort of long in the tooth but it really does help' (Attendee 6. Health service group).

All commercial and health service groups provided information about physical activity. One commercial organisation included an integral aerobic exercise session and one health service groups provided an optional physical activity session delivered by a trained professional after the group session.

Discussion

This study is the first to compare leader's and attendee's experiences of attending a range of UK commercial and health service weight management groups. Observations and discourses differed between commercial and health service groups and they convey meanings about group purposes and the underlying assumptions about how group settings and interactions might change behaviour. Club and class styles predominated in the commercial sector whereas more interactive discussion groups and classes predominated in the health service. Commercial organisations provide a fixed branded package focusing on products (sold and provided) and attendees value their high autonomy and flexibility for choosing how to access and engage with group sessions. In contrast health service "groups" or "classes" offer smaller periodic fixed term groups with diverse styles, developed by individual champions, usually with gatekeeper referral systems and have a healthy lifestyle focus. In commercial groups marketing theory was applied, with adherence to the branded package (Hankinson and Cowking 1993) translating into weight loss, which included selling products with distinctive logos and specific group processes which differentiated their group from other commercial and health service competitors. In the health service the application of theoretical models, behaviour change and weight loss were often much less explicit.

This study recruited across three health board regions of Scotland and may not be representative of other countries or health care systems. In particular there may be other professional disciplines running health service groups and group provision is a rapidly changing service with the increasing government and health care focus on obesity. Wider geographical sampling or multiple observations over time would have been desirable if resources had been available. However participants reported diverse experiences of a wide range of groups throughout the UK. Ethnic minorities and younger adults were under represented and one large commercial organisation did not wish to participate, although some participants had attended their groups. Our sample consisted of 27% men, substantially higher than the 3% group attendance reported in some studies (Bye*, et al.*, 2005), however theoretical saturation for male perspectives on several themes was not reached.

Currently there are no National Health Service guidelines for how weight loss groups should be operationalised and models for delivering behavioural change interventions have not been well tested in group settings (Paul-Ebhohimhen and Avenell, 2009). Attendees desire a "quick fix" and interestingly some research reports of group interventions refer to "treatments" which could reinforce this expectation (Paul-Ebhohimhen and Avenell, 2009). The time limited nature of health service groups is a concern, as on-going support helps to prolong weight loss (Jeffery*, et al.*, 2000). Our study reveals a lack of health service training in group facilitation skills and delivering a behavioural change intervention in a group setting when compared with the commercial sector. Running health service groups is predominantly learnt through experience and transferring theory and skills from other small group predominantly education focused groups (Elwyn et al., 2001). Running groups calls for specific skills that differ from one-to-one skills and health professionals feel ill

equipped to manage obesity (Epstein and Ogden, 2005, Hankey et al. 2003, Mercer and Tessier, 2001). The effect of providing specific training, peer support and supervision to those running health service based weight management groups has not been tested.

The "expert weight loser" background of many commercial group leaders contrasts with the health service "professional with expert theoretical knowledge" leaders. Analogies can be drawn with how the expert patient model and experiential learning in chronic diseases can complement the professional medical model (Lorig, 2002). Group leader's own weight experiences influence interactions with attendees and this should be addressed in health service training. Similarly others report that slim primary care nurses are concerned about lacking empathy or authenticity when managing obesity and larger nurses are concerned about being poor role models despite having greater personal experience and perceived empathy (Brown and Thompson, 2007).

Men differed from women and valued an educational style health service group. They perceived commercial groups as being designed for women and unsuitable, concurring with Australian research (De Souza and Ciclitira, 2005). Men-only groups warrant further investigation as clinically significant weight loss after 8 weeks has been reported (Bye, *et al.*, 2005).

There is no consensus about whether to weigh, not weigh or how to weigh in a group setting. In a review of group processes which does not specifically address groups in health care, groups have been categorized as either task orientated (where either the group or individual members have goals) or socio-emotional groups (where the primary aim relates to the feelings of group members) (Brown, 2000). Our data suggest that although in some commercial groups the primary aim is task orientated;

some commercial and particularly health service groups attempt to combine both task and socio-emotional aims. An either/or binary classification does not appear to fit and the effectiveness of combining tasks with socio-emotional aims in the context of weight management is unknown. Commercial leaders tended to be more hierarchical and advocates of their brand, whereas health service leaders tended to be more autonomous and facilitating (Heron, 1999, Kiiti and Nielson, 1999)

If health service groups are to become more prevalent, then attention to leader training, protected time to extend access and a stronger evidence based theoretical approach to behavioural change in a group setting is required. The needs of men and women may differ with respect to weight management groups and this requires further exploration. Targeting specific populations who are less likely to attend commercial groups, would begin to address inequalities of access, for example those with financial constraints or chronic diseases where a holistic health approach is likely to be beneficial.

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