

Report on best practice approaches to tailoring lifestyle interventions for obese men in the primary care setting

A Resource Booklet for Health Care Professionals
working with obese men in the
Primary Care Setting

**Ms Majella McCarthy &
Dr Noel Richardson**

Centre for Men's Health
Department of Health and Science
Institute of Technology Carlow
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Introduction

This booklet summarises the key findings from an MA thesis conducted at the Centre for Men's Health, Institute of Technology Carlow, which sought to establish best practice guidelines in tailoring lifestyle interventions for obese men in the primary care setting.

The study was conducted between October 2008 and September 2010 and was carried out in partnership with the Community Nutrition and Dietitian Service (CNDS), HSE South, and a number of General Practices in the south-east area.

The booklet is intended to assist health care professionals in using lifestyle interventions with obese men in the primary care setting. The best practice approaches that are identified are based on the findings from this study as well as a thorough consideration of the best available evidence.

Preamble

“We enjoy one of the most luxurious lifestyles on earth. Our food is plentiful. Our work is automated. Our leisure is effortless. And it’s killing us” ^[1:46]

Unhealthy diets and physical inactivity are among the leading causes of the major non-communicable diseases including cardiovascular disease, type 2 diabetes and certain types of cancer, and contribute substantially to the burden of disease, death and disability^[2]. Male obesity poses a specific challenge to health care professionals in Ireland. Obesity levels are higher in men than in women and the rate of increase in obesity over recent times is also higher among men^[3,4]. Ireland’s National Men’s Health Policy (NMHP⁴) highlights the need for a more gender-specific approach to tackling male obesity in the primary care setting. In addition, the most rigorous evidence-based research^[5] clearly points towards targeted action in this area through the development of tailored lifestyle interventions.

“There is limited evidence on the effectiveness of interventions based in non-clinical settings to manage obesity in adults, particularly men” ^[6:3]

Current lifestyle interventions tend to adopt a gender-neutral approach to lifestyle modification and by failing to account for the gendered nature of human behaviour; such interventions have limited success in addressing health issues among men. The purpose of this booklet is to address the gap in current Irish research by establishing best practice approaches for health care professionals in tailoring lifestyle interventions for obese men in the primary care setting.

1. Patterns of Male Obesity in Ireland

- The trend towards increasing overweight and obesity in Ireland is more pronounced in men than in women. The most recent statistics indicate that 43.8% of men in Ireland are overweight with a further 25.8% obese^[3]. This compares to 30.9% and 21.3% respectively for women.
- Obesity levels in men have more than tripled since 1990 (up from 7.8% in 1990 to 25.8% in 2011). The greatest increase has been observed in 51-64 year old men; with the rate quadrupling from 10.7% to 42.1% during the same period^[3].
- Central (or visceral) obesity is more prevalent among men than women and is associated with an increased risk of hypertension, diabetes and metabolic syndrome^[2].
- Based on the most recent available data, Irish men ranked 3rd highest in male overweight/ obesity prevalence in the EU^[7].

2. Applying a Gender Lens to Male Obesity

Underpinning the worrying male obesity statistics highlighted in Section 1, are a number of important gendered aspects to male obesity.

1. Men’s diets are less healthy than women’s diets.

Men eat more fried foods and high-caloric items and less fruit and vegetables than women^[8]. In a survey of EU member states^[9], men were less likely than women to associate a healthy diet with eating more fruit and vegetables or with not eating too much fatty foods.

2. Men who are overweight/obese tend not to see their [excess] weight as a cause of concern.

Men tend to become concerned about their weight only when their weight has reached obesity proportions or becomes associated with obesity-related co-morbidities^[10]. Irish data shows that, despite two-thirds (66.4%) of Irish males surveyed being overweight/obese; 55% felt that they did not have to make changes to their diet as it was healthy enough^[11]; only 37% reported having modified their eating habits in the past year^[11]; and yet, the vast majority of men in Ireland (86%) categorise their health as ‘very good’ or ‘good’^[12].

3. Men tend to lack control over their diets and are less knowledgeable about healthy eating.

Against a backdrop of women’s traditional role in purchasing, preparing and providing food; (i) men tend to lack control over their diet^[13]; (ii) men tend to be less knowledgeable than women about the health benefits of particular foodstuffs^[14,15]; (iii) men are less likely than women to read food labels^[16]; and (iv) men tend to rely on women for advice and support on food and dietary matters – which may have particular negative consequences for the dietary habits of single men living alone^[17].

¹ Overweight is defined as a Body Mass Index of 25-29.9 and obesity as 30 and over.

4. Men's dietary habits are influenced by working hours.

Previous studies have shown that men working shift hours and commuting long distances, tend to have an increased reliance on convenience foods, snacking and eating out^[18,3].

5. Men's approach to food is often pleasure-oriented.

A Scottish qualitative study^[17] found that men tended to see healthy food as insubstantial, reinforcing the masculine orientation towards large portions and plenitude, and an approach to food that is pleasure-oriented. Indeed, the very notion of healthy eating was associated with 'hassle,' 'self-denial' and being 'bland' and 'boring'.

6. 'Bigness' is associated with more dominant notions of masculinity.

There is a tendency for men to associate 'bigness' with more ideal or valorised notions of masculinity and therefore to strive for a large body frame as opposed to a 'normal' body weight^[19]. For men, meat-based diets and bulk items remain privileged within discussions of food, particularly with reference to fitness rather than health. The conventional positioning of men within manual labour and sporting contexts emphasises the male body as a machine, designed to perform and in need of appropriate fuel^[20].

7. Men can often be resistant to healthy eating messages or to being told what to eat.

Previous qualitative studies^[17,20-21] reported scepticism and cynicism among the men who were interviewed toward healthy eating messages filtered through the media, with a tendency among some men to view such information as misleading or contradictory and as an affront to their freedom of individual choice in terms of what they ate. In reacting against such messages and choosing to forge their own paths with regard to their dietary habits, endeavours to promote healthy eating among men could, paradoxically, lead to a rejection of healthy food choices. More dominant constructions of masculinity tend to be associated with autonomous decision-making over obedience to authority, and plenitude and fulfilment over scarcity and self-denial^[22].

8. Men are much less likely than women to consider dieting as a means to weight-loss.

This is borne out by the statistics on dieting among EU member states, with women (26%) being much more likely than men (15%) to have been on a diet over the past 12 months^[9]. The same study^[9] highlighted that, with the notable exception of having attempted to reduce alcohol consumption, men were less likely than women to have attempted to make changes to their diet over the past 12 months.

9. Men tend to view exercise and sport as a more acceptable means of trying to lose or maintain weight.

From the point of view of weight management, men tend to see physical activity and sport as more relevant than nutrition^[14] and are therefore more likely to seek to manage their weight by means of exercise than by dieting^[23]. A study of Irish men's health highlighted that men's retirement from competitive sport – often associated with an inability to maintain more youthful levels of physical fitness and sporting performance - may coincide with their retirement from physical activity in general^[24]. Given the potency of physical activity as a defence against all of the chronic illnesses associated with modern living, it is imperative that Irish men are encouraged and supported to remain physically active throughout their lifespan.

10. Men are more open to dietary change or to losing weight when prompted to do so by their GP.

Resistance to altering diets, for men, may be reduced when they are prompted by their GP to consider losing weight or when there are medical grounds to do so^[17]. This highlights the potency of appropriate medical advice in altering the dietary behaviours of men.

3. What is the Community Nutrition And Dietitian Service (CNDS)?

This study targeted obese men who had previously attended the Community Nutrition and Dietitian Service (CNDS) HSE South in 2008. The CNDS is a lifestyle intervention service run by dietitians in the HSE South region and is an element of the primary care network. Part of the service includes the tailoring of lifestyle changes among patients who are referred to the service, with obesity management being a core element of the service.

4. Methodology

This study adopted a mixed methods approach and comprised three separate phases:

- Quantitative Phase 1 comprised (i) a review of overall HSE (South) referrals data for the year 2008, to establish if differences existed in the number of referrals for men and women to the service; and (ii) phone questionnaires with 67 obese men who had previously attended the CNDS in 2008.
- Qualitative Phase 2 involved semi-structured interviews with a purposive sub-sample of questionnaire respondents (n=4), in addition to a convenience sample of obese men (n=6).
- Qualitative Phase 3 involved two focus groups with dietitians (n=16) working with obese men from the service in the HSE South.

5. Summary of Key Findings

1. Men are less likely than women to be referred for lifestyle counselling for obesity

Despite overweight/obesity levels being higher among men, women were much more likely to be referred to the CNDS. A review of 2008 referrals data (HSE South) revealed that men comprised 38% (n=3,200) of overall referrals (n=8,424) to the CNDS for lifestyle interventions.

2. Addressing Obesity as a Health Issue – 'the elephant in the room'

Despite been described as an epidemic, the consensus among the dietitians in this study was that obesity is largely being ignored at primary care level. It emerged that, obesity, as a sole condition, was generally seen as the 'elephant in the room'. Although recognised as a medical condition in its own right, it tends not to be treated with the same importance as other chronic conditions such as CVD or diabetes. The dietitians reported that, in the main, only those patients with what were deemed to have more pressing medical conditions were referred, and were prioritised over those patients who were

'just' overweight or obese. Obesity therefore presented much more frequently as a secondary rather than a primary condition.

“They (GPs) may have people to refer, or that they would like to refer, but they choose not to, so that those with more complex situations or more pressing medical conditions get access to our service.” (FOCUS GROUP 1)

From the dietitians' point of view, it was felt that budgetary constraints meant that obesity wasn't being tackled early enough and there was insufficient follow-up with patients.

“Although a patient, for now, may be ‘just’ overweight or obese, they are at a significantly increased risk of developing heart disease or becoming diabetics in the future, so tackling that earlier and preventing those problems at an earlier stage would be far more beneficial.”
(FOCUS GROUP 2)

“We should have a clear defined plan of weight loss followed by a clear weight maintenance stage; I don't have an option of offering that.” (FOCUS GROUP 1)

3. Avoiding 'the Weight' Issue

Many participants [in the qualitative study] tried to distance themselves from their excess weight, referring to it as 'the weight'. In fact, when asked at interview, all 10 participants reported that their ideal weight corresponded to a BMI within the overweight/obese range, with many being ambivalent about their weight:

“I'm not fat I just have a bit of a pouch.” (HARRY, 42)

A number of participants reported not being in control of factors that led to their excess weight and becoming aware of their excess weight only when it became associated with other health problems:

“I was just packing it in (food) because she [mother] wouldn't take no for an answer.” (TIM, 32)

“I never had these [health] problems before so it had to be the weight that caused them.” (TOM, 66)

In the focus groups with dietitians, it was felt that GPs could be more proactive in terms of talking about weight to their patients. They felt that rather than being seen as a taboo subject between GP and patient, it should be a natural and routine part of the consultation.

“That need is there before they ever get to us, so that it (discussion on weight) is a common thing, that it is talked about and that it is not taboo.” (FOCUS GROUP 2)

4. Challenges Posed to Obese Men in Achieving Sustained Weight Loss

Table 1 gives an overview of the key challenges and barriers posed to obese men in achieving sustained weight loss. Some 55% of men reported that 'giving up their favourite food' was their biggest challenge. Within this group, large portion size (88%); the consumption of sugary snacks (75%); and alcohol consumption (58%) were the most important factors that respondents felt had contributed to their excess weight.

Table 1

Challenges and Barriers	Frequency	%
Giving up 'Favourite Food'	37	55
Increasing Physical Activity	23	34
Lack of Motivation	12	18
Looking forward to the 'Challenge'	11	16
Not enough Time	7	10
Not enough Support	3	4
Other	21	31

From the dietitians' view, the challenges and barriers posed to obese men in achieving sustained weight loss, were reported to be outside of the actual patient and were associated more with structural and economic barriers:

“For the service in general, there are not enough resources; we don't have enough time and we are constantly under pressure.” (FOCUS GROUP 2)

5. Relationship between obesity, identity, self concept and self-esteem

Obesity was reported to have had a significant negative impact on the men's physical, mental and emotional well-being. Depression, anxiety, stress, feelings of embarrassment, feeling emasculated and being physically limited and disabled by their weight were cited as consequences of excess weight:

“I would have died if she (air hostess) knew that I couldn't clasp the seat belt on the plane – I had to put my hands over it to hide it from her” (JOE, 56)

“The belly would be on show – I hate it when people stop and stare at me” (MICHAEL, 52)

“I have to go to special shops in Dublin to buy the 'XXXL' shirts” (TIM, 42)

“I just wasn't able to walk, just couldn't walk” (SEAN, 63)

6. Tailored lifestyle interventions have a key role to play in tackling male obesity

The CNDS was credited with having a major impact on men's dietary and lifestyle behaviours.

Dietary Habits

The vast majority of respondents (93%; n=62) reported implementing dietary changes as a result of attending the CNDS. Such changes included the adoption of healthier dietary behaviours such as reducing fat content, reducing portion sizes and increasing fruit and vegetable consumption. These changes were reported to be directly related to an increased knowledge and awareness of what constituted a healthy diet.

Physical Activity

Those reporting as being physically active increased from 72% to 96% after having attended the CNDS. Respondents also reported increases in the frequency and duration of physical activity.

Alcohol Consumption

The CNDS was found to have had little impact on respondents' alcohol consumption or on the monitoring of alcohol consumption.

7. Lifestyle behaviour change targeted at men should emphasise personal choice and responsibility

Men in this study welcomed the fact that they were centrally involved in deciding what actions to take and in negotiating their weight management plan with a dietitian. Joe, a married employed man, reported how the service was tailored to his individual needs, and this approach was deemed effective for him in successfully enacting lifestyle changes:

“With my knee I can't really exercise, so it was all mainly dietary advice I received – I liked that as she wasn't getting on to me to do things that I just can't do.” (Joe, 56)

The men described feeling like equal partners in a shared decision making process, actively involved in negotiating a lifestyle plan. In the dietitians' view this approach underpinned the key philosophical and patient-centred approach of their work:

“Patients might be frightened off very soon if they feel that they are coming to someone who is going to judge them and tell them what is to be done.” (FOCUS GROUP 2)

Whilst this patient-centred approach was the preferred approach for most of the men, some men did acknowledge that getting a 'wake-up call' from their GP was also important in getting them started on addressing their weight:

“I needed to be told [by GP] I had to lose weigh in the first place; otherwise I wouldn't have done anything about it.” (SEAN, 42)

“Once he (GP) told me I had some health problems like the blood pressure and cholesterol, I decided I had to do something about it.” (TOM, 66)

6. Best Practice Approaches

Against a backdrop of a growing obesity epidemic among men in Ireland, it is imperative that there is an increased and gender-specific policy focus on promoting healthy eating and balanced nutrition, as well as increasing physical activity levels throughout the lifespan of men and boys. It is well established that the most effective interventions at a population level are those that (i) adopt an integrated, multidisciplinary, and comprehensive approach; (ii) involve a complementary range of actions; and (iii) work at an individual, community, environmental and policy level^[25]. It is within this context that the following Best Practice Approaches are proposed in tackling male obesity in the primary care setting.

Best Practice Approaches to tackling male obesity in the primary care setting

1. Don't ignore the problem [of male obesity]

There is an urgent need to strengthen the capacity of current primary care based lifestyle interventions to enable health care professionals to meet current policy recommendations in relation to tackling obesity. GPs in particular have a crucial role to play in raising the issue of obesity as a health issue in its own right with their male patients. Indeed, men are more likely to take weight-loss seriously when prompted to do so by their GP.

2. Adopt a 'shared investment' approach to lifestyle change

Support and empower men to take responsibility for lifestyle changes that can bring about long-term and sustained weight-loss. Men like to be consulted and to feel as equal partners in negotiating lifestyle changes that revolve around personal choice and responsibility. Trust and rapport are also key characteristics when working with obese men and help to instill confidence towards weight-loss and to build an effective working relationship.

3. Increase the breadth and capacity of primary care teams to deal with obesity

There is a need to increase the capacity within primary care to ensure that all overweight/obese patients requiring extra support in reducing weight can be referred appropriately (particularly with regard to mental health services and addiction services).

4. Consider the impact of key 'transitional' periods in men's lives

Transitional periods in men's lives often coincide with weight-gain – becoming a father, 'retiring' from competitive sport, losing one's job and stopping smoking - and are periods when support is particularly needed. Conversely, the onset of a health problem (in relation to oneself or a loved one) may be the catalyst for increased motivation and commitment towards losing weight.

5. Account for and anticipate likely problems or barriers to weight-loss

Tailor advice to account for potential barriers that can occur in men's lives, i.e. work or family commitments, food affordability, environments conducive to physical activity, cookery skills etc.

There is also a need to create an association between healthy foods and substance/satiation to counter perceptions of healthy food as bland or unappetising.

6. Place a strong focus on physical activity as a means to weight loss for men

Men tend to see physical activity and sport as more relevant than nutrition to weight-loss and are therefore more likely to seek to manage their weight by means of exercise than by dieting. Physical activity should therefore occupy a central role in lifestyle counselling aimed at tackling obesity in men.

7. Use practical approaches when working with men

A good incentive when working with men is to describe processes in terms of bodily mechanics or the use of visual aids. Men tend to like gadgets (e.g. pedometers), measurements and scores (e.g. BMI, waist circumference) and tend to respond well to the identification of targets and goals.

8. Provide long term follow up with men to enable them to sustain lifestyle changes

It is critically important to put in place long term strategies and supports to help avoid relapse and to increase motivation. For example, follow-up texts or telephone calls can be used if one-to-one consultations are not feasible. A good approach might be to develop a wider network of supports for obese men to help maintain changes.

9. Tailor interventions to the individual - not all men are the same

Services need to account for the significant differences between men and not just between men and women. Particular focus should be placed upon men who are older (aged 45-64), unemployed, live alone, are less educated or who work unsociable hours (e.g. truck drivers, security men, taxi drivers). Lifestyle counselling should be tailored to account for men's individual circumstances.

10. Provide training for primary care teams on how to work effectively with men

The provision of such training should take account of the following: (i) increasing men's awareness of the potential ill effects of excess weight; (ii) ensuring that discussions on weight are an in-built and a natural part of GPs' consultations with overweight/obese men; (iii) availing of opportunistic brief interventions with men in relation to their weight that can fit appropriately within a typical consultation; (iv) adopting a client-centred approach to weight loss; (v) improving lines of communication between dietitians and GPs in relation to referrals; and (vi) using BMI and/or waist circumference measurements as a routine part of all consultations.

References

- [1] Newman, C. (2004). 'Why are we so fat?' *Official Journal of the National Geographic Society*, 206 (2): 46-61
- [2] World Health Organisation (2009). On behalf of the European Observatory on Health Systems and Policies. *Health in the European Union: Trends and analysis*. WHO Regional Office, Copenhagen
- [3] Irish Universities Nutrition Alliance (2011). *National Adult Nutrition Survey: Summary Report*. Available at: <http://www.iuna.net/wp-content/uploads/2010/12/National-Adult-Nutrition-Survey-Summary-Report-March-2011.pdf> (Accessed 21st May 2011)
- [4] Department of Health and Children (2008). *National Men's Health Policy: Working with men in Ireland to achieve optimum health and wellbeing*. Department of Health and Children, Hawkins House, Dublin
- [5] National Institute for Health and Clinical Excellence (NICE; 2006). *Obesity: the Prevention, Identification, Assessment and Management of Overweight and Obesity in Adults and Children*. London: NICE
- [6] National Health Service (2010). *Treating Adult Obesity through lifestyle change intervention – A briefing paper for commissioners*. Available at: http://www.noo.org.uk/uploads/doc/vid_5189_Adult_weight_management_Final_220210.pdf (Accessed 21st May 2011)
- [7] International Association for the Study of Obesity (2008). *Overweight and Obesity in the EU27*. UK: IASO. Available at: <http://www.un.org/popin/data/html>.
- [8] Morgan, K., Mc Gee, H., Watson, D., Perry, I., Barry, M., Shelley, E., Harrington, J., Molcho, M., Layte, R., Tully, N., Lente, E., Ward, M., Lutomski, J., Conroy, R., Brugha, R. (2008). *The National Health and Lifestyle Survey (SLAN) Survey of Lifestyle, Attitudes and Nutrition in Ireland*.
- [9] Eurobarometer (2006). *Health and Food Special Eurobarometer 246/ Wave 64.3 - TNS Opinion and Social*. European Commission
- [10] Mc Pherson, K.E. (2004). *Body Image Satisfaction in Men; Its implications for promoting health behaviours*. Presentation at 5th National Men's Health Conference, Arlington, Virginia: USA
- [11] Irish Universities Nutrition Alliance (2001). *North/South Ireland Food Consumption Survey, Irish Universities Nutrition Alliance*. Dublin: Food Safety Promotion Board.
- [12] Central Statistics Office (2007). *Health Statistics and Health Service Utilisation*. Cork: CSO
- [13] Harnack, L., et al. (1998). *Guess who's cooking? The role of men in meal planning, shopping and food preparation in US families*. *Journal of the American Dental Association*. 98: p. 995-1000
- [14] Kiefer, I, T. Rathmanner, and M. Kunze (2005). *Eating and dieting differences in men and women*. *Journal of Men's Health and Gender*. 2(2): p. 194 – 201.
- [15] Parmenter K Waller J and Wardle K (2000). *Demographic variations in nutrition knowledge in England*. *Health Education Research* 15(2):173-184
- [16] Satia, J. A., Galanko, J. A., Neuhouser, M. L. (2005). *Food nutrition label use is associated with demographic, behavioural, and psychosocial factors and dietary intake among African Americans in North Carolina*. *Journal of the American Dietetic Association*, 105(3): 392-402

- [17] Gough, B. and M.T. Connor (2006). *Barriers to healthy eating among men; A qualitative analysis*. Social Science and Medicine, 62:387-395.
- [18] Department of Health and Children (2005). *Obesity: The Policy Challenges. The Report of the National Task Force on Obesity*. Hawkins House, Dublin
- [19] McCreary, D.R. and Sadava, S.W. (2001). 'Gender differences in relationships among perceived attractiveness, life satisfaction and health in adults as a function of body mass index and perceived weight', *Psychology of Men and Masculinity*, 2:108-16.
- [20] Watson, J.M. (2000). *Male Bodies: Health, Culture and Identity*. Buckingham: Open University Press
- [21] Richardson N. (2010). 'The 'buck' stops with me' – reconciling men's lay conceptualisations of responsibility for health with men's health policy. *Health Sociology Review*; 20(2):419-436
- [22] Connell, R.W. (1995). *Masculinities*, ed. R.W. Connell., Cambridge: Polity Press.
- [23] Westenhöfer, J., (1996)/ *Gezugesenes essen und storbarkeit des essverhaltens*. Gottingen: Hogrefe.
- [24] Richardson, N. (2004). *Getting Inside Men's Health Kilkenny*: Health Promotion Department, South Eastern Health Board
- [25] Sjöström, M and Stockley, L (2001). *Toward public health nutrition strategies in the European Union to implement food based dietary guidelines and to enhance healthier lifestyles*. *Public Health Nutrition* 4(2):307-324

