Participants' explanatory model of being overweight and their experience of standard primary care compared with a commercial weight loss intervention

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ABSTRACT

Purpose: To explore participants' accounts of weight loss interventions to illuminate the reasons behind the greater weight loss observed amongst those attending a commercial programme (CP) compared with those receiving standard care (SC) in a recent large-scale trial. To examine how participants' general 'Explanatory Model' of being overweight related to the two different interventions.

Methods Thematic Analysis of semi-structured telephone interviews with a purposeful sample of 16 female participants from the UK centre of a randomised controlled trial of weight loss in primary care.

Results:

The commercial provider delivered weight management in a non-medical context, which mirrors how participants regard being overweight. Participants felt they needed support and motivation rather than education, and valued the ease of access and frequent contact the commercial provider offered. However, some participants preferred individual level support with their primary care provider and all were positive about the opportunity to access support through the primary care setting.

Conclusions: Primary care referral to a commercial weight loss programme for people who do not require specific clinical care appears to accord with people's general Explanatory Model about being overweight, offering motivation and support to lose weight outside a strictly medical context. However, this approach may not be effective or acceptable for everyone, and there are likely to be significant variations in Explanatory Models held. Findings support the argument that a range of evidence-based options for weight management should be available in primary care.

Keywords: Obesity, Weight Loss, Primary Health Care, Qualitative

INTRODUCTION

It is well established that obesity is associated with considerable health consequences, including diabetes, cardiovascular disease and some cancers[1]. Intensive lifestyle interventions led by health professionals can produce clinically significant weight loss of 5-10%[2] but these are costly given the high prevalence of obesity. Nevertheless, obesity accounts for 2-7% of health care costs in some developed countries[1], so governments are increasingly making prevention and treatment of obesity a priority. For example, the US Centre for Medicare and Medicaids Services now includes intensive behavioural counselling for obesity in its coverage, providing it is delivered by primary care physician in a primary care setting[3]. However, interventions delivered in primary care can be costly in terms of staff resources, set-up and training, whilst weight loss achieved is often less than 5% of initial weight[4-6]. In the UK, the National Institute for Health and Clinical Excellence recommends consideration of any intervention that meets best practice guidelines including referral to commercial weight loss programmes[7], which are delivered to large groups and are thus more affordable. Audit data demonstrates the increasing use of referral schemes in the UK [8 9] and two recent randomised controlled trials provide evidence to support this approach[10 11].

We recently published the results of an international randomised controlled trial, in which 772 participants from three countries (UK, Australia, and Germany) were recruited by their primary care provider and randomised to receive 12 months free membership of a commercial programme (CP; Weight Watchers) or standard care (SC) in general practice[10]. Those allocated to CP lost twice as much weight as those who received SC, and were three times as likely to lose ≥5% initial weight. Full details of this trial are reported elsewhere[10]. Main aspects of the two interventions are detailed in Table 1.

At the end of the trial, we interviewed a sample of UK participants and used qualitative methods to explore accounts of their experience of the two interventions, as well as their previous experience of weight management. Our overarching approach was to capture the general 'Explanatory Model' that all participants held about being overweight and to examine participant experience of the two weight loss interventions within this context. It also considered how

patients regard the roles of primary care providers and their attitudes towards partnerships with commercial providers.

METHODS

Sampling and Data Collection

Sixteen female participants were recruited from the UK centre of a trial comparing primary care referral to a commercial weight loss program (Weight Watchers) with standard care[10]. They were purposefully sampled to represent both intervention groups according to basic descriptive variables (see Table 2), and to ensure we had respondents from each participating practice, completers and non-completers, and different levels of weight loss to provide maximum potential variation in accounts.

Participants completed a semi-structured telephone interview with AA within 6 months of their 12 month assessment date. The interview schedule was developed following a review of the literature and consideration of topics raised by participants and practitioners during first–hand interactions during the main trial. Specific prompts such as, 'What were your expectations of treatment?', 'What, if any, do you think are your main barriers to losing weight?', 'How do you feel about your weight now?', were embedded in the narrative-style interview approach that encouraged participants not only to give an account of their experiences chronologically, but also elaborate their general views and beliefs. Any previous experience of weight loss initiatives in primary care, both within and outside of the trial was also elicited.

Written informed consent, including consent to have their interview recorded and transcribed, was obtained from all participants and this was reviewed verbally immediately before each interview. This study was approved by Nottingham Research Ethics Committee, UK.

Data Analysis

Interviews were digitally recorded and transcribed verbatim. An iterative thematic analysis was conducted following an initial and relatively open interpretive framework derived from the topic guide[12]. All of the transcripts were

read by three of the researchers (AA, EB, SC), who identified main themes and ideas independently and then met together to reach consensus and establish reliability. AA and EB worked together to augment the original themes, and identify key areas that in combination constituted a general model of beliefs and values associated with being overweight. A final set of themes was established once no new ones emerged from the dataset; in contrast to an entirely open grounded theory approach, data saturation was consequently achieved by the pre-determined limits of our initial topic guide. EB continually re-coded all transcripts where necessary, collating sections of data that supported and refuted each theme for review by the rest of the research team.

The overall rationale of the interview schedule was to elicit the general views of participants about being overweight, both in relation to themselves and others. We sought to establish what key themes constituted a general cultural Explanatory Model of being overweight, and the extent to which this framed how they described their experiences in the trial. We use the term 'Explanatory Model' to encapsulate the ideas about a particular health issue that are intrinsically related to beliefs about its status as an illness, what strategies are believed to be effective, and who are considered the most appropriate people to help[10].

Adopting this approach, we have explicitly avoid using the terms 'patient' and 'treatment' since these imply a dominant medical model and do not necessarily reflect participants' own beliefs about being overweight. Although Explanatory Models, by definition, vary amongst different people, in this study we sought only to establish the general characteristics across the trial cohort via a representative sample of participants. The emerging themes were consequently grouped together with this purpose in mind, and assembled into a general hierarchy in order to establish the overall dominant themes. Key aspects of this Explanatory Model are outlined in Table 4, with descriptions of how experiences of the two interventions fit with these.

Results

Background accounts: experiences prior to the trial

Participants reported prior experience of weight loss and weight regain but had little experience of assistance with weight loss from primary care providers. A small number had been told by their GP that their weight was a health issue, but none had been offered any support with losing weight. Very few had specifically sought support from their GP for weight management and most were unaware this was available. On the whole, participants described weight loss as a personal responsibility and not important enough to 'bother' their GP. Despite having a Body Mass Index (BMI) >30 kg/m2 none considered themselves to be obese, instead describing themselves as '*overweight'* or '*too fat'.* Participants did not think of their weight as a medical problem; although they perceived 'obesity' as being a medical issue, with associated health implications relevant to primary care:

Participant: 'No, not really, no, I wouldn't go to the doctors for weight loss'.

AA: 'Why not?'

Participant 1: 'I don't know. Unless there was something medically wrong with me, I wouldn't think it was one of their problems. Because it's your lifestyle, isn't it? It's how you eat and move around or not.'

(Participant 1)

In contrast, 13 participants (81%) had previous experience of attending commercial weight loss programmes. They generally described the experience as positive and defined it as successful if weight was lost while attending, even though weight had been regained afterwards in all cases. All participants were familiar with leading commercial providers and typically expressed trust of the brand names. Some scepticism was expressed on their profit-making nature, with suggestions that there was not adequate support for weight maintenance because members who maintain their goal weight do not pay to attend. However, the vast majority of participants felt that if a commercial programme had a proven track record and their approach was perceived as "healthy", it provided an appropriate setting for weight loss support.

Descriptions of weight loss provision during the trial

Contact and Structure

Participants emphasised the importance of regular contact in order to maintain motivation and focus on the weight loss goals, although there was significant variation in what was perceived as the ideal frequency.

> '*I need to go regularly to keep me on track'* (Participant 1)

> '*I went every couple of weeks...they would have liked me to have gone every week but...that doesn't suit me'* (Participant 3)

Greater frequency of contact was seen as a benefit of the commercial programme over standard care, and was associated with other organisational features of the two weight loss approaches. The CP was largely perceived as a 'structured' programme, with weekly meetings at set times. Some participants felt that this was incompatible with their busy routines:

> '*With the Weight Watchers you can only go to a class when it's on...I don't have a regular shift pattern.'* (Participant 15)

However, others acknowledged there was always a meeting available if they chose to be adaptable about which group to attend, and not having to make an appointment was seen by some as adding to the flexibility and ease of participation.

Conversely, the appointment-based format in primary care was referred to as ad hoc and experienced as predominantly participant-led. Though some appreciated this, many expressed frustration about limited appointment availability. Appointments generally had to be initiated by participants and access problems sometimes encountered at their GP surgery meant they felt they had had to 'create' their own support. Following our theoretical approach, participants' explanatory model appears to suggest weight loss interventions should balance the need to provide a sense of agency, while not making the individual entirely responsible for their weight management.

A sense of support and accountability

Perhaps counter to public health assumptions, none of the participants talked about needing an intervention to include education about food, eating or diet, as they felt they already had the necessary knowledge. Instead, they referred to the importance of receiving motivation and 'support', although some found it difficult to specify what form they should actually take:

> '*It isn't that I need educating, it's more that I need motivating*' (Participant 1)

> *'I just think I couldn't do it on my own without seeing somebody*' (Participant 5)

Related to such comments was a general sense of what we have chosen to call 'accountability'. This feeling was engendered by attending either type of session, especially through the act of being weighed rather than weighing themselves. It was identified by many as the key motivating factor for successful weight loss, accompanying a sense of obligation and that they would be 'letting someone else down' if they had not lost weight:

> *'For me...what works is the fact that I know...I've got to go and see somebody...and I've got to explain why I haven't lost any weight*' (Participant 6)

The related themes of support and accountability underscored the largely positive accounts of CP, in which it was reported that even though it was group-based it provided good, individually-tailored advice. Several commented specifically on the positive, encouraging and supportive approach of CP generally and of the group leader in particular:

> '*They congratulated you as much for losing half a pound than they would if you lost half a stone*' (Participant 9)

In addition, the group format was deemed to create an atmosphere of collective motivation, an opportunity to share experiences, allow talk to focus on problematic behaviours raised by members, and provide a source of inspiration derived from the success of other members. Crucially, the sense of support and accountability was driven not by a fear of embarrassment as might be associated

with a notion of peer pressure, but of loyalty and obligation to the CP leader and membership of a group:

> *'That class motivation I felt worked… building up that… friendly atmosphere and team motivation I found worked quite well'* (Participant 12)

Some participants nevertheless felt that group leaders were inclined to apportion blame to a member if there had been no weight loss, and there was insufficient acknowledgment of weight maintenance as a valid, complementary aim.

Some SC participants described how the opportunity to be weighed in private at the GP surgery was preferable and more supportive:

> *'Just doing it on an individual basis meant I could...be more private about it...without having to...go and be weighed in front of everybody' (Participant 11)*

These SC participants talked about CP in terms of 'peer pressure' and the use of stigma as a crude source of motivation. The group 'weigh-in' aspect of CP was particularly highlighted as a likely source of embarrassment that might deter those with more extreme weight problems from attending. One SC participant described CP as a 'social pressure group'.

The summaries of SC sessions suggested that there was considerable variation between GP practices in terms of content and delivery. Several reported the style was relatively 'passive' and that this, from the participants' point of view, suggested the low priority it was given. Some said advice given was no better than that given in relevant websites, or that their time could be better spent going to the gym. However, while some felt that too much relied on them to provide the initiative, others interpreted this as a positive attribute, which fitted the type of support they wanted:

> `*I just don't think that [support with weight management] seemed to be of particular importance to them'* (Participant 12)

> *'It was more of a personal journey with medical support... It was just how I wanted it'* (Participant 14)

Making sense of personal results

Whatever their results after the trial, participants largely attributed their success or failure to lose weight to the allocation they were given through randomisation. This retrospective rationalisation drew on a repertoire around perceived differences in levels of encouragement, a sense of inspiration derived from monitoring, and notions of support and accountability:

> '*If I'd gone to Weight Watchers and had to go every week and I got somebody monitoring me...I feel that that would have really, really encouraged me to do it'* (Participant 10)
>
> *'Weight Watchers was a structured plan and the GP was more trial and error yourself really, but I actually think the GP worked better'. KC1205*
>
> '*I don't think that I would have been inspired enough really [on SC arm]'* (Participant 6)

Whilst it may well be the case that some people would have responded better to the style of assistance offered in the other trial arm, it seems just as likely that attribution of outcome would always have followed this pattern.

In contrast, some participants reported that the treatment arm they were allocated to simply 'didn't work for *them'*. This apparently innocuous explanation implies a belief that different kinds of people suit different kinds of support. Thus, in terms of the participants' Explanatory Model, being overweight is not conceived of as the same problem for all people but is a very personal issue, and as a consequence calls for a meaningful match between the kind of help given and how a person makes sense of trying to lose weight.

Commercial partnerships and use of health service resources.

The commercial programme was clearly positioned as a non-medical intervention. However, participants did not report any concerns about group leaders not having professional qualifications. Indeed, this was seen as an appropriate context in which to receive weight loss support. The potential availability of 'free' weight loss assistance, paid for through the National Health

Service (NHS) was seen as an attractive alternative to 'paid-for' commercial treatment. Some described a sense of obligation because attendance was being paid for them by the NHS:

> *'I had to use my little voucher every week'* (Participant 9)

Others felt less pressure to lose weight because they were not personally contributing financially to attend:

> *'It almost felt because it was being funded, I didn't have the pressure there...I felt more comfortable with it'* (Participant 3)

Most interviewees were initially hesitant about whether weight loss was a legitimate focus for their GP, and were concerned that this might constitute a waste of NHS resources. However, by the end of the trial many SC participants felt that the experience had changed their views, and that they were now more likely to approach their primary care provider for help in the future. It should be noted though that in the vast majority of cases, a nurse or health care assistant was responsible for providing support during the trial, and this was regarded as more appropriate for weight management than seeing a GP. Interestingly, although participants who had received SC during the trial perceived this as extra to what they might normally receive, they did not attribute monetary value to it in any way.

DISCUSSION

This study is based on a sample of UK participants from a randomised controlled trial of weight loss in primary care, which found that a commercial provider was more successful in helping participants lose weight than standard care[10]. Though limited to a small representative sample from only one of the participating countries, our study enhances the main findings by exploring participants' general views and beliefs about being overweight, and the ways these relate to experiences of the two interventions. Our findings suggest that by providing weight loss support outside a medical context, referral to a commercial provider resonates with a general Explanatory Model of being

overweight. This includes issues relating to notions of responsibility and agency, ideas of what is experienced as effective and supportive, feelings of accountability and obligation with those charged with helping them, and a resistance to the 'medicalization' of being overweight.

Although there is limited data on the experience of weight loss interventions in primary care from the participant's perspective, our findings are consistent with some cross-sectional data that indicates that professional credentials are not important to patients[13] and that patients are reluctant to approach their doctors about weight concerns[14]. Findings strengthen recent evidence of the clinical effectiveness of commercial weight loss providers [10] [11] and informs the consideration of wider rollout of such service provision. Together they support an approach being adopted in the UK of including commercial partnerships as an option for weight management in primary care, and have implications for health service provision in other countries. Despite this, commercial provision may not be suitable for all and some preferred an individual approach. This highlights the need to offer people a range of different evidence-based options and to consider what best suits their needs and lifestyle.

In addition, there was some scepticism around weight maintenance, although to a lesser degree than in some previous research[15]. Although the trial upon which our study is based examined weight loss over a period of 12 months (considered by NICE as a long term outcome)[7], post-treatment weight regain is common in obesity[2], a problem not restricted to commercial programmes. Participants' general Explanatory Model, in which being overweight is linked to on-going experiences of everyday life, suggests that it may be relevant to consider weight management as an on-going process and to focus on sustainability.

A limitation of the qualitative approach is that the generation of data is subject to layers of social construction[11]. While some studies have found the quality of telephone interviews to be comparable to face-to-face interviews[16], it is possible that this method of data collection will have influenced and may have restricted responses. However, the fact that the interviews were often extensive, and the data proved so illuminating, suggests that the interviewer successfully ensured participants came to feel at ease and talk openly. It might also be that the greater anonymity elicited more open responses. Particular care was taken to ensure participants' comments were interpreted in the wider context in which

they were spoken and every effort was given to ensuring a fair representation of the original intended meaning. Although interviews could only address participant perspectives retrospectively, this limitation was also carefully considered throughout the analysis.

The key themes of the Explanatory Model that we have drawn on, whilst useful to address our main research question, are necessarily broad. The trial provided an opportunity to explore participants' views and experiences of two weight loss approaches offered in primary care and participants were purposefully sampled to capture a range of attitudes and experiences. However, findings may not be representative of all overweight people in the UK who would benefit from weight loss interventions. Indeed, participants in this research were predominantly white British females and it is important to consider the different needs of men and other ethnic groups, and possible cross-cultural variations. Likewise, there may be important differences in intervention experience according to education, socioeconomic status, and expectations regarding the nature of the prevailing national healthcare provision, as these might well lead to different variants of the Explanatory Models held about being overweight.

Conclusions

Participants welcomed the offer of weight loss support from their primary care provider. Providing support for weight management outside a medical context, referral to a commercial programme fitted better with participants' general Explanatory Model of being overweight. Findings further strengthen the evidence of greater weight loss in CP than SC [10 11], to support the use of some commercial weight loss programmes as part of a range of evidence based weight loss interventions available in primary care in the UK. Other health care providers may also wish to consider including interventions outside of the traditional medical setting in their service provision. It is likely that different groups of people hold variants of the Explanatory Model that may well have subtle, but significant, differences on the effectiveness or acceptability of treatment options. Further research should explore these different models of overweight and also examine patient experience of other weight loss interventions.

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References

1. WHO. Global health risks: mortality and burden of disease attributable to selected major risks. In: press W, editor: World Health Organization., 2009.
2. Franz MJ, VanWormer JJ, Crain AL, Boucher JL, Histon T, Caplan W, et al. Weight-loss outcomes: a systematic review and meta-analysis of weight-loss clinical trials with a minimum 1-year follow-up. *J Am Diet Assoc* 2007;107(10):1755-67.
3. Decision Memo for Intensive Behavioral Therapy for Obesity (CAG-00423N): Centers for Medicare and Medicaid Services 2011.
4. Evaluation of the Counterweight Programme for obesity management in primary care: a starting point for continuous improvement. *Br J Gen Pract* 2008;58(553):548-54.
5. Nanchahal K, Townsend J, Letley L, Haslam D, Wellings K, Haines A. Weight-management interventions in primary care: a pilot randomised controlled trial. *Br J Gen Pract* 2009;59(562):e157-66.
6. Tsai AG, Wadden TA, Rogers MA, Day SC, Moore RH, Islam BJ. A Primary Care Intervention for Weight Loss: Results of a Randomized Controlled Pilot Study. *Obesity (Silver Spring)* 2009.
7. NICE. Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children. London: National Institute for Health and Clinical Excellence, 2006.

8. Ahern AL, Olson AD, Aston LM, Jebb SA. Weight Watchers on prescription: An observational study of weight change among adults referred to Weight Watchers by the NHS. *BMC Public Health* 2011;11:434.
9. Stubbs RJ, Pallister C, Whybrow S, Avery A, Lavin J. Weight outcomes audit for 34,271 adults referred to a primary care/commercial weight management partnership scheme. *Obes Facts* 2011;4(2):113-20.
10. Jebb SA, Ahern AL, Olson AD, Aston LM, Holzapfel C, Stoll J, et al. Primary care referral to a commercial provider for weight loss treatment versus standard care: a randomised controlled trial. *The Lancet* 2011.
11. Jolly K, Lewis A, Beach J, Denley J, Adab P, Deeks JJ, et al. Comparison of range of commercial or primary care led weight reduction programmes with minimal intervention control for weight loss in obesity: lighten Up randomised controlled trial. *Bmj* 2011;343:d6500.
12. Pope C, Ziebland S, Mays N. Qualitative research in health care. Analysing qualitative data. *Bmj* 2000;320(7227):114-6.
13. Wang S, Wadden T, Womble L, Nonas C. What consumers want to know about commercial weight loss programs: A pilot investigation. *Obesity Research* 2003;11:48-53.
14. Tham M, Young D. The role of the General Practitioner in weight management in primary care--a cross sectional study in General Practice. *BMC Fam Pract* 2008;9:66.
15. Thomas SL, Hyde J, Karunaratne A, Kausman R, Komesaroff PA. "They all work...when you stick to them": a qualitative investigation of dieting, weight loss, and physical exercise, in obese individuals. *Nutr J* 2008;7:34.
16. Sturges JE, Hanrahan KJ. Comparing Telephone and Face-to-Face Qualitative Interviewing: a Research Note. *Qualitative Research* 2004;4(1):107-118.

Table 1 Details of the two interventions

Commercial Programme	Vouchers to attend Weight Watchers for 12 months Weekly group meetings in local community venue - promotes a hypoenergetic, balanced diet based on healthy eating principles - advice on increasing physical activity - weight measurement - group support Access to internet-based systems to monitor food intake, activity, and weight change; to participate in community discussion boards; and to access a library of information, recipes, and meal ideas. Average participant attendance whilst in trial = 3 meetings per month
Standard Care	In line with national guidelines (see http://www.nice.org.uk/CG043) Weight loss advice from primary care professional at local practice (usually practice nurse) - 1 to 1 meetings; Minimum level of care 6 visits over 12 months - Weight measurement - Dietary advice based on British Heart Foundation booklet "So you want to lose weight... for good" Average participant attendance whilst in trial = 1 meeting per month

Table 2: Characteristics of participants in this study, and the UK trial participants from which they are drawn

	Commercial Programme		**Standard Care**		**Overall**	
	UK RCT Participants (N=120)	Interview Sample (N=9)	UK RCT Participants (N=116)	Interview Sample (N=7)	UK RCT Participants (N=236)	Interview Sample (N=16)
Mean Age (years)	47	44	46	49	47	47
Mean Start BMI (kg/m²)	31	30	31	31	31	31
Ethnicity (% white)	95	100	95	89	95	94
Gender (% female)	92	100	91	100	91	100

Participant	Intervention	Completed	Time in trial	Baseline Weight (kg)	Weight Change (%)
1	SC	Withdrew	4 months	81	1.98
2	SC	Completed	12 months	70	-7.43
3	CP	Completed	12 months	81.7	-17.87
4	CP	Withdrew	4months	80	-3.5
5	SC	Completed	12 months	64.8	-0.77
6	CP	Completed	12 months	81.8	-13.57
7	SC	Completed	12 months	87.5	-13.71
8	CP	Withdrew	4 months	71.3	0.14
9	CP	Completed	12 months	86.8	-11.29
10	SC	Withdrew	Baseline only	90.7	-
11	SC	Completed	12 months	73.8	-9.08
12	SC	Withdrew	9 months	74.6	-0.94
13	SC	Withdrew	Baseline only	74.9	-
14	SC	Withdrew	2 months	76.8	-5.6
15	CP	Withdrew	2 months	87.2	-1.95
16	CP	Withdrew	9 months	88.6	-0.68

Table 3 – Individual participant characteristics

Key features of a general Explanatory Model of being overweight	Standard Care	Commercial Provider
Overweight not regarded as a disease needing medical treatment	Based in local GP practice. Delivered by health care professionals.	Based in various (non-medical) community venues. Delivered by community members who have lost weight with CP.
Need motivation and support for weight loss, rather than information	Health care professionals varied widely in their interest in weight loss and their ability to support and motivate. Care primarily participant-led.	Key role of CP leader is to motivate the group. Most participants experience the group environment as supportive, though not suitable for all.
Frequent contact and accountability needed.	Meetings arranged in advance by participants. Appointments need not be at a regular time or day but must be on weekdays during "office hours". Can be difficult to get an appointment.	Weekly meetings held in accessible community venues. Local meetings at a variety of set days and times. Participants can "drop-in".
Cannot be 'treated' or 'cured'. Weight regain likely.	On-going support possible, but would require specific additional care provision.	Weight management is viewed as on-going process and continued provision offered. Continued provision would require self-payment or further payment by primary care provider. Members who have reached their goal weight can attend free of charge.

Table 4: Summary of how a generally held Explanatory Model of being overweight aligned with Standard Care and a Commercial Weight-loss Programme