

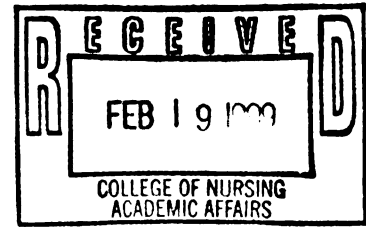
ASSESSMENT OF ADVANCED PRACTICE NURSE'S
ATTITUDES TOWARD CLIENTS WHO PRESENT WITH
WEIGHT-RELATED CONCERNS IN PRIMARY CARE:
IMPLICATIONS FOR PRACTICE

Scholarly Project for the Degree of M. S. N.
MICHIGAN STATE UNIVERSITY
CINDY K. TOKARZ

1999

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CLIENTS WHO PRESENT WITH WEIGHT-RELATED CONCERNS IN
PRIMARY CARE: IMPLICATIONS FOR PRACTICE**

By

Cindy K. Tokarz

A SCHOLARLY PROJECT

**Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of**

MASTER OF SCIENCE IN NURSING

College of Nursing

1999

ABSTRACT

ASSESSMENT OF ADVANCED PRACTICE NURSE'S ATTITUDES TOWARD CLIENTS WHO PRESENT WITH WEIGHT-RELATED CONCERNS IN PRIMARY CARE: IMPLICATIONS FOR PRACTICE

By

Cindy K. Tokarz

Current literature supports the ineffectiveness and probable physiological and psychological risks of popular weight loss regimens. Advanced Practice Nurses (APNs) frequently counsel primary care clients who present with weight-related concerns. Because traditional methods of weight and diet counseling have been shown to be ineffective, APNs need to learn newer, more effective and compassionate approaches for counseling these clients.

This paper reports the development of an assessment to examine APN's attitudes toward clients presenting with weight-related concerns. This assessment will function as a beginning step for the APN in appraising and determining his or her attitudes toward large clients in the primary care setting. This initial step is important because research has shown that health professionals share the negative attitudes of the general public toward larger-than-average clients. Negative attitudes of health care professionals are likely to impair the effectiveness of weight-focused counseling interventions for these clients.

To my family for all their sacrifices and help in
reaching my dream

ACKNOWLEDGMENTS

I would like to thank my mentor and chairperson, Celia Wills, for all the guidance, assistance, understanding, and setting realistic deadlines for myself to complete this scholarly project. I would also like to thank my other committee members, Brigid Warren and Jon Robison, for their ongoing support and feedback, and for the time they devoted to reviewing the many versions of this scholarly project.

TABLE OF CONTENTS

LIST OF FIGURES.....	vi
INTRODUCTION.....	1
PROJECT PURPOSE.....	5
THEORETICAL FRAMEWORK.....	7
Prochaska's Model.....	8
Watson's Model.....	9
Conceptual Definitions.....	14
Adapted Conceptual Model.....	15
REVIEW OF LITERATURE.....	18
Current Weight Paradigm.....	18
Personal Attitudes.....	24
New Weight Paradigm.....	28
PROJECT DEVELOPMENT PLAN.....	33
IMPLICATIONS FOR THE APN.....	38
REFERENCES.....	41
APPENDIX A: GLOSSARY.....	50
APPENDIX B: PROCHASKA'S MODEL.....	52
APPENDIX C: WATSON'S CARATIVE FACTORS.....	53
APPENDIX D: ATTITUDES TOWARD OBESE PERSONS (ATOP).....	54
APPENDIX E: ATTITUDES TOWARD OBESE ADULT PATIENTS.....	56
APPENDIX F: FAT PHOBIA SCALE (FPS).....	57

LIST OF FIGURES

Figure	Page
1 Watson's Model of Humanistic Caring.....	10
2 An Adapted Model of a Caring Relationship.....	17

INTRODUCTION

Obesity, an excess of body fat, has long been considered an epidemic throughout the United States. Body mass index (BMI), defined as weight (in kilograms) divided by height (in meters) squared, is the medical standard used to define obesity. A BMI greater than 27 indicates obesity (Thomas, 1995). Healthful weights are defined as those associated with BMIs of 19 to 25 (Meisler & St. Jeor, 1996). The latest national survey data demonstrates a striking increase in obesity in all segments of the population during the last 20 years (Kuczmarski, Flegal, Campbell, & Johnson, 1994). As a nation that "eats too much and exercises too little," the US has been accused of exporting an obesity-prone lifestyle to other nations around the globe. The weight loss industry accounts for nearly 50 billion dollars annually, and about 65 million Americans are dieting at any one time (Robison, 1997). Weight loss programs produce short term effects, with a 90 to 98% failure rate, with dieters regaining the lost weight within two to five years (National Institutes of Health, 1992).

Fraser (1997) and Gaesser (1996) report that Americans today are "obsessed" by weight loss and dieting. The reasons given for dieting often stem from the purported health benefits of weight loss and the societal pressures to be

thin. Traditional advertisements have used thin models and have added to the creation of the current weight paradigm that equates obesity with poor health. What has resulted from this "obsession" are large percentages of chronic dieters who have lost pounds for a short time, not only regaining the lost weight, but often additional weight.

An epidemic of serious eating disorders, anorexia nervosa and bulimia, has been exacerbated by a weight-preoccupied society. Approximately 50 percent of adolescent and young adult age women are dieting, even though at least half of these individuals are at or below normal weight (Centers for Disease Control, 1991). These young girls and women feel pressured to spend significant amounts of their energy and resources in pursuit of an "ideal" body shape and size that, for the vast majority, is neither achievable nor healthy (Fallon, Katzman, & Wooley, 1994). Eating disorders affect men as well, reflecting a dissatisfaction with one's own natural body and an intense desire to change it (Berg, 1995). According to Berg (1995), the current high rates of eating disorders are believed by many specialists to be the inevitable outcome of 60 to 80 million Americans dieting, losing weight, rebounding, and learning to be chronic dieters. Also, most professionals agree that dieting precedes the onset of an eating disorder, and dieting is suggested as an important step in the progression from weight dissatisfaction to binge eating (Parham, 1996;

Gaesser, 1996). The result of Americans having this preoccupation with weight is not only an increase in the incidence of eating disorders, but also it may contribute to the increase in overweight. (Polivy, 1996). Both of these conditions in turn lead to lowered self-esteem, body image, quality of life, and health status (Wooley & Garner, 1991). Our culture's preoccupation with thinness has resulted in social stigma that causes tremendous suffering and social isolation for individuals of larger-than-average size. American society labels obese people as "weak-willed," "ugly," and "awkward," and there is evidence that obese people are discriminated against because of their weight (Murphree, 1994). Obesity research and health interventions to reduce weight need to be more closely examined. Although severe obesity is clearly associated with increased mortality, the health consequences of being mildly to moderately overweight remain controversial (Ernsberger & Haskew, 1987; Pamuk, et al., 1992; Troiano, Frongillo, Sobal, & Levitsky, 1996).

Despite evidence that the current diet paradigm is not effective in producing lasting change, and growing evidence of potentially dangerous physical and psychological consequences of dieting, weight-related research and interventions continue to focus on the promotion of weight loss through dietary restriction. The current diet paradigm applies a model of therapy, behavior interventions of

dieting, which are not supported as effective in research on behavior change (Glanz, Lewis, & Rimer, 1997). These models of therapy are theories of personality and psychopathology which deal with why people do not change and are not consistent with research on stages of behavior change (Prochaska, 1992). Effective treatment for obesity should focus on strategies that can produce health benefits independently of weight loss (National Institutes of Health, 1992; Kratina, King, & Hayes, 1996).

There is a need in the primary care setting for an introduction of a new paradigm for weight management, one which does not consider "fat" (for definition see Appendix A) a fatal disease. With the immense social stigma associated with being "overweight" (for definition see Appendix A), weight loss is a predominant reason for patients coming to their primary care provider (Wooley & Garner, 1991). It is also one of the most commonly prescribed interventions to treat chronic conditions such as heart disease, hypertension, and diabetes. In addition, obese patients encounter great social stigmatization, and research literature shows that these patients often encounter similar discrimination when dealing with health professionals who are supposed to be helping them (Maroney & Golub, 1992; McArthur & Ross, 1997; Sobal & Devine, 1995).

Most counseling of patients by advanced practice nurses (APNs) around weight-related concerns occurs in primary care (Allison, 1995; Keller, Oveland, & Hudson, 1997). As

professionals, seeking to enhance the health of large people, APNs must be sensitive to the devastating effects of "fatism" (for definition see Appendix A), and be willing to examine their own assumptions, beliefs, and behaviors (Berg, 1995; Kratina et al., 1996). In addition, it is important for APNs to gain an understanding of the new weight paradigm to enable them in guiding and motivating patients to a healthier lifestyle.

PROJECT PURPOSE

The purpose of this project was to develop an assessment to examine APN's attitudes toward clients who present with weight-related concerns in primary care. Prochaska and Watson provided the theoretical perspectives for the basis of this project. The project specifically focuses on objective number 2 (*) listed below. An entire (comprehensive) educational module is outlined in the Project Development Plan section, and addresses the remaining objectives. The overall goal of the module is for APNs to gain an understanding of the new weight paradigm and to learn new approaches for working with their clients effectively and compassionately. The specific objectives of the project are:

1. Examine the current paradigm of dieting and review the information regarding failure rates and the risks involved in weight fluctuation.

- *2. Examine personal attitudes about obesity and how these attitudes are communicated to obese and/or overweight patients.
- 3. Present information on the association of weight and health risks.
- 4. Explore a new weight paradigm focusing on healthier lifestyle which includes elements of physical activity, normalizing eating habits, and promotion of self-acceptance and self-esteem.
- 5. Develop interventions relative to client readiness.

THEORETICAL FRAMEWORK

This project is based on two theoretical perspectives: Prochaska's (1992) processes of human behavior change and Watson's humanistic caring (1985). Two models were chosen as Prochaska's model does not provide a fully sufficient conceptualization to guide the project, but is successfully utilized in combination with Watson's model, which adds essential holistic sensitivity aspects.

There are certain assumptions inherent in these frameworks which are important in helping the APN guide interventions when working with clients on weight-related problems. An "intervention" is a concept defined as an act performed to improve the mental, emotional, or physical function of a patient (Anderson, Anderson, and Glanze, 1998).

A key assumption from Prochaska is that it is important to assess "where the client is" relative to making behavior changes. "Behavior change" can be defined as new behaviors that clients willingly undertake to achieve self-selected goals or desired outcomes (Pender, 1996). Before introducing interventions leading to a healthier lifestyle, these interventions should be based on the clinical assessment. Behavior change is complex, and involves the human aspect, not just a systematic passage through a sequence of stages. A linear progression through stages of change is rare; most people relapse at some point (Prochaska, 1994). During relapse, individuals go back to functioning at an earlier

stage of change. Some relapsers feel like failures-embarrassed, ashamed, and guilty, becoming demoralized, and resist thinking about behavior change (Prochaska, DiClemente, & Norcross, 1992).

A key assumption from Watson is that the client-nurse relationship is approached on the basis of compassion and caring. Another assumption applicable to compassion and client readiness is that a caring environment offers the development of potential while allowing the person to choose the best action for themselves at a given point in time (Fitzpatrick & Whall, 1996). The client's life context, including barriers to change, must be considered when a client is ready to explore options for a healthier lifestyle. For example, a client may be going through a divorce, changing a job, or experiencing an illness; these issues may assume priority at first.

Prochaska's Model

Dr. James O. Prochaska (1992) developed the Transtheoretical Model to explain how people change and what is involved in successful behavior change. He has identified six stages of behavior change: precontemplation, contemplation, preparation, action, maintenance, and termination (see Appendix B for model). Although Prochaska presents an analysis of weight loss in his research on behavior change, weight loss itself is not a behavior change, but an outcome of interventions which lead to a healthier lifestyle. Prochaska's model is helpful in trying

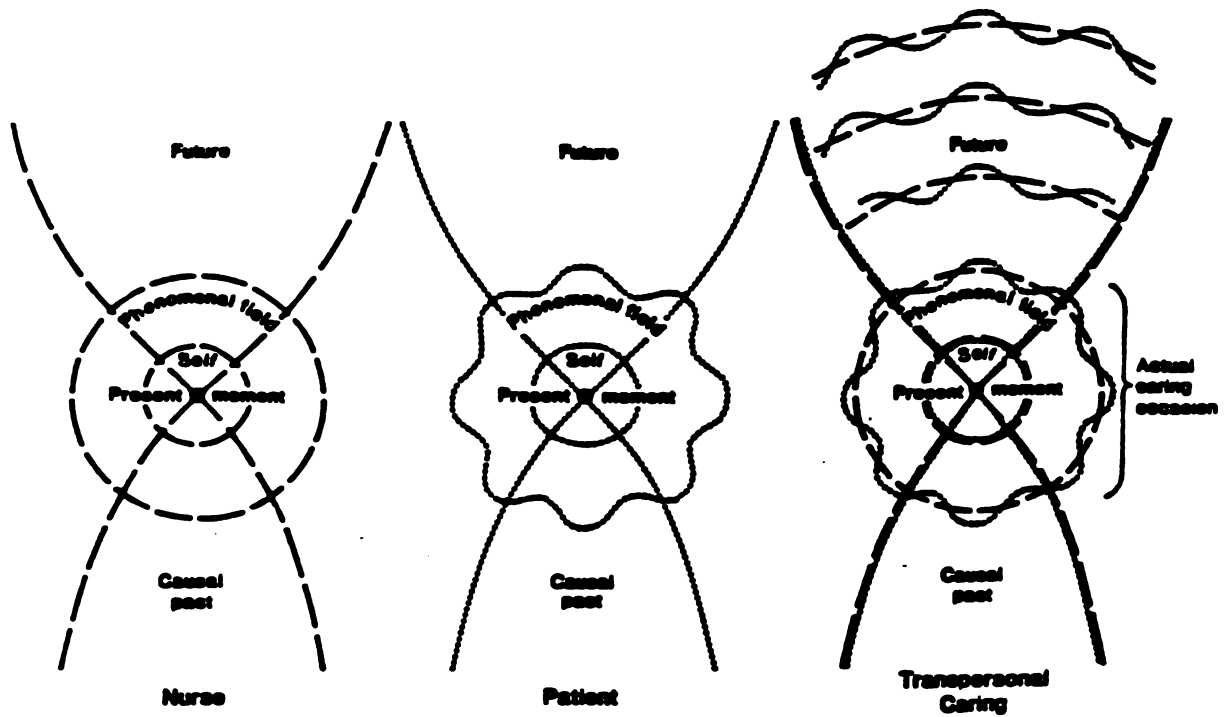
to determine where the patient is on the trajectory of change and to implement interventions which are appropriate for a given stage of change.

According to Prochaska (1994) the reason people do not exercise and eat less fat is because change does not begin with action even when they know these things are "good" for them. Whenever advice to change starts with action, as consistent with assumptions of the current diet paradigm, it sets up failure. Cessation of problem behaviors or installation of more adaptive responses does not occur automatically with one bold action or effort; change requires movement through successive stages in order to achieve maintained cessation or initiation (Prochaska & DiClemente, 1992). Effective change depends on engaging the right process at the right time.

Watson's Model

Jean Watson developed a model of nursing that uses humanistic caring as the framework for nursing intervention (Watson, 1985). The Theory of Human Caring applies to this project's central theme of creating a therapeutic relationship to facilitate healthy change. The major concepts of Watson's (1985) model are human care, transpersonal caring relationship, carative factors, self, phenomenal field, event, and an actual caring occasion (for definitions see Appendix A). Watson's model of humanistic caring is shown in Figure 1.

Figure 1. Watson's model of humanistic caring.
(Watson, 1985, p. 59).



For the purposes of this project, an APN will be defined as a nurse practitioner prepared at the master's level, who utilizes transpersonal caring relationships in working with patients who present with weight-related concerns in primary care. A transpersonal caring relationship is defined by Watson (1985) as a specific type of professional human-to-human contact having the goal of restoring the patient's experience of inner harmony. The APN uses and discloses self while engaging in the phenomenal fields of the other. When both parties choose to be in a transpersonal caring relationship, a new phenomenal field is created that is different from the unique fields of the APN and patient.

Watson describes the carative factors as intervention processes or modalities used in a transpersonal caring relationship (see Appendix C for list). The fourth factor, development of a helping-trust relationship, is directly linked to the process of empathy. Wheeler and Barrett (1994) define empathy as the capacity to understand other's feelings as if they were their own, while remaining fully aware of their own identity. Wheeler and Barrett (1994) also state that empathy is the quality responsible for creating a caring environment. Empathy is considered crucial to caring and assists the development of a helping-trust relationship between the APN and patient. The process of empathy relates to this project's overall goal of enabling APN's to use

their coaching/counseling role to effectively assist patients to make positive changes to improve the quality of their lives regardless of weight status.

An event occurs when two people with their unique histories and phenomenal fields engage in a human care transaction. An actual caring occasion, a particular type of event, is the result of a transpersonal caring relationship, and has a phenomenal field that is unique to the event and greater than the actual time-bound occasion (Fawcett, 1993). It involves actions and choice by the APN and the individual. The moment of coming together in a caring occasion presents the two persons with the opportunity to decide how to be in the relationship-what to do with the moment.

Watson also defines a human being as a valued person to be cared for, respected, nurtured, understood, and assisted. In relation to this project, the concept of human care is important in dispelling the prejudice against large people, or sometimes called "fatism" (Kratina et al., 1996). As professionals who seek to enhance the health of large people, APNs must be sensitive to the devastating effects of fatism, and be willing to examine their own assumptions, beliefs, and behaviors. Watson contends that caring can assist the patient to gain control, become knowledgeable, and promote health changes (George, 1995).

Watson is the only nursing theorist who assigns special significance in human existence to the soul. The characteristics relating to the soul that she identifies are self-awareness, high and greater degrees of consciousness, inner strength and power (Nicoll, 1997). These characteristics relate to the importance of APN's educator role by helping patients develop normalized eating skills by becoming aware of their body's inner signals and feelings, and to help examine their souls to gain the strength and power to love the body they already have. Instillation of faith-hope, the 2nd carative factor, also describes the APN's role in promoting wellness by helping the patient adopt positive health behaviors. Harmony of body and soul is important in the APN's holistic approach in the relationship. Holistic care is the basis of the traditional nursing model.

Furthermore, Watson's theory acknowledges the concept of causal past and proposes that a troubled inner soul can lead to underlying causes of unhealthy behaviors thereby producing illness. This concept relates to a weight cycling patient, who from repeated experiences of weight gain in the past, directly effects their health physically with the development of other diseases, and psychologically by creating feelings of depression, shame, and disappointment. The goal of the APN utilizing their coaching/counseling role is to assist the patient to a healthful lifestyle that can

be maintained indefinitely, rather than a short term "diet" that will most likely be abandoned and produce more overweight and psychological discomfort (Polivy, 1995).

Conceptual Definitions

To aid in the understanding of the adapted model for the project, definitions of the key concepts of knowledge, attitude, paradigms, current weight paradigm, and new weight paradigm are defined. The dictionary's (Merriam-Webster, 1994) definition of knowledge is information acquired through learning or the condition of being aware of something. Attitude is defined as a learned tendency that can change with new information (Pender, 1996). Paradigms are defined by Kratina et al. (1996) as the theoretical frameworks by which professional practices are formulated, evaluated, and adapted. Paradigms can shift due to repeated experiences with limitations and failures of existing paradigms (Robison, 1997). The current weight or traditional diet paradigm is a concept also defined by Kratina et al. (1996) that teaches that there is a lean optimal body weight for all persons to maintain and achieve and is used as a measure of success. This paradigm argues that diets are necessary because the incidence of disease and premature death increases in direct proportion to body weight. Kratina et al. defines the new weight or non-dieting weight paradigm as a concept that focuses on a healthy lifestyle regardless of weight status; it is a holistic, nondiet view that

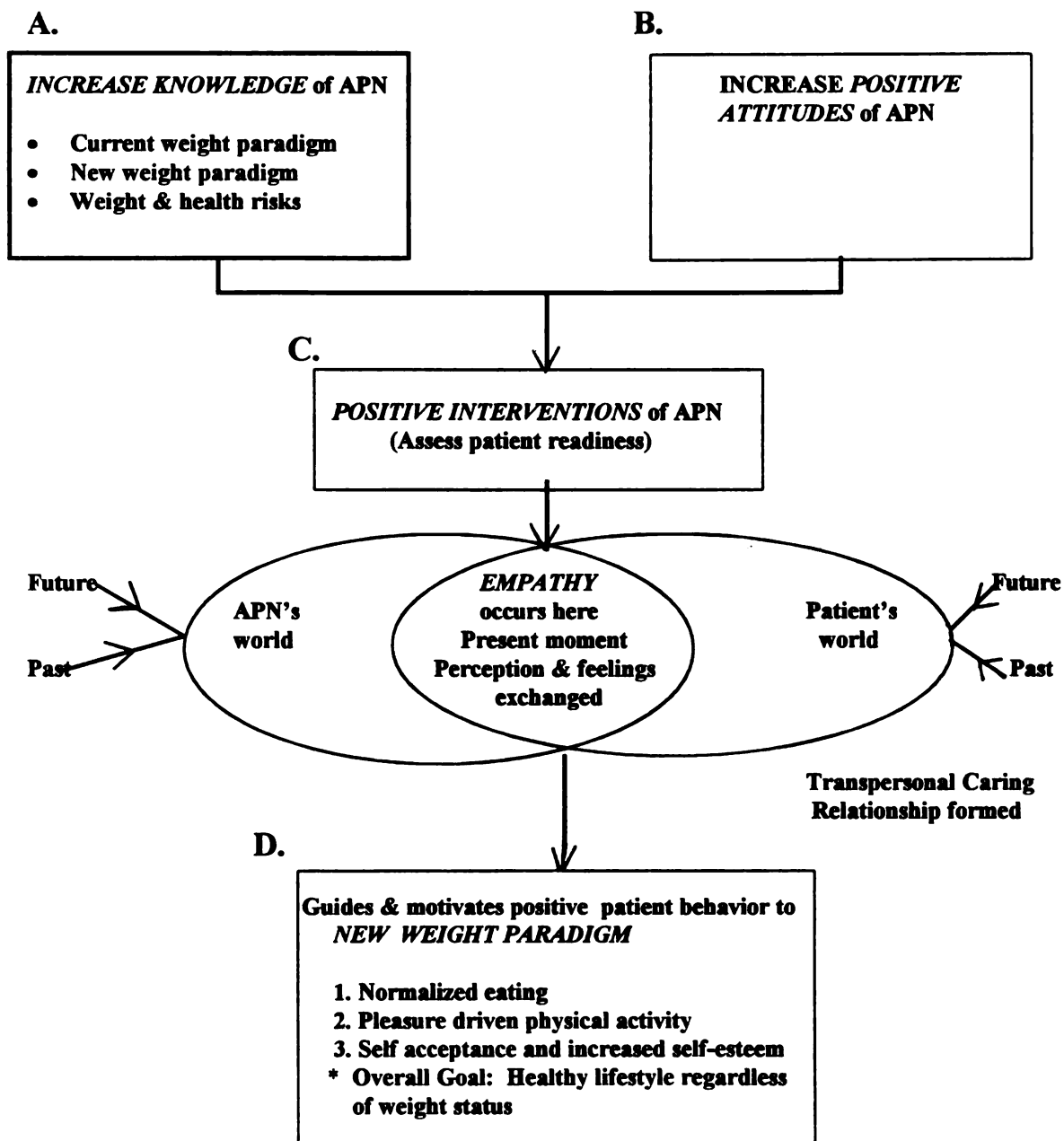
recognizes the many dimensions of personal health, including its physical, emotional, mental, and spiritual aspects.

Adapted Conceptual Model

For the purpose of this project, an adapted conceptual model has been developed to represent the relationship of empathy within Watson's theory (see Figure 2). Depicted in the model is that by increasing the knowledge of the APN of the current and new weight paradigms with the associated weight and health risks, and by increasing positive attitudes of the APN, interventions of the APN result which are positive. At the same time, the APN is sensitive to assessing where the patient is in terms of readiness for change. This model shows the worlds of the nurse and patient merging in an exchange of their feelings in the present moment and empathy occurs. The future and past of both selves (APN and patient) are influences of the interaction. The outcome of this transaction is a transpersonal caring relationship which results in motivating positive patient behavior to the new weight paradigm. These specific patient behaviors include normalized eating habits, pleasure driven physical activity, self acceptance and increased self-esteem, with the resulting overall goal of a healthy lifestyle regardless of weight status. The ability of the APN to have empathy for the patient gives depth and meaning to the relationship, adding a dimension of real understanding and communication between the participants.

Prochaska's spiral model of stages of change is conceptually consistent within Watson's theory of human caring in relation to this project. In Prochaska's contemplation and preparation stages, it is important for the individual to become more aware of themselves and their behavior by seeking new information, understanding and feedback. Change does not begin with action and prerequisites of awareness, decision making, and readiness are necessities in contemplation and preparation. Watson's theory is consistent here as it contends that caring aids the patient in gaining control, becoming knowledgeable, and promoting health change. Furthermore, Prochaska's action stage utilizes helping relationships for support during attempts to change behavior from individuals (APNs) who understand and care about their behavior. This is congruent with Watson's central theme of creating a therapeutic helping-trust relationship by using empathy to promote healthy changes thereby leading to a healthy lifestyle.

Figure 2. An adapted model of a caring relationship.



***Caption:** This project focuses on “B,” attitudes of APNs

A. = Increasing the knowledge of the APN

***B.** = Increase positive attitudes of APN

C. = APNs are now intervening using knowledge of the New Weight Paradigm

D. = Clinical Outcomes for patients

REVIEW OF LITERATURE

Current Weight Paradigm

Diets, as defined in the traditional paradigm, prescribe restrictions on usual eating behavior (Kratina et al., 1996). The restrictions could be on calories, type of food, or time when food could be eaten. Research shows these types of restrictions do not work. The resulting effect is exactly the opposite of what the dieter intended. Starvation and self-imposed dieting appear to result in eating binges once food is available as well as psychological manifestations such as preoccupation with food and eating and distractibility (Polivy, 1996). This diet/binge cycle is very common among those who diet frequently.

All dietary weight loss programs are able to demonstrate moderate success in promoting at least some short-term weight loss, but there is virtually no evidence that significant weight loss can be maintained over the long-term by the vast majority of people (National Institutes of Health, 1992). Because health professionals recommend weight loss as the treatment of choice for people who are judged to be overweight, it appears that health care providers as a whole need to become more knowledgeable about the relationship of body weight and health (Garner & Wooley, 1991).

Few studies in the medical literature indicate weight loss decreases mortality risk. According to Manson et al. (1995), in examining the results of the Nurses' Health

Study, there is not conclusive evidence to support that weight loss increases longevity, and conversely, weight loss may increase mortality. Other studies have indicated that weight loss may actually contribute to a shortened life span. For example, Ernsberger and Haskew (1987) found that weight reduction in obese people was associated with a nearly two-fold increase in probability of dying. According to Gaesser (1996) and Berg (1995), research shows that fat people have a lower incidence of and mortality from lung and breast cancer, decreased overall cancer rates and increased survival, decreased osteoporosis and number of hip fractures, decreased lung diseases, and decreased incidence of infectious diseases, especially tuberculosis. "Many of the cardiovascular changes in obesity, such as increased cardiac output, can be attributed to increased lean body mass, rather than adipose stores" (Ernsberger & Haskew, p. 30). Furthermore, it has been shown that body shape is of great importance in determining such health risks as cardiovascular disorders. This is significant when one considers that heart disease is the leading cause of death. The person whose body fat is concentrated in the abdominal area is at greater risk. Thus, "the highest mortality (29%) is in lean persons who have relatively narrow hips relative to their waist" (Ernsberger, 1989, p. 129).

The relationship of obesity to an increased incidence of cardiovascular disease and all-cause mortality has been questioned because of conflicting results from

epidemiological studies (Garner & Wooley, 1991). "The data linking overweight and death, as well as the data showing the beneficial effects of weight loss, are limited, fragmentary, and often ambiguous" (Kassirer & Angell, 1998). Most of the evidence has been derived from epidemiologic studies which have serious methodologic flaws. Kassirer and Angell (1998) also stated that many of these studies fail to account for a number of extraneous variables that may be important to conclusions of the studies. An example given is that mortality among obese people may be misleadingly high because overweight people are more likely to be sedentary and of low socioeconomic status. Therefore, although some claim that every year 300,000 deaths in the U.S. are caused by obesity, the validity of this research has not been well established. Study conclusions may be derived from weak data, and also questionable on methodological grounds (Kassirer & Angell, 1998).

The medical profession considers obesity to be a chronic disease that increases the likelihood of premature morbidity and mortality. Because of the assumption that obesity is synonymous with poor health, people have become accustomed to viewing obesity as illness. Although severe obesity is clearly associated with increased mortality, the health consequences of being mildly to moderately overweight remain controversial. Leanness has been linked to elevated mortality in several studies (Manson et al., 1995; Troiano et al., 1996).

In some studies, the health risks associated with being fat do not escalate until severely obese, or about 75 to 100 pounds over an ideal weight. Severe obesity means a BMI of 35 or heavier (Gaesser, 1996). Overweight does not mean the same as obese. Overweight, defined as a BMI of 27 to 30, is termed by some researchers as "mildly obese," and is not associated with poor health. Several studies found that obese people who exercise live longer than lean people who do not exercise. They discovered that being heavy did not increase the risk of dying prematurely, but when considered in combination with fitness level, being overweight seemed to be better than being underweight according to Blair et al. (1989), Ekelund et al. (1988), Paffenbarger et al. (1986), as cited in Garner and Wooley (1991, p. 763). Inactivity may be the cause of many of the problems associated with obesity, not obesity itself (Troiano et al., 1996).

Permanent weight loss is almost impossible to maintain and the effects of yo-yo dieting appear to be deleterious. Yo-yo dieters develop a constant cycle of weight loss and gain which is called weight cycling or "yo-yoing," resulting in adverse effects on their health status, physiologically and psychologically (Foreyt et al., 1995). Recent research has shown that this cycling has health consequences for a number of people and it has been suggested that people have a biologically determined natural weight which they would be better off maintaining (Wooley & Garner, 1991; Brownell &

Rodin, 1994). The weight cyclers or "yo-yoers," by gaining and losing considerable amount of weight, are found to have higher rates of heart disease due to the artery-clogging increases in cholesterol during the weight-regaining phase of the cycle (Gaesser, 1996).

In a study done by Foreyt et al. (1995), an attempt was made to determine psychological correlates of weight fluctuation. Nonfluctuators reported significantly higher general well-being, greater self-efficacy, and lower stress than weight fluctuators, regardless of body weight. People with a history of weight cycling showed greater pathologic characteristics than people with stable weights, independent of weight. Results suggested that weight fluctuation is strongly associated with negative psychological attributes in both normal weight and obese individuals.

The negative societal attitude toward obesity finds its way into medical as well as standard dictionaries, where the word is typically defined as "excessive bodily fat," "excessive weight," or "grown fat by eating." Gaesser (1996) stated that dictionaries do not generally distinguish between "fat" and "weight," a distinction that has become fashionable only in the last couple of decades. Other definitions of obesity used at various times, now and in the past, are 20 percent or more over "ideal" or "desirable" weight (National Institutes of Health, 1992). Because obesity is usually measured using either body weight, body mass index, or percentage of body fat, pathological levels

of any of these measures are most often decided using guidelines based on height and weight charts originally developed by the life insurance companies. These recommendations, unfortunately, suffer from a lack of scientific validity. According to Garner and Wooley (1991), the use of height and weight tables to define obesity is arbitrary as there is no consideration of the different shapes and sizes of bodies.

Health professionals have advised their patients to lose weight as a preventative measure to reduce chronic disease and early death (Ernsberger & Haskew, 1987; Garner & Wooley, 1991). The opinion that weight loss or dieting is a benign activity, has not been questioned until relatively recently. The American Dietetic Association (1997) has stated that there is only a 5% success rate for the maintenance of weight loss, and success was defined as weight loss with maintenance for only 1 year. Despite these figures it has been estimated that at any one time approximately 25% of men and 45% of women are trying to lose weight (Williamson et al., 1992). With the failure of dieting, it has been documented that there is an increased incidence of negative cognitive states (Foreyt et al., 1995; Polivy, 1996). Depression is one of the most common diagnoses in primary care, with an estimated one in eight people requiring treatment during their lifetime (Depression Guideline Panel, 1993). Psychological treatment of obese people often centers on looking for underlying emotional

problems that led to obesity (Wooley & Garner, 1991). For many people, there are no underlying emotional problems and therapy may create problems where there were none (Burgand & Lyons, 1991; Kratina et al., 1996; Hirschmann & Munter, 1995).

Diets for weight reduction have always been an easy intervention for the professional. If the diet failed, it was the patient's fault. Of course, the diet companies did not mind either because these failures kept an ample supply of new recruits wanting a quick and easy remedy. Previous studies have shown the five year success rate to be low. One in twenty who try will reach their weight loss goal. The National Institutes of Health (1992) emphasizes that there have been few scientific studies evaluating the safety and effectiveness of most weight loss methods. Most health care professionals are trained in college to give advice based on the traditional medical model. Research suggests that guidance, rather than advising, is actually more effective in helping people change lifestyle (Reiff & Reiff, 1992). Giving advice is much more specific and time-efficient than providing a client with guidance (Kratina et al., 1996).

Personal Attitudes

The ways that health professionals have been educated have fostered negative attitudes towards overweight clients. There are many definitions of attitude in the psychology literature and several in health practice sources. Several conceptualizations were incorporated from the literature to

define attitude for this project. Attitude was viewed as a concept that could change with new information, and the values of the individual had an influence on the attitude. Furthermore, an attitude, which could be either positive or negative, was a learned tendency based on personal beliefs, values, perceptions, and experiences.

Obesity is one of the last conditions in the United States in which prejudice is still socially acceptable (Segal-Iaacson, 1996). This is a vast problem considering that more than one-third of U.S. adults are overweight (Kuczmarski et al., 1994). Bias against overweight people, "fattism" or "fat oppression," extends to many areas in life and drives the need to diet and lose weight (Berg, 1995). Discrimination against the overweight is prevalent in hiring and promotion opportunities, in education, in life insurance, and everyday social relationships (Sobal & Devine, 1995). As a result, the overweight have come to be judged on the basis of their appearance rather than upon their character.

Research has shown that US health professionals share in the negative attitudes of the general public of the obese and assume that they bring on their condition on themselves through lack of willpower and self-control (Garner & Wooley, 1991). A recent study by McArthur and Ross (1997) assessed the attitudes of dietitians toward personal overweight and overweight clients. Results showed that dietitians believed

that client overweight was due to emotional factors and that overweight clients can not set realistic goals for weight loss. It was also shown that dietitians had more positive attitudes toward personal overweight status than toward overweight clients.

Another study by Bagley et al. (1989) referenced similar findings of prejudice against overweight patients and demonstrated nurses' withdrawal from obese patients. It was noted that older nurses exhibited more withdrawal which may have been attributed with fear of lifting. The study also found that nurses with more years of professional education had more favorable attitudes toward the obese. Another finding was that dissatisfaction with own body weight was linked to negative attitudes towards obese adults. A comparable study by Maroney and Golub (1992), regarding nurses' attitudes toward obese persons, found similar results with negative stereotypic attitudes toward the obese. They reported that nurses felt uncomfortable, physically exhausted and psychologically stressed when caring for an obese patient. Both studies concluded with the need for continued education in the care of unpopular obese patients to reduce some of this stigmatization.

Several classic studies show that physicians also hold negative attitudes toward the obese. Maddox, Back, and Liederman (1968) found that physicians regarded overweight patients as weak-willed, ugly and awkward. Maiman et al.

(1968) discovered that 84% of physicians and health professionals considered the obese to be self-indulgent, 88% assumed they ate to compensate for other problems, and 70% assumed they were emotionally disturbed. Lazare (1987) suggests that physicians may deal with their patients in a negative way because they, themselves, are feeling shame and humiliation when their therapy is not producing the desired result.

Since women are more likely to be judged on how they look, the stigmatization of overweight and obese women exceeds that of men. Unfortunately, many women delay or avoid needed health care because they are overweight and fear being criticized or embarrassed. Olson, Schumaker, and Yawn (1994) found that this occurs even when the women are health care providers themselves. In addition, many physicians report that they are reluctant to perform preventative health exams on obese patients (Adams, Smith, Wilbur, & Gray 1993).

Not surprisingly, these negative stereotypical views of the obese begin in early childhood. Studies indicated that children as young as six already understood the importance of looking good and being thin and expressed consistent aversion to "chubby silhouettes" (Goldfield & Chrisler, 1995). Other frequently cited historical studies have shown that by grade school children associated larger body shapes with adjectives such as "stupid," "dirty," "sloppy," "mean,"

and "sad" (Staffieri, 1967; Staffieri, 1972; Lerner & Gellert, 1969).

Presently, there are great limitations in what can be predicted or safely accomplished in terms of permanent, significant weight loss (Ernsberger & Haskew, 1987; Berg, 1995). Health care professionals need to recognize that it is unrealistic for most people to attain society's ideal weight and instead need to guide patients toward the new paradigm. Differences need to be accepted, not scorned. There is great human diversity in genetics, body size, and shape. APNs, in their role as primary care providers, have a need for evaluating their own attitudes towards patients' overweight to successfully affect patient outcomes.

New Weight Paradigm

The new weight or non-dieting paradigm is a concept that moves away from diets and focuses on total health rather than on the number of pounds on the scale. Weight is only a single measurement, which may or may not have a direct bearing on health status. Being overweight according to the height and weight charts does not automatically imply poor health, just as being "ideal weight" does not guarantee good health (Kassirer & Angell, 1998). The overall goal in the nondiet approach is to support a healthy lifestyle by focusing on four basic tenants (Kratina et al., 1996; Robison, 1997) (See list of four basic tenants at end of this section).

An important aspect in the new weight paradigm, which needs addressing, is the terminology used to describe the relationship between health and weight. In order to work compassionately and effectively with clients with weight-related concerns, it is important for new paradigm practitioners to avoid such labels as obese, overweight, overfat, and morbidly obese (Robison & Erdman, 1998). It is recommended that they not be used as not only are they not compassionate, but they are not scientifically defensible (Garner & Wooley, 1991; Kassirer & Angell, 1998).

Many health professionals, APNs as well as physicians, have not been introduced to the new non-dieting weight paradigm. They do not realize that a person can be "fit and fat," and continue to prescribe disastrous interventions such as restricted calorie diets, instead of treating the underlying health conditions (Berg, 1995). The underlying causes of overweight are unknown. The National Institutes of Health (1992) notes that "increasing physiological, biochemical and genetic evidence suggests that overweight is not a simple problem of will power, as is sometimes implied, but a complex disorder of appetite regulation and energy metabolism" (p. 943).

The APN can use other interventions in place of promoting restrictive eating. The role of the APN in the non-diet approach is to facilitate a path to self-care. Unlike a diet, this new paradigm is not a quick fix. "If indeed the lifestyle factors are responsible for health

risks, then it may be more prudent to focus directly on lifestyle rather than obesity, where treatment compliance and long term weight reduction results have been so poor" (Garner & Wooley, 1991, p. 761).

The literature indicates that an active lifestyle, with normalized eating habits will promote health and well-being, even without the achievement of weight loss (Kratina et al., 1996). In their book, Moving Away From Diets, (p. 6), the authors cite four basic tenets the new paradigm is concerned with:

1. Total health enhancement and well-being, rather than weight loss or achieving a specific ideal weight.
2. Self-acceptance and respect for the diversity of healthy, beautiful bodies, rather than the pursuit of an idealized weight at all cost.
3. The pleasure of eating well, based on internal cues of hunger and satiety, rather than on external food plans or diets.
4. The joy of movement, encouraging all physical activities rather than prescribing a specific routine of regimented exercise.

Erdman (1996) advises large women to "eat healthfully (no diets); move your body because it feels good, not because you think it will help you to lose weight; and get on with your life" (p. 21). In addition, exercise has been shown to produce significant improvements in blood pressure,

lowered lipoproteins, lowered fasting plasma insulin, reduced stress, and there is evidence that physical fitness reduces mortality (Garner & Wooley, 1991). Many larger individuals may be too discouraged to engage in exercise for fear of the embarrassment and ridicule that they have experienced over the years. Pleasure-driven physical activity can help them reveal and reconnect to the bodies they have been accustomed to hate and neglect (Robison, 1997).

Whatever the patient's size, self-acceptance is essential in the non-dieting paradigm. Feeling good about their bodies and trusting internal signals are essential. For some, self-acceptance and body-size acceptance is one of the most difficult components to grasp. It directly relates to self-esteem and is essential for building a healthy lifestyle. Individuals are motivated to successful behavior change when they learn self-acceptance skills and feel good about themselves (Robison, 1997).

Normalized eating is another importance focus of this new paradigm which involves reducing anxiety about food, calories, fat, etc. and relearning to regulate food intake in response to physical hunger and satiety cues (Satter, 1987). Increased attention to internal needs and mindful eating is accomplished by re-teaching patients how to recognize true hunger, as distinguished from cravings. Chronic dieters often have learned to ignore hunger and

their satiety signals are altered. Normalized eating enables them to use normal physiological and psychological cues to guide food intake.

Since the current dieting weight paradigm has been shown to be ineffective in producing lasting results and creates more problems for clients, both physiological and psychological, the need for the introduction of an alternative paradigm is needed. The widespread presumption that fatness is always pathological and the relentless pressure to lose weight has created a stigmatization and social prejudice for large people. This attitude has been documented in many studies to be shared by health professionals and actually impedes the development of compassionate, and clinically effective care.

Since most counseling of clients around weight-related concerns occurs in primary care, APNs must be sensitive to the devastating effects of their own negative attitudes. In order to be effective in the treatment of these clients, they need to be introduced to the new weight paradigm to develop positive interventions to guide and motivate positive patient behavior to the new weight paradigm. A theoretical framework adapted from Watson's theory of human caring will be instrumental in promoting a caring relationship between the APN and their clients. The overall goal for APNs in the alternative paradigm is to use these

new approaches to empower people to live healthier, more fulfilled lives regardless of weight status.

PROJECT DEVELOPMENT PLAN

The purpose of this project is to develop an assessment to examine APN's attitudes toward clients who present with weight-related concerns. This assessment will function as a beginning step for the APN in appraising and determining their attitudes toward large clients in the primary care setting. The first step is important because the literature has shown that US health professionals share in negative attitudes of the general public (Garner & Wooley, 1991) toward large clients, and these negative attitudes potentially hinder the effectiveness of counseling interventions for clients. Because attitudes are defined as learned tendencies that can change with new information, this project has the potential to result in positive attitude change by increasing the APN's knowledge of the new weight paradigm. A desirable result of this change is use of clinical interventions, enabling APNs to therapeutically guide and motivate clients to a healthier lifestyle.

A comprehensive educational module would present information on current and new weight paradigms, assess APN's attitudes and knowledge, and teach the four tenets of the new weight paradigm. The comprehensive program is outlined below:

- *I. Assess APN's attitudes toward the overweight
 - A. Attitudes Toward Obese Persons Scale (ATOP)
 - B. Attitudes Toward Obese Adult Patients
 - C. Scale Fat Phobia (FPS)

*Focus of current project
- II. Assess APN knowledge of current and new weight paradigms
 - A. Short quiz on assessing knowledge of weight paradigms
 - B. Present information on the current weight paradigm
 - C. Present information on the new weight paradigm
 - D. Present information on the correlation of weight and health
- III. Address the four tenets of the new weight paradigm
 - A. Normalized eating
 - B. Pleasure-driven physical activity
 - C. Self acceptance and increased self-esteem, including how to "size-friendly" their office setting
 - D. Total health and well-being, rather than weight loss

* Resource List for the non-dieting (new) weight paradigm made available to include:

books, magazines, videos, organizations,
catalogs, workshops, and newsletters

For the purposes of this project, the first objective: "Assessing APN's attitudes toward the overweight" is addressed. This objective is the first step in the educational module, to assess the nature of the health professional's attitudes prior to the actual teaching portion of the module.

This project is for use in the primary care setting to assess APN attitudes toward clients who present with weight-related concerns. This project uses a series of three previously-developed surveys that assess attitudes and beliefs about obese people (from Allison, 1995; see Appendices D, E, F). Attitude scales consist of a series of statements that respondents rate by indicating the extent of their agreement or disagreement with each statement, or by selecting appropriate adjectives from a list they are given. These surveys can be distributed either through the mail or in person to APNs. Questionnaires are usually considered to be less expensive and more objective than interviews, which can bias answers, by the way the questions are asked (Allison, 1995). Assurance of confidentiality will be important as personal attitudes are a socially sensitive topic. Incentives for the participants to complete and return the surveys will assure a higher representation, i.e., entering their name in a raffle, a pre-addressed, stamped return envelope.

A demographic questionnaire will be completed together with surveys. This portion of the assessment will include personal information about the participants (APNs): gender, age, APN's height and weight, number of years in practice as an APN, practice setting or type of specialty, education level, whether the respondent currently practices as an APN, and a response to the question, "What is the new weight paradigm?".

The first survey listed in Appendix D, "Attitudes Toward Obese Persons Scale or (ATOP)," was adapted from Yuker and Block (1995). This model tends to focus on "discriminatory" and "stereotypical" perceptions of stigmatized individuals as examples of negative attitudes toward these people (Allison, 1995). The ATOP, described by Allison (1995), utilizes a Likert-type scale with reliability coefficient alphas ranging from .80 to .84, reflecting good internal consistency for reliability in various samples. These samples consisted of 514 members of the National Association to Advance Fat Acceptance and 124 college and graduate students.

The second survey is listed in Appendix E, "Attitudes Toward Obese Adult Patients" and was developed by Bagley et al. (1995) to assess nurses' attitudes toward obese patients. This questionnaire also uses a Likert-type scale, consisting of two scales, "Nursing Management" (15 items) and "Personality and Lifestyle" (13 items). These two scales were found to correlate .75 with each other (Allison, 1995),

indicating that a negative attitude toward caring for obese patients is associated with a negative attitude toward obese persons in general. Reliability data were not provided. Construct validity was assessed in a sample of 107 nurses. Scores on the two scales were associated in expected directions (r values ranging between .54 and .64) with various semantic differential ratings of "an obese adult." Scoring instructions are not given for "The Attitudes Toward Obese Adult Patients Scale," although high scores indicate favorable attitudes and low scores indicate unfavorable attitudes (Bagley et al., 1995). For the purposes of this project, a sum score will be used.

The third survey (see Appendix F), "Fat Phobia Scale (FPS)," was developed based on a theoretical model of Robinson, Bacon, and O'Reilly, (1995). This model affirms that "fat phobia" refers to a pathological fear of fatness which is most often manifested as negative attitudes and stereotypes about fat people (Robinson et al., 1995). Fat phobia is defined as dislike of, hatred for, or disgust for fat people and a fear of becoming fat oneself (Allison, 1995). Robinson et al. (1995) reported an alpha coefficient of .92 for the Fat Phobia Scale showing very high internal consistency reliability for a sample of people who entered a motor vehicle license bureau in a Minnesota suburb (exact number not reported). Robinson et al. (1995) stated that their method of item development demonstrates that the scale has "content validity," as evidenced by a quasi-experimental

study. It showed that a treatment designed to improve attitudes toward obese persons did demonstrate significantly improved attitudes as measured by the total FPS.

After completion, the surveys would be sent back to the administrator (preferable arrangement is for someone else to collect/analyze for protection of confidentiality), for computation and recording of the results. Data regarding attitudes would be gathered using a pre-test/post-test descriptive survey design. It would be important for these surveys to be repeated after the entire educational module was completed by the APNs to compare results showing evidence that the incorporation of this new knowledge improved their attitudes toward clients who present with weight-related concerns. Further evaluation would be important to see what effect this project had on patient clinical outcomes.

IMPLICATIONS FOR ADVANCED NURSING PRACTICE

There are many goals for primary care, among which are promoting wellness and healthy lifestyle behaviors. APNs are in the pivotal position to accomplish this. What other health-related issue is better for APNs to be involved in than with weight-related issues? However, to be maximally therapeutic, APNs in general must become knowledgeable about the new weight paradigm and change their own behavior and attitudes toward clients who present with weight-related concerns in primary care.

When introducing a new paradigm, it is important to show what is being done differently now that is an improvement over the old paradigm (Robison, 1997). First is the enhancement in the quality of care as a result of APN's increased knowledge of the new weight paradigm. The APN utilizes the teaching/coaching/counseling role that will assist them in developing positive interventions to empower their patients to make positive changes in their health, facilitating a productive path to self-care.

Another potential improvement as a result of APNs embracing the new weight paradigm and utilizing the role of the teacher, coach, and counselor, is lower costs of health care. Because weight itself is not the focus, the client would be more likely to return to the primary care provider for preventive care. Studies have shown in the literature that patients, especially women, put off preventive care as they fear the embarrassment of being weighed (Adams et al., 1993). Instead of continuing to work on diet failures and weight loss, time would be better spent on health promotion techniques. This is so important when the literature states that there is a 95% plus failure rates of diets (National Institutes of Health, 1992). Furthermore, the improvement of self acceptance and increased self-esteem as a positive clinical outcome would result in less depression which would result, too, in lower health care costs.

The project can also serve as a starting point to further research. The APN is qualified to design and

implement research projects based on implementation of the assessment tool. Success in intervening with clients with weight-related concerns has much room for improvement. Research conducted and published by the APN is needed to better understand the nature of the clinical problem and to test nursing theory to advance nursing knowledge for clinical practice. The knowledge development that can be generated with this project is a publishable assessment of APN's attitudes toward weight. To date there has been limited research in this area with published attitude assessments having been conducted only with dietitians and physicians.

Another potential area for research is the development of a framework for APNs to assess where patients are in regard to readiness for behavior change. This would be a helpful tool for formulating interventions for the new weight paradigm to promote healthy lifestyle regardless of weight status. This research is essential in order to document the APN's positive interventions on client outcomes.

This project reports development of an assessment of APN's attitudes toward clients who present to primary care. It represents the first step in a comprehensive educational module for APNs to be introduced to the new weight paradigm. This tool can serve as a springboard for the APN for future nursing research, education, and practice.

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APPENDICES

APPENDIX A

GLOSSARY

GLOSSARY

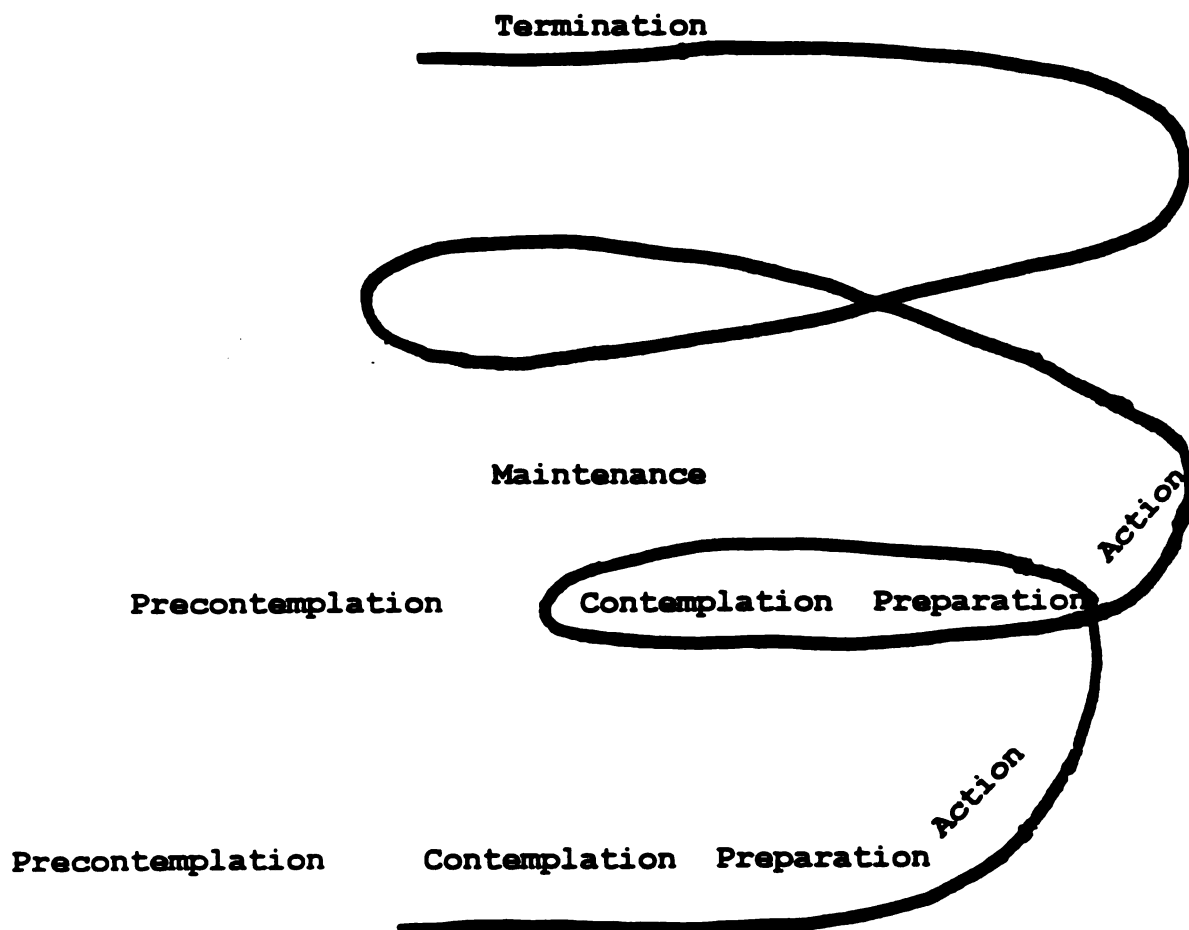
1. **Actual caring occasion**-a particular type of event and is the result of a transpersonal caring relationship (Watson, 1985; Fawcett, 1993).
2. **Attitude**-a learned tendency that can change with new information (Pender, 1996).
3. **Body Mass Index (BMI)**-Weight (in kilograms) divided by height (in meters) squared; the medical standard used to define weight status (Thomas, 1995).
4. **Carative Factors**-intervention processes or modalities used in a transpersonal caring relationship (Watson, 1985).
5. **Current Weight Paradigm**-a paradigm that teaches that there is a lean optimal body weight for all persons to maintain and achieve. This paradigm argues that diets are necessary because the incidence of disease and premature death increases in direct proportion to body weight; also termed "old paradigm," "traditional paradigm," or "dieting paradigm" (Kratina et al., 1996).
6. **Empathy**-the capacity to understand other's feelings as if they were their own, while remaining fully aware of their own identity (Wheeler & Barrett, 1994).
7. **Event**-an outcome that occurs when two people with their unique histories and phenomenal fields engage in a human care transaction (Watson, 1985).
8. **Fat**-a complicated word that many large people are offended by as it brings back memories of childhood taunts like "fatso" and "fatty" (Kratina et al., 1996).
9. **Fat Oppression**-bias against overweight people; synonymous with "fatism" (Berg, 1995).
10. **Fatism**- bias against overweight people; synonymous with "fat oppression" (Berg, 1995).
11. **Human Care**-human to human contact which becomes a way of knowing the self and the other (Watson, 1985).

12. **Knowledge**-information acquired through learning or the condition of being aware of something (Merriam-Webster, 1994).
13. **Obesity**-an excess of body fat; a BMI of 35 or heavier (Gaesser, 1996).
14. **Overweight**-a BMI of 27 to 30; sometimes termed as "mildly obese" by some researchers (Gaesser, 1996).
15. **New Weight Paradigm**-a paradigm that focuses on a healthy lifestyle regardless of weight status; a holistic, nondiet view that recognizes many dimensions of personal health, including its physical, emotional, mental, and spiritual aspects; also termed "nondietering paradigm" (Kratina et al., 1996).
16. **Paradigms**-the theoretical frameworks by which professional practices are formulated, evaluated, and adapted (Robison, 1997).
17. **Phenomenal Field**-the subjective experience of the person; one's frame of reference and can only be known by others indirectly through empathetic understanding (Watson, 1985).
18. **Self**-the ideal self that the person would like to be, and also the spiritual self which is synonymous with the geist or soul of the person (Watson, 1985).
19. **Transpersonal Caring Relationship**-a specific type of professional human-to-human contact having the goal of restoring the patient's experience of inner harmony (Watson, 1985).

APPENDIX B
PROCHASKA' S MODEL

APPENDIX B

A Spiral Model of the Stages of Change starts with precontemplation, moving through a series of attempts, until maintenance and termination is reached (Prochaska, DiClemente, and Norcross, 1992).



APPENDIX C

WATSON' S CARATIVE FACTORS

APPENDIX C

Watson's ten carative factors

1. Formation of a humanistic-altruistic system of values
2. Instillation of faith-hope
3. Cultivation of sensitivity to one's self and to others
4. Development of a helping-trusting, human care relationship
5. Promotion and acceptance of the expression of positive and negative feelings
6. Systematic use of a creative problem-solving caring process
7. Promotion of transpersonal teaching-learning
8. Provision for a supportive, protective, and/or corrective mental, physical, societal, and spiritual environment
9. Assistance with gratification of human needs
10. Allowance for existential-phenomenological-spiritual forces

APPENDIX D

**ATTITUDES TOWARD OBESE
PERSONS SCALE
(ATOP)**

Attitudes Toward Obese Persons Scale (ATOP)

Please mark each statement below in the left margin, according to how much you agree or disagree with it. Please do not leave any blank. Write a +1, +2, +3, or -1, -2, -3, according to the scale below.

+3 = I strongly agree

+2 = I moderately agree

+1 = I slightly agree

-1 = I slightly disagree

-2 = I moderately disagree

-3 = I strongly disagree

-
1. _____ Obese people are as happy as nonobese people.
 2. _____ Most obese people feel that they are not as good as other people.
 3. _____ Most obese people are more self-conscious than other people.
 4. _____ Obese workers cannot be as successful as other workers.
 5. _____ Most nonobese people would not want to marry anyone who is obese.
 6. _____ Severely obese people are usually untidy.
 7. _____ Obese people are usually sociable.
 8. _____ Most obese people are not dissatisfied with themselves.
 9. _____ Obese people are just as self-confident as other people.
 10. _____ Most people feel uncomfortable when they associate with obese people.
 11. _____ Obese people are often less aggressive than nonobese people.
 12. _____ Most obese people have different personalities than nonobese people.
 13. _____ Very few obese people are ashamed of their weight.
 14. _____ Most obese people resent normal weight people.
 15. _____ Obese people are more emotional than other people.
 16. _____ Obese people should not expect to lead normal lives.
 17. _____ Obese people are just as healthy as nonobese people.
 18. _____ Obese people are just as sexually attractive as nonobese people.
 19. _____ Obese people tend to have family problems.
 20. _____ One of the worst things that could happen to a person would be for him to become obese.

(Yuker & Block, pp. 106-107, 1995) .

Scoring instructions for ATOP.

Step 1: Multiply the response to the following items by -1 (i.e., reverse the direction of scoring):

– Item 2 through Item 6, Item 10 through Item 12, Item 14 through Item 16, Item 18 through Item 20

Step 2: Add up the responses to all items.

Step 3: Add 60 to the value obtained in Step 2. This value is the ATOP score. Higher numbers indicate more positive attitudes.

(Yuker & Block, pp. 106–107, 1995)

APPENDIX E

**ATTITUDES TOWARD OBESE
ADULT PATIENTS SCALE**

Attitudes Toward Obese Adult Patients

Note: All statements (items) are scored using a 1-5 Likert-type scale:

1 = Strongly Agree

2 = Agree

3 = Unsure

4 = Disagree

5 = Strongly Disagree

-
1. _____ Obesity in adults can be prevented by self-control. (P&L)
 2. _____ Most obese adults have poor food selection. (P&L)
 3. _____ Obese adults should be put on a diet when in hospital. (NM)
 4. _____ Most obese adults are pushy and aggressive. (P&L)
 5. _____ Caring for an obese adult is physically exhausting. (NM)
 6. _____ Nurses often feel uncomfortable when caring for obese adult patients. (NM)
 7. _____ Obese adults experience less success in life. (P&L)
 8. _____ It is unlikely that an adult of normal weight would want to marry an obese adult. (P&L)
 9. _____ Weight loss is only a matter of changing one's lifestyle. (P&M)
 10. _____ Caring for an obese patient is stressful. (NM)
 11. _____ Caring for an obese adult patient usually repulses me. (NM)
 12. _____ Most obese adults are more demanding than other patients. (NM)
 13. _____ Caring for an obese adult patient is emotionally draining. (NM)
 14. _____ I often feel impatient when caring for an obese adult patient. (NM)
 15. _____ Most nurses find it difficult to obtain the cooperation of obese adult patients. (NM)
 16. _____ Most obese adults lack self-confidence. (P&L)
 17. _____ If given the choice, most nurses would prefer not to care for an obese adult patient. (NM)
 18. _____ I'd rather not touch an obese adult. (NM)
 19. _____ It is difficult to feel empathy for an obese adult. (NM)
 20. _____ Most obese adults are overindulgent. (P&L)
 21. _____ It does not hurt to apply "scare" tactics to obtain the compliance of the obese adult patient. (NM)
 22. _____ Most obese adults are unkempt. (P&L)
 23. _____ Obese adults rarely express their true feelings. (P&L)
 24. _____ Obese adult patients require a firm approach. (NM)
 25. _____ Most obese adults can lose weight if they change their eating habits. (P&L)
 26. _____ I feel disgust when I am caring for an obese adult patient. (NM)
 27. _____ Most obese adults experience unresolved anger. (P&L)
 28. _____ Most obese adults are lazy. (P&L)

(Bagley et al., pp. 109-110, 1995).

APPENDIX F

**FAT PHOBIA SCALE
(FPS)**

Fat Phobia Scale (FPS)

Listed below are adjectives sometimes used to describe *obese or fat* people. Please indicate your beliefs about what fat people are like on the following items by placing an X on the line that best describes your feelings and beliefs.

- | | | |
|-----------------------------|-----------|-----------------------|
| 1. lazy | _ _ _ _ _ | industrious |
| 2. sloppy | _ _ _ _ _ | neat |
| 3. disgusting | _ _ _ _ _ | not disgusting |
| 4. friendly | _ _ _ _ _ | unfriendly |
| 5. nonassertive | _ _ _ _ _ | assertive |
| 6. no willpower | _ _ _ _ _ | has willpower |
| 7. artistic | _ _ _ _ _ | not artistic |
| 8. creative | _ _ _ _ _ | uncreative |
| 9. warm | _ _ _ _ _ | cold |
| 10. depressed | _ _ _ _ _ | happy |
| 11. smart | _ _ _ _ _ | stupid |
| 12. reads a lot | _ _ _ _ _ | doesn't read a lot |
| 13. unambitious | _ _ _ _ _ | ambitious |
| 14. easy to talk to | _ _ _ _ _ | hard to talk to |
| 15. unattractive | _ _ _ _ _ | attractive |
| 16. miserable | _ _ _ _ _ | jolly |
| 17. selfish | _ _ _ _ _ | selfless |
| 18. poor self-control | _ _ _ _ _ | good self-control |
| 19. inconsiderate of others | _ _ _ _ _ | considerate of others |
| 20. good | _ _ _ _ _ | bad |

(Robinson, Bacon, & O'Reilly, pp. 117-118, 1995).

21. popular	— — — — —	unpopular
22. important	— — — — —	insignificant
23. slow	— — — — —	fast
24. ineffective	— — — — —	effective
25. careless	— — — — —	careful
26. having endurance	— — — — —	having no endurance
27. inactive	— — — — —	active
28. nice complexion	— — — — —	bad complexion
29. tries to please people	— — — — —	doesn't try to please people
30. humorous/funny	— — — — —	humorless/not funny
31. inefficient	— — — — —	efficient
32. strong	— — — — —	weak
33. individualistic	— — — — —	not individualistic
34. pitiful	— — — — —	not pitiful
35. independent	— — — — —	dependent
36. good-natured	— — — — —	irritable
37. self-indulgent	— — — — —	self-sacrificing
38. passive	— — — — —	aggressive
39. indirect	— — — — —	direct
40. likes food	— — — — —	dislikes food
41. dirty	— — — — —	clean
42. does not attend to own appearance	— — — — —	very attentive to own appearance
43. easygoing	— — — — —	uptight
44. shapeless	— — — — —	shapely
45. overeats	— — — — —	undereats
46. smells bad	— — — — —	smells good
47. sweaty	— — — — —	not sweaty
48. moody	— — — — —	even-tempered
49. insecure	— — — — —	secure
50. low self-esteem	— — — — —	high self-esteem

(Robinson, Bacon, & O'Reilly, pp. 117-118, 1995).

Scoring instructions for the FPS.

Step 1: For items 4, 7-9, 11-12, 14, 20-22, 26, 28-30, 32-33, 35-36, and 43, score the FPS as follows:

1 2 3 4 5

Step 2: For items 1-3, 5-6, 10, 13, 15-19, 23-25, 27, 31, 34, 37-42, and 44-50, score the FPS as follows:

5 4 3 2 1

Step 3: Add up the score for each item to get the total score for the FPS. The range of scale is 50-250.

– High score = more “fat phobia”

– Low score = less “fat phobia”

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