CASE REPORT

Wellness Coaching for Obesity: A Case Report

肥胖健康辅导

Formación de bienestar para la obesidad

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ABSTRACT

D.S. presented to a medical and surgical weight-loss program to initiate bariatric surgery. He had made numerous attempts at weight loss to no avail and was taking steps toward bariatric surgery as a last viable option. D.S.'s health insurance provider required 3 months of supervised weight loss prior to approval for surgery, and this was initiated with a board-certified bariatrician (MD) and a registered dietitian nutritionist (RDN)/wellness coach.

D.S. presented with a body mass index (BMI) >40 and was classified as morbidly obese with comorbidities of high cholesterol and hyperglycemia and degenerative joint disease (DJD) of the knees. D.S. began the process outlined by his insurance company, meeting with the MD and RDN/wellness coach monthly. A plan was developed by D.S. and his RDN/wellness coach that alligned with his wellness vision, values, and lifestyle. D.S. ate meals and snacks at regular intervals throughout the day, consumed little to no red meat, increased his consumption of fruits and vegetables, and spent 1 hour daily in a swimming pool—walking, swimming, or both.

By the end of the 3-month period required by the insurance provider, D.S. had lost more than 30 lbs, improved his exercise capacity, no longer used a cane, and chose to continue with coaching rather than undergo bariatric surgery. D.S. continued to meet with the MD and RDN monthly for 1 year and averaged a 10-lb weight loss per month for a total of 120 lbs, normalizing his blood panels and improving his joint mobility. D.S. continued to meet with the RDN/wellness coach for a total of 10 visits during year 2 and quarterly visits through year 3. D.S. lost a total of 240 lbs, maintained the weight loss over the 3-year period, and achieved these results solely through lifestyle interventions.

Although bariatric surgery is a viable treatment option for class 2 and 3 obesity, many patients pursue this treatment option without the help of medical and commercial weight loss personnel to improve the likelihood of weight loss sustainability. The investment of lifestyle intervention in this circumstance was less than $5000 (exclusive of blood panels) compared with the $20000 cost of bariatric surgery at the time of intervention.

摘要

D.S. 被介绍到一个医学和手术减重计划，以开始减肥手术。他曾多次尝试减重，但均无效果，并且正准备将减肥手术作为最后一个可行选择。D.S. 的健康保险提供者在批准手术前需监督其减重 3 个月，这将由通过委员会认证的肥胖治疗专家 (MD) 和注册营养师 (RDN) / 健康教练开始。

D.S. 提交的身体质量指数 (BMI) > 40，被列入病态肥胖类，并患有高胆固醇、高血糖和膝盖退化关节病 (DJD) 的合并症。D.S. 开始了其保险公司提出的流程，每月与 MD 和 RDN / 健康教练见面。D.S. 及其 RDN / 健康教练制定了一项符合其健康愿景、价值观和生活方式的计划。D.S. 每天定时进餐和吃小吃，几乎不吃红肉，增加了水果和蔬菜的摄入量，并每天花 1 小时在游泳池内行走、游泳，或两者都做。

在保险提供者规定的 3 个月结束前，D.S. 已减去 30 多磅，他提高了运动能力，不再使用拐杖，并选择继续接受辅导，而不进行减肥手术。D.S. 在 1 年内每月继续与 MD 和 RDN 见面，平均每月减重 10 磅，总共减去 120 磅，他的血液检测趋于正常，关节的活动能力也得到改善。D.S. 继续与 RDN / 健康教练见面，在第 2 年总共见面 10 次，在第 3 年每季度见面一次。D.S. 总共减去了 240 磅，并在 3 年的时间内维持减去的体重，而这些成效仅通过生活方式干预便得以实现。

虽然对 2 级和 3 极肥胖而言减肥手术是一种可行的治疗选择，许多患者在没有医疗和商业减重人员的帮助下，寻求这种治疗选择以提高持续减重的可能性。在这种情况下，生活方式干预的投资低于 5000 美元（不包括血液检测），相对干预时的减肥手术费用达 20,000 美元。

SINOPSIS

D. S. acudió a un programa médico y quirúrgico de pérdida de peso para someterse a una cirugía bariátrica. Había realizado numerosos intentos infructuosos para perder peso y se dirigió hacia la cirugía bariátrica como última opción viable. El proveedor del seguro médico de D. S. le exigía que perdiera peso de forma supervisada durante 3 meses antes de acceder a la intervención quirúrgica, para lo cual se puso en manos de un médico bariatra titulado y de un nutricionista dietista titulado/monitor de bienestar.

D. S. presentaba un índice de masa corporal (IMC) > 40 y su estado se clasificó como de obesidad mórbida con las comorbilidades de colesterol elevado, hiperglucemia y artropatía degenerativa de las rodil-

las. D. S. inició el proceso establecido por su compañía de seguros, durante el cual se reunió cada mes con el médico y con el nutricionista/monitor de bienestar. D. S. y su nutricionista/monitor de bienestar elaboraron un plan de acuerdo con su visión del bienestar, sus valores y su estilo de vida. D. S. ingirió alimentos y tentempiés a intervalos regulares a lo largo del día, apenas consumió carnes rojas, incrementó su consumo de frutas y verduras, y pasó una hora diaria en la piscina caminando, nadando o haciendo ambas cosas.

Al final de los 3 meses establecidos por su compañía de seguros, D. S. había perdido más de 13,5 kg, mejoró su capacidad para hacer ejercicio, dejó de usar un bastón y decidió continuar con la formación en lugar de someterse a la cirugía bariátrica. D. S. siguió manteniendo reuniones mensuales con el médico y con el nutricionista durante 1 año y perdió por término medio 4,5 kg al mes hasta un total de 55 kg, con una normalización de sus valores hematológicos y una mejoría de su movilidad articular. D. S. acudió a un total de 10 visitas con el nutricionista/monitor de bienestar durante el segundo año, y a lo largo del tercer año se reunió con él trimestralmente. D. S. perdió un total de 109 kg, mantuvo la pérdida de peso a lo largo de los 3 años y consiguió estos resultados exclusivamente mediante intervenciones en el estilo de vida.

Aunque la cirugía bariátrica constituye una opción de tratamiento viable para las obesidades de clase 2 y 3, muchos pacientes recurren a esta opción sin ayuda del personal médico y comercial dedicado a la pérdida de peso para incrementar la probabilidad de que esta se mantenga. En este caso, la suma invertida en la intervención sobre el estilo de vida fue inferior a 5.000 dólares (sin contar los análisis de sangre), en comparación con los 20.000 dólares que costaba la cirugía bariátrica en el momento de la intervención.

INTRODUCTION

Although weight loss is difficult to achieve, weight maintenance has historically proven to be a greater challenge. As a result, bariatric surgery has become a standard treatment option for individuals who demonstrate the ability to achieve medically appropriate weight loss yet are unable to sustain the loss. Based on a literary review of existing research on weight maintainers, Elfhag and Rössner concluded that weight maintainers not only exhibit lifestyle behaviors predictably to enhance weight maintenance, they also have an internal motivation to lose weight, social support, better coping strategies and ability to handle life stress, self-efficacy, and autonomy; they also assume responsibility in life and are more psychologically strong and stable overall.[1]

Wellness coaching is an emerging field with deep roots in psychology, professional coaching, and expertise in one or more areas of fitness, nutrition, and/or health promotion. Wellness coaching facilitates behavior change through building self-efficacy, knowledge, and resources to enable clients to be autonomous keepers of their health.[2] Increasing evidence suggests that obesity treatment is not a matter of willpower but rather a complex disorder requiring effective strategies combining dietary and physical activity using behavioral interventions.[3] Further, successful intervention helps people move beyond deciding what to change and helps them identify how to change.[4]

The traditional healthcare approach to weight loss and many consumer-driven weight-loss programs tend to provide education, often without increasing knowledge, and prescribe treatment with little to no input from the patient/client as to the approach. This is often a "one-size-fits-all" approach to a chronic disease with many variables contributing to the individual's etiology.

PRESENTING CONCERNS

D.S. is a 55-year-old white male who presented to a medical and surgical weight loss program to initiate bariatric surgery. He had "tried everything" to no avail and saw bariatric surgery as his "last hope." He had attempted and documented more than 5 years of attempts at weight loss, including commercial weight-loss programs, popular diet books, and physician-prescribed weight loss. D.S presented with a body mass index (BMI) of >40 and was classified as obese class 3 with comorbidities of high cholesterol (low-density lipoprotein [LDL] > 140 and high-density lipoprotein [HDL] < 40); hyperglycemia with blood glucose > 120; and degenerative joint disease (DJD), requiring that he walk with a cane. He worked at an "active" job in construction management but engaged in little activity outside of work.

D.S. has two grown children, one of whom also had a chronic weight problem. His family was somewhat supportive, as were his social network and extended family. He was less than 5 years from retirement when he initiated contact with the facility and aspired to an active retirement.

DIAGNOSTIC FOCUS AND ASSESSMENT

D.S.'s diagnosis of obesity class 3 was based on his height (6 ft, 5 in) and weight (450 lbs). This was the focus of his diagnosis and treatment at our facility. D.S. was referred to a clinical psychologist per pre–bariatric surgery protocol for testing, which was normal and did not indicate a need for further treatment. Each visit was initially covered by insurance; however, when the board-certified bariatrician (MD) visits were discontinued, D.S. paid out of pocket for the registered dietician nutritionis (RDN)/wellness coach.

THERAPEUTIC FOCUS AND ASSESSMENT

D.S.'s insurance provider required 3 months of

supervised weight loss prior to approval for bariatric surgery, and it was begun in-house with the MD and RDN/wellness coach. D.S. began the process outlined by his insurance company with expectations of a means to bariatric surgery and met with the appropriate professionals at the center, both of whom used a coaching or motivational interviewing approach. Following wellness coaching practice, D.S.'s RDN/wellness coach guided D.S. in developing a wellness vision. D.S., his MD, and his RDN/wellness coach then developed a lifestyle plan that aligned with his wellness vision, values, and lifestyle. D.S. would eat at regular 3- to 4-hour intervals throughout the day, consume little to no red meat, increase his consumption of fruits and vegetables, and add exercise to his routine. D.S. continued to consume a large bagel and cream cheese for breakfast 5 days per week. At his first return visit 1 month later, D.S. commented, "I've never tried anything close to this before; it's not too hard!" D.S. met monthly with his MD and RDN/wellness coach, evaluating outcomes data of weight loss and goal achievment. He revisited his wellness vision every 3 months and set new behavior goals weekly.

By the end of the 3-month period required by his insurance provider, D.S. had lost more than 30 lbs, improved his exercise capacity, did not require a cane to walk, and chose to continue with coaching rather than undergo weight loss surgery. D.S. continued to adopt an eating pattern that was more plant-based and lower in saturated fat and animal proteins yet still contained elements that would be considered "failures" in mainstream "diets." D.S. spent 1 hour in the pool daily without fail, first walking, then combining walking and swimming, and ultimately swimming laps.

D.S. continued to meet monthly with the MD and RDN for 1 year and averaged a 10-lb weight loss per month for a total of 120 lbs, bringing his cholesterol panel and blood glucose level within normal limits. D.S. continued bimonthly visits with the RDN/wellness coach for an additional year and then quarterly visits for a third year. His total weight loss was 240 lbs, which was maintained during the last year of treatment. Durning the last year, D.S. recieved a total knee replacement and was back in the pool swimming laps 8 weeks after his surgery. Over 3 years, D.S. consistently made arrangements prior to travel for personal or business reasons to continue to swim daily.

OUTCOMES

D.S. lost a total of 240 lbs, delayed knee replacement surgery secondary to DJD for more than 24 months, and normalized his blood glucose and blood cholesterol levels. Further, he reported greatly improved quality of life, social life, and feelings of overall well-being. D.S. served as a role model for his adult children who also reported achieving the recommended weight for their height.

DISCUSSION

The strengths of this case report are attributed to the skills of the treatment team and the motivation and values of the patient. The team worked cooperatively and in a nontraditional healthcare approach using wellness coaching training and skills. The literature on the challenges to sustainable weight loss is exhaustive, leaving bariatric surgery as a viable treatment option. However, the traditional approaches and fad diets tend to apply a one-size-fits-all approach to weight loss and assume that the patient lacks motivation and discipline and that failure to maintain weight loss is inevitable. This case points to the need for and efficacy of a fresh approach in which the healthcare team is supportive, positive, and skilled in defining value-driven motivators, enhancing the likelihood and sustainability of weight loss.

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