Author's response to reviews

Title: Overweight and obese adults have low intentions of seeking weight-related care: a cross-sectional survey.

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Author's response to reviews:

Dear editor,

Thank you for your comments on the manuscript. Below you will find a point by point response.

Comment:
- Factor Analysis: Please provide reliability information of scales used (Cronbach’s alpha). Also, exploratory factor analysis might be a useful addition in order to exclude the possibility of several subscales within the 9 items. The explanation of the authors in response to the reviewer’s comment is still a little unsatisfactorily.

Response:
We agree that exploratory factor analysis might be a useful addition in order to exclude the possibility of several subscales. Therefore we have examined whether there were any subscales within the 9-item scale, this was not the case. Scale information was added to the manuscript (line 176-179): “The Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy was high (0.85) and one factor had an eigenvalue of greater than one (3.78). The data demonstrated strong internal reliability with Cronbach alpha of 0.87. ”

Comment:
- Psychological interventions does not equal dietary advice from psychologists, I would recommend rephrasing this addition to the manuscript.

Response:
Thank you for this comment. We have rephrased the following sentences (line 328 – 332): “Furthermore, respondents believed that psychologists were the least suitable to give dietary advice. The role of psychologists in weight management, as described in clinical guidelines, is mainly focussed on providing psychological support for behaviour change (4). The psychological component of weight
management might be quite unknown amongst the population.”

Comment editor:
- BMI cut off at 25: reviewer seems to refer to presenting findings for BMI 25-30 and BMI 30 and above separately, authors do no sufficiently address this comment yet.

Response:
We are not sure we have interpreted it well, however we assume that the original comment the editor is referring to is: “Minor concerns – It does appear like there are significant differences between those more severely obese e.g. >30 than those 25-30. There are more health related issues in those who are more severely obese then those who are in the overweight category. It might have been revealing to look at how the level of WRHR affected table 1.”

Our apologies for insufficiently addressing this comment. After rereading the comment we now believe that we understand what the reviewer meant. The presence of interaction between the variables of table 1 and WRHR on readiness to change was tested. As several aspects showed significant interaction, the results of table 1 and 2 are now stratified according to WRHR. Consequently, several changes were applied to the manuscript, which are listed below:

Abstract
Line 34-36: Depending on level of WRHR; educational level, marital status, individuals with an accurate perception of their weight and better perceptions and expectations of dietitians were significantly related to readiness to lose weight

Line 44-46: For this group, strategies for behaviour change may depend on weight related health risk, perceptions of weight and dietitians, educational level and marital status.

Data-analysis
Line 169-170: Results on readiness to lose weight were stratified by WRHR. The small sample size of respondents intended to use weight-related care limited further statistical analysis.

Results - What type of persons were ready to lose weight?
Line 232 – 240: Results of multivariate regression analyses varied between levels of WRHR (see Table 2). Respondents with a mildly increased WRHR had significantly higher odds for readiness to lose weight in case they perceived the dietitian as suitable caregiver, or in case they had an accurate perception of weight. Subsequently, respondents with a moderately increased WRHR had significantly higher odds for readiness to lose weight in individuals with an accurate perception of weight, in those with an advanced or high educational level and in those with higher expectation scores of dietitians. Furthermore, individuals with a severely or very severely increased WRHR and not married had a higher odds for readiness to lose weight compared to married individuals.
Table 1 – 2: results are stratified by WRHR
Table 3: results are presented regarding determinants associated with intention to use weight-related care

Discussion
Line 333 – 339: Further results show several predisposing factors associated with readiness to lose weight. Depending on one’s WRHR, higher odds for readiness to lose weight were observed for those who perceive the dietitian was a suitable caregiver and those with higher expectations of dietitians. Therefore, promoting dietitians’ activities may potentially stimulate the motivation to change weight, which can be seen as a prerequisite for obesity management. In addition, persons with a moderately increased WRHR and higher educational level were associated with being at advanced stages of readiness for weight loss.

Line 344 – 354: Furthermore, sociologists argue about the importance of marital status in affecting adults’ body weight. Results from our study showed that divorce, widowhood and never being married was significantly associated with being ready to lose weight in individuals with severe WRHR, compared to those who are married. This result was in line with a systematic literature review reporting that transitions into marriage were associated with weight gain, whereas transitions out of marriage (through divorce and widowhood) were associated with triggering weight loss [29]. Further results showed that accurately perceiving oneself as being overweight or obese is considered to be an important aspect of weight change, which was in agreement with others [30]. Overall, the results on readiness to lose weight need to be confirmed by others, as the observed associations are inconsistent among different levels of WRHR.

Line 360 – 362: Multivariate regression analysis stratified by weight related health risk was not applied, considering the small sample size of persons intending to use weight-related care from a care provider.

Conclusion
Line 396 – 398: Moreover, many people are not ready to lose weight. For this group, strategies for behaviour change may depend on weight related health risk, perceptions of weight and dietitians, educational level and marital status.

Comment:
'Please add a reference to the manuscript in support of your ethics statement.'
Response:
The ethics statement is now extended with reference 19.