

## ABSTRACT

### THE LIVED EXPERIENCE OF DIETING IN OBESE ADULT WOMEN

By Patricia M. Depies

Currently, two out of every three Americans are overweight or obese. Healthcare providers frequently recommend dieting as a primary obesity intervention despite the lack of empirical evidence demonstrating its long term effectiveness (Yaskin, Toner, & Goldfarb, 2009). Few nursing researchers have explored the experiences of obese people with dieting. The purpose of this qualitative, descriptive study was to examine the attitudes of obese women toward dieting, their experiences with dieting, and what they felt would assist them in improving their health and wellness.

The theoretical framework for this study was based on the Neuman Systems Model (Neuman & Fawcett, 2002). Participants were recruited from a patient population who sought healthcare services from a bariatric clinic in the Midwest. Informed consent and a demographic questionnaire were completed prior to each interview. Interviews were audio-taped and transcribed verbatim.

The following questions were asked; 1) What has been your experience with dieting? 2) What did you feel were positive aspects of the dieting programs? 3) What did you perceive to be barriers to long term weight loss maintenance with the dieting programs? 4) What would be helpful to you now in dealing with your obesity? Data analysis incorporated Spiegelberg's (1965) three-step process of 1) intuiting, 2) analyzing, and 3) describing. Colaizzi's (1978) method of analysis was used to develop an exhaustive description of the phenomenon of dieting experiences of adult women. The following themes emerged after data analysis: (a) If at first you don't succeed, try, try, and fail again; (b) Recognizing the problem is easy; finding a solution is difficult; (c) The great dieting barriers: stress and emotion; and (d) Exercise is a four letter word.

The primary implications for advanced nursing practice included the importance of treating the obese woman with a holistic approach, as well as development of an individualized plan of care to assist her in achieving increased health and wellness. Understanding the limitations of dieting for many obese patients reinforces the need for practitioners to explore alternative interventions for future obesity management.

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I dedicate this paper to my family, without whom I would not have had the courage and perseverance to complete this project. I also thank Dr. Vicki Moss for her gentle guidance along the way. Finally, I am grateful to the wonderful women who graciously participated in this study and taught me valuable lessons about their struggles with obesity.

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## Chapter I

### Introduction

Obesity has become a global epidemic, and by the year 2015, it is projected that 75% of adult Americans will be overweight or obese (Yaskin, Toner, & Goldfarb, 2009). Thus, it comes as no surprise to learn that there are approximately 45 million people who diet each year (Cole & Horacek, 2009). It has been estimated that 70% of those dieters are women (Outland, 2010). Females have been the focus of several studies because they have been identified as more susceptible to problematic relationships with food and more concerned with regulating their food intake in order to modify their appearances (Gast & Hawks, 1998; Tylka, 2006). Our present United States culture places a high value on thinness, which has impacted both genders; however, the effect on women is deemed greater. One statistic which supports the latter statement is “35%-45% of adolescent females report difficulties with weight control, regard themselves as too fat, or aspire to become thinner” (Goolsby & Grubbs, 2006, p. 412).

The predominant weight loss interventions involve dieting, diet medications, and/or surgical procedures. Dieting has been associated with negative outcomes, such as yo-yo dieting, increased fat storage potential, preoccupation with food, shame, and low self esteem, as well as an increased risk of disordered eating (Avalos & Tylka, 2006; Hawks, Merrill, & Madanat, 2004; Outland, 2010; Robison, Putnam, & McKibbin, 2007; Smith & Hawks, 2006; Tylka, 2006). Multiple studies have established a lack of empirical evidence supporting the long term success of dieting (Avalos & Tylka, 2006; Gast & Hawks, 1998; Gast & Hawks, 2000; Hawks et al., 2004; Ikeda, Lyons, Schwartzman, & Mitchell, 2004; Mann et al., 2007; Outland, 2010; Robison, Putnam, &

McKibbin, 2007; Shields, 2009.; Smith & Hawks, 2006; Tylka, 2006; Urbszat, Herman, & Polivy, 2002).

Despite a \$40 billion, for-profit, dieting industry (Sherrid, 2003), the American waistline has continued to grow. This paradox of inflated rates of obesity despite increased investment and participation in weight loss programs provided the impetus for this study.

### **Background of Problem**

There is significant evidence in the literature documenting health risks associated with obesity [National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), 2010; Smith & Hawks, 2006]. These include: heart disease, diabetes, hypertension and stroke, some forms of cancer, anxiety, and depression. In fact, compared to persons with a normal body mass index (BMI) between 18.5 and 24.9, obese persons with a BMI greater than 30 are:

20 times more likely to develop diabetes; two times more likely to develop heart disease or stroke; 2.5 times more likely to develop hypertension; 3 times more likely to develop gallstones; and 1.5 times more likely to develop colon cancer (Yaskin et al., 2009, p. 305).

The current living environment in the United States contributes to the struggles of people who are obese (Shields, 2009). Technological advances have greatly reduced the necessity to be physically active, which have contributed to a sedentary lifestyle. This decreased expenditure of energy, in addition to an abundance of high calorie, energy dense, convenience foods have contributed to the rising rates of obesity. In addition, many overweight or obese persons are influenced by their environment, social

structures, and their emotional feelings, which have also contributed to eating for reasons other than satisfying physiological hunger.

Several authors reported that diets failed to result in long term weight loss success and even triggered overeating and additional weight gain (Ikeda, Lyons, Schwartzman, & Mitchell, 2004, Mann et al., 2007, Urbszat, Herman, & Polivy, 2002). Mann et al. (2007) evaluated the current scientific literature on dieting and concluded that it did lead to weight loss in the short-term; however, most participants were not able to maintain the loss in the long-term. In fact, it was found that 83% of the dieters actually gained more weight back than they had lost after being followed for 2 or more years. In another study, 79% of 148 dieters reported a lack of success in weight loss maintenance (Ikeda et al., 2004). Additionally, many expressed negative feelings, such as shame, constant hunger, humiliation about their size, and poor treatment from family and healthcare providers. Another study looked at the Weight Watcher's diet program and found evidence of diet cycling, whereby participants would join the program and lose weight, but upon stopping the program would gain the weight back and return to the program again (Thomas, Hyde, & Karunaratne, 2008).

### **Significance to Advanced Nursing Practice**

Obesity is the "second leading preventable cause of disease and death in the United States" (Yaskin et al., 2009, p. 305). Advanced practice nurse prescribers (APNP) are on the front line when it comes to addressing patients who struggle with obesity issues. The importance of tackling issues of obesity with patients is highlighted in a review of survey data, which showed that "increased primary care physician density at the county level is associated with decreased obesity prevalence" (Gaglioti et al.,

2009). Advanced practice nurse providers, who truly embrace evidence-based practice, need to acknowledge the growing research data that document the current strategies for promoting weight loss in many obese patients do not work in the long term and can actually cause increased weight gain and psychological harm. Focusing on lifestyle changes and other parameters of metabolic fitness, such as blood pressure and lipid levels instead of weight reduction only, may increase success in assisting obese women in attaining improved health (Ikeda et al., 2004).

There is also pressure for the APNP to be cognizant of the stressed economic climate of the current healthcare system. The economic impact of obesity is alarming. When compared to normal weight individuals, obese persons pay an average of 42% more in healthcare costs (NIDDK, 2010). In 2000, staff from the Office of the United States Surgeon General estimated that the cost of medical bills and lost productivity each year attributable to obesity was approximately \$117 billion (Shields, 2009). In 2002, total costs for weight loss strategies and health problems stemming from obesity were estimated to be \$92.6 billion, and over half of these expenditures were paid for by Medicaid and Medicare (CDC, 2010). If obesity trends continue, it is projected that the financial stability of Medicare could be overwhelmed by the year 2020 (Yaskin et al., 2009).

Advanced practice nurses (APN) need to continue to explore and examine the reasons many obese people don't have long term success with dieting programs. Understanding the complexity of obesity as an individual, biological, societal, and cultural chronic health problem is needed in order to facilitate change. Simply viewing obesity as too much energy consumed compared to energy expended does not adhere to the holistic ideology of nursing which the APN embraces. Promoting positive body

image and adaptive behaviors, instead of negative body image and maladaptive behaviors, is necessary to help obese women strive for improved health and wellness (Avalos & Tylka, 2006). Avoiding authoritarian dictates and biased behavior regarding obesity in women is necessary to move forward in the search for answers to the obesity epidemic (Meetoo, 2010).

### **Problem Statement**

Advanced practice nurse practitioners continue to promote dieting as a primary solution for obesity, despite ample research documenting the lack of success with long term weight loss. Obesity trends continue to rise despite an increased investment and participation in dieting.

### **Purpose of the Study**

The purpose of this study is to explore and describe the lived experiences of obese women with dieting in order to gain a better understanding of why dieting is often unsuccessful in obtaining long term weight loss.

### **Research Question**

What are the lived experiences of dieting in obese adult women?

## Definition of Terms

### Conceptual definitions.

*Lived experience:* “(W)hat is true or real in his or her life... that which gives meaning to each individual’s perception of a particular phenomenon” (Streubert Speziale & Carpenter, 2007, p. 77).

*Obese:* An adult with a BMI greater than 30 (NIDDK, 2010).

*Adult Woman:* “(A)n adult female human being” (Morris, 1979, p. 1472).

*Dieting:* “(C)aloric restriction for the purpose of achieving weight loss” (Ikeda et al., 2004, p. 972).

### Operational definitions.

*Lived experience:* Study participants will verbalize their reality of dieting experiences in their lives.

*Obese:* A BMI table will be used to determine a participant’s BMI based on height and weight documented in the demographic questionnaire. Participants with a BMI greater than or equal to 30 are considered to be obese (CDC, 2009)

*Adult Woman:* Any female, 18 years of age or older.

*Dieting:* Any non-surgical method utilized to reduce consumption of food in order to lose weight.

## Assumptions

1. Each female in the study will be honest in her responses to her lived experiences with dieting.
2. The experience of dieting is unique to each individual.

3. Being a woman in a culture that places a high value on thinness is a unique experience.
4. Data that emerge from this qualitative study can add to the body of knowledge on helping persons who struggle with obesity.
5. Participants will be able to read, write and speak the English language.

### **Chapter Summary**

Obesity contributes to a large number of physical and psychological maladies in the United States. Dieting is one treatment option which has been shown to be unsuccessful in the majority of patients who attempt to lose weight and maintain weight loss over an extended period of time. Advanced practice nurses are in a unique position in the primary healthcare setting to assist obese women in achieving improved health and wellness. Results from this study exploring the lived experience of adult women with dieting will give primary care APNPs and other health professionals information to better understand how women deal with obesity.

## **Chapter II**

### **Theoretical Framework and Literature Review**

This chapter covers the theoretical basis for this study and provides a critical review of pertinent literature pertaining to obesity and dieting methods. A gap in the literature regarding the lived experiences of obese women with dieting is demonstrated and provides support for the effort to undertake this study.

Health promotion, as it applies to nutrition and physical activity, should focus on the development of healthy eating behaviors and improved enjoyment of movement rather than on weight loss only (Pender, Murdaugh, & Parsons, 2006). The aspects of health, which APNPs need to assess and gain further understanding of in their patient population, include biopsychosocial, spiritual, cultural, and environmental elements. It is through a holistic approach that effective interventions for chronic health problems, such as obesity, can be developed. Looking at healthcare challenges of obesity from a positive perspective, and focusing on the capabilities and potentials of our patient population, practitioners can promote the development of healthy relationships with the patients and communities being served.

#### **Theoretical Framework**

In order to understand the phenomena of obesity in adult women, the qualitative researcher looks to theory to provide a “set of guiding principles” (Streubert Speziale & Carpenter, 2007, p. 11). The Neuman Systems Model (1972) encompassed the holistic aspect of nursing the author employed in conducting this qualitative study. This theory ascribes to the holistic nursing process to assist a patient in achieving and maintaining

stability. Neuman believed a person has physiologic, psychologic, sociocultural, developmental, and spiritual components (McEwen & Wills, 2007). This model has value in examining interventions for the obese woman who needs education, guidance, and support in order to develop a healthy balance of exercise and food intake, while maintaining a positive self esteem, healthy relationships with family and friends, and spiritual peace.

### **Case Study with the Neumans System Model as a Framework**

Christine is a 48-year-old mother of three, who works part-time as a registered nurse in a hospital. She states she never really had a problem with her weight until after the birth of her third child. She gained twice as much weight with that pregnancy compared to her first two, and has been on a roller-coaster ride with dieting, weight loss and then weight regain (plus a few extra pounds) ever since. She currently has a BMI of 35 and feels exhausted all of the time, trying to keep up with the demands of her family, work, and friends.

Christine avoids clothes shopping unless absolutely necessary and develops anxiety whenever she has to go to a family gathering, as she feels everyone there must think she is just lazy and eats junk food all day long. She has tried popular weight loss programs and every kind of exercise program, but never seems to be able to get her weight down anywhere near to her pre-pregnancy weight. She has basically given up on the ideal of being 'normal weight' again. She turns her head away in shame whenever she passes by a mirror.

Christine decided to go and see a nurse practitioner (NP) at a local clinic. She explained her roller coaster history of dieting, with resultant extra weight gain, and her

desire to stop working so hard to achieve nothing. The NP spent 45 minutes with her, discussing her pertinent medical history and health risks, but also took time to learn more about the stressors in her life. She pointed out her positive health parameters, which included a normal blood pressure and lipid panel. She offered empathy and support for Christine, discussing various ways to handle daily stressors other than reaching for comfort foods. She offered information on local resources available for counseling, exercise, and healthy eating tips. The NP encouraged Christine to find time for herself each day doing something she enjoys. Christine had dreaded this appointment, but afterwards actually felt empowered for the first time in a long time to try and develop a healthier lifestyle.

Over the next few months, Christine began to feel better about her life. She didn't lose a lot of weight, but at least she stopped gaining weight. Her co-workers and family and friends commented on her improved attitude and wanted to know what her secret was. She found herself thinking about being more active and preparing tasty, healthy meals. She was no longer preoccupied with dieting and weight loss. She was getting more rest and coping better with parenting her three children. She felt like she was beginning to have some balance in her life again.

#### **Summary of case study.**

Christine met a provider who actually took the time to listen to her concerns. She was thrilled to know that despite her extra weight, she still had a normal blood pressure and lipid panel. She was also happy to hear that any activity throughout the day was helpful to her joints, muscles, and general sense of well being. This gave her hope that she could still make some lifestyle changes to improve her health. She appreciated the time the NP took to listen to her stressors involving her work and family. It was like she

needed permission to get more rest! Overall, this NP had assessed Christine's physiological, psychological, developmental, spiritual, and sociological needs. In doing so, she made a difference in this patient (Figure 1).

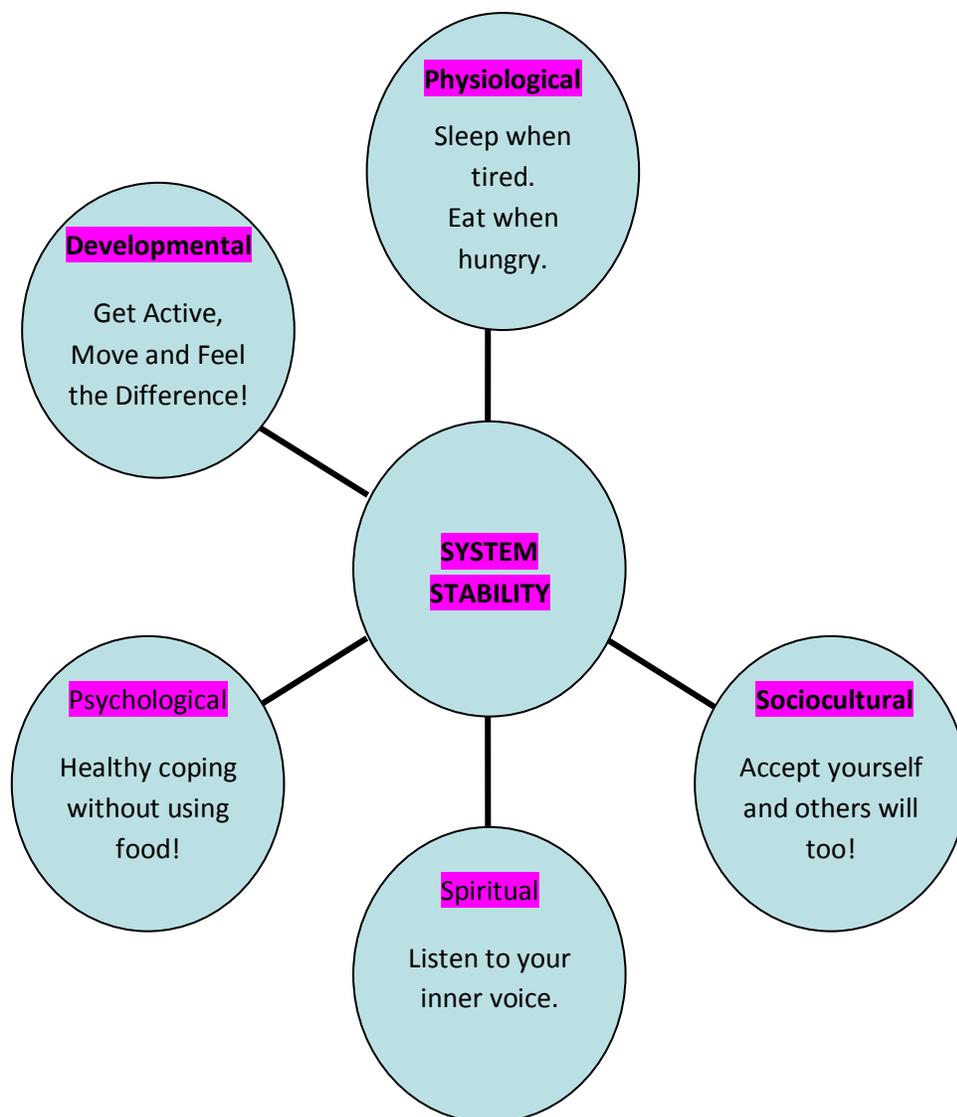


Figure 1. Neumans System Model (1972)

## Literature Review

An obesity prevention initiative coordinator from the University of North Carolina, Wilmington, explored the obesity epidemic from a behavioral perspective (Shields, 2009). She emphasized that over the past 40 years, there has been an increase in the time spent in sedentary activities, a greater consumption of fast food, as well as an expanded number of women in the work force, which have all contributed to the current obesity epidemic. The author reported that community and individual level strategies are needed to address the obesity epidemic. Examples of community level strategies given included media campaigns that advertize increased physical activity, suitable portion sizes, and healthy diets. Government bodies and community organizations have the potential to positively affect the health of its communities. Examples given included the provision of safe and accessible settings for physical activity, such as community health centers, as well as increasing access to healthy foods in the public school system. According to the author, individual strategies, which produce long term results rather than a “quick fix,” are needed. Behaviorally-based programs, such as self-monitoring, goal setting, and stimulus control, cognitive behavioral strategies, reinforcement control, and relapse prevention were suggested to be more successful long-term strategies in obesity management.

A team from the Jefferson School of Population Health in Philadelphia reviewed the evidence in regards to obesity management interventions (Yaskin et al., 2009). They utilized criterion from the National Institutes of Health (NIH) to assess the evidence. A reduction of 5% to 10% of weight from baseline, maintained for over 1 year, was needed to qualify an intervention as a success. Of the 151 clinical trials examined, most did not meet the latter criteria for efficacy. The most successful interventions were found to be a

combination of behavior changes with pharmaceutical or surgical treatment. Surgical interventions for obesity, including restrictive procedures, malabsorptive procedures, or a combination of the latter, were found to result in significant reductions in weight, as well as lowered co-morbidities, such as diabetes, hypertension, and obstructive sleep apnea. The Swedish Obese Subjects (SOS) study supported the efficacy of bariatric surgery with its long-term evaluation of 4,047 bariatric surgery patients over 2 years and 1,703 patients over 10 years, documenting an overall 16.1% decrease in weight. The researchers cited multiple limitations of the studies reviewed due to “flawed or absent controls, invalid randomization methods, and high drop-out rates” (Yaskin, et al., 2009, p.313). They stressed the need for more research in the area of population interventions to treat the complex social problem of obesity.

A team of researchers from the Department of Psychology at the University of California, Los Angeles, conducted a review of literature to determine if dieting was an effective treatment for obesity (Mann et al., 2007). They utilized the GRADE system to assess the quality of evidence, determine the critical nature and quality of outcomes, and considered the balance of benefits versus harms of dieting. They found dieting to be the most commonly recommended obesity treatment. Using their evaluation system, they determined the following: (a) Diets do result in short term weight loss, (b) Diets do not result in long term maintenance of weight loss, (c) Increased exercise frequency did correlate positively to long term weight loss maintenance, (d) Dieting should not be recommended without giving consideration to the potential ill effects of weight cycling, (5) The potential benefits of dieting do not outweigh the risk of potential harm, and (f) Exercise should be the focus of future research as a treatment for obesity.

A nutrition education specialist and her team conducted a quantitative study of the dieting experiences of obese women using self-administered questionnaires (Ikeda et al., 2004). The sample consisted of 149 women with a BMI of 30 to 77. The data were obtained from participants at two conferences for large women in San Diego, CA and Chicago, IL, as well as health professionals and community activists who interacted with obese women. Of the sample participants, 62% were placed on their first diet before the age of 14 years. There was a significant correlation between early dieting and higher BMI as adults. Many of the early dieters had been on diets more than 20 times, compared to participants who began dieting later in life. This group was also found to express a negative correlation between dieting and their health and self esteem and a positive association of dieting with weight gain, compared to dieters who started later in life. Finally, 79% of those who started dieting prior to age 14 were unable to sustain any weight loss over the long term. A major limitation of this study was the possibility of social desirability response bias. Since many participants were attending a conference for large people, they might have been more critical of dieting than other obese women. Another limitation was the quantitative survey research design, which could not capture the true essence of being obese.

A prospective cohort study was conducted by a team from the School of Public Health at the University of Minnesota to examine weight control strategies of adults in the United States and subsequent weight and behavior changes over a period of 4 years (French, Jeffery, & Murray, 1999). The sample consisted of 1,120 adult volunteers who took part in the Pound of Prevention (POP) study that had as its focus weight gain prevention. The participants were divided into a treatment or a control group and were assessed four times throughout the 4-year study. The treatment group received monthly

newsletters, which stressed exercise, increased fruit and vegetable consumption, decreased intake of high fat foods, and regular self-weight monitoring. There were nine dependent variables that were examined and compared between year 4 and year 1 of the study: (a) body weight, (b) total energy, (c) percent fat energy, (d) percent carbohydrate, (e) percent alcohol energy, (f) percent energy from sweets, (g) physical activity score, (h) vegetable servings, (i) fruit servings (French et al., 1999). Dieting and increased exercise were the most commonly reported weight control measures by the study participants. The duration of any given weight gain prevention strategy employed varied between 8.7% and 19.2% of the entire 4-year time period. The researchers concluded that weight control strategies do work while they are being utilized, but a major barrier to weight loss or control is sustainment of the healthy behaviors. Limitations of the study noted by the authors included the lack of qualitative information regarding behavior changes, which could have provided more insight into the type of food changes chosen, the continuity and length of the behavior changes made, and the motivating factors behind the changes. Additionally, it is possible that social desirability bias might have impacted the responses given for the checklists and self-administered tools to measure dietary intake and physical activity.

The psychological and emotional consequences of dieting were also explored by researchers from the School of Public Health, University of Minnesota, in a review of all dieting studies conducted with college students and adults during the time period of 1967 to 1993 (French & Jeffery, 1994). Discrepancies between the desire to lose weight and actual behaviors that could lead to weight loss were often found, depending on the wording of questions in the studies. The authors reported that this may have contributed to a greater number of affirmative responses in regards to dieting, and highlighted the

importance of clearly defining and operationalizing the term in future studies.

Interestingly, the prevalence of dieting in normal weight people was found to be greater than the obese population. The team also reported that dieting was most prevalent amongst women age 30 years to 44 years; White; higher socioeconomic groups; and professional groups, such as models, actresses, and athletes. Decreasing food intake and increasing exercise were the most frequently cited dieting activities. The epidemiologic data reviewed indicated that large weight gains, significant weight losses, and possible weight cycling were associated with decreased health outcomes. As far as the psychological impact of dieting, some studies showed that when caloric restriction was utilized in combination with behavior modification, there was an improved sense of well being amongst the participants. Other studies found dieters to experience more negative feelings, lower self esteem, and increased depression and anxiety than non-dieters. Whether or not there were pre-existing psychiatric conditions which were exacerbated by dieting would benefit exploration in future study groups.

The Scientific Director of Slimming Magazine Clubs in London, UK, collected structured data through self-administered questionnaires (SAQ) given to obese people who had lost weight through participation in a commercial weight loss group in the UK (Evans, 1999). The sample consisted of 346 women and 26 men. Information was obtained regarding weight loss methods that had been tried and the resultant weight loss, type of medical advice given by the doctor and whether or not the advice led to successful weight loss, and reactions of doctors to patients who had achieved weight loss. While the majority of participants were previously advised to lose weight by their physicians, only 22% received specific recommendations as to how to go about losing weight, and 64% of the respondents did not attribute success to the doctor's advice.

The author described obesity as a chronic condition with a causal agent that cannot be avoided, since food is required for survival. She described the effect of negative attitudes of providers toward obese patients and the resultant lowering of standards of care. She also reported that providers often lack knowledge regarding nutrition, diet, and exercise, and emphasized the importance of providing positive and long term support to obese patients owing to the chronicity of this medical condition. Limitations of the SAQ in this study were difficult to determine, since so little information was provided about the content of the SAQ. In general, close-ended questions may not offer a response that reflects the respondent's opinion and may seem superficial.

Only one study was found in the literature which utilized a qualitative design to assess obese persons' experiences with dieting (Thomas et al., 2008). The researchers looked at the positive impact of empowering obese persons to make healthier lifestyle choices without focusing solely on weight loss. They obtained a purposive sample of 76 people from Victoria, Australia. Face-to-face and telephone interviews were used for data collection. Findings indicated that overall health and well-being, advice from providers, and social acceptance were motivations cited for dieting. Younger participants were most likely to engage in fad diets, whereas older participants leaned more toward commercialized diets, such as Weight Watchers and Jenny Craig. When participants lost weight, they felt better; however, if they were unable to maintain the weight loss, they developed feelings of depression, failure, and anger. Many felt that diets did work if you were able to continue the restrictions. Physical activity was difficult for many because of their weight, embarrassment, time constraints, and lack of motivation. The participants believed that individualized dieting solutions and ongoing support from family practice providers was needed to assist them in making lifestyle

changes to improve their health. They also reported that a focus on health, instead of just weight, would be helpful. Limitations of this study included a small sample size (n=76) in addition to a homogeneous sample (mostly White); which the authors reported limited the generalizability of the study results. The data were analyzed using a constant comparative method, and the participants were given an opportunity to comment on the research findings, which enhanced the trustworthiness of the results.

### **Chapter Summary**

A review of the literature showed a gap in qualitative research involving obese women and their experiences of dieting. Nursing embraces the concept of holism because it is believed that a person is more complex than just the sum of his/her parts. Neumans model echoes this challenge in her wellness/illness concept which states, "... all system parts and subparts are in harmony with the whole system of the client. Illness indicates disharmony among the parts and subparts of the client system" (McEwen & Wills, 2007, p. 154). Healthcare professionals must continue to explore chronic health problems, such as obesity, given the evidence that many current dieting interventions are found to be lacking in long term success, and can also negatively affect one's physical and psychological well-being.

## **Chapter III**

### **Methodology**

The purpose of this study was to explore and describe the lived experiences of obese women with dieting in order to gain a better understanding of why dieting is often unsuccessful in obtaining long term weight loss. The study design, sample, setting, data collection procedure, data analysis, and limitations of the study are presented in this chapter.

#### **Research Design**

A qualitative design with a descriptive phenomenological perspective was used to conduct the study. The researcher strived to gain an understanding of the experience of dieting as it is lived by each obese woman in the study.

#### **Population, Sample, and Setting**

The target population consisted of adult women, aged 18 years or older, who were obese (BMI>30), and had tried dieting as a method to lose weight. The accessible population was a purposive convenience sample of 10 participants who accessed healthcare services at a bariatric clinic in the Midwest and through snowball sampling. In addition to the criteria listed above, participants had to be able to speak and converse in English for the face-to-face interview process. They also had to agree to participate in the study and complete an audio-taped face-to-face interview.

### **Data Collection Instrument**

The researcher was the instrument in the interview process. The interview consisted of semi-structured open-ended questions, such as: (a) What has been your experience with dieting? (b) What did you feel were positive aspects of the dieting programs? (c) What did you perceive to be barriers to long term weight loss maintenance with the dieting programs? (d) What would be helpful to you now in dealing with your obesity? (See Appendix C)

The trustworthiness of the data was established by allowing two of the participants to review the identified themes as understood by the researcher. This member check validated the findings as reflective of the participants' experiences with dieting. The researcher left an audit trail, so that the process of uncovering central themes and subthemes would be clear to the reader. Rigor of the study was enhanced since only one researcher conducted the interviews and all interviews were audio-taped and transcribed verbatim and checked for accuracy.

The demographic background profile contained questions regarding age, race/ethnicity, education, marital status, occupation, and current height and weight. It also asked about types of diets tried, number of times on a diet, amount of weight lost while dieting, and length of time weight loss was maintained.

### **Data Collection Procedures**

Institutional Review Board (IRB) approval was obtained from UW-Oshkosh. After IRB approval was given, the researcher developed a flyer identifying herself as a graduate nursing student seeking participants for a school project, which was posted in the patient care areas of the Midwest bariatric clinic (See Appendix D). She explained

her interest in learning more about dieting experiences in women who are obese. She requested that any interested participants, who would be willing to share their experiences with dieting, contact her on her cell phone or at her e-mail address. Inclusion criteria were listed on the flyer. The researcher communicated with the potential participants and explained the purpose of the study and what was required of them. She obtained informed consent from the participants that emphasized the voluntary nature of participation and the steps the researcher took to assure confidentiality (See Appendix B).

The researcher determined a convenient time with each participant to conduct a face-to-face interview. The interviews each took approximately 30 to 60 minutes and were conducted in the respondents' homes or a meeting place of their choosing. The interviews were recorded in order to maintain accuracy of the data and then transcribed by a professional so that a proper analysis could be done.

#### **Pilot study.**

A pilot study was done on one participant before proceeding with any other interviews. This allowed for modification of interview questions prior to proceeding with the rest of the study.

#### **Data Analysis Procedures**

Descriptive statistics were obtained through a demographic questionnaire completed before the interview (Appendix A). The researcher employed bracketing in order to identify any preconceived points of view or beliefs about obesity and dieting to avoid contributing personal bias to the study. Spiegelberg's (1965) three step process of: (1) Intuiting, (2) Analyzing, and (3) Describing was utilized throughout the study. In

essence, this meant the researcher maintained an open and creative mind when examining data in order to allow a common understanding to emerge. The researcher became completely absorbed in the phenomena under study in order to begin to know the essence of dieting in the obese study participant.

Utilizing a modification of Colaizzi's (1978) method of analysis, the researcher undertook the following steps:

1. Read all protocols to acquire a feeling for them.
2. Reviewed each protocol and extracted significant statements.
3. Spelled out the meaning of each significant statement.
4. Organized the formulated meanings into clusters of themes.
5. Integrated results into an exhaustive description of the phenomenon under study.
6. Formulated an exhaustive description of the phenomenon under study in as unequivocal a statement of identification as possible.
7. Asked two participants about the themes as a final validating step (Colaizzi, 1978).

### **Limitations**

The following were limitations of this study:

1. Use of a convenience sample.
2. Possible response bias.
3. Interviewed only English speaking participants.
4. Small sample size detracted from the generalizability of the findings.

**Chapter Summary**

A qualitative design was used in this study in order to gain a greater understanding of the experience of obese women with dieting. Face-to-face interviews were conducted with voluntary participants obtained from a health clinic. Conversations were recorded and transcribed verbatim. The data were analyzed using a modification of Colaizzi's method of analysis. The findings were shared with two participants in order to validate the researcher's discoveries as truly reflective of their lived experiences with dieting.

## **Chapter IV**

### **Results and Discussion**

The purpose of this study was to explore dieting experiences in obese adult women. The researcher hoped to gain a better understanding of why dieting interventions for obesity have not resulted in significant long term weight loss success. The results and discussion from this study are presented in this chapter.

#### **Description of the Sample**

The original sample for this study consisted of eight women from the Midwest who were to be interviewed about their experiences with dieting. Seven respondents were obtained from a bariatric support group, after they responded to a flyer posted in patient care areas at the bariatric clinic (Appendix E). The eighth respondent was obtained through snowball sampling. Two of the respondents, however, changed their mind regarding participation in the study, with a resultant final n=6. The mean age was 45 years and all were White. They had a high school education, college degree, post-graduate degree, or some college. All were employed full-time. Three were married, two were never married, and one was separated. All of the respondents had tried Weight Watchers; four had tried stimulant medications or diet supplements; five had had bariatric surgery; and four had tried other dieting methods. Four of the subjects had been unable to maintain weight loss from any non-surgical dieting method for more than 2 years. Four of the respondents had never heard of non-dieting weight loss programs. All were contacted within 48 hours after the interview, and no adverse effects from the data collection procedure were reported.

Table 1

*Demographics (n=6)*

Age 38 – 56 years	Number
BMI 33 – 48	
<b>Ethnicity</b>	
White	6
<b>Education</b>	
High school degree	2
College degree	2
Some college	0
Post-graduate degree	2
<b>Employed</b>	
Full-time	6
Part-time	0
<b>Marital status</b>	
Married	3
Never married	2
Separated	1
<b>Weight loss methods attempted</b>	
Weight Watchers	6
Diet pills	4
Bariatric surgery	5
Other	3
<b>Length of weight loss maintenance &gt;2 years?</b>	
Yes	2
No	4
<b>Heard of non-dieting methods?</b>	
Yes	2
No	4

## Data Collection

A pilot interview was conducted initially, which assisted the researcher in developing a more comprehensive list of semi-structured interview questions. The following additional questions helped the researcher gather increased focused data regarding dieting experiences of the respondents during future interviews: (a) What role do healthcare providers have in assisting obese patients with the problem of obesity? (b) What role does your lifestyle play in regards to your eating and exercise habits? (c) What triggers you to eat, other than feelings of hunger? and (d) What eating habits have contributed to your obesity?

A demographic questionnaire and informed consent were completed by all respondents prior to each interview. A digital recorder was used for all data collection. The first interview was conducted in the respondent's home in a quiet living room. There were no distractions during the interview process. The second interview took place at a Midwest bariatric surgeon's office. A conference room was used which allowed for privacy and no interruptions or distractions. The third interview took place in the respondent's home, sitting at the kitchen table. A house cat crept into the kitchen several times, but did not disrupt the flow of the interview. The fourth interview took place at the respondent's place of employment. A quiet conference room was used, which also prevented any disruptions during the interview process. The fifth interview took place in the respondent's school classroom where she is a teacher. Her young daughter was in the room during the interview and asked a couple of questions regarding her homework, otherwise the interview proceeded smoothly. The sixth interview took place in the respondent's home, also in a quiet living room. There was one short telephone call during the interview, but otherwise no further distractions.

The researcher listened to the audiotapes of the interviews on the day following data collection, and began writing down what she thought were significant statements in a notebook. After all of the data was collected, the digital recorder was given to a transcriptionist, who spent 19 hours transcribing the data onto 8 ½ x 11 inch paper with two inch margins, so that notations could be made during analysis. The researcher then read and re-read the interviews repeatedly until several themes began to emerge. Thematic headings were written in a notebook, and supporting statements were listed below. Subcategories were then identified within the main themes and an exhaustive description of the dieting experiences of these obese women emerged.

### **Data Analysis**

Spiegelberg's (1965) three-step process of (1) Intuiting, (2) Analyzing, and (3) Describing was employed in this descriptive phenomenological analysis. The researcher immersed herself in the data and then reviewed the transcribed interviews repeatedly to begin analysis of the dieting experiences as described by the respondents. Key words and phrases were identified and listed under thematic headings, which were further subdivided into categories and then described in detail. Colaizzi's (1978) procedural process of data analysis was used to interpret the phenomenon of dieting experiences in these obese adult women. The researcher presented themes and subcategories to two respondents to assess if they found them to be representative of their true experiences with dieting. One respondent replied that she would not change a thing, and the other respondent felt more clarification was needed in the second theme regarding empathy and support. Adjustments were made to the second theme and then presented again to the respondents. They both agreed that the themes were representative of their true

experiences with dieting. The respondents were assigned fictional names to make discussion points more personal to the reader.

### **Themes**

- Theme I: If at first you don't succeed, try, try and fail again, with subcategories of (a) length of dieting, (b) boredom, (c) weight cycling, (d) difficulties dieting as a young person, and (e) genetics .
- Theme II: Recognizing the problem is easy: Finding a solution is difficult, involving (a) I know I have a weight problem, (b) frame of mind, (c) empathy, (d) authoritarian dictates, and (e) support from healthcare workers.
- Theme III: The great dieting barriers: Stress and emotions, with subcategories of (a) food as comfort and (b) family issues.
- Theme IV: Exercise is a four- letter word, involving (a) it's hard to move, (b) heavy people hobbies, (c) fatigue, and (d) futility.

#### **Theme I: If at first you don't succeed, try, try and fail again.**

##### ***Length of dieting.***

In examining 72 pages of transcribed interviews, it was readily apparent that the respondents had made multiple attempts to lose weight, utilizing various dieting strategies. Not only had they dieted frequently, but all had also dieted for many years. While they had success at times, the weight would usually come back within a short period of time after stopping the dieting method. Ann said, "I have dieted probably the last ten years." Carol echoed a similar experience: "I've dieted periodically all of my life, so it's been up and down, they call it the roller coaster, yo-yo dieting, things like that..." Ida confirmed that this has been a lifelong struggle when she stated: "I was at my first

Weight Watchers meeting at (age) 10 with my grandma, so this is something I've dealt with my entire life, struggled with all the way along." Mary concurred with this statement: "Whenever I try dieting, I always gain the weight back...I tried diets and I tried everything I could."

***Boredom.***

Ellen had difficulty with maintaining weight loss due to boredom, which is supported by the following statement: "...then all of a sudden I relax and I say, Oh, I'm o.k., after I lost thirty or forty pounds...and then I kind of get bored with it."

***Weight cycling.***

Weight cycling was frequently a part of the dieting experience. Often, when these dieters regained their weight, it was more than they had actually lost. Ann stated, "The most successful has been Weight Watchers but unfortunately, within six months of going off Weight Watchers, I have gained all the weight back, plus a few pounds." Carol added:

(B)ut then slowly but surely I went into those bad old habits. Those habits are more a part of me than the ones of being thin and eating correctly, so I went back, I reverted, and I ended up gaining all the weight back...

Gina had a similar experience: "I started dieting probably at an early age. I would say late teens...what began to happen is I would lose some weight, gain some. It would be like lose two, gain four, lose four, gain eight."

***Difficulties dieting as a young person.***

Kris addressed the challenge of dieting as a young person in this statement:

I probably tried everything all the while I was in high school, but that was not eating, that was eating vegetables and only vegetables, and you know, you can

only do that for so long and then you're like 'okay, now I'm going to pig out with all of my friends'...so truly it was up and down, up and down.

Ida recalls feeling out of place at her first Weight Watchers meeting:

I hated it because I was the only kid that was there. I felt like I was actually a freak because they were all older people and I just felt like I didn't belong there. You know, when you're ten years old, your really concentrating on what you're eating is not probably the most important thing.

***Genetics.***

Difficulties maintaining weight loss was also attributed to genetics. Carol said:

I started being heavy from when I was six or seven years old...I do believe, where, if you do have more fat cells, that when you gain weight and you lose weight that it comes back so fast and then you happen to be on that for the rest of your life.

Ellen was often compared to her father who was obese. She said, "It's also the genes, I want to say the genetics of it too. My father was a heavy man..."

**Theme II: Recognizing the problem is easy: Finding a solution is difficult.**

***I know I have a weight problem.***

According to the respondents in this sample, they didn't need someone to tell them that they had a weight problem. Carol said:

So, should our doctors, our nurses take us on the side and talk to us? We know we have a weight problem and a health problem. If they have an idea, 'Oh, there's something here-would you be interested in trying this?' That would be a great approach, because we know we're heavy.

Ellen shared a similar experience and said: “They come in and they sit there and say; ‘Well, you wouldn’t have this problem if you were to lose weight’ and then they walk out the door...and I’m like, Okay, so help me, show me, tell me.”

***Frame of mind.***

Carol emphasized the need for the obese person to be ready to lose weight with this statement:

If a heavy person is not ready to start to lose weight, they won’t lose weight...until the day that your mind is in the right set frame, you’re not going to lose a pound because you just have to be there.

Ellen had a similar sentiment, “You’ve got to be the one to change it. You’ve got to be the one to get up and say, ‘Okay, this is it!’”

***Empathy.***

Several of the respondents wished others knew what it was like to be obese, so that they could empathize with the difficulties people have with being obese. Carol said obese people need to be treated with respect:

...why can’t I just get this weight off? I don’t want to be in a body like this. So, if they think we don’t think of those things, we do. But we just would like to be treated with respect, everybody deserves respect. I don’t care what size, it’s the truth.

Ellen had this to say about different healthcare providers she had over the years: “You get some with such a negative attitude about an obese person. Oh, my God, I have had so many of them through the years; you just want to slap them.”

Gina acknowledged how difficult it was for the obese patient to ask for help in this statement:

...don't judge that 350 pound person coming in there because they probably want to lost weight, but they are having a terrible time getting to the position where they need to be and to help them find that path to get there and to give them the resources...

Gina also described empathy as one of the benefits of attending her bariatric support group: "One is going to be support and the fact that it's support from people that have been in my shoes."

***Support from healthcare workers.***

So obese women know they have a weight problem, but what they are looking for are solutions, as evidenced by Ann's statement:

Finding out why you've gained it and helping you to set some goals and give some direction...I see obesity the same as heart issues or kidney failure or diabetes or whatever. It's a big issue and I guess they (healthcare providers) should treat it the same and do follow-ups.

Gina asked for continued support with weight loss, but her provider seemed disinterested:

He would give me advice, and the advice changed every time I saw him...I would ask 'Would you like me to come back and see how I'm doing?' He'd say, 'If you feel like it.' It was as if he was saying, 'Here, here's some information, now get out of my office.'

Mary said she needed more options presented to her, "Putting more options in front of them because doctors never provided any options, so I didn't know where to go or how to handle it."

***Authoritarian dictates.***

Authoritarian attitudes and dictates were not helpful to these obese adult women who were trying to lose weight. Gina repeated what a provider once said to her: “‘You need to lose weight’, not, ‘This is what you need to do’, not, ‘If you’ve tried this or that’. It was, ‘you need to lose weight’, with him shaking a finger and that was it.”

Ida recalled a similar experience:

When I was younger, we went to a family practice doctor who I swore from the time he walked in the door I was going to hear a lecture on how much I weighed and how I should lose weight and how it wasn’t good for me, but he never really said, ‘How can we help you?’...I need someone who will talk to me and really be open with me and give me the feedback that I need. If she see’s that I’m slipping or something, I need her to say, ‘Hey, what’s going on here, what can we do?’

**Theme III: The great dieting barriers: Stress and emotions.**

***Food as comfort.***

A common theme from all of the bariatric support group respondents was the impact of stress and emotions as key undermining elements of dieting attempts. The following excerpts highlight the importance of food as a comfort measure for these individuals. Gina shared this statement:

To say I’m a stress eater would be accurate. I get under stress, I could inhale a bag of Doritos within probably twenty minutes....you eat, everything is great, and then you crash and burn...but for me, emotional eating, stress eating, it was those two right there. I know that was my be-all, end-all.

Carol likened food to friendship in this statement, “...it was me and my food, my best friends.” Mary also pointed to stress as a culprit in her problem with obesity: “...and

then became more stressed with more stuff coming on in my life and I gained the weight back to where I was...It was tough, sad, depressing, not feeling like I'm wanted or worthy of it." Gina also recalled emotional stressors from childhood: "...my grandparents would tell us that we were so fat that we could use our stomachs as a table. You tell me that and I'm going to go eat a roll of cookie dough!"

Ellen described what food meant for her after being sexually abused: "...during that time, it was pure comfort."

***Family issues.***

Ida related to some emotional wounds that originated in her childhood:

My dad always wanted a boy, so my brother, the one next to me, is like the golden child. So I always felt like I was second best...I always felt like I wasn't good enough...I think I realized that there was a negative tape playing in my head that said, 'I'm a loser, I'm a loser, I'm a loser...'

Ellen also recalled her difficult childhood:

...the stress from my parent's separation and pending divorce and growing up with stress from that and my mother's drinking problems kind of escalated and when I graduated high school, I went off the program and I was back to being heavy again.

**Theme IV: Exercise is a four-letter word.**

***It's hard to move.***

The importance of exercise in combination with proper diet is emphasized in the health literature daily. Unfortunately for obese people, exercise is often a formidable and unpleasant task. Carol put it very bluntly when she said, "Exercise is more like a 4-letter word to me. It is to most obese people. The moving of it. It's harder to move when

you're heavier anyway." She expressed the need for people to take into consideration the obese person's difficulty with exercise when she said: "...that's the worse thing someone can say is 'you should go out and run or walk all the time' or something like that, because until you get to be able to do that physically, it's very difficult.

Ellen found it difficult to do something as simple as sit on the floor, "Before, when I was 350 pounds, the damndest thing was to get up off the floor...I couldn't get on the floor and I couldn't get off of it if I wanted to."

### ***Heavy people hobbies.***

Carol noted what activities obese people do find agreeable to participate in with this statement: "...if you would ask heavy people what their hobbies are, they would come up with probably cards, board games, watch T.V., watching movies, things like that."

### ***Fatigue.***

Between busy work schedules and children's activities, many respondents found they were too fatigued to exercise. Ann stated: "...by 8:00 o'clock at night I'm too tired to do my workout...the exercise part of it has been put on the back burner." Gina said she would try to exercise, "but I would tire out real easy and quit midway through or I would have to stop for a while and then go back, stop and go back." Mary had this to say about exercise after giving birth to her twins; "There were no exercise habits. I could hardly move. I was so tired, exhausted, the twins wore me out. So, whatever exercise I got was with them, which was bare minimum. I didn't have exercise. I hated to exercise."

***Futility.***

Gina felt that exercise was really futile when she said, "...and there's no exercise going on because, I know it's really good for you, when you're in that moment, you don't think about it and then you're like, 'Well, I'm already 200 pounds, why does it matter?'"

**Summary.**

Four major themes emerged after data analysis in this study of dieting experiences in obese adult women. The first theme regarded the multiple attempts the respondents had made to lose weight with no resultant long term weight loss success. The second theme expressed the many difficulties these obese women had in finding solutions to their excess weight problems. The third theme signified the relationship between emotional stressors and food as a coping mechanism. Finally, the fourth theme illustrated the difficulty these obese women had with incorporating exercise into their weight loss plans.

**Discussion**

The first theme, *If at first you don't succeed, try, try and fail again*, which deals with multiple dieting attempts with little long term weight loss success is consistent with most of the literature regarding obesity and dieting (Mann et al., 2007; Smith & Hawks, 2006; Tribble & Resch, 2003; Tylka, 2006). Two educators from Brigham Young University agree that not only is calorie counting ineffective over the long run for many obese patients, but it also seems to correspond with emotional and psychological distress in some people (Smith & Hawks, 2006). Authors of a review of dieting studies go as far to say that no dieting method should be suggested without thinking about the potential harms of weight cycling (Mann et al., 2007). A researcher from Ohio State

University has found that people who restrict the amount and type of food they eat subsequently increase their preoccupation with food, which can lead to binge eating and eating for reasons other than physiological hunger (Tylka, 2006). Supporters of the Health at Every Size (HAES) conceptual framework concur that weight cycling and resultant increased weight often are the results of a focus on weight. They believe in:

1. The naturally existing diversity in body shapes and sizes.
2. The ineffectiveness and dangers of dieting for weight loss.
3. The importance of relaxed eating in response to internal body cues.
4. The critical contribution of social, emotional, spiritual, and physical factors to health and happiness (Robison et al., 2007, p. 185).

Two registered dietitians and authors of a self help book on the non-dieting, intuitive eating program, describe American's obsession with dieting as contributing to the obesity epidemic and gave the following reasons why (Tribble & Resch, 2003):

1. Dieting is a form of starvation and people have evolved to store fat for survival, therefore after going on a low-calorie diet, the body will go into fat storage mode.
2. Dieting is a stressor in and of itself. This contributes to disordered eating and losing control over eating.
3. The dieting mentality is a person who judges their success or failure based on a number on a scale.

Several of the respondents in this study explained how their multiple dieting attempts had led to further weight gain, which often negatively affected their feelings of self worth.

Wing and Phelan (2005) disputed the evidence that long term weight loss and maintenance are often unsuccessful. They looked at data collected by the National

Weight Control Registry, which has over 4,000 members. Their research showed that 20% of dieters are successful in losing 10% of their body weight and maintaining the loss for 1 year.

The second theme, *Recognizing the problem is easy; finding a solution is the difficult part*, involved finding solutions to improving their health and wellness. One author who offered suggestions for obesity management reported that many primary care providers do not have the time or financial resources to adequately deal with obese patients (Hainer, 1999). He also remarked that healthcare providers do not have a sufficient understanding of obesity and often have a negative attitude due to repeated unsuccessful experiences with obese patients and long term weight loss.

Evans (1999) addressed the need to treat obesity as a chronic health problem in order for obese patients to receive the ongoing support that is needed to be successful with improving their health. The author acknowledges that the ultimate responsibility for weight loss lies with the patient, but negative attitudes on behalf of healthcare providers have contributed to the difficulty in managing the obese patient. Another researcher concluded that a major barrier to weight control is the inability to find a way for obese people to embrace healthy eating behaviors over the long term so that weight loss can be sustained (French et al., 1999).

Translating research findings into practice guidelines was the goal of a group of researchers from Maryland (Shay, Shobert, Seibert, & Thomas, 2009). They recommended the following steps in treating the obese patient, which included frequent contact with a healthcare provider, something several of the respondents in this study indicated would have been helpful to them:

1. Calculate the patient's daily caloric goal and ideal weight
2. Teach patients how to track caloric intake, expenditure, and body weight
3. Have patients return every 2-3 weeks for a check in
4. Develop a weight maintenance plan when goal weight is reached (pp. 200-203).

Another researcher agreed that obese people want their primary healthcare provider to assist them with their problem with obesity, but they felt overall lifestyle changes were more important than just a weight loss focus (Thomas et al., 2008).

The findings from Robison et al. (2007) are consistent with the findings from this study, where the obese women interviewed expressed repeatedly a desire for others to empathize with their plight. Prejudices against obese individuals are very real and present in the United States, where thinness is the cultural expectation. The author referenced the term weightism, which is a form of prejudice defined as "visible cues, defines a large group of individuals within a narrow range of negative characteristics and behaviors, elevated the status of one group of individuals at the expense of another, and serves as a vehicle for bigots' anxieties, frustrations and resentments" (Robison et al., 2007, p. 186).

Tribole and Resch (2003) describe the need for a different approach to the obesity epidemic. They developed a non-dieting solution that has three central concepts: (a) unconditional permission to eat when hungry, (b) eat to satisfy physical hunger, and (c) rely on satiety cues to guide how much to eat. Four of the six respondents had never heard of this non-dieting concept, and none of them had ever been offered a non-dieting solution to assist with weight loss and improved wellness.

The third theme, *The great dieting barriers: Stress and emotions*, highlighted the impact that stress and emotions had on the obese respondents. Torres and Nowson (2007) also looked at the relationship between eating behaviors, stress, and obesity and supported this concept that stress is a factor in the development of obesity. Cortisol hormones, which are released during hyper activation of the hypothalamic-pituitary-adrenal (HPA) axis, were found to prompt an increased appetite during periods of chronic stress. Findings from one large cross-sectional study by Ng and Jeffrey (2003) found that foods with a higher fat content were also preferred when participants were stressed. Another researcher (Mehlum, 1999) suggested that women may be more likely to turn to food to deal with stress.

Dealing with individual stressors and weight was emphasized in a review paper written by a dietician who cited the Cochrane Database of Systematic Reviews' conclusion "...that people who are overweight or obese would benefit from behavioral and cognitive-behavioral-based strategies to promote weight loss, especially when combined with diet and exercise interventions" (King, 2007, p. 278). Two professors from the Department of Health, Physical Education, and Recreation at Utah State University examined the non-dieting, intuitive eating paradigm, which emphasizes the importance of understanding why people eat for non-physiological reasons (Gast & Hawks, 2000). They agreed that environmental, social, and emotional reasons, such as boredom or anxiety, contribute to eating for reasons other than physiological hunger. Another article on intuitive eating by a doctor of public health reported that people who diet chronically often experience stress due to "feeling of shame and guilt that arise when they are unable to sustain dieting or weight loss" (Outland, 2010, p. 38). In summary, the intuitive eating authors agree that food is not going to fix problems with

boredom, anxiety, loneliness, or other emotions. Food consumption only distracts a person from acknowledging their discomfort and can “even numb you into a food hangover” (Tribole & Resch, 2003, p. 146). This study’s respondents who associated food as their friend and source of relief during times of stress supported this concept.

Roth (2010) wrote that the path to ending the battle with food and overeating is to explore the reasons people have an obsessive relationship with food. She referred to her own discovery that led her to improved health when she, “...stopped fighting with myself, stopped blaming myself, my mother, my latest boyfriend for my weight. And since diets were my most flagrant attempts at fixing myself, I stopped them as well” (p. 28). In this study, Ellen and Ida both sought counseling to help them deal with many of their emotional issues and stressors in order to regain a healthier relationship with food.

Another self help book for women addressed the impact of “stuffing down feelings” in relation to obesity (Johnston, 1996, p. 56). The author stresses the importance of living a life of joy instead of a life focused on food. All of the respondents in this study reported a lengthy history of dieting which went hand in hand with a preoccupation with food.

The fourth theme, *Exercise is a four-letter word*, concerns the difficulties the obese respondents had with incorporating exercise into their lives. The results of one qualitative study indicated that the majority of participants did not engage in physical activity during their weight loss attempts (Thomas et al., 2008). The reasons given included: difficulty due to weight and health problems, inability to afford gym memberships or trainers, and lack of time or feeling embarrassed or uncomfortable in group exercise activities. Shields (2009) reported that the average American watches television for 4 hours a day, increasing exposure to advertising for high fat and calorie

dense foods. In addition, she added that fewer people are relying on public transit, bicycles, or walking for transportation.

The current recommendation by healthcare providers is that healthy adults should participate in a medium intensity physical activity most days of the week for at least 30 minutes (Shay et al., 2009). In the obese patient, the recommendation increases to 60 minutes per day in order to facilitate weight loss. Shay et al. (2009) stressed the importance of setting realistic goals in the obese patient. Results from another study, which looked at higher physical activity in overweight men and women, concluded that exercise does assist in long term weight loss more effectively than the standard recommendations (Jeffery, Wing, Sherwood, & Tate, 2003). However, the researchers noted larger number of injuries in the high physical activity group, as well as a tapering effect on weight loss maintenance over time.

According to the intuitive eating authors, Tribole and Resch (2003), the problem with dieting and exercising at the same time is that with decreased caloric intake there is not an adequate energy supply for obese people to feel enthusiastic about exercise. This often leads to a negative association with exercise and subsequent return to inactivity. They encourage people to delay exercising until they feel ready, which is consistent with what Carol from the present study said during her interview. They also offered the following suggestions: (a) people should choose activities that are enjoyable to them, (b) make exercise a priority, and (c) Include strength training, since people who have dieted frequently have probably lost a lot of muscle mass.

**Chapter Summary**

There were multiple studies and other support from the self-help literature which uphold the respondents' themes of repeated, failed dieting attempts and the problematic relationship between stress, emotions, and food. Much of the health research literature continues to focus on dieting and exercise as mainstream solutions to the obesity epidemic. There is, however, more and more emerging literature that suggests a paradigm shift in developing an effective approach to obesity management; that being, the non-dieting approaches to health and wellness, such as Health at Every Size and Intuitive Eating. These other approaches are needed and offer more hope for long term solutions to addressing the obesity epidemic.

## Chapter V

### Summary, Conclusions, and Recommendations

A comprehensive literature review revealed a gap in research regarding qualitative studies of dieting experiences in adult obese women. This study was done in order to gain a greater understanding of dieting experiences and the impact dieting has on the physical, emotional, psychological, social, and spiritual aspects of the obese woman. An increased understanding of dieting experiences was essential in recommending future strategies for obesity management.

#### Summary of Study and Findings

A qualitative study with a phenomenological perspective was conducted in order to capture a greater understanding of the experience of dieting in obese adult women. The final sample consisted of five women who had undergone bariatric surgery and responded to a flyer, and one woman who was identified through snowball sampling. The respondents completed a demographic questionnaire and informed consent before participating in in-depth, audio-taped interviews. The interview data was transcribed verbatim and analyzed utilizing Speigelberg's (1965) three-step process of 1) Intuiting, 2) Analyzing, and 3) Describing, as well as Colaizzi's (1978) phenomenological method. There were four themes which emerged after analysis: *If at first you don't succeed, try, try and fail again; Recognizing the problem is easy; Finding a solution is difficult; The great dieting barriers: Stress and emotions; and Exercise is a four-letter word.*

## Conclusions

The researcher concluded that dieting had a negative impact on the obese respondents' emotional state and physical health, and did not result in long-term weight loss maintenance. The Neuman Systems Model (Neuman & Fawcett, 2002) was relevant in examining the issue of obesity in adult women because it examines the total person and the impact of stress on the human condition. The respondents attributed their failure of dieting attempts to physical variables, such as genetics and difficulty with movement. They emphasized the role that psychosocial and emotional stressors played in the development of their obesity, often at a young age. Frequently, food was used as a line of defense in dealing with stress and emotion. Neuman and Fawcett (2002) believed that environmental stressors can alter a normal line of defense with resultant negative outcomes. She also believed that nurses need to assist clients with making adjustments in order to regain system stability. The respondents had all experienced a lack of support at times from their healthcare providers. To deal with the multi-factorial causes of obesity a holistic approach, such as the Neuman Systems Model (Neuman & Fawcett, 2002), is needed in order to assist the obese woman to attain greater health and wellness.

Five of the six respondents ended up having bariatric surgery after years of failed dieting attempts. These women praised the team approach at the bariatric center pre- and post-operatively, and all reported successful weight loss and weight loss maintenance after surgery. They did emphasize the gravity of the decision to have surgery, due to the high cost and incidence of post-operative complications. They all agreed that obesity prevention in children should be a top healthcare priority and described bariatric surgery as an effective, but last resort.

### **Implications for Practice and Education**

Dieting can have multiple negative effects on the physical, psychological, and emotional well being of obese women. There is little empirical evidence demonstrating its usefulness in long term weight loss and weight loss maintenance. Future educational efforts need to address the multi-factorial causes of obesity, as well as the imperative to implement weight loss interventions with caution. Understanding the limitations of dieting for this population will assist the APNP with development of sensitive, individualized, holistic, and multidisciplinary approaches. A shift in focus from a rigid number on a scale, or x numbers of hours of physical activity, to improved health parameters, such as blood pressure, glucose control, healthy lipid profiles, improved mental health, and positive coping mechanisms, can help obese people develop a healthy relationship with food and an increased enjoyment of activity.

### **Recommendations for Further Research**

Based on the results of this study, future research should focus on non-dieting strategies, which emphasize the development of a healthy relationship with food, such as intuitive eating. Other research should address the efficacy of obesity management centers and the impact a multidisciplinary approach can have on the obese patient.

### **Chapter Summary**

Obesity has become a global epidemic. Current strategies for managing this problem have not proven to be effective in the long term. A gap in qualitative research regarding dieting and obesity management in adult women was the impetus for this

study. The Neuman Systems Model (Neuman & Fawcett, 2002) provided the theoretical framework. Interviews with six respondents were analyzed repeatedly until four main themes emerged. Multiple, failed dieting attempts, stress, emotions, genetics, difficulty with exercise, and lack of support from healthcare workers were all implicated in the obese respondents' development of obesity. Five of the respondents ended up choosing bariatric surgery as a weight loss solution; however, this resulted in a high financial cost, as well as multiple post-operative complications.

The main implication for advanced nursing practice is understanding the limitations of dieting in many obese adult women. Additionally, grasping the need for further exploration of approaches to obesity management is imperative in addressing the escalating incidence of this phenomenon. The main implication for nursing education is emphasis of the multi-factorial causes of obesity and the need to implement weight loss interventions with sensitivity.

Recommendations for further research include exploring non-dieting strategies, as well as the efficacy of obesity management centers. The time is now to shift focus from weight outcomes to a focus on health outcomes, utilizing the holistic approach that advanced practice nurses embrace.

APPENDIX A  
DEMOGRAPHIC QUESTIONNAIRE

## DEMOGRAPHIC QUESTIONNAIRE

This questionnaire will provide important information about your background. Please fill in the blank or mark an x by the appropriate answer after reading each question carefully. If none of the answers seem exactly right, please choose the closest appropriate response.

1. What is your age? \_\_\_\_\_
2. What is your race/ethnicity?  
\_\_\_\_\_ Caucasian/Non-Hispanic  
\_\_\_\_\_ African American  
\_\_\_\_\_ Hispanic  
\_\_\_\_\_ Asian American  
\_\_\_\_\_ American Indian  
\_\_\_\_\_ Other
3. What is the highest level of school you have completed?  
\_\_\_\_\_ Grade school or less  
\_\_\_\_\_ Some High School, no graduation  
\_\_\_\_\_ High School Graduate  
\_\_\_\_\_ Technical School after High School  
\_\_\_\_\_ Some College  
\_\_\_\_\_ College Graduate  
\_\_\_\_\_ Post Graduate
4. Are you married? \_\_\_\_\_, Widowed? \_\_\_\_\_, Separated? \_\_\_\_\_, Divorced? \_\_\_\_\_  
Never married? \_\_\_\_\_

5. What is your occupation?

\_\_\_\_\_

6. Have you ever tried any of these weight loss methods before? (Mark all that apply)

\_\_\_\_\_ Weight Watchers, Jenny Craig, NutriSystem, or other similar  
program

\_\_\_\_\_ Stimulant medications or diet supplements

\_\_\_\_\_ Surgical Interventions (gastric bypass or banding)

\_\_\_\_\_ Other dieting methods

8. Have you been able to maintain weight loss for more than two years with  
dieting? \_\_\_\_\_ Yes \_\_\_\_\_ No

9. In order to calculate your Body Mass Index, please fill in your height and weight  
(all information is strictly confidential):

\_\_\_\_\_ Weight in pounds

\_\_\_\_\_ Height in inches

10. Have you ever heard of non-dieting weight loss programs?

\_\_\_\_\_ Yes \_\_\_\_\_ No

APPENDIX B  
INFORMED CONSENT

## INFORMED CONSENT

I am a graduate nursing student at the University of Wisconsin- Oshkosh. I am conducting a study to learn more about obese adult women's experiences with dieting. I would appreciate your participation in this study.

I hope to utilize the results of this study to increase the clinical knowledge base of primary care practitioners regarding obese women and their experiences with dieting. As a participant in this study, you will first be asked to complete a demographic questionnaire. You will then be asked to participate in a face-to-face audio-taped interview. I will place a follow-up phone call to you within 48 hours of the interview to address any concerns or questions you might have. If you experience any emotional distress after the interview process, you can contact a crisis intervention hotline at 1-800-359-0056.

All of the data gathered will be confidential. I will not put any identifying information on your paperwork, nor will I record any identifying information during the interview. The total amount of time to complete the demographic questionnaire and the interview should not exceed one hour. The demographic questionnaire and audiotapes will be kept locked and only accessible to the researcher.

The risks to you as a participant include a time commitment to fill out the questionnaire and answer interview questions, in addition to possible emotional distress during the interview. Participation in the study may not benefit you directly but may benefit others who are coping with dieting and weight issues. Your

participation in this study is completely voluntary. You may withdraw from this study at any time.

Once the study is completed, I would be happy to share the results with you.

Please let me know during the interview and I will make sure to mail the results to you. If you have any questions or concerns, please contact me directly:

Patti Depies, RN, BSN, FNP Graduate Nursing Student, UW-Oshkosh

920-559-7966

depiep69@uwosh.edu

If you have any concerns about your treatment during your participation in this study, please call or write:

Chair, IRB

C/o Grants Office @ UWOSH

Oshkosh, WI 54901

920-424-1415

I have received an explanation of the study and agree to participate. I understand my participation in this study is voluntary.

Name \_\_\_\_\_

Date \_\_\_\_\_

I consent to be audio taped:

Name \_\_\_\_\_

Date \_\_\_\_\_

APPENDIX C  
SEMI-STRUCTURED INTERVIEW QUESTIONS

1. What has been your experience with dieting?
2. What did you feel were positive aspects of the dieting programs?
3. What did you perceive to be barriers to long term weight loss maintenance with the dieting programs?
4. What would be helpful to you now in dealing with your obesity?
5. What role do healthcare providers have in assisting obese patients with problems of obesity?
6. What role does your lifestyle play in regards to your eating and exercise habits?
7. What triggers you to eat, other than feelings of hunger?
8. What eating habits have contributed to your obesity?
9. How have your eating habits and/or exercise habits changed over your lifetime? What are the reasons for those changes?

APPENDIX D  
STUDY FLYER

## **PARTICIPANTS NEEDED FOR STUDY**



- ❖ **Are you an adult female and considered to be obese?**
- ❖ **Have you tried dieting to lose weight?**
- ❖ **Would you be willing to discuss your experiences with dieting with a graduate nursing student who is working on a research project for her master's program?**

If you answered yes to the above questions, I would love to hear from you! I would need 30-60 minutes of your time, and by sharing your experiences, you could be helping future family practice providers do a better job of assisting obese patients achieve improved health and wellness.

- ❖ **If interested, please call Patti Depies, Family Nurse Practitioner Graduate Student, UW-Oshkosh @ 920-559-7966 or e-mail [depiep69@uwosh.edu](mailto:depiep69@uwosh.edu)**

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